A STUDY OF DETERMINANTS OF MODERN FAMILY PLANNING USE AND NON-USE IN UGANDA

A CASE OF EIGHT UNFPA SUPPORTED DISTRICTS

September 2012

Reproductive Health Uganda

ACKNOWLEDGEMENT

The study of family planning use and non-use in Uganda was commissioned by Reproductive Health Uganda (RHU) and implemented by Focus Development Associates (FDA). UNFPA provided all the required funds for the study and RHU provided technical support. FDA is most grateful to both UNFPA and RHU for the support and facilitation provided that enabled the successful implementation of the survey.

Before the report was finalized, it was presented to and reviewed by officials from RHU, Population Secretariat and UNFPA. In addition, the draft report was reviewed by a special Technical Review Team appointed by RHU. Arising from the above reviews were some invaluable comments and input that led to the finalization of the final report. Focus Development Associates is highly indebted to RHU and UNFPA for this contribution.

The FDA team consisted of Dr. Alex Opio, Michael Muyonga, Noordin Mulumba.

Dr. Herbert Kadama and Patrick Nsamba Oshabe. The contributions of each of these consultants are highly appreciated.

The study participants were drawn from the eight districts where the study was conducted. Focus Development Associates is highly indebted to all the study participants. Without their participation, it would not have been possible to successfully conduct the survey.

The study also involved key informant's interviews drawn from the participating districts, national programmes and funding agencies. The Consultants are most grateful for the input of all the key informants.

TABLE OF CONTENT

TABLE OF FIGURES

ACRONYMS AND ABBREVIATIONS

AIDS	-	Acquired Immune deficiency Virus
ANC	-	Antenatal Care Clinic
BCC	-	Behavioral Change Communication
BP	-	Blood Pressure
CDFU	-	Community Development Fund Uganda
CMD	-	Community Drug Distributors
CSO	-	Civil society organization
DHO	-	District Health Officer
EAs	-	Enumeration Areas
EPI	-	Expanded Programme for Immunization
FGD	-	Focus Group Discussion
FP	-	Family Planning
HIV	-	Human Immune Deficiency Virus
HSSP	-	Health Sector Strategic Plan
IEC	-	Information Education Communication
IUD	-	Intra Uterine Device
KI	-	Key Informants
LAM	-	Lactational Amenorrhea
LC	-	Local Councils
MDGs	-	Millennium Development Goals
MHCP	-	Minimum Health Care Package
MMR	-	Maternal Mortality Ratio
MOH	-	Ministry of Health
NGO	-	Non-governmental organization
RHU	-	Reproductive Health Uganda
SC	-	Sub County
UBOS	-	Uganda Bureau of Statistics
UDHS	-	Uganda Demographic Health Survey
UGX	-	Uganda Shillings

UNFPA	-	United Nations Population Fund
HC	-	Health Centre
UNICEF	-	United Nations Children Fund
UPE	-	Universal Primary Education
USE	-	Universal Secondary Education
VCT	-	Voluntary Counseling and Testing
VHT	-	Village Health team
WHO	-	World Health Organization

GLOSSARY OF TERMS

Contraceptive prevalence rate: Is the percentage of women between 15-49 years who are practicing or whose sexual partners are practicing any form of contraception.

Discontinuers: Individuals who have ever used a family planning method before but are currently not using one.

Emergency contraception: Contraceptive methods used to prevent pregnancy after unprotected sex

Ethnographic study: Is a qualitative method aimed to learn and understand cultural phenomena which reflect the knowledge and system of meanings guiding the life of a cultural group.

Family Planning; The right of an individual to receive adequate information about the method of family planning of their choice and to determine responsibly and freely the number and spacing of their children

Fertility rate; Is the average number of children that would be born to a woman over her life time

Modern contraception: Intentional prevention of conception or impregnation through the use of various devices, agents, drugs, sexual practices, or surgical procedures that have been proved to be scientifically effective.

Natural family Planning: A general term that applies to various methods that have been developed to help women and men determine the fertile and infertile times of a woman's menstrual (monthly) cycle. These methods can be used to achieve or avoid pregnancy:

Non Users: Individuals who have never used any family planning method in their life

Reproductive age: Refers to women aged 15-49 years

Unmet need: Percentage of women in reproductive age who are fecund and sexually active who report not using any contraceptive method, yet they do not want any more children or want to delay the birth of their next child

Users; Individuals who are currently using a family planning method

EXECUTIVE SUMMARY

Background and survey methods

The main aim of the study is to establish the determinants of continued use or non-use of modern family planning methods. To achieve the study objectives, primary and secondary data were collected using a combination of quantitative and qualitative research methods; including structured questionnaires interviews, key informant interviews, focus group discussions and client exit interviews at family planning clinics. Desk review of key relevant documents on family planning was also conducted.

The questionnaires interviews covered a statistically representative sample of 658 respondents drawn from the 8 study districts. The individuals were drawn from 26 clusters and 310 households. Information collected by this method included demographic characteristics, knowledge on contraception methods, attitudes on contraception methods, provision of information on contraception methods, source of contraception methods, outcomes of FP use, determinants of use or non-use of contraception methods, as well as general information on reproductive/sexual health, marriage and sexual activity. Before the main fieldwork, the questionnaires were pretested in 3 enumeration areas in Kampala. All aspects of the survey data collection were pretested.

To supplement information from the structured questionnaires, focus group discussions were conducted in all the study districts. Key informant's interviews were also conducted at central and district levels. In addition, client's exit interviews were conducted at both private and Government family planning service delivery points.

In general, the survey participants were women and men aged 15-49 years; and who were resident in the selected households the night before the interview day. Respondents consented to the survey. Fieldworkers were trained before the fieldwork. The training programme covered various aspects of the study including interviewing, conducting focus group discussions and in-depth-interviews. Social mobilization was done in the study districts ahead of the survey. Quantitative data was entered using Epiinfo software package following double data entry technique. Data cleaning was done before analysis commenced. Quantitative data analysis was done guided by the analysis plan. Qualitative data analysis was done based on thematic areas and followed transcription of the responses from the field.

Findings

Response rate; Overall, the household and individual response rate is high, 99 and 95 percent, respectively. A total of 658 respondents were interviewed during the household questionnaires interviews. Most of the respondents are young; about 72 percent of them are age less than 35 years.

Family planning awareness; Radio is the single most common source of FP messages cited by both men and women. Of men and women who had heard of a family planning method, 73 and 78 percent said it is from radios, respectively.

Newspapers/magazines are the second most common source of FP messages. Awareness of a contraceptive method is almost universal in the surveyed districts. Ninety eight percent of all the respondents have ever heard of a contraceptive method; the most commonly heard of method is male condom (92 percent) followed by pill/injectable method (87 percent).

Use of family planning; About twenty seven percent of women age 15-49 years is currently using some method of contraception; 26.5 percent are using modern methods and 0.4 percent are using traditional methods. Approximately 23 percent of all women and 27 percent of women who are currently married are using some method of contraception. Virtually all women are using modern contraception methods with injectable method being the most popular one across all age groups except for the 15-19 and 45-49 age groups. Most of the clients get their modern contraception methods from two main sources, all of which are Government facilities (40 percent from hospitals and 40 percent from health centres). Since Reproductive Health Uganda works through strengthening Government clinics, RHU Health Centres/Clinics were not cited as sources for any modern methods of contraception.

Among respondents who have ever had sex, 44 percent said that they have ever used a family planning method. Of these, 25 percent reported changing a method. Injectables and implants are the two most consistently used methods of contraception. Twenty three percent of men and 27 percent of women said that the fertile period is halfway between two periods, meaning, most clients are not competent to use this method.

Thirty five percent of women who are currently pregnant or got pregnant sometime back said that their current pregnancy or their last birth (for non pregnant women) was mistimed/unwanted. The proportion of women who are currently using a family planning method who say that the last time they became pregnant they wanted to become pregnant then is 15 percent. Fifty five percent of all women and 52 percent of currently married women said that they intend to use a family planning method in the future.

Perceptions and misconceptions

The common misconceptions included the following**:** Women using contraceptives regarded as prostitutes, FP a women business, a mode of murder of the unborn, Contraceptives leading to delivery of children with deformities, disappearance of the IUD in the body leading to death, accumulation of contraceptives in the abdomen and need for blood tests before an FP method is used.

Determinants of use and nonuse

The determinants of modern family planning use identified in the survey include; level of education, religion, mobility, period of stay in the area (for immigrants), distance to former place of residence, place of residence, knowledge of source of FP methods, exposure to media messages on FP, needs and demand for FP services, preference of number of children and agreement of partner to use FP methods. The other individual

factors which show a relationship with use include peer pressure, support by the spouse and holding of misconceptions on family planning. At community level, availability of friendly services at affordable cost ,easy service access, opposition from cultural leaders and other significant others influenced use and none use of modern contraceptives.

Specifically 22% of the respondents cited need for more children followed by 12.2% who cited fear of side effects as the reasons for not using any methods. The other key reasons extended included: Having no knowledge of FP method (9.4%), culture (8.5%) and opposition by partner (7.9%).

Maintenance and change of methods

Among the sexually active women who had ever used any modern contraceptive method, it was noted that 31% had changed a family planning method while 69% reported to have maintained the same method

The analysis revealed that four factors determined change/maintenance of FP method used, these were; mobility, period stayed in area, distance to former place of residence and getting discouragement from partner. Convenience and less side effects were additional factors for maintenance of a method.

Discontinuation of use of family planning methods

Thirty six percent of the women users reported to have discontinued using a family planning method. The reasons for discontinuation included desire to become pregnant/have more children, fertility related reasons, side effects/health reason, preferred method not available and partner objection, as well as method being perceived to be against religion/culture.

Conclusion

Use of contraceptive methods is low in the surveyed population; about one quarter of the respondents reported using a family planning method. Various factors have been identified to be responsible for either use or non-use of family planning methods. Based on the findings, the following recommendations have been made:

Tailored information-education-communication and advocacy interventions should be designed and implemented targeting the key barriers to modern contraceptive use. These interventions should especially address the established cultural norms. Furthermore, educational campaigns need to be organized to address misconceptions about family planning.

Promote community dialogues in communities where there is a strong culture opposed to modern contraception. Community dialogue and discussions are critical in enhancing the positive values related to family planning. The dialogue should be facilitated by trained local volunteers.

Male involvement in FP should be promoted through initiatives that are designed to target men/husbands; ultimately, this is expected to bring about change in the perceptions about family planning.

To reduce gender inequality related factors that lead to non-use of FP services, empower women through skills building, income generation activities and girl child education. Furthermore, FP implementers need to advocate for district level involvement to pass bylaws, policies and campaigns that encourage young girls to continue schooling because findings suggest that higher educational attainment has a positive effect on the use of modern methods.

To address FP service access-related issues, expand family planning service outlets through outreach services. Village Health Teams should be empowered through training to provide the services. In addition, there is need for training and equipping of health workers in private facilities especially on insertion of implants and IUD.

Develop Partnership with Religious and Cultural Groups. Establish and implement programmes that target the involvement of these leaders in family planning. These leaders should be engaged through dialogue on population and the economy as a buy-in-process so as to create strong partnerships that can facilitate advocacy for and promotion of contraceptive use.

Chapter One

1.0: Background to the Study

In 2000, 189 Heads of Nations endorsed the Millennium Declaration and eight Millennium Development Goals (MDGs). The declaration consists of a package of actions that needed to be jointly taken by the Member States in order to address some critical areas of concern. Prominent among the critical areas of concern is the need to improve maternal health (Blanchfield et al 2010).

In order to measure progress towards the attainment of the MDGs, a number of targets for 2015 with 1990 as baseline were set. Specifically, for MDG 5: improve maternal health, the Member States set Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and Target 5.B. Achieve, by 2015, universal access to reproductive health.

Family Planning is the right of an individual to receive adequate information about the method of contraception of their choice and to determine responsibly and freely the number and spacing of their children. It can also be simply referred to as having children by choice and not by chance.

Half of the world's population is in or entering the child bearing years, therefore this calls for increase in use of family planning especially in countries with rapidly growing population and high fertility rates like Uganda (World Bank 2007)

Uganda's population is one of the fastest growing in the world. With an annual growth rate of 3.2%, the population is expected to double within the next 20 years. Fertility in Uganda is high and at current fertility levels, a Ugandan woman will have an average of 6.7 children in her lifetime. This persistently high fertility is contributing to the high maternal mortality and morbidity (UDHS 2006, Nalwadda 2005). High fertility and high maternal morbidity and mortality negatively affects individuals, families, communities and deters economic development (Cleland J 2006). The use of family planning have the potential to avert unplanned births, decrease maternal morbidity and mortality, increase welfare and protect future generations (Cleland J 2006).

Despite Uganda's liberal family planning policy, which states that all sexually active men and women should have access to contraceptives without need for consent from partner or parent, contraceptive use remains low, one of the lowest in the world. However what is surprising is that knowledge about contraceptives is almost universal; Ninety-seven percent of married women and 99% of married men know at least one method of family planning. Over 90% of both women and men know about pills, Injectable contraceptives, and condoms.

Although the use of modern contraception among married women in Uganda has more than doubled, from 7.8% in 1995 to 18% in 2006, the level of unmet need for family planning has continued to increase steadily. The contraceptive prevalence rate (any method) among all women aged 15 -49 increased from 15% in 1995 to the current level of 24%. According to the 2006 Uganda Demographic and Health Survey (UDHS), 41% of married women report that although they wish to space or limit their births, they are not currently using any form of family planning. This is the third-highest rate of unmet need for contraception in the world. Twenty-five percent of women with an unmet need for family planning would like to space births, while 16% want to limit births. The demand for family planning services continues to increase as more young people reach reproductive age. Additionally, UDHS data indicates that 65% of married women not using any contraception at the time of the survey intend to use family planning in the future.

It has been estimated that satisfying the unmet need for family planning alone could cut the number of maternal deaths by almost a third. In line with this, the United Nations Global Strategy for Women's and Children's Health was developed with the aim of preventing 33 million unwanted pregnancies between 2011 and 2015 and to save the lives of women who are at risk of dying of complications during pregnancy and childbirth, including unsafe abortion (United Nations 2011).

Quantitative demographic and facility based previous studies in Uganda and other countries have identified limited contraceptive method choice, high costs, mis-information, anti-abortion laws, constraints of women's decision-making and negative providers attitudes as barriers to fertility regulation. Further more Social, cultural, and religious values have a strong influence on reproductive choices for women in Uganda. Early and frequent childbearing and large family size reflect long-standing societal norms among most segments of the population, although they conflict with the apparent desire reported by the UDHS among individual women and men to space childbearing and to limit family size. Over 14% of married women who are not using family planning and do not intend to do so in the future say their spouse, their church, or others disapprove of contraceptive use.

Contraceptive methods offer varying levels of protection from pregnancy. The level of protection is dependent on the type and efficacy of a contraceptive method. Modern medical contraceptive methods are most effective. Less than 1 % of users of oral contraceptive, injection, implant and IUD become pregnant within the first year of perfect use; the pregnancy rate however rises to 5% for typical use of oral contraceptives to 85% of non-users (Kelly et al 1990). Efficacy of barrier methods is lower; 3% of users of male condom users, 5% of female condom users and 6% of diaphragm users becoming pregnant within the first year of perfect use compared to 14%, 21% and 20% for typical use, respectively.

In Uganda, maternal and child health is a key priority area of focus by the Ministry of Health. Under this, a number of strategies are being implemented. Among the strategies is the provision of family planning services. Improving reproductive health

of sexually active women calls for access to and appropriate use of safe and effective methods of fertility control, the primary aim of which is avoidance of unplanned pregnancy. In order to increase access to reproductive health services in Uganda, the Ministry of Health works in collaboration with partners such as UNFPA through the 7th country programme that is implemented in 8 districts of Uganda and RHU.

Despite the above interventions, Program efforts and commercial marketing strategies in Uganda, they have not yielded plausible rise in contraceptive use (Katende C 2003). Previous studies have recommended exploration of barriers to contraceptive use that would explicitly explore the factors in decision making process about use and non-use of forms of contraceptives.

In line with above, a study that explored determinants on use and non-use of modern family planning methods in eight UNFPA supported districts in Uganda was commissioned by Reproductive Health Uganda/United Nations Population Fund (RHU/UNFPA). Reproductive Health Uganda (RHU) is a national, not-for-profit, Non-Governmental Organization registered under the Trustees Incorporation Act of Uganda. It is affiliated to the International Planned Parenthood Federation (IPPF), the largest international NGO promoting and providing sexual reproductive health and rights in the world. RHU as an implementing partner for the Reproductive Health component of the 7th GOU/UNFPA Country Program in partnership with other agencies has been, and is undertaking numerous activities that promote provision of family planning services in eight focus districts of Uganda with support from the United Nations Population Fund (UNFPA).

A combination of quantitative and qualitative research methods was employed by the study. It is envisaged that this study report will inform development of culturally sensitive policies, programs and interventions to increase family planning use in the study districts in particular and Uganda in general. Many studies have been conducted on family planning (FP). This has led to wide availability of information on FP-related knowledge, attitudes and behaviors. Information is also available on the determinants of FP use or non-use. However, relatively fewer number of FP studies have dug deep into the reason behind use or non-use of modern contraceptives; hence some gaps in related information exist. Furthermore, most of the studies have used quantitative methods. Such methods have a limitation in providing deeper understanding of the reasons behind use or non-use of modern contraceptives. Therefore, this study was designed to address the gap; it has provided both quantitative and qualitative information that can facilitate deeper understanding of the determinants of FP methods.

1.1. Objectives of the study

The main aim of the study was to establish the determinants of continued use or non-use (discontinuation) of modern family planning methods.

The specific objectives of the survey were:

1. To identify the factors influencing sustained/continued use or non-use of modern FP methods among women and men at individual, community and institutional levels.
2. To establish the experiences, lessons and challenges of using modern contraceptives among current users and ever-used modern family planning method clients to determine trends and characteristics of users and non-users of modern family methods.
3. To make recommendations based on findings on possible interventions and strategies that would ensure sustained use of contraceptives.

Chapter Two

2.0: Study Methodology

2.1 Study Approach, Design and Data Collection Methods

To achieve the study objectives, primary and secondary data were collected using a combination of research methods which consisted of both quantitative and qualitative data collection methods. Specifically, the following methods were employed:

1. Desk review of documents.
2. Key informant (KI) interviews.
3. Focus Group Discussions (FGDs).
4. Structured questionnaires interviews.
5. Client Exit interviews at family planning service delivery points

The quantitative data were mainly collected through conducting interviews using the structured questionnaire. The client exit interviews also generated some quantitative data which were used to corroborate the data that were generated from the structured questionnaire. Qualitative data were gathered through Focus Group Discussions (FGDs) and Key informant (KI) interviews. Desk review of documents generated information on the existing literature about the use/non use and discontinuation rates of FP methods. In addition this method solicited information on the existing work-plans and policies related to provision of FP services by the different agents (WHO, MOH, districts, and so forth). The approach of using multiple survey methods provided the opportunity for triangulation of data from the different methods.

In both the qualitative and quantitative elements of the study, the data collection framework consisted of a set of questions which were used to elicit socio-cultural perceptions of social identity, sexual knowledge and sexual behavior, reproductive behavior and fertility decision-making, health seeking behavior and access to and quality of health services.

2.1.1 Desk Review

Desk review of key relevant documents to family planning was conducted. Among the documents reviewed are UDHS reports (Uganda Bureau of Statistics 2006, Uganda Bureau of Statistics 2011), Ministry of Health Reproductive Health policy and strategy documents, the Health Sector Strategic and Investment Plan (Ministry of Health 2010), WHO Reproductive Health Strategy and so forth. Documents that describe FP service availability and utilization, FP programme coordination; as well as institutional structures for the delivery of FP were also reviewed. Information from the

desk review has been used to complement findings from the survey as well as guide discussion and conclusion.

2.1.2 Key informant's interviews

Key informant interviews were conducted for people regarded to be having comparatively higher knowledge on issues of family planning. A selected number of Family Planning key informants were enrolled to participate in the Key informant's interviews. These participants were drawn from both private and public institutions providing family planning services. In order to get a good mix of participants, the respondents were purposively selected. The participants were drawn from the national level, the 8 study districts and community level. At the national level, participants were drawn from the organizations that are involved in FP-related service delivery, including; Ministry of Health, UNFPA, RHU, WHO, UNICEF, Uganda Muslim Medical Council and Uganda Catholic Medical Bureau. At district level the District Health Officer, District Health Visitor and Secretary for Health were interviewed.

At community level, Family planning providers, key community members and FP clients were interviewed. The FP providers were included so as to determine how providers perceived FP-related problems and how they managed them. Family planning field workers who distribute contraceptives in the communities were also interviewed to get their experience/opinion on determinants of users and non users of family planning in the communities they serve.

A total of thirty one (31)FP service providers were interviewed across all the eight districts. Twenty seven (27) community level and 23 program level KI respondents were interviewed. During the interviews, discussions were held to probe into FP service delivery, availability of and determinants of FP service use and non-use.

2.1.3; Structured Questionnaire Interviews and Sample Design

Individual survey respondents were interviewed using structured questionnaires. The questionnaires were translated into five major local languages that are spoken in the 8 districts, namely; Kiswahili, Luganda, Luo, Akarimajong and Runyankole/Rukiga. The questionnaires were back-translated into English by people other than the initial translators, in order to ensure that the questions did not lose meaning.

In order to generate an optimal sample size required for the study, a statistical formula developed by Kish and Leslie (1965)was used and the following assumptions were made:

1. The main variable of interest (p) was taken to be the "discontinuation rate" and according to UDHS (2006) p - 58% - 0.58
2. A confidence level of 95% was assumed, thus the standard normal variate takes the value of 1.96 (two tailed)

3. A cluster design effect (DE) of factor 2 was assumed (standard figure if DE data are not available).
4. The response rate was estimated at 93.8%, UDHS (2006)
5. An average of 1 female and 1 male aged 15-49 years per household was assumed.
6. Standard error was estimated at 5% of main variable (p)

$$n = \frac{Z_{\alpha}^2 pq}{\ell^2} \times DE$$

Where $Z_{\alpha} = 1.96$ at 95% confidence level (assumption 2),

p - 0.58 (that is 58% from assumption 1); *q* - 1-*p* - 1-058 -0. 42,

λ=The permissible error - z_{α} xSE - 1.96x5%x0.58 - 0.05684 ≈ 5.7%

DE - 2

After factoring in the above assumptions, the formula yielded an optimal sample size of 620 respondents.

The sampling design employed multistage cluster sampling techniques, in which case the primary sampling units (PSUs) were clusters and the secondary sampling units (SSUs) were households. A cluster was equivalent to an enumeration area (EA)/village as defined by Uganda Bureau of Statistics (UBOS). The sampling procedure was designed to select the 620 individuals from 310 households since an average of 2 persons aged 15-49 years was expected per household. The 310 households were selected from 26 clusters by selecting 12 households from each of the clusters. The two figures 26 and 12 above were determined on the principle that in cluster sampling it is more efficient to have a larger number of smaller clusters than to have a smaller number of large clusters. In other words if a few big clusters were selected it would lead to higher intra cluster correlation (since there is a high likelihood for neighboring units to be positively correlated) and this would yield poor estimates. The solution to this would be to have as many small clusters as possible but caution had to be taken because the bigger the number of clusters the higher the costs. An equilibrium level therefore had to be sought of not having too few clusters and at the same time not having too many clusters; and the optimum position taken was to have 26 clusters of size 12 each. The 26 clusters were selected from a list of clusters in the study area (all the clusters in the 8 districts taken as a pool), using systematic sampling. The use of systematic sampling involved computation of a sampling interval from the cumulative total number of households, and this enabled a cluster with more number of households to have a higher probability of being included in the sample, thereby making the sample more representative of the target population

In each of the selected clusters, twelve (12) households were selected by simple random sampling (SRS) from a full list of all households of that cluster. SRS was employed in order to preserve the statistical efficiency of the sample. Institutional households such as hotels, dormitories, military barracks and so on, were excluded since such units have transit populations and would bias results of the host community. All men and women aged between 15-49 years who are usual residents of the sampled households were recruited for the study. In case of visitors that were found in the selected households, the survey recruited all persons in the same age range who had spent a previous night on the day the survey team visited that household the first time during the survey. There was no sampling within the selected households; all eligible respondents in the household were given an opportunity to participate in the survey.

The age group 15-49 years was chosen on account that it is internationally believed to cover most women of reproductive age and most sexually active men. The adoption of this age group will allow comparison of the results of this study with those of similar studies that have been conducted in Uganda and in other parts of the world. Although the focus of this study was on women, men also play an important role in the realization of reproductive health goals; thus both males and females were considered for this study. Men's knowledge and attitudes on use of contraceptives were assessed since this has a big bearing on the influence men can cause to women's use of contraceptives.

Based on the structured questionnaires, the survey generated quantitative information in the following areas:

- Demographic characteristics (Age, sex, ethnic background, educational attainment, marital status, for the married whether staying together with spouse and occupation)
- Knowledge on contraception methods
- Attitudes on contraception methods
- Provision of information on contraception methods
- Source of contraception methods
- Outcomes of FP use (Acceptors of contraception methods and Discontinuers of contraception methods)
- Determinants or factors contributing to use or non-use of contraception methods, including reasons for continuing use and non-use of contraception methods
- Information on general reproductive and sexual health, marriage and sexual activity

Before the main fieldwork, the questionnaires were pretested in 3 enumeration areas in Kampala. All aspects of the survey data collection tools were pretested. After the

pretest, appropriate adjustment to the questionnaires was made taking into consideration fieldwork and translation related issues which had been identified.

2.1.4 Focus Group Discussions (FGDs)

To supplement information from the structured questionnaires, FGDs were conducted in all the study districts. The interviews were guided by topic guides. A total of 33 FGDs were performed in all the eight districts (refer to table 2.1). Each of the FGDs consisted of 8 to 10 members who were purposively selected. The FGD interview sessions were moderated by trained research assistants. In principle, the categories of FGD respondents included Female FP users, FP non-users, FP clients who have discontinued contraception methods and adolescents aged 15-18 years.

Table 2.1 presents a summary of sources of qualitative data. As shown, 23 participants from district level, 31 from facility level and 27 from community level provided information during the KI interviews;. In the case of FGDs, a total of 33 focus group discussions were conducted.

Table 2.1; Number of Interviews by Method of Data Source and District

	District Level Key informants	Facility Service Provider KI	Community Provider KI	Focus Group Discussions
National Level	04	00	00	00
Kaabong	02	03	02	02
Kotido	02	04	02	03
Moroto	02	04	02	04
Katakwi	02	04	02	05
Oyam	03	03	03	04
Yumbe	02	05	04	06
Mubende	03	04	06	05
Kanungu	03	04	06	05
Total	**23**	**31**	**27**	**33**

2.1.5 Client's exit interviews at family planning service delivery points

Interviews were conducted by a group of trained research assistants and supervisors in a selected number of FP clinics which are representative of the FP clinics of the study districts. This was done because knowledge and opinion of the clients of FP services is very important. Based on the interviews, the survey generated additional information of FP determinants. In order to complement the findings from the questionnaires interviews, a number of exit interviews (EIs) were conducted.

Respondents were female clients exiting from FP clinics in the districts where the survey was conducted. Both government and private health units were enrolled into the study. In total, 82 female respondents were interviewed. Sample size determination in this survey was done following the recommended principles in literature (Boyce et al 2006). Literature indicates that the general rule on sample size for interviews is that when the same stories, themes, issues, and topics are emerging from the interviewees, then a sufficient sample size has been reached. Secondly, Williams wrote in his paper entitled "Measuring family planning service quality through client satisfaction exit interviews" that a sample size of about 100 is recommended for most interviews.

When reviewing the findings from this survey component, it should be noted that when in-depth interviews are conducted, generalizations about the results are usually not able to be made because small samples are chosen and random sampling methods are not used. In-depth interviews however, provide valuable information for programs, particularly when supplementing other methods of data collection. In this survey, the EIs complemented the findings from the questionnaires interviews.

The table below summarizes how the methods discussed above were used to answer the research questions.

Table 2.2: Methods Used per Research Question

Proposed Method	Target Sub Population	Data/Information collected	Description of how methodology was used
Research Question1: What are the factors influencing sustained/continued use or non-use of modern FP methods among women and men at individual, community and institutional levels?			
Structured questionnaire interviews	Women and men aged 15-49 years in the 8 study districts.	Individual level data on stained knowledge, use or non-use of FP methods. This constituted the main quantitative data for the survey	Used a structured questionnaire to interview a selected sample of respondents.
Desk review of documents	Institutions that are responsible for delivering FP services and organizations responsible for collection of data on reproductive health;	Institutional level Information on use/non use, availability and utilization of FP services as well as institutional	Review of documents like Reproductive Health policy and strategy documents, the Health Sector Strategic and

Proposed Method	Target Sub Population	Data/Information collected	Description of how methodology was used
	MOH, WHO, UBOS, etc	structures for the delivery of FP services	Investment Plan (MOH 2010), UDHS reports, WHO Reproductive Health Strategy, etc
Focus Group Discussions	Female FP users, FP non-users, FP clients who have discontinued using contraception methods and adolescents aged 15-18 years	Qualitative data at community level to explain factors for sustained use or non use of FP methods	FGDs were conducted in all the 8 study districts by use of topic guides. The FGD interview sessions were moderated by trained research assistants.
Key Informant Interviews	People regarded to be having comparatively higher knowledge on issues of family planning, at national, district, and community levels.	Institutional level qualitative data on policies and determinants of use or non use of FP services. Community based information on the Key informants' experience/opinion on determinants of use and non use of FP in the communities they serve, how the providers perceived FP-related problems and how they managed them.	Used a KI guide to interview selected key informants at national, district, and community levels. Also interviewed KIs identified in private and public institutions which provide family planning services
Research Question 2: What are the experiences, lessons and challenges of using modern contraceptives among current users and ever-used modern FP method clients			
Structured questionnaire interviews	Women and men aged 15-49 years in the 8 study districts.	Quantitative data generated from Individuals giving their experiences, lessons and	Used a structured questionnaire to identify individuals currently using and those that have ever

Proposed Method	Target Sub Population	Data/Information collected	Description of how methodology was used
		challenges of using modern contraceptives	used modern FP methods; then specific questions were asked to find out the individuals experiences and challenges in use of the FP methods.
Client's exit interviews	FP clients at FP service delivery points in the 8 study districts	Quantitative data on opinion of the FP clients on the quality of services provided, determinants of use of FP methods and discontinuation of specific methods	Interviews were conducted using Client exit data collection tool on the clients exiting a selected group of FP service delivery points scattered in all the 8 study districts

2.2 : Study Areas

Respondents were drawn from the following 8 districts; Kanungu, Mubende, Yumbe, Oyam, Katakwi, Moroto, Kaabong and Kotido (See Figure 1). These are districts where Reproductive Health Uganda (RHU) UNFPA supported Project operates.

Briefs of the Study Districts

Moroto District

Moroto District is part of the larger Karamoja sub-region bordered by Kaabong District to the north, the Republic of Kenya to the east, Amudat District to the south, Nakapiripirit District to the southwest, Napak District to the west and by Kotido District to the northwest. It lies on the foot of Mt. Moroto and its plainly covered by Savannah grassland and some low lying rocky hills. The district comprises three counties: Bokora, County Matheniko County and Moroto Municipality and It is estimated that by 2010, the district population had grown to about 97,900.The sampled areas were Camp Swahili Juu, and Singilla, in Moroto municipality and Looli and Nangorikipil in Loputuk parish Matheniko County.

Kotido District

The district of Kotido is part of the Karamoja sub-region with an estimated population

of 1.2 million people according to the 2002 national census. The annual population growth rate in Kotido District was 3.3%. It is estimated that in 2010, the population of Kotido District was approximately 203,900. Kotido District is bordered by Kaabong District to the north, Moroto District to the east, Napak District to the south and Abim District to the west. Agago District and Kitgum District lie to the northwest of Kotido District. The district has six sub-counties Kacheri, Kotido sub-county, Kotido town council, Nakapelimoru, Regen, and Panyangara.

Kaabong District

Kaabong District is one of the districts in Karamoja sub-region with a rocky landscape comprising hills and valleys that are primarily covered by the bushy and shrub vegetation. Kaabong is bordered by South Sudan to the northwest, Kenya to the northeast, and the east, Moroto District to the southeast, Kotido District to the south and Kitgum District to the west. Kaabong has one county, Dodoth which is divided into one town council,i.e. Kaabong, and eight sub-counties: Karenga, Kapedo, Lolelia, Kathile, Sidok, Kalapata, Kaabong and Loyoro.The study area in Kaabong included Kachemichem village in Moroto parish Kalapata sub-county, Lobatou village in Kathile parish, Kathile sub-county and Lomusian in Lobongia parish in Kaabong town council. The national census in 2002 estimated the population of the district at approximately 379,800. The annual population growth in the district was estimated at 4.0%. In 2011, it is estimated that the population of Kaabong District was approximately 540,500.

Katakwi District

Katakwi District is a district in Eastern Uganda and like most other Ugandan districts; it is named after its 'chief town', Katakwi, where the district headquarters are located. Katakwi District was created in 1997. It was formerly part of Soroti District. The district is located in the Teso sub-region, home to an estimated 2.5 million people of Iteso and Kumam ethnicities, according to the 2002 national census. In June 2005, the western part of the district was carved out to create Amuria District.The estimated population of Katakwi District in 2010 was approximately 153,600. Katakwi District is bordered by Napak District to the north, Nakapiripirit District to the east, Kumi District to the south, Ngora District and Soroti District to the southwest and Amuria District to the west

Mubende District

Mubende District is in the central region of Uganda with an estimated population of about 550,000 people in 2010. The population is predominantly Baganda with a population growth rate of 3.6%. Mubende is surrounded by Mpigi and Mityana districts in the East, Kiboga in the North, Sembabule and Masaka districts in the South, Kyegwegwa and Kibaale districts in the West. The district headquarters is 157 Kms west of Kampala. The total area of Mubende District is 4645 sq. Km. Mubende has 18 Lower Local governments that include a town Council – Mubende Town Council.

Kanungu District

Kanungu district is located in south western Uganda with a population of about 241,800 who are predominantly Christian (95.3%) most of whom are rural based. The district is named after its chief town Kanungu and it has one County with nine sub-counties. Its neigbouring districts include Rukungiri to the north and east, Kisoro to the south west, Kabale to the south east and Democratic Republic of Congo to the west. Its major hospital is Kambuga.

Yumbe District

Yumbe district was created in November 2000 from Arua District. It is located in the North-western part of Uganda. The district is bordered by: Republic of Sudan (to the North); Moyo district (to the East); Koboko district (North-west) and to the South by Terego-Maracha District. The District covers a total area of 2,411sq km (which is 1.2% of the total national area), where; 1,929 sq km (80.01%) of the area is for agriculture, 411.78 sq km (17.08%) for forestry and woodlands, while water bodies and wetlands cover 70.22 sq km (2.912%). Yumbe is a one County district (i.e. Aringa County) with seven Sub-Counties and one Town Council. These are further sub-divided into 42 parishes and 321 villages.

Oyam District

Oyam district is a district in the Northern Region of Uganda. Like most Ugandan districts, it is named after its 'chief town, Oyam, where the district headquarters are located. The District is bordered by Gulu District to the north, Lira District to the northeast, Apac District to the east and south, Kiryandongo District to the southwest and Nwoya District to the west. The administrative headquarters of the district at Oyam, are located 73 km by road, west of Lira, the largest town in the sub-region.

Oyam District with total land area of 2.207 sq km was established by the Ugandan Parliament in 2006. Prior to that, Oyam District was part of Apac District. Together with Lira District, Amolatar District, Apac District and Dokolo District, Oyam District is part of the larger Langi sub-region, home to an estimated 2.7 million people in the region. The district is a predominantly rural district.

2.3: Selection Criteria/Eligibility Criteria

In the case of structured interviews, respondents who met the following inclusion criteria for the household and individual interviews were recruited in the study:

1. Women aged 15-49 years.
2. Men aged 15-49 years.
3. A person who is the usual resident or spent the previous night in the selected household.
4. Consent and assent for the survey.

Anybody who does not meet the above criteria was excluded from the study.

Respondents of the client's exit interviews were selected based on the following inclusion criteria:

1. Women aged 15-49 years exiting a selected FP clinic.
2. Men aged 15-49 years exiting a selected FP clinic.
3. Resident of one of the 8 districts being surveyed.
4. Consent for the survey.

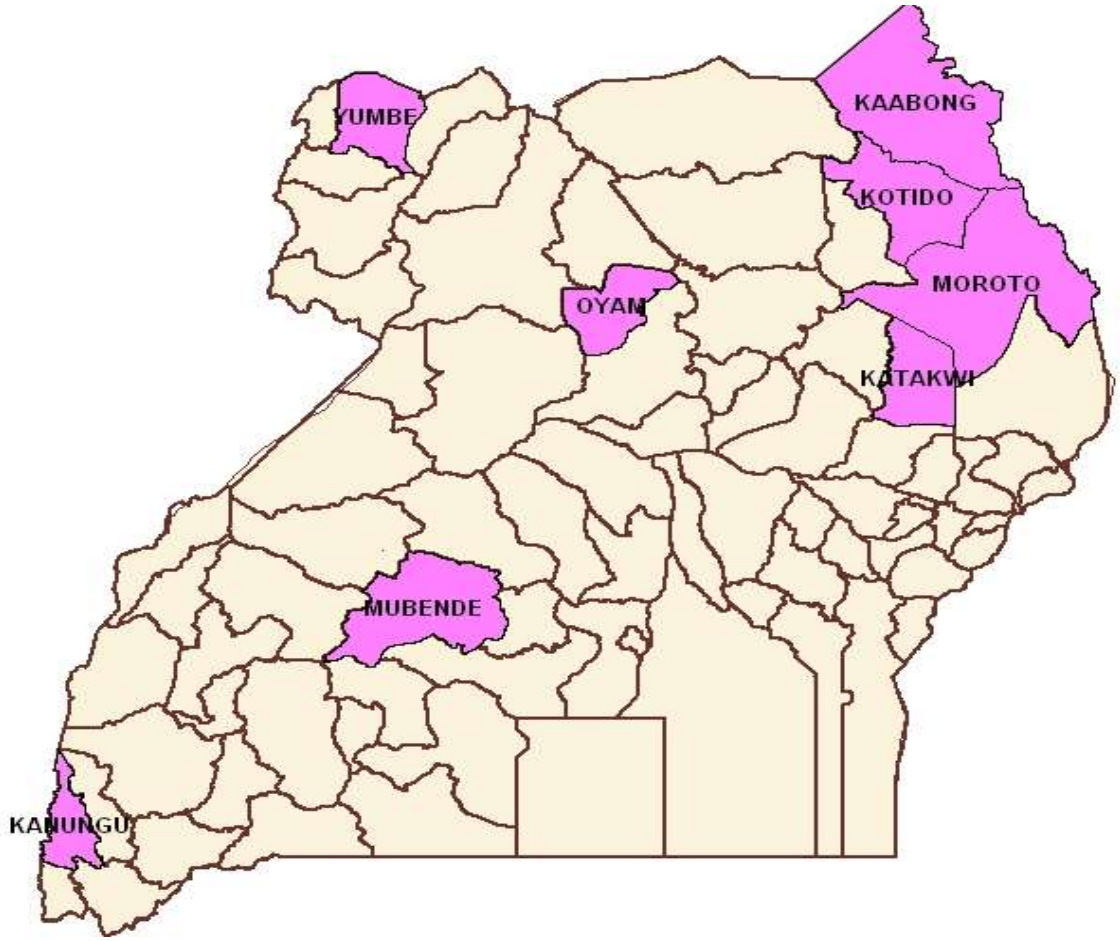
Participants in FGDs were purposively selected in every district. Respondents were individuals falling in the sexually active age group (15-49) and who may be users or non-users of contraception methods. The details are provided in table 2.1.

Focus group discussion participants were recruited based on the following inclusion criteria:

1. Current users of modern family planning methods.
2. FP clients who have discontinued FP methods
3. Non-users of modern family planning methods.
4. Youth both male and female
5. The elderly individuals
6. Consent for the survey.

Anybody who does not meet the above criteria was excluded from the study.

Figure 2.1: Study Area



Last but not least, respondents of the key informant interviews were drawn based on the following inclusion criteria:

1. Family planning policy makers.
2. Family planning programme persons.
3. Working in an organization that provides funding or services for family planning.
4. Consent for the survey.
5. Family planning satisfied users
6. Key community members

2.4: Personnel and Survey Fieldwork

Fieldwork of the survey was implemented by a team of 5 investigators, 4 supervisors and 16 research assistants. Composition of the teams was a multidisciplinary in nature to match with the scope of work. In order to ensure quality in the survey work, a one-week training of research assistants was conducted prior to the survey. The

training programme covered various aspects of the study including interviewing, conducting focus group discussions and in-depth-interviews. During the training, trainees conducted mock interview sessions with fellow trainees. They also participated in the pretest survey as a way of acquainting themselves with fieldwork procedures including data collection. This approach enhanced the ability and confidence of the research assistants. Following the training, the fieldworkers were deployed.

During the fieldwork, deliberate efforts were made to promote quality in the implementation of the study. This was done through support supervision, mentoring and regular checks of the work of research assistants.

In order to elicit community support and good participation in the survey, social mobilization was done in the study districts ahead of the survey. Contact was made with key important district and local leaders to inform them about the study and the support needed.

2.5: Data Management Procedures

Following fieldwork, filled questionnaires were brought to the central data management unit headed by a Statistician. Thereafter, the questionnaires were processed; editing of the questionnaires and coding of any open ended responses was done to facilitate data entry. Data was entered into the computer using the 2000 Epiinfo software package. In order to ensure quality control during data entry, double data entry technique was used.

Quantitative data were analyzed using SPSS and STATA data packages. Data cleaning was done before analysis commenced. Data validation was done through checking of ranges, structures and internal consistency of the data tables. Descriptive analysis was employed to generate data related to means, medians, proportions, modes and cross tabulations for the selected variables.

Quantitative data analysis was done guided by an agreed upon analysis tables. Responses to each question were distributed using univariate analysis. Continuous variables were analyzed using means and their standard deviations. Graphs, charts and tables were produced.

Chi-square (χ^2) statistical tests of significance were used to test existence of association between variables. This study assumed a confidence interval of 95%. This means that the probability of committing type 1 error (stating that there is no relationship when it is actually there) is 5% (*p-value* - 0.05). This implies that if the calculated p-value is less than 0.05, the probability of committing type 1 error is less than the threshold that was set. In this case the probability of making an error is very minimal and this renders the test to be significant, hence a p-value less than 0.05 would suggest that there is a relationship. On the other hand if the calculated p-value is greater than 0.05 it would mean that the probability of committing type 1 error is big, hence the test would not be significant, and thus the available data would not provide evidence of existence of a relationship.

Ordinarily, estimates obtained from a sample survey are affected by two types of errors; i) non sampling errors and ii) sampling errors. Non sampling errors are the errors that are caused not by sampling but by mistakes made during implementation of the survey. They are systematic errors arising at every stage of data production process and can be much higher in censuses as compared to sample surveys. They include coverage errors, non response errors, response contents, measurement errors and processing errors. These errors were controlled/minimized during the study design, fieldwork and during data management; through: extensive pre-testing of survey instruments and data processing system; use of pre-coded questions as much as possible; training of all staff involved in the survey; supervision of both fieldwork and data entry; editing of questionnaires both in the field and office; and conducting callbacks.

On the other hand, sampling errors arise basically because sample results are used instead of using results from a complete inquiry. Sampling errors are minimized by increasing the sample size. There are many possible samples that would be selected from the target population. Estimates from all the probable samples, would vary from sample to another. Thus for a given variable, an estimate is a random variable with a probability distribution. This probability distribution gives rise to a standard error which is the standard deviation of the sampling distribution of the estimate. And it is the square root of variance of the values from the different samples. However in practical terms not many samples are selected. For instance in this survey, only one sample was selected, thus there were not many values of a given estimate (statistic/proportion) that were generated for a given variable. Statisticians have however used the concept of sampling distribution to develop formulas to compute variance of a given statistic. Computer packages like SPSS, Epi-Info and STATA save the bother of tracing the many steps in computing this variance and standard error. The standard error is used to estimate confidence intervals within which the true value of the population parameter (like proportion P) is assumed to fall. In this survey, the proportion P is estimated to fall within a range of about two (1.96) times the standard error (SE) of a given proportion p estimated from the survey results ($p \pm Z_{\alpha/2}$ SE - $p \pm 1.96$ SE(p) ≈ $p \pm 2$SE). Also, related to standard error is the Relative Standard Error (RSE) which is obtained by dividing the standard error of the estimate by the estimate itself (SE/p). RSE in simple terms measures the contribution of the estimate to the noise (dispersion) surrounding the data that have generated it. In other words it is a measure of the reliability of the estimate. Estimates with large RSEs (greater or equal to 30%) are considered unreliable.

The design effect has also been computed for each variable. Design effect is the factor by which a sample obtained by using a complex sample design should be multiplied in order to obtain survey results with same precision as those of a Simple Random Sample. A complex sample design is the one where the selection of elements from the population into the sample is done by a method which is not simple random sampling (SRS). Examples of complex designs include; cluster

sampling, multistage sampling and systematic sampling. Mathematically design effect can be computed as:

$$\text{Design Effect} - \frac{Var(p)_{\text{complex design}}}{Var(p)_{SRS}}$$

The design effect of value 1.0 will imply that the sample design that was used to obtain the estimate is as efficient as SRS. On the other hand, if the design effect assumes a value that is greater than 1.0 it indicates that the complex design yielded a bigger variance than that of SRS and thus it was a statistically less efficient design, which led to a bigger sampling error.

Thematic analysis approach was used in managing the qualitative data; recorded responses from the field were transcribed. Common verbatim quotes which were found in the focus group discussion were considered for analysis. Findings, together with pertinent verbatim quotations were organized according to the thematic areas so that differences of thoughts, beliefs and emotions of groups representing diverse characteristics would become evident. Thematic analysis was used to document and understand the communication of meaning (reflected in various modes of information exchange, format, rhythm and style) as well as to verify theoretical relationships.

2.6: Limitations of the Study

The survey was limited to the sampled entities, namely; only 8 districts were surveyed. Therefore, the results may not be representative of all districts of Uganda. However, information generated may apply to the regions where the districts are located.

Due to limited budget, it was not possible to conduct a study that could provide district level estimates. This was a big missed opportunity; the study could have generated district level data in addition to regional level data.

Information obtained from respondents of the structured individual interviews was based on what was reported as opposed to observed behaviors. Hence, there is a possibility of social desirability effect; it is attributed to the respondents telling you what they think you want to hear.

The survey also had a qualitative study component. This was done to provide information that would complement quantitative data. Although information generated from this study component is invaluable, the findings may not be generalisable to the whole country, but may be applicable to parts of Uganda where the study was conducted.

Chapter Three

3.0: Findings

3.1: Introduction:

In Uganda, information on family planning has been primarily derived from the Uganda Demographic Health Surveys (UDHS). To date, 5 UDHS have been conducted; the latest was done in 2011. In addition to UDHS, some sub-national and small surveys have been conducted on family planning in Uganda.

The results presented in this chapter are from both the quantitative and qualitative survey methods; and are presented according to thematic areas. However, information on the survey response rate and characteristics of the survey respondents precede those on thematic areas. The descriptions of the methods used to generate the data are presented in chapter 2.

The results presented include knowledge of contraceptive methods, current use of contraceptive methods, methods preference, factors influencing the use of contraceptive methods, source of modern contraception methods, provision of information to aid decision on contraceptive methods, need and demand for family planning among women who have ever been pregnant, discontinuation of contraceptives use, consistency in use of methods and reasons for doing so, reasons for discontinuing contraceptives use, support from partners in the use of modern contraceptives and reasons for doing so.

In order to complement findings from the quantitative survey method, relevant information from qualitative survey methods are presented together. This approach led to triangulation of information from various sources. However, the detailed information from qualitative survey methods are maintained in chapter 4 so as to provide district based data since the quantitative data is not available at district level.

Furthermore, the key findings of the quantitative survey methods are summarized in boxes as below.

Key Findings

- About twenty seven percent of women age 15-49 years is currently using some method of contraception; 26.5 percent are using modern methods and 0.4 percent are using traditional methods.
- Approximately 23 percent of all women and 27 percent of women who are currently married are using some method of contraception.
- Virtually women of all age groups are using modern contraception methods with injectable methods being the most popular one across all age groups except for the 15-19 and 45-49 age groups.
- The determinants of modern family planning use identified in the survey include; level of education, religion, mobility, period of stay in the area (for immigrants), distance to former place of residence, place of residence, knowledge of source of FP methods, exposure to media messages on FP, needs and demand for FP services, preference of number of children and agreement of partner to use FP methods. Age is a weak determinant.
- The other individual factors which show a relationship with use include peer pressure, support by the spouse and holding of misconceptions on family planning.
- At community level, availability of friendly services at affordable cost ,easy service access, opposition from cultural leaders and other significant others influenced use and none use of modern contraceptives.
- Most of the clients get their modern contraception methods from two main sources, all of which are Government facilities (40 percent from hospitals and 40 percent from health centres).
- Reproductive Health Uganda HCs/Clinics were not cited as sources for any modern methods of contraception.
- Injectables and implants are the two most consistently used methods of contraception.
- 23 percent of men and 27 percent of women said that the fertile period is halfway between two periods.
- Fifty five percent of all women and 52 percent of currently married women said that they have intention to use a family planning method in the future.
- Among women who have ever had sex, 47 percent reported to have ever used a family planning method. Of these, 31 percent reported changing a method.

Key Findings (continued)

Of the 82 exit interview clients, 34 percent reported that they have ever changed a family planning method. Of the 34% who said that they have ever changed a method, half of them (50 percent) said that they did so due to fear of side effects of a previous method. The second most common reason for change is the method being inconvenient to use.

Exit interview respondents had received information from the clinics; the majority (83 percent) had received information on contraception.

Generally, clients who were recruited for exit interviews were satisfied that their right to family planning is being met.

Private facilities are doing better than Government facilities in meeting the right to family planning except for the right to continuity of care where clients were better satisfied with Government facilities.

Sixty five percent of the respondents from the exit interviews said that they have ever been encouraged by their partners to use family planning method; among the specific support that had been received from partners are moral support and giving advice/ideas (32 percent).

Sixty four exit interview clients cited specific reasons for liking the services being provided by the clinics; of these, 46 percent said they were satisfied because the staff/client relationship is good or that staff members are kind and not rude, as well as give them the required information.

Some 33 percent of clients said they disliked some things at the family planning clinics. Among the reasons for the dislike is shortage of medical equipment and supplies (25 percent).

3.2: Background Characteristics

3.2.1: Response Rates - Structured Questionnaire

Analysis was done to provide information on the response rate. This information provides an indication of the representativeness of the survey population. The survey findings show that the response rate was very high. Overall, the household response rate was 99.4 percent. A total of 310 households were selected for the survey; of these, 308 (99.4%) completed the household schedule (Table 3.1). The results further show that a total of 695 individuals were selected to be interviewed; of these, 658 (94.7%) completed the questionnaires indicating an individual response rate of about 95 percent (Table 3.2).

Table 3.1: Results of Household Interviews

Item	Number
1. Number of households with completed household schedule (A)	308
2. Entire household moved away/absent for extended period (B)	2
3. Number of household selected; C: (C - A+B)	310
4. Mean number of eligible respondents per household	2.1
5. Household Response Rate (R_H- A/C x 100 %)	99.4%

Table 3.2: Results of Individual Interviews

Item	Number
1. Number of respondents with fully completed questionnaire (D)	658
2. Moved Away/Absent for extended period (E)	27
3. Number of respondents incapacitated (F)	1
4.Number of respondents that refused to participate in survey (G)	9
5. Number of respondents selected; H: (H - D+E+F +G)	695
6. Percent interviewed in relation to total selected (P- D/H x 100 %)	94.7%
7. Personal Inteview Response Rate (R_I - RH x P x 100 %)	94.1%

3.2.2: Characteristics of the Respondents - Structured Questionnaire

Information on the demographic and socioeconomic profile of the individual women and men interviewed in the survey is presented in this section. Specifically, information on the basic background characteristics such as age, marital status, religion, education and employment status are presented. This information further provides an indication of the representativeness of the survey population.

A total of 658 respondents were interviewed. Of these, about two thirds (63 percent) are females and about one third (37 percent) are males (Figure 3.1). Across all the districts, the female to male ratio is more or less similar except for Katakwi where the number of females is a lot higher than that of their male counterparts (Figure 3.2).

The distribution of the respondents by district of origin is shown on table 3.3. The respondents are distributed as follows; Karamoja region (31.6 percent), Oyam (17 percent), Mubende (15.5 percent), Katakwi (12 percent), Kanungu (12 percent) and Yumbe (11.9 percent).

Most of the respondents are young; about 72 percent of them are age less than 35 years. The highest (22 percent) and lowest (7.9 percent) proportions of respondents are in the age categories of 15-19 and 45-49, respectively.

Respondents were also asked whether they were married or not. The results show that 69 percent of the respondents are married whereas 23 percent of them have never been married.

Furthermore, inquiry was made into the educational standards of the respondents. Overall, 27 percent of the respondents have never gone to school, 53 percent reached secondary school level and only 20 percent attained secondary education or higher. The majority of the respondents are Christians (62 percent are Catholics and 27 percent are Protestants/other Christians). About 10 percent of the respondents are Muslims. Furthermore, about three quarters of the respondents are employed. Of 658 respondents who were interviewed, 27 percent reported that they are employed.

Figure 3.1: Distribution of respondents by sex

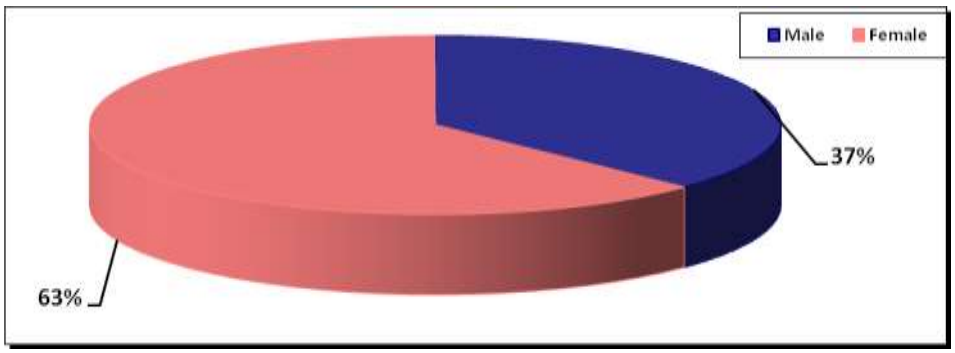


Figure 3.2: Sample distribution by sex and district

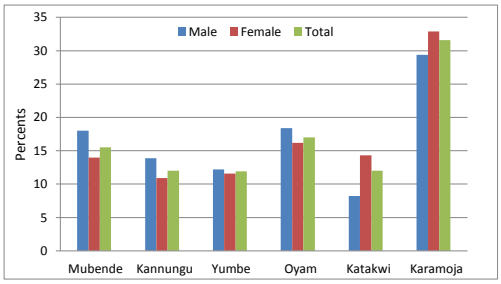


Figure 3.3 a: Percent distribution of the de facto respondents by five-year age groups, according to sex

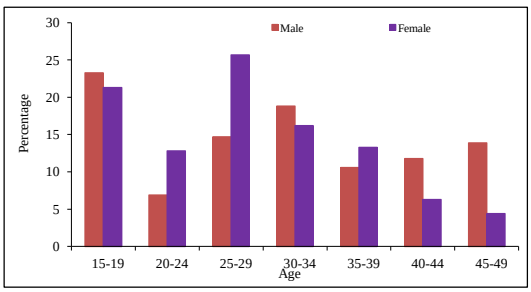


Table 3.3: Percent distribution of respondents by selected background characteristics

(n-658)

Background characteristic	Male	Female	All
Residence			
Mubende	18.0	14.0	15.5
Kannungu	13.9	10.9	12.0
Yumbe	12.2	11.6	11.9
Oyam	18.4	16.2	17.0
Katakwi	8.2	14.3	12.0
Karamoja	29.4	32.9	31.6
Age			
15-19	23.3	21.3	22.0
20-24	6.9	12.8	10.6
25-29	14.7	25.7	21.6
30-34	18.8	16.2	17.2
35-39	10.6	13.3	12.3
40-44	11.8	6.3	8.4
45-49	13.9	4.4	7.9
Marital status			
Never married	26.9	20.6	22.9
Married/ Living together	69.8	68.5	69.0
Divorced/Separated	2.4	6.5	5.0
Others like widowed	0.8	4.4	3.0
Education			
Never went to school	20.0	30.8	26.7
Primary	52.2	54.0	53.3
Secondary +	27.8	15.3	19.9
Religion			
Roman Catholic	61.2	62.7	62.2
Protestant/Other Christian	27.3	26.2	26.6
Muslim	9.0	10.2	9.7
Others	2.4	1.0	1.5
Employment status			
Employed	76.7	70.9	73.1
Not employed	23.3	29.1	26.9
Percent total	100	100	100
Number of respondents	245	413	658

3.2.3: Background Characteristics of Exit Interview Respondents

Table 3.5 shows that of the 82 exit interview respondents, the majority (70 percent) were from Government facilities while 30 percent were from private facilities. Most of the respondents are married (85 percent); 10 percent are single. The majority of the respondents are in the age group 26 to 34 years (79 percent).

During the interviews, clients exiting FP clinics were asked to determine which services they had come for. This was done because usually clients visit health facilities for various reasons. Understanding the reasons is important to inform the planning of services. In line with above, respondents were asked to state the reasons why they came to the health facilities, that is, for which particular FP services had they come for on the interview day. In response, the majority of the respondents (83 percent) reported that they had come for contraceptive services; including getting pills, IUDs, injectable methods, and so forth. Nine percent of the respondents came for condoms while 6 percent came for HIV and STI screening and treatment. The rest of the clients had come due to various reasons such as maternal care, pregnancy testing, treatment for other gynecological matters, sexuality counseling services, pap smear test, services related to sexual, physical or emotional violence, abortion services, as well as pre- and post-abortion care. It should however be noted that some clients had come for more than reason.

In regard to the timing of the clinic visit during this particular survey, determination was made whether the client's visit was the first or it was a follow up one; in response, 21 percent said this is the first visit while 89 percent said the visit is a follow up one (Figure 3.3 c).

Figure 3.3 b; Percent distribution of the de facto exit interview participants by age

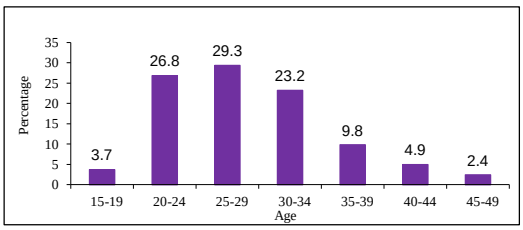


Figure 3.3 c: Distribution by type of visit (n-82) - Exit Interviews (EIs)

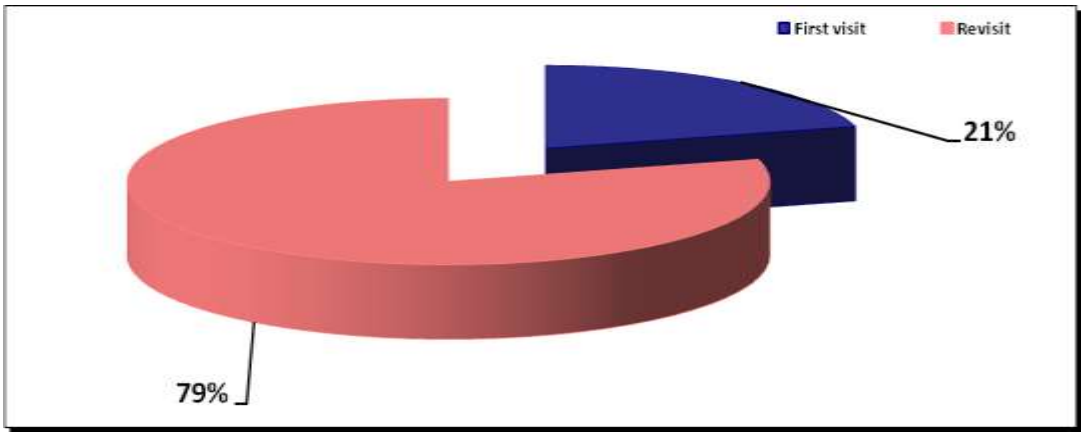


Table 3.4: Distribution of respondents by service came for on day of interview (N - 82)

Type of service	Number	Percent
Contraceptives (pills, IUD, injections, etc)	68	82.9
Condoms	7	8.5
HIV and STI testing and treatment	5	6.1
Maternal care	4	4.9
Pregnancy testing	3	3.7
Treatment for other gynecological matters	3	3.7
Sexuality counseling services	2	2.4
Smear test	1	1.2
Services relating to experiences of sexual, physical or emotional violence	1	1.2
Abortion services	0	0
Pre- and post-abortion care	0	0

Note: Some clients came for more than one service

Table *3.5*: Percent distribution of respondents by background characteristics (n - 82)

Background characteristic	Number	Percent
Residence		
Mubende	20	24.4
Kannungu	20	24.4
Yumbe	12	14.6
Oyam	12	14.6
Katakwi	3	3.7
Karamoja	15	18.3
Type of facility		
Private	25	30.5
Government	57	69.5
Age		
15-19	3	3.7
20-24	22	26.8
25-29	24	29.3
30-34	19	23.2
35-39	8	9.8
40-44	4	4.9
45-49	2	2.4
Marital status		
Single	8	9.8
Married	70	85.4
Divorced	2	2.4
Widowed	2	2.4
Total	82	100.0

3.3: Knowledge of Contraceptive Method

Overall, knowledge of any family planning method was universal and therefore it could not show any consequence to use and non-use. The survey results show that 98 percent of all the respondents have ever heard of a contraceptive method; there was no difference between women and men in this variable. Among the contraceptive methods which respondents have ever heard of, male condom is commonest (92 percent) followed by pill/injectable method (87 percent) and next is LAM (78 percent).

Among respondents who have ever heard of any method (modern or traditional), there is little variation by district. The proportion of respondents who have ever heard of any FP method in Mubende and Karamoja districts are 99 and 93 percent, respectively; but is 100 percent in each of the other surveyed districts. There is also little variation of family planning awareness by age; it ranges from 94 percent among the 40-44 year old to 100 percent among the 20-24 age groups. When marital status is considered, 97 percent of the currently married respondents reported that they have ever heard of a contraceptive method compared to 99 percent among those who have never married.

Overall, the results show that the awareness about contraception methods is very high. The proportion of men who heard of any method is 98 percent. In the case of women, the awareness is equally high; the proportion who heard of any contraception methods is the same (98 percent).

Table 3.6 Knowledge of contraceptive methods by sex (n - 658)

Percentage of men and women who have heard of any contraceptive method, by specific method

Method	Men	Women	All
Any modern method			
Female sterilization	72.2	72.4	73.2
Male sterilization	57.1	56.7	56.8
Pill	84.9	88.4	87.1
IUD	46.1	62.2	56.2
Injectables	85.3	88.4	87.2
Implants	70.2	78.9	75.7
Emergency contraception	40.4	39.0	39.5
Lactational amenorrhea (LAM)	75.1	78.9	77.5
Female condom	68.6	69.2	69.0
Male condom	93.1	90.8	91.6
Diaphragm	24.9	26.6	26.0
Foam/Jelly	20.4	19.1	19.6
Any traditional method			
Rhythm/moon beads	49.0	57.6	54.4
Withdrawal	63.3	51.8	56.1
Other traditional method	5.7	5.1	5.3
Any method	97.6	97.8	97.7
Number of respondents	245	413	658

Table 3.7 : Knowledge of contraceptive methods by sex and sexual relationship

Percentage of currently married respondents, and respondents having sex with regular or non regular partner(s) who have heard of any contraceptive method, by specific method

	Men			Women		
Method	Currently married men	Men having regular partner(s) [1]	Men having non regular partner(s)[2]	Currently married women	Women having regular partner(s)[1]	Women having non regular partner(s)[2]
Any modern method						
Female sterilization	72.7	72.2	(57.1)	71.2	82.9	*
Male sterilization	61.2	66.7	(38.1)	56.9	60.0	*
Pill	86.7	86.1	(71.4)	90.4	94.3	*
IUD	52.7	44.4	(28.6)	63.1	71.4	*
Injectables	90.3	77.8	(71.4)	87.7	88.6	*
Implants	73.9	66.7	(57.1)	77.7	82.9	*
Emergency contraception	41.8	52.8	(38.1)	33.1	48.6	*
Lactational amenorrhea (LAM)	82.4	77.8	(66.7)	83.1	85.7	*
Female condom	70.3	83.3	(57.1)	68.5	74.3	*
Male condom	93.9	94.4	(90.5)	89.2	94.3	*
Diaphragm	21.8	25.0	(14.3)	23.5	31.4	*
Foam/Jelly	19.4	30.6	(19.0)	18.8	25.7	*
Any traditional method						
Rhythm/moon beads	57.0	55.6	(28.6)	61.9	57.1	*
Withdrawal	72.1	66.7	(71.4)	50.8	74.3	*
Other traditional method	6.1	13.9	(4.8)	3.8	11.4	*
Any method	96.4	97.2	(95.2)	97.7	100	*
Number of respondents	165	36	21	260	35	18

NA - Not applicable.

[1] Regular partner is someone other than the husband/wife with whom a respondent had had a sexual relationship for more than 12 months.

[2]Non regular partner is someone other than the husband/wife with whom a respondent had had a sexual relationship for less than 12 months. Figures in parentheses are based on 20-29 cases while an asterisk indicates that a figure is based on less than 20 cases and has been suppressed

3.4: Misconceptions about Modern Contraceptives

The existence of misconceptions among a population has a likelihood of negatively influencing utilization of a service. Table 3.5 below shows that men have some misconceptions about use of contraception methods. Among sexually active men age 15-49, 22 percent believe that contraception is a woman's business. Further, 26 percent of these men believe that women who use contraception may become promiscuous. These misconceptions appeared to be more common among the catholic respondents and those who had never gone to school.

Figure: 3.4: Misconception about family planning among men

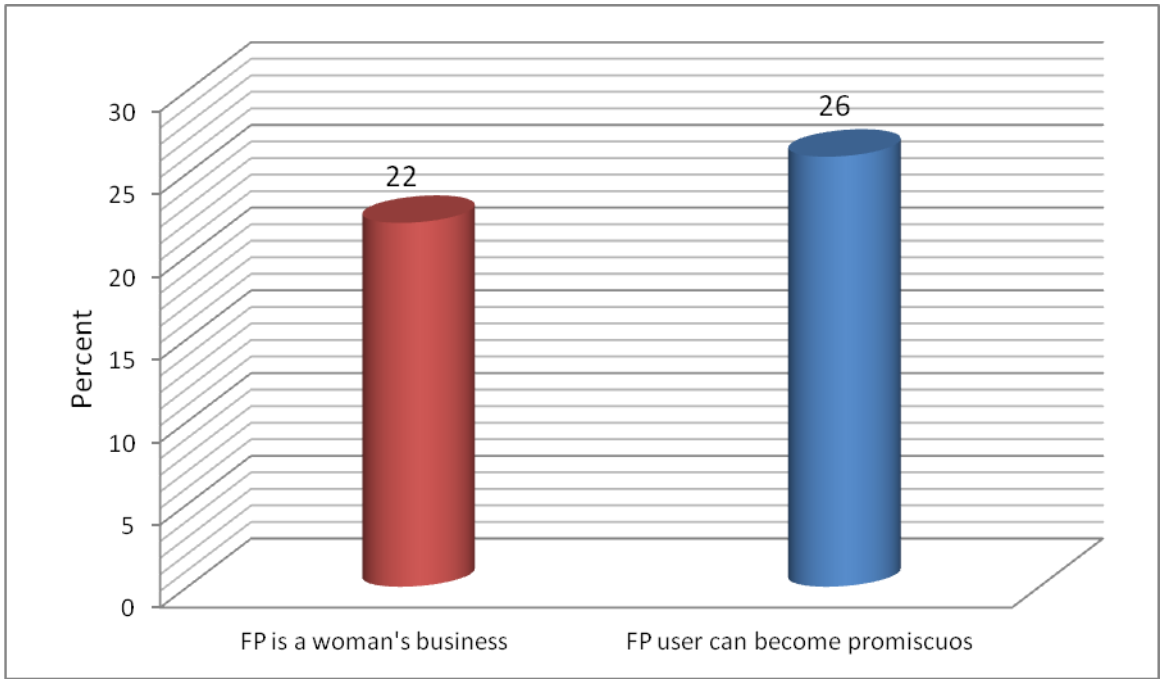


Table 3.8: Misconception about Use of Contraception Among Sexually Active Men

Among sexually active men age 15-49, the percentage who believe that contraception is a woman's business and that the man should not mind about it and the percentage who believe that women who use contraception may become promiscuous, by background characteristics

Background characteristics	Percentage who believe that contraception is a woman's business	Percentage who believe that women who use contraception may become promiscuous	Number of men
Age			
15-19	(19.0)	(9.5)	21
20-24	*	46.2	13
25-29	13.9	38.9	36
30-34	13.0	19.6	46
35-39	(26.9)	(34.6)	26
40-44	(44.8)	(20.7)	29
45-49	23.5	20.6	34
Number of living children			
0	26.7	13.3	30
1-2	(13.8)	(24.1)	29
3-4	24.1	38.9	54
5+	21.7	22.8	92
Residence			
Mubende	23.1	12.8	39
Kannungu	(57.1)	(25.0)	28
Yumbe	(21.7)	(26.1)	23
Oyam	9.7	19.4	31
Katakwi	*	*	15
Karamoja[1]	14.5	37.7	69
Education			
Never went to school	25.0	40.9	44
Primary	20.8	22.8	101
Secondary +	21.7	20.0	60
Religion			
Roman Catholic	19.8	34.1	126
Protestant/Other Christian	25.5	10.9	55
Muslim	*	*	19
Others	*	*	5
Employment status			
Employed	21.9	24.2	178
Not employed	(22.2)	(37.0)	27
Total	22.0	25.9	205

Note: Figures in parentheses are based on 20-29 cases while an asterisk indicates that a figure is based on less than 20 cases and has been suppressed.

[1] Karamoja districts include; Moroto, Kotido and Kaabong

Similar to the above information generated from the quantitative survey methods, the qualitative survey methods also revealed that there were similar misconceptions on family planning. The common one included the following**:** Women using contraceptives regarded as prostitutes, a mode of murder of the unborn, Contraceptives leading to delivery of children with deformities, disappearance of the IUD in the body leading to death, accumulation of contraceptives in the abdomen and need for blood tests before an FP method is used. Some of the misconceptions are cited below:

The implant once inserted in the body and stays there for so long, it can disappear within the body especially if you put on weight and require to operate all over body to search for it or it reaches the heart and you die ***(Users FGD Mubende).***

The pills don't dissolve in the body but pile in the woman's body and when she delivers a baby it will be abnormal ***(Discontinuers FGD Mubende).***

Contraceptive use is associated with promiscuity, so this is a discouraging factor, hence non use. There is a misconception that family planning use stops women from bearing children. This misconception brings fear among the society that the women will stop bearing children yet among the Karamojong children are given value as a source of wealth, labour during old age and a source of security ***(Non users FGD Kaabong)***

Family planning methods cause barrenness in women, some people in the community say once a woman joins any family planning method, she will never give birth ***(Community level KI Oyam).***

Some say, that family planning use causes deformity in babies, for example of recent a woman gave birth to a baby with a very big head and later on died ***(Non-Users FGD Oyam).***

Women on family planning will never give birth normally; they will go under Caesarean section which weakens the woman in the long run and at the same time that it also stops delivery ***(Non-Users FGD Oyam).***

They say that since eggs are not being replaced, they collect in the abdomen, an example of a women in the community who was a user of FP and the talk

was that she died because eggs collected in her abdomen (which was very big) and lead to her death ***(Service Provider KI Oyam).***

3.5: Current use of Contraceptive Method

During the survey, women were asked to name a family planning method which they are currently using. We inquired into both modern and traditional contraceptive methods. By modern method of contraception, we refer to intentional prevention of conception or impregnation through the use of various devices, agents, drugs, sexual practices, or surgical procedures that have been proved to be scientifically effective. Specifically, the survey considered use of male sterilization, female sterilization, pill, IUD, implants, female condoms, male condoms and lactational amenorrhea.

Information on FP use is presented on Figure 3.5 below.

Figure 3.5: Contraceptive method currently in use

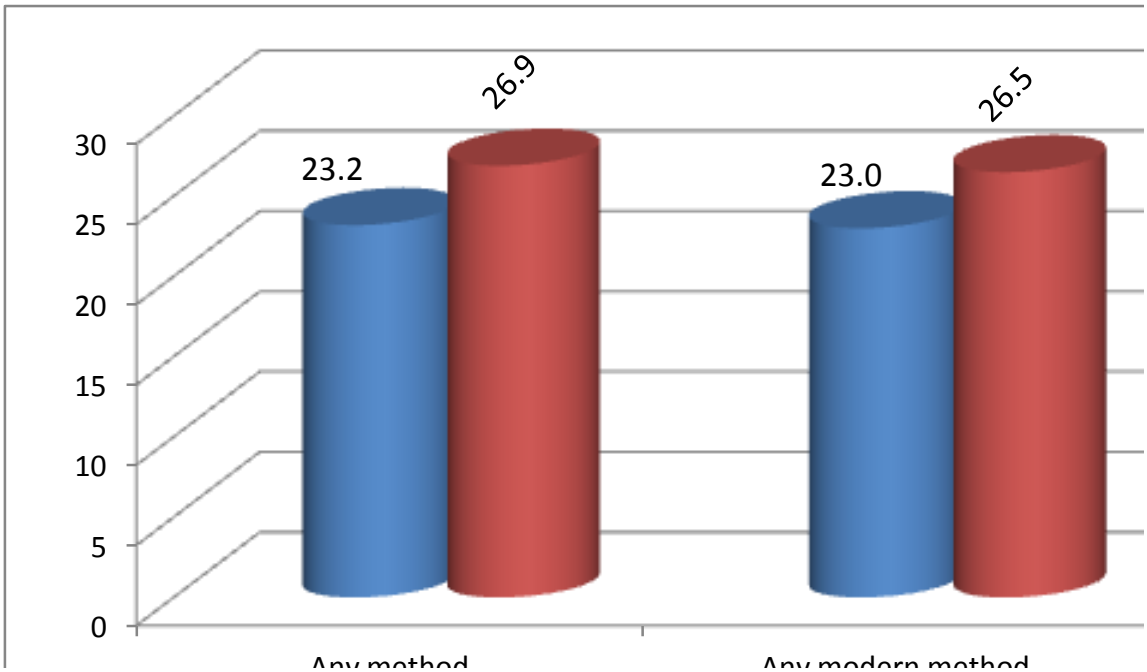


Figure 3.5 show that about 23 percent of all women and 27 percent women who are currently married are using some methods of contraception. This implies that virtually all women who reported FP use are using modern contraception methods; only 0.4 percent of these women use traditional methods, while 26.5 percent were using modern methods. Injectable methods are the most popular modern methods across all age groups except for the 15-19 and 45-49 age groups.

3.6: Source of Modern Contraception Methods

Inquiry was made to determine the source of modern contraception methods from which clients are receiving family planning services. As shown in Table 3.9, the results show that most of the clients get their modern contraception methods from two main sources, all of which are government facilities (40 percent from from health centres and 27 percent from hospitals).

Female sterilization method is obtained only from Government hospitals and health centres. Family planning clinics only act as sources for pills; they do not provide other methods. The intra uterine devices (IUDs) are only provided in hospitals. Injectable contraception methods are mainly sourced from three facilities, namely; Government hospitals (16 percent), Government HCs (30 percent) and private hospitals (49 percent). Implants are provided mainly by Government hospitals and HCs. Male condoms are sourced from village health teams (VHTs), Government hospitals and HCs. Reproductive Health Uganda HCs/clinics were not cited as sources for any modern contraception methods.

Table 3.9: Source of modern contraception methods

Percent distribution of current users of modern contraceptive methods age 15-49 by most recent source of the method, according to method

Source	Female sterilization	Male sterilization	Pill	IUD	Injectables	Implants	Male condom	Female condom	Total
Public sector									
Government hospital	40.0	NC	28.6	0	16.3	37.0	66.7	NC	26.7
Government health center	60.0	NC	28.6	100.0	30.2	55.6	16.7	NC	40.0
Family planning clinic	0	NC	14.3	0	0	0	0	NC	1.1
Outreach	0	NC	14.3	0	0	7.4	0	NC	3.3
Government VHT	0	NC	0	0	0	0	16.7	NC	1.1
Other public	0	NC	0	0	0	0	0	NC	0
Private medical sector									
Private hospital/clinic	0	NC	0	0	51.1	0	0	NC	24.4
RHU health centre/clinic	0	NC	0	0	0	0	0	NC	0
Pharmacy/drug shop	0	NC	14.3	0	0	0	0	NC	2.2
Nursing/maternity home	0	NC	0	0	0	0	0	NC	0
NGO fieldworker/VHT	0	NC	0	0	0	0	0	NC	0
Other private	0	NC	0	0	0	0	0	NC	0
Other source									
Shop	0	NC	0	0	0	0	0	NC	0
Religious institution	0	NC	0	0	0	0	0	NC	0
Friend/relative	0	NC	0	0	0	0	0	NC	0
Other	0	NC	0	0	0	0	0	NC	0
Not stated	0	NC	0	0	2.3	0	0	NC	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	5	0	7	2	43	27	6	0	90

Note: Total includes other modern methods but excludes lactational amenorrhea method (LAM).

NC: No case reported

3.7 Current Use and Method Preference

In all the study districts, there was reported use of modern contraceptives and the most popular or preferred method was the injectable FP methods. According to both the qualitative data and information generated from the quantitative study, the preference was attributed to the convenience and availability of the FP method. The convenience was related to opportunity for secrecy in the event of lack of male support and in cases where the clients consume alcohol. The pill was however more popular among the young people while the IUD was perceived wrongly because of the related misconceptions. Those opposed to the pill stated that they were not comfortable with the burden of swallowing the pills daily. These statements below illustrate the above points:

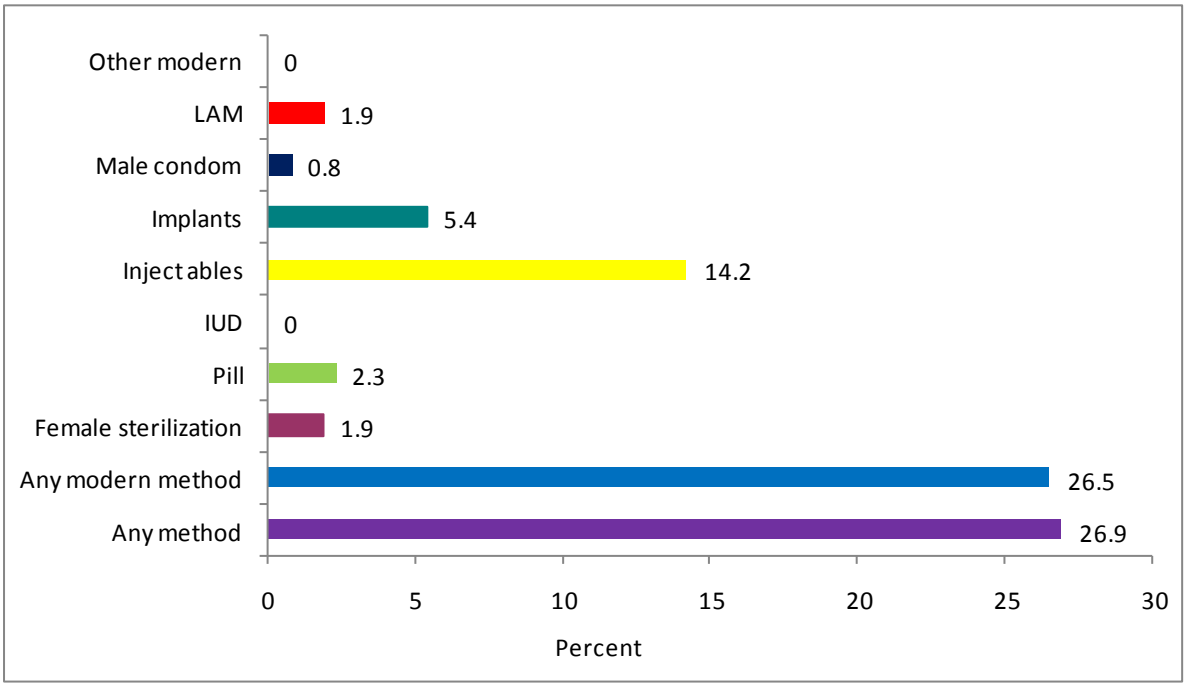
> *As for the coil, if it is inserted, you are not supposed to stress yourself with hard work yet for us in our village we have to dig, so we use pills and injections. You also need to eat and feed well* ***(Discontinuers FGD Mubende).***

> *The preferred method in the community is an injection because it is deemed easy. It can be obtained from every clinic and health centre. Another method that is preferred is the pills. These are also preferred because they are readily available and can be obtained from every health centre. The method is also cheaply obtainable than any other* ***(Elders FGD Mubende).***

> *Depo provera is preferred especially in cases where the male support is lacking on family planning because an injection is taken in secrecy. Implants are long term methods and once initiated, it does help you to properly space the next birth from the previous ones and it's also a very private method (****Service Providers KI Kotido).***

> *Most women prefer injectables and implants because of the convenience unlike swallowing pills which is not easy, most women take alcohol hence the chance of forgetting to swallow when drunk* ***(Satisfied user Kotido).***

Figure 3.6: Contraception method currently being used by married women (n-260)



3.8. Determinants of Contraceptive Use at Individual level

The determinants and factors are presented at individual level and community level though in some cases some overlap was observed. This section presents some detailed analysis and description of each of the identified determinants of FP use and non-use at individual level. In order to select the determinants of family planning use and non-use, Chi-square (χ^2) statistical tests of significance of association between a number of predictor variables and family planning use and non-use were carried out. Although the results are based on bivariate analysis, they give an indication of what the determinants of FP use and non-use are. Due to small sample sizes that arise after multiple desegregations, it was not possible to conduct logistic regression analysis to control for confounders.

As alluded to in section 2.5, a p-value less than 0.05 suggests that there is a relationship. On the other hand if the calculated p-value is greater than 0.05 it implies that the association is not significant and thus the available data would not provide evidence of existence of a relationship. Relative Standard Error (RSE) has also been computed for each estimate. RSE in simple terms measures the contribution of the estimate to the dispersion surrounding the data that have generated it, and it is a measure of the reliability of the estimate. Estimates with large RSEs (greater or equal to 30%) are considered unreliable.

The estimates (proportions) with their standard errors, confidence limits and design effects of current use of modern FP methods by categories of a selected number of key variables

are presented in table 3.11. Through conducting the above analysis a number of determinants of family planning use and non-use were identified.

Tables 3.10 and 3.11 reveal that statistically significant association exists between FP use and the following variables; education, religion, mobility, period of stay in the area (for immigrants), distance to former place of residence, place of residence, knowledge of source of FP methods, exposure to media messages on FP, needs and demand for FP services, preference of number of children and agreement of partner to use FP methods. As discussed in subsection 3.8.13, age is a weak determinant of family planning use. The factors which are identified from the quantitative data are described in the next subsections (3.8.1 to 3.8.13) and data from the qualitative methods are accordingly triangulated to corroborate these associations. In addition, some other factors that were not found significant on the quantitative data, but which were supported by qualitative data were also taken as determinants of FP use and non-use and they are presented from subsection 3.8.14 to 3.8.17. Subsections 3.8.18 and 3.8.19 mention some factors that may be thought to be determinants but the study has found them non determinants.

Table 3.10: Relationship between Current Use of FP Method (Sexually Active Women) with Selected Variables – χ^2 Tests

Significance p-values generated when relationship is tested between women's current use of Modern FP methods with selected variables

Selected Variables	p-value
Age	0.253
Education	0*
Religion	0*
Tribe	0*
Marital status	0.822
Employment	0.074
Mobility	0.010*
Period stayed in area (for immigrants)	0.009*
Distance to former place of residence	0.019*
Number of children ever born	0.408
District/area of residence	0*
Sexual Relationships; Regular partners	0.385
Sexual Relationship; Non regular partners	0.432
Having children	0.382
Ever been pregnant	0.056
Knows source of FP method	0*
Exposure to media messages on FP	0.005*
Need and demand for FP services	0.041*
Preference for number of children needed by women	0*
Agreement with partner regarding child spacing	0.018*

An asterisk indicates that the p-value is significant at level of significance a - 5%; that is, there is a significant difference in the different categories considered for a variable under consideration.

Table 3.11: Sampling Errors And Proportion (p) of Women Currently Using Modern FP Methods

Selected Variables	Value (p) in %	Standard Error(SE) in %	95% C.I Lower (%)	95% C.I Upper (%)	Design Effect	Relative Standard Error (SE/p) in %	Number of Cases
Education (Significance p-value - 0)							350
Never went to school	8.3	3.5	1.1	15.6	1.917	42.2	120
Primary level	35.0	4.7	25.3	44.7	1.768	13.4	183
Secondary and above	44.7	11.1	21.9	67.5	2.282	24.8	47
Religion (Significance p-value - 0.0003)							350
Roman Catholics	22.7	5.1	12.0	33.3	3.270	22.5	216
Protestant/Other Christians	38.9	5.4	27.7	50.2	1.183	13.9	95
Muslims	16.7	9.9	0	37.1	2.472	59.3	36
Other	*	*	*	*	*	*	3
Tribe (Significance p-value - 0)							350
Ankole/Toro/ Munyoro / Muganda/Mukiga	50.0	7.3	35.0	65.0	1.417	14.6	68
Ateso	38.3	5.9	26.1	50.5	0.878	15.4	60
Karamajong	6.1	4.4	0	15.2	3.254	72.1	98
Langi	31.9	7.2	17.1	46.7	1.089	22.6	47
Lugbara	12.8	6.2	0	25.7	1.319	48.4	39
Others/Not stated	31.6	7.4	16.2	46.9	0.950	23.4	38
Marital Status (Significance p-value - 0.822)						*	350
Never married	(29.2)	8.7	11.1	47.2	0.856	29.8	24
Married/cohabiting	27.3	5.0	17.0	37.6	3.524	18.3	282
Divorced/separated	(29.6)	10.9	7.1	52.2	1.495	36.8	27
Others e.g widowed	*	*	*	*	*	*	17
Employment Status (Significance p-value -0.074)							350
Employed	29.0	4.6	19.6	38.4	2.855	15.9	283
Not employed	19.4	7.8	3.4	35.5	2.564	40.2	67

Mobility (Significant p-value-0.01)							346
Born in that area	20.4	5.5	9.0	31.8	2.670	27.0	142
Immigrant	32.4	5.2	21.7	43.1	2.503	16.0	204
Period stayed in area; for immigrants (Significant p-value-0.009)							204
Below 5 years	16.3	6.2	3.4	29.2	1.369	38.0	49
Between 5-10 years	43.1	6.8	28.9	57.2	1.355	15.8	72
Above 10 years	32.5	8.4	15.1	49.9	2.654	25.8	83
Distance to former residence (Sig p-value-0.02)							350
Born in that area	20.4	5.5	9.0	31.8	2.670	27.0	142
Came from 1-50km	32.8	5.6	21.2	44.4	1.913	17.1	134
Came from 50-99km	(13.0)	8.2	0	30.0	1.319	63.1	23
Came from 100km +	38.8	11.2	15.6	61.9	2.558	28.9	49
Not stated	*	*	*	*	*	*	2
Knowledge of source of FP methods (Significance p-value - 0)							350
Knows source of FP methods	29.7	4.5	20.3	39.0	3.147	15.2	320
Do not know source	0.0	0.0	-	-	-	-	30
Number of children ever born(Sig p-value-0.41)							350
Never given birth	*	*	*	*	*	*	15
1-2 children	21.2	6.8	7.1	35.3	2.359	32.1	85
3-4 children	28.2	6.8	14.1	42.3	2.684	24.1	117
5 and more children	30.8	6.0	18.5	43.1	2.203	19.5	133
Residence (Significance p-value - 0)							350
Mubende	42.0	5.3	31.0	53.0	0.571	12.6	50
Kanungu	57.1	7.7	41.3	73.0	0.823	13.5	35
Yumbe	12.8	6.3	0	25.9	1.368	49.2	39
Oyam	32.7	7.1	18.1	47.2	1.089	21.7	49
Katakwi	37.5	3.2	30.9	44.1	0.243	8.5	56
Karamoja	9.9	7.7	0	25.8	7.976	77.8	121
Exposure to FP message (Sig p-value - 0.005)							350
Heard about FP on media like radio/T.V	30.2	4.9	20.2	40.3	3.158	16.2	281
Didn't get FP messages	14.5	5.2	3.8	25.2	1.482	35.9	69
Demand for FP services at time of pregnancy (Sig p-value - 0.042)							341
Pregnant not timely	34.2	5.6	22.6	45.7	1.657	16.4	120
Pregnancy timely	23.5	5.4	12.4	34.6	3.433	23.0	213
Not stated	*	*	*	*	*	*	8
Agreement with partner regarding number of children (Sig p-value - 0.001)							310

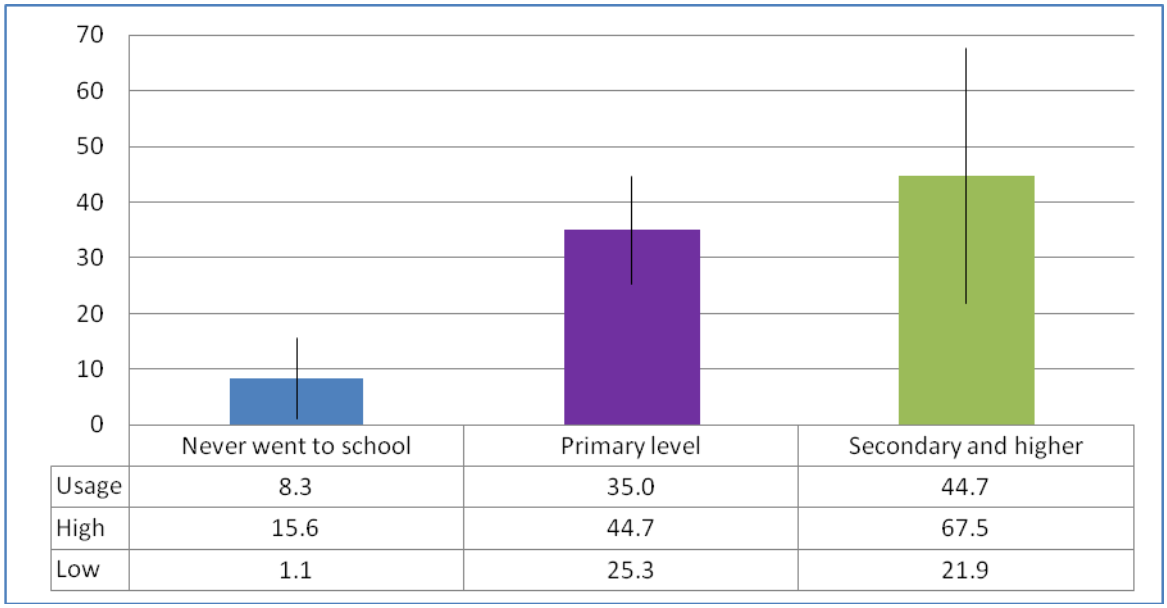
Want same number like partner	39.4	6.8	25.4	53.3	1.882	17.3	99
Want more children	29.9	8.3	12.8	47.0	3.161	27.8	97
Want fewer children	(19.2)	9.7	0	39.3	1.533	50.5	26
Do not know what partner wants	11.4	3.7	3.7	19.0	1.066	32.5	79
Not stated	*	*	*	*	*	*	9
Agreement with partner regarding child spacing (Sig p-value - 0.018)							310
Agree with partner on child spacing	31.8	6.0	19.4	44.2	2.878	18.9	173
Do not agree	30.6	6.8	16.6	44.6	1.332	22.2	62
Have no children to space	(20.0)	8.7	2.2	37.8	0.889	43.5	20
Never discussed it	10.9	5.2	0.1	21.7	1.534	47.7	55

Note: Figures in parentheses are based on 20-29 cases while an asterisk indicates that a figure is based on less than 20 cases and has been suppressed.

3.8.1 Education

Respondents who achieved secondary education and above were more likely to use modern contraceptives compared to those who had lower or no formal education (χ^2 - 34.5, p-value-0). It was observed that 44.7% of those respondents who had a minimum of secondary education were currently using modern contraceptives compared to about only 8% among those who had never gone to school. Figure 3.7 below, further confirms significance in the difference in prevalence of use of modern contraceptives. For instance the point prevalence for those that attained secondary education and higher is outside the 95% boundaries of both never went to school and those that attained primary level.

Figure 3.7 Proportion (and 95% Confidence Interval) of Sexually Active Women Using Modern FP Methods by Level of Education



	Never went to school	Primary level	Secondary and higher
Usage	8.3	35.0	44.7
High	15.6	44.7	67.5
Low	1.1	25.3	21.9

3.8.2 Religion

The study established that there is a relationship between religion and the use of contraception methods (χ^2 -18.9, p-value-0.0003). The current use of modern contraceptives was lowest among Muslims (16.7 percent) and Catholic respondents (22.7%). The use was highest among Protestants (38.9 percent). Figure 3.8 below, further confirms that this difference was significant; as it can be seen from the point estimate of contraceptive use for protestant is outside the 95% boundaries of both Catholics and Muslims. The results from quantitative data are consistent with the statements that emerged from the key informants study participants. The emerging feedback observed that some religious leaders were opposed to the use of modern contraceptives. This was more prominent among the Catholic and Muslim establishments. This was through preaching sending out opposing messages and not providing modern family planning services at their outlets. On the other hand, it appears the religious beliefs negative effect was not universal as some members of the stated denominations continued to use modern family planning irrespective of the resistance. The other religious denominations like the Protestants did not show any opposition to the modern contraceptive use. The influence of religion especially the Muslim and catholic religions appear to have had negative effects in Yumbe district and the Karamoja region where uptake of family planning services were at 12.8% and 9.9%, respectively compared to 57% in Kanungu district. Issues related to religion are illustrated in the statements below:

> *The church which has a very conservative view towards modern contraceptive use would rather promote and advocate for the natural methods which are consistent with the traditional child spacing and cultural methods that are common among*

the Karamojongs. The Biblical concept of produce, multiply and subdue the earth is promoted

(Kaabong Local Government Key informant).

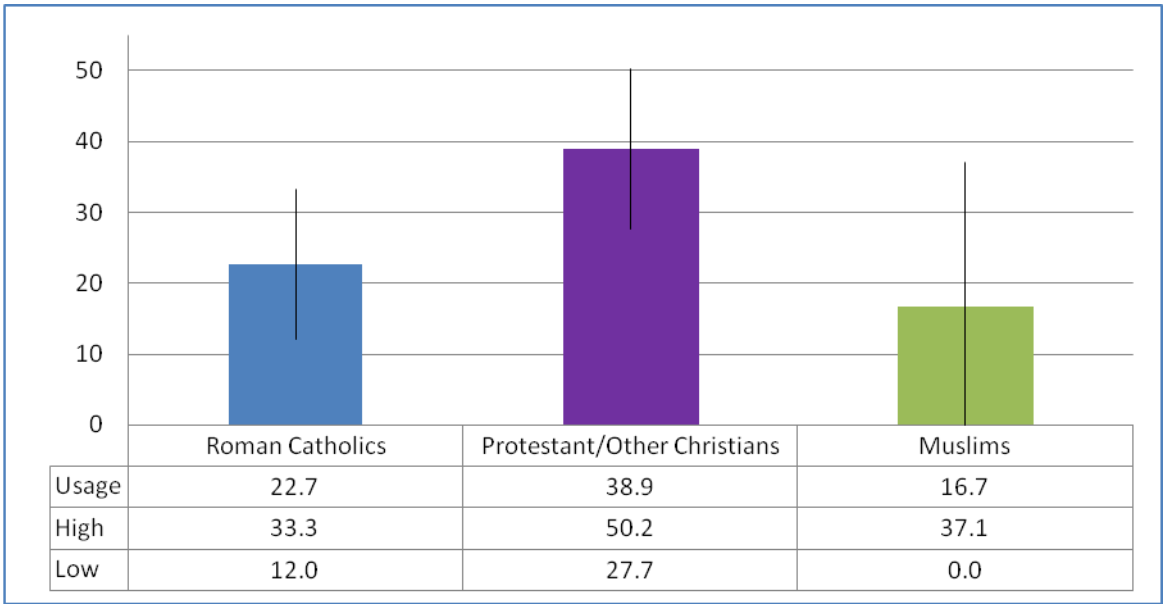
Catholics don't support the use of artificial family planning methods and equate it to murder which the bible condemns. Therefore, true Christians should not use family planning ***(Non-Users FGD Kanungu).***

Basically, it's the Catholic Church that does not provide for modern family planning and strongly opposes any form of scientific family planning methods. It only promotes natural ones. Other religious sects (Bisika group in Fort portal and the Pentecostals) discourage family planning uptake. Many people believe them and follow their advice. Some even discourage use of any modern medicines ***(District Level KI Kanungu).***

Among most religions like Islam and Catholics, the practices of modern family planning methods are seen as a sin against God. It's taken as murder. They discourage it totally. The Protestants are more liberal but do not support it openly ***(Community Service Provider, Kanungu).***

There are few Christians in this community and the Quran does not allow the use of contraceptives. If Allah has refused, we cannot use it, though I would want to use it, I fear the repercussions ***(Non-Users FGD Yumbe).***
Catholics say the use of contraceptives is a sin, its being discouraged. Our religious leader says using contraceptives is wasting the chance God gave you to have children ***(Users FGD Yumbe).***

Figure 3.8: Proportion (and 95% Confidence Interval) of Sexually Active Women Using Modern FP Methods by Religion



	Roman Catholics	Protestant/Other Christians	Muslims
Usage	22.7	38.9	16.7
High	33.3	50.2	37.1
Low	12.0	27.7	0.0

3.8.3 Tribe

The use of contraceptive use varied across the different tribes, that is some ethnic groups were more likely than others to use FP methods (χ^2 - 48.6, p-value-0). The use of FP methods was higher in Runyakitara and Buganda tribes (50%) and lowest among the Karamajong (6.1%). This influence is likely to have impacted on the prevalence of contraceptive use in Yumbe district and the Karamoja region where uptake of family planning services were at 12.8% and 9.9%, respectively compared to 57% in Kanungu district.

3.8.4 Mobility

Respondents that were continuously living in the surveyed area were less likely to use contraceptives compared to respondents that had immigrated that is lived somewhere other than where the survey team found them (χ^2 -5.4, p-value -0.01); modern contraceptive use was 20.4% and 32.4% respectively.

3.8.5 Period stayed in Area (for immigrants)

Immigrants that had stayed less than 5 years in the study area were less likely to use contraceptives compared to those that had stayed for more than 5 years (χ^2 -9.5, p-value-0.009); the contraceptive use was 16.3% and 37.4% respectively.

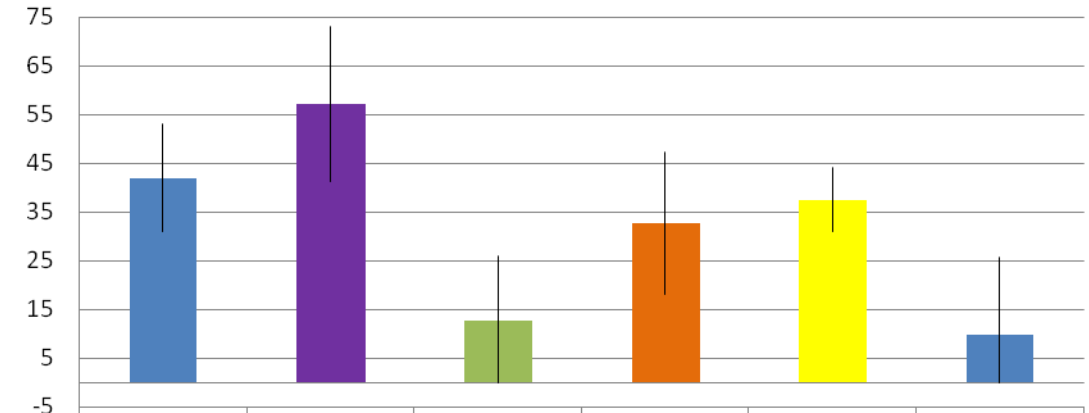
3.8.6 Distance to former place of residence

Respondents who indicated that they came from a distance that was 100 kilometers and above away from where the survey team found them, were more likely to use contraceptives compared to those that came from below 100 kilometers (χ^2 -11.8, p-value-0.02); the prevalence of contraceptive use was 38.8% and 29.9% respectively.

3.8.7 Area of Residence

The findings of this study indicate that there was heterogeneity in prevalence of contraceptive use among the surveyed districts (χ^2 -47.5, p-value-0). While the prevalence of FP use was about 13% in Yumbe district this figure was as high as 57% in Kanungu district. When the confidence interval estimates around the prevalence of family planning use were determined across the eight study districts, the results revealed that compared to the districts in the Karamoja region which had the lowest level of use of modern family planning methods, female respondents from the districts of Kanungu, Katakwi and Mubende had significantly higher level of modern FP use. The 95% confidence intervals shown in figure 3.9 indicate that there was no difference in modern FP use between Karamoja and Yumbe districts.

Figure 3.9: Proportion (and 95% Confidence Interval) of Sexually Active Women Using Modern FP Methods by Residence



	Mubende	Kanungu	Yumbe	Oyam	Katakwi	Karamoja
Usage	42.0	57.1	12.8	32.7	37.5	9.9
High	53.0	73.0	25.9	47.2	44.1	25.8
Low	31.0	41.3	0.0	18.1	30.9	0.0

3.8.8 Knowledge of source of FP Method

A clear association was noted between knowledge of the source of the FP method and use. Those who knew a source of FP method were more likely to use FP than those who did not know FP source(χ^2 -12.2, p-value-0.00005). About 30% of those who knew the source of FP methods used modern contraceptives compared to none at all among those who were not aware of the source of family planning methods. As a means of validating information from the structured questionnaire, information was sought about the understanding of the concept of family planning and the awareness of modern contraceptive methods. This was done through key informant interviews and FGDs. The observation from these other approaches confirmed that the study population understood the family planning concepts and methods. There was higher knowledge in urban areas compared to rural areas. Some methods like the pills and injectables were more known whereas the implants were not known especially in Mubende district. The respondent's understanding (knowledge) of family planning is illustrated in following statements on family planning:

> *This is when two partners agree when to and when not to have children. It's reducing the rate of producing or giving birth to children through using contraceptives that allow you to space the births* ***(Male user FGD Moroto).***
>
> *This is when a child has grown up and is able to walk and even fetch for his parents drinking water, then a woman is ready to conceive again and her menstrual periods have returned"* ***(Female non user FGD Moroto)***

Family planning is the way one can control his/her birth rate and take good care of them i.e. Controlling the production of children one can take care for, even when marrying wives, one must be aware that he can provide for them. Human beings are not supposed to be like pigs ***(Elders FGD Mubende).***

The methods we know are the IUD "Kaweta", the pills, the implant, jelly/foam, injections and sterilization. The implants have just been introduced so many people don't yet know them ***(Youth FGD Mubende).***

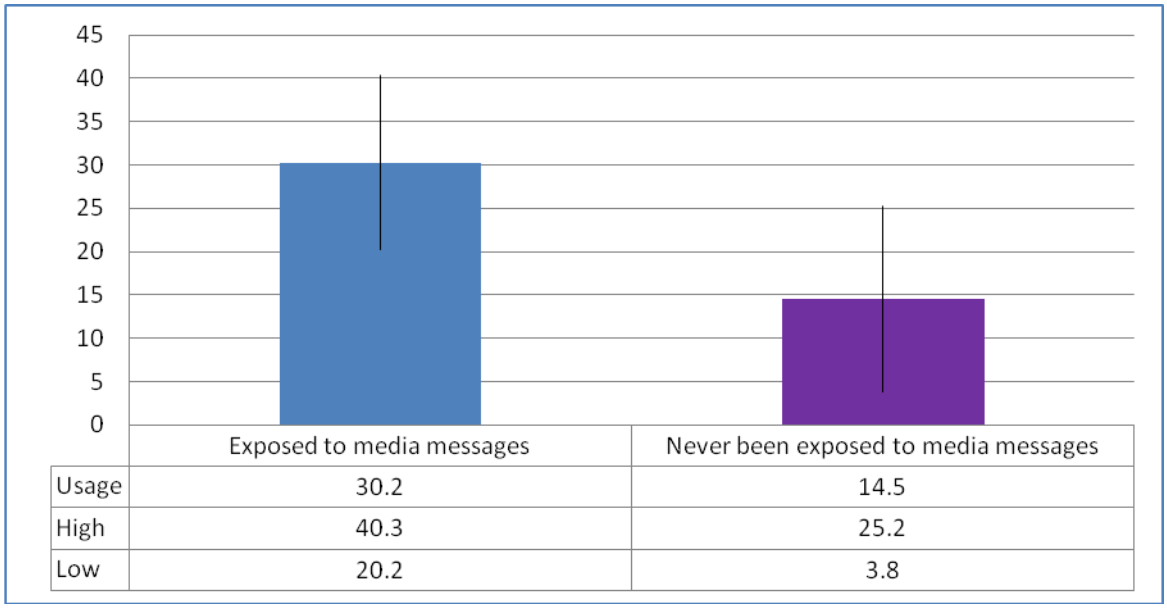
We know the pills and injections. We have heard about the coil but we have never seen it. There are capsules/norplant which they put in the hand ***(Discontinuers FGD Mubende).***

3.8.9 Exposure to media messages on FP

Awareness and knowledge of FP is very important in facilitating the use of FP. This is so because knowledge of the benefits of and knowledge of a source where a family planning method could be accessed are a precursor to FP use. Such type of information can be obtained through exposure to FP messages that are disseminated through various channels including the mass media. During the survey, assessment was made whether respondents had been exposed to FP messages and if so, the sources of messages. The analysis of quantitative data has indicated that a number of respondents had been exposed to FP messages from a variety of different sources. Radio is the single most common source of FP messages cited by both men and women. Of men and women who had heard of a FP method, 73 and 78 percent said it is from radios, respectively.

Newspapers/magazines are the second most common source of FP messages. Among men and women who had heard of a FP messages, 27 and 22 percent said they got it from newspapers/magazines, respectively. The third most commonly cited methods are both TVs and film shows. The χ^2 statistical test of significance showed that sexually active women who were exposed to family planning messages were more likely to use a modern contraceptive method than sexually active women who were not exposed to FP messages (χ^2 -6.2, p-value-0.005). Hence, exposure to FP media messages is regarded as a key determinant to the use of modern contraceptive services. Figure 3.10 below shows the confidence limits around the estimates.

Figure 3.10: Proportion of Sexually Active Women Using Modern FP Methods by Exposure to Media Messages on FP in Recent Months



	Exposed to media messages	Never been exposed to media messages
Usage	30.2	14.5
High	40.3	25.2
Low	20.2	3.8

3.8.10 Encouragement from Male partners

Male support for family planning use is critical in promoting use of family planning services. An assessment was made through the different approaches of the level of male support and how it influenced contraceptive use. During the exit interviews, clients were asked whether they had received encouragement from their partners. In response, 65 percent of the respondents said that they have ever been encouraged while 35 percent said that they had never been encouraged (figure 3.11). The specific support that had been received from partners was in form of moral support and giving advice/ideas (32 percent), provision of financial support (26 percent), provision of consent (24 percent) and escorting the women to the clinics (15 percent). Equally, information from the respondents in the general population (structured) questionnaires interviews show that 52 percent of respondents reported getting encouragement to use a family planning method from their partners while 36 percent said that they had never been encouraged (figure 3.12). When comparison is made between women who want the same number of children as their partners with those women who do not know the partners' preferences, the difference in family planning use was statistically significant (see Figure 3.13). Respondents that needed the same number of children like their partners were more likely to use contraceptives than those whose preference (on number of children) differed from that of the partners (χ^2 -18.7, p-value-0.0009).

Figure 3.11: Percent ever got encouragement from partner to use an FP method (N-82); Exit interviews

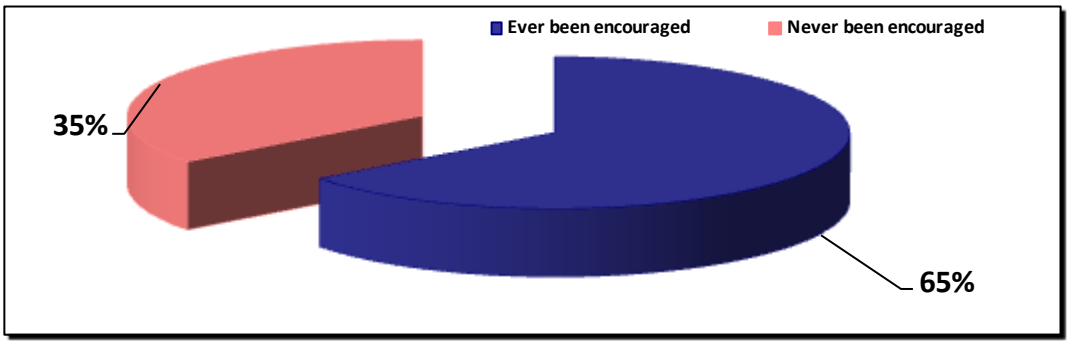


Figure 3.12: Women Ever Obtained Encouragement from Partners to Use a Family Planning Method (n-166); Structured Questionnaire interviews

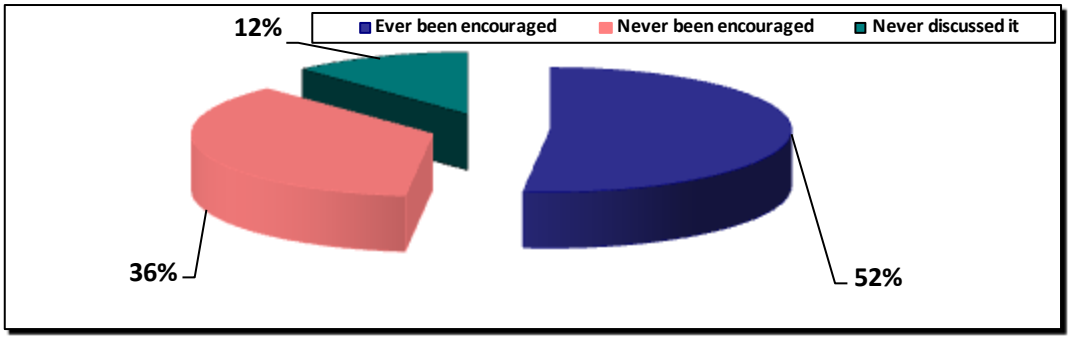
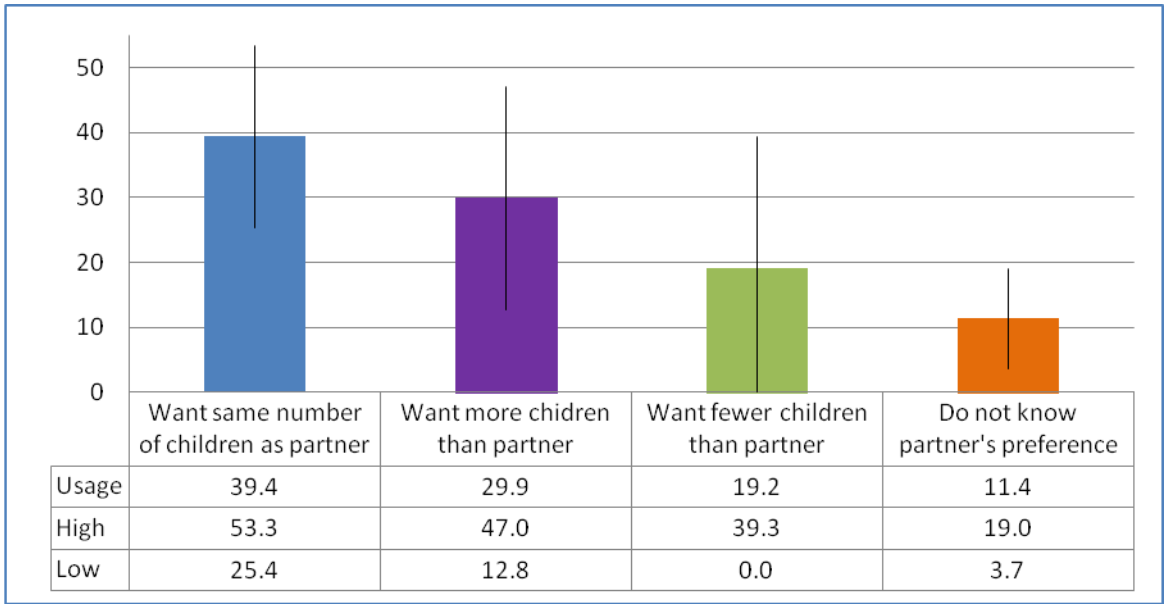


Figure 3.13: Proportion of Sexually Active Women Using Modern FP Methods by Agreement with Partner on Number of Children

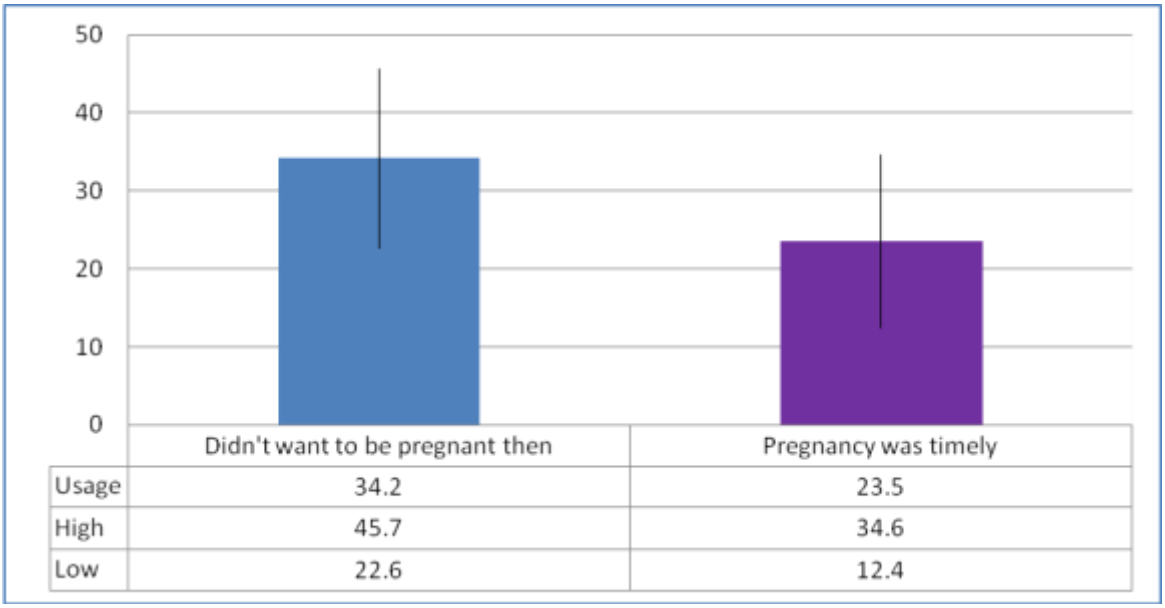


	Want same number of children as partner	Want more chidren than partner	Want fewer children than partner	Do not know partner's preference
Usage	39.4	29.9	19.2	11.4
High	53.3	47.0	39.3	19.0
Low	25.4	12.8	0.0	3.7

3.8.11 Need and demand for FP services at time of pregnancy

Analysis was done to determine among women age 15-49 who have ever been pregnant, the percentage whose current pregnancy or last birth (for non pregnant women) was mistimed/unwanted; and also, out of those women who are currently using some method of family planning, the proportion who reports that the last time they became pregnant they wanted to become pregnant then, by background characteristics. The results show that 35 percent of women who are currently pregnant or got pregnant sometime back said that their current pregnancy or their last birth (for non pregnant women) was mistimed/unwanted. When analysis was done considering the respondent's number of living children, The magnitude of this reported undesired pregnancy decreases with the number of living children; it is 51 percent in those with 1-2 children, 33 percent in those with 3-4 children and 27 percent in those with 5 or more living children. Analysis also reveals that the proportion of women who are currently using some method of family planning who say that the last time they became pregnant they wanted to become pregnant then is 15 percent. There is variation in the variable by employment status, number of living children, education and age of the respondent; it is higher among the employed respondents (16 percent) than in the unemployed respondents (8 percent); it increases with the number of living children where it is 8 percent among those with 1-2 living children, 14 percent among those with 3-4 living children and 21 percent among those with 5 or more living children. The variable also increases with age; varying from 4 percent among the 20-24 age group to 21 percent among the 30-34 age group; thereafter, it remains more or less the same (20 percent). In summary, it was observed that need and demand for family planning services leads to more use of the services. Respondents that found the previous pregnancy untimely were more likely to use contraceptives compared to those who found it timely (χ^2 -6.4, p-value-0.042). Among those who needed to get pregnant later or not at all 34.2% were using modern contraceptives. The results are shown in the Figure 3.14. This proportion is significantly higher than the level of modern family planning use among women who said that their pregnancies were timely (23.5%). Therefore, the results suggest that the need and demand for family planning can be a determinant for family planning use.

Figure 3.14: Proportion of Sexually Active Women Using Modern FP Methods by Demand for FP Services at Time of Pregnancy



	Didn't want to be pregnant then	Pregnancy was timely
Usage	34.2	23.5
High	45.7	34.6
Low	22.6	12.4

3.8.12 Agreement with partner regarding child spacing

Those who had agreement with partners to use FP method were more likely to use FP methods than those who never discussed FP use with their partners (χ^2 -10.1, p-value-0.018). It was observed that in some study districts like Katakwi male support was more evident compared to others and this was also influenced mainly by economic challenges in the families and as a means of enjoying the health benefits related to family planning. Overall, the male support appears to be a lot higher than what is usually assumed and this is consistent with the observation among the female family planning users in the general population and clients of exit interviews which was noted to be 52% and 65%, respectively. Additional support for this finding is reflected in the statements below:

> *The family members are in support of child spacing because it gives the children an opportunity for healthy growth. However, on how it should be done is left to the husband and wife to decide on* ***(Female user FGD).***

> *The family trend here generally is that most men are supportive and give a go ahead for women to enroll for contraceptive use on consent although there are cases of a few who seem not to give support* ***(Community member KI Katakwi).***

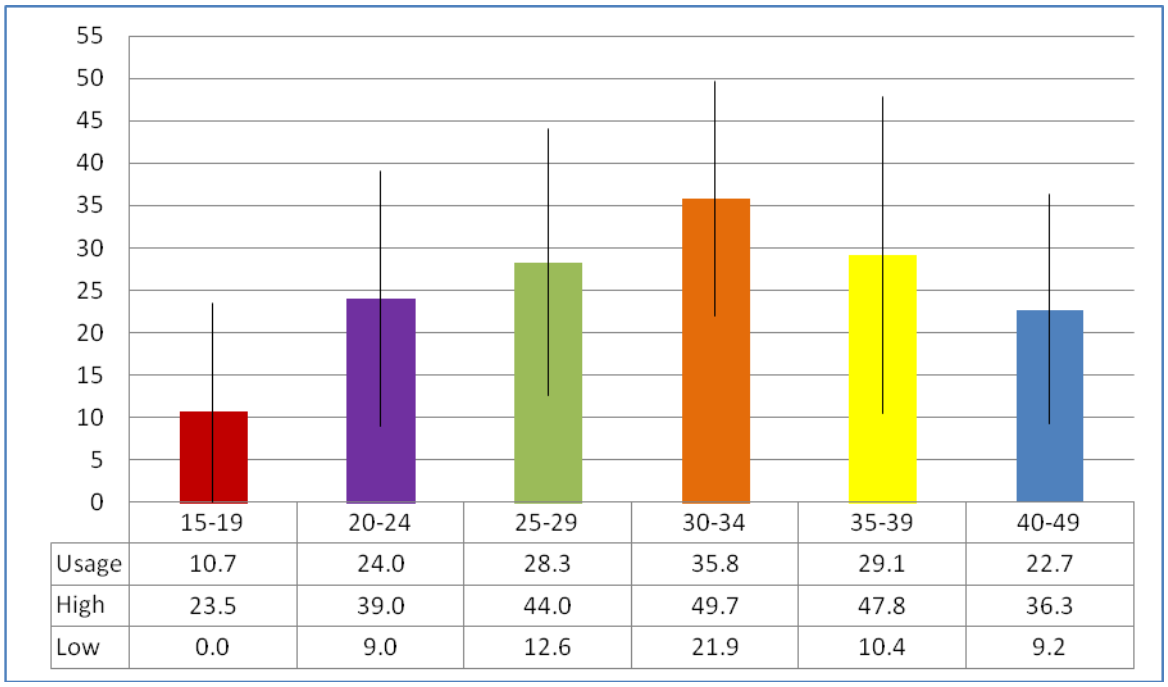
> *Husbands only succumb to the use of family planning once there are emergencies and difficulties like during birth and difficulty at labour period. The family members and relatives are encouraging proper spacing and fewer*

children due to the limited family/clan land for settlement and agriculture ***(Community service provider Katakwi).***

3.8.13 Age

The use of modern contraceptives appears to increase with age in the study area up to the age of 34 years after which a decline is noted until the age of 49 years. This is illustrated in Figure 3.15; the figure shows that there is some relationship between the ages of women with the use of modern contraceptives. For instance the point estimate for age 15-19 is significantly different from the 95% intervals for 25-29 and 30-34 age groups; since 10.7% (for 15-19) is outside the intervals [12.6-44.0%] for 25-29 and [21.9-49.7%] for 30-34. However, on testing for significance this study did not identify a clear relationship between age with the use of modern contraceptives (χ^2 -7.9 and p-value- 0.246). Thus age is a weak determinant of FP use.

Figure 3.15: Proportion of Sexually Active Women Using Modern FP Methods by Age



	15-19	20-24	25-29	30-34	35-39	40-49
Usage	10.7	24.0	28.3	35.8	29.1	22.7
High	23.5	39.0	44.0	49.7	47.8	36.3
Low	0.0	9.0	12.6	21.9	10.4	9.2

3.8.14 Marital Status

From the quantitative survey methods, the survey results revealed that marital status did not have significant impact on the current use of modern contraceptives. Twenty seven percent (27%) of the married 29% of those who had never married, and about 30% of those who had divorced/separated reported to be using modern contraceptives (χ^2 -0.9, p-value-0.82). The χ^2 test shows that the use of FP methods is similar in all the different categories of marital status. Therefore, marriage is not regarded as a determinant of use of modern family planning according to study results.

However, according to data from qualitative survey methods, the nature of female relationship, whether single or married or polygamous led to the creation of a conducive environment for use of modern family planning. In rural setting, those in single relationships were in a better environment to use modern contraceptives. In addition, the state of the marriage influenced either use or non-use of modern contraceptive as those in stable marriages with minimal domestic conflicts were likely not use modern contraceptives as compared to those respondents in unstable insecure relationships who dreaded having children. On the other hand, those wives in polygamous relationships tended to compete with co-wives to establish who among them was more fertile. This is supported by statements below:

> *This being mostly a slum area, the household structures vary, there are quite many single women who are involved in unstable relationships, however unlike the married women, these women have the ability to use contraceptive freely* ***(Community member KI Moroto).***
>
> *If the man has more than one wife, there will be competition on who produces more than the other. The first wife would perhaps want to stop when the second wants to edge out the first one on the number of children she has in the family* ***(Elders FGD Mubende).***

3.8.15 Socio-economic insights

Again, findings from the questionnaire interviews demonstrate that there is a significant relationship between education and use of modern contraceptives whereas that of employment was not statistically significant. The questionnaire did not capture data on rural-urban dimensions but the results from qualitative part of the survey assessed this relationship and revealed that the more educated urban based and economically stable women were noted to be more likely to use modern contraceptives compared to their rural counter parts. The other socio-economic factors affecting the use of modern contraceptives include: poverty leading to failure to afford transport to service outlets, having many children was taken as a source of future wealth and as an opportunity for better package of handouts from relief organizations like World Food Programme, since food was provided at FP service clinics, going for FP services was taken as an opportunity for getting a meal, and especially by poverty stricken families. The above viewpoints are supported by the statements below:

> *The cost of transport to health facilities is high and the roads are inaccessible especially during the rainy season. The population here is so conservative on particular activities which they don't see as being important, some cannot sacrifice the little money they have to board cars to go for family planning services* ***(Kaabong Local Government Key informant).***
>
> *Women with economic independence; and are educated have the ability to use family planning freely and even some of them visit the health facility for service as a couples but this is only witnessed here in Kaabong town where*

most of the users are educated workers who are only here to work but not natives of Kaabong ***(Kaabong Local Government Key informant).***

As earlier mentioned, children are attached to property value of dowry especially for the girl children who are taken as a source of wealth, so such desire certainly affects contraceptive use. The children also build on a man or woman's social status and value and this is responsible for the desire of more children for respect in the communities. The more the children, the bigger the handouts from the relief and humanitarian organizations like WFP, and this is highly appreciated in the community as the bigger numbers are perceived to be the wealthy ones ***(Kaabong Local Government Key informant).***

Those who are well educated and have seen the need for fewer children and child spacing and are planning according their resources are the ones to go for contraceptives; however, it's the poor who desire more children and therefore do not consider enrolling for family planning ***(Female user FGD Katakwi).***

3.8.16: Individual Benefits and Risks

This section provides information on how the expected individual benefits and risks affected the initiation and continued use of modern contraceptive services. It was observed that the clients using family planning services were motivated by the benefits like, having healthier families, better bonding between mother and child, better upbringing for the children, adequate time for the mother to regain strength and heal. On the other hand the fear of risks and problems like side effects led to either non-use or discontinuation of methods.

As already mentioned, the study reported method side effect as the number one cause of method discontinuation, the second most common cause of non-use and the number one cause of method change. Except for users that desire to go for longer term methods, the method side effects have been instrumental in causing users to change to other methods. Key common side effects associated with all methods depending on the user included; loss of desire for sex, weight gain, non-stop headache, heavy menstrual flows or over bleeding, Weight loss/slimming which people misinterpret as HIV and AIDS, general body weakness which comes with nausea and dizziness, taking long to conceive after discontinuation.

Some side effects were found to work in favour of sustained family planning use, but the majority of them were discouraging to users. Weight gain is said to make women look healthier than being skinny prior to using the method. Other side effects make users to opt for other methods, in situations that that side effects persist they discontinue.

It should be noted that despite the side effects, sometimes the desire to stop unplanned pregnancies is strong enough prompting users to persevere with side effects. Strong desire

that cause users to persevere against the odds include; school and job commitments, desire to have a manageable family, hence controlling the escalating number of children and hard economic times that makes it hard to care for large number of children. These scenarios are reflected in the statements below:

> *At first, I used an injection, but I bled until the end of the 3 months, took another injection for 3 months but the bleeding couldn't stop, I gave up and started on using pills which never had any effect on me, hence I went on to use pills because they were acceptable in my body* ***(Discontinuers FGD Mubende).***
>
> *When people hear complaints from those that are having bad side effects like loss of weight, vomiting and prolonged menstruation, they get discouraged and they shun modern methods (****Discontinuers FGD Yumbe****).*
>
> *They mainly stop due to side effects especially over bleeding and persistent spotting. Some mothers fail to get health services due to long distances and other commitments they have at home e.g. house hold chores, child care and farming, so they get discouraged. When the child makes one year, they stop because they want to get pregnant (****Service Provider Yumbe****).*
>
> *It gives you enough time for yourself and your children. Ability for the women to regain all the strength lost during child birth and also gives the womb the time to properly heal. The sickness syndrome is reduced in the family as the immunity of the children is boosted through prolonged breast feeding and proper care and love* ***(Satistified user KI Kaabong).***
>
> *Children of families on family planning get better upbringing especially given the fact that the parents have more time for the children in between births* ***(Community FGD Kotido).***
>
> *They may start family planning use because of the experience of the previous delivery if an individual had a complication. The poverty, increasing age and minimal side effects with proper sensitization influences them to initiate a family planning method* ***(Service Provider KI Mubende).***

3.8.17: Peer Influence

Results from the key informant interviews suggest that peer influence contributes to both initiation and continued use of modern contraceptives. Some respondents reported that peers influence their colleagues by influencing discontinuation and discouragement to enroll for modern contraceptives. Men and women often share experiences including reproductive health matters. Individuals who experienced complications in using modern methods use this platform to convince others not to enroll or discontinue current method. However, this platform was found to be used by satisfied users too to convert those that

have fears on modern methods. Men were reported to be convinced by their peers to give birth to as many children as possible including getting encouragement to marry other women. Women were also reported to share experiences on the number children they have and they plan to have. The study findings indicated that women in polygamous families are advised by their peers to compete with co-wives on who gives the husbands more children.

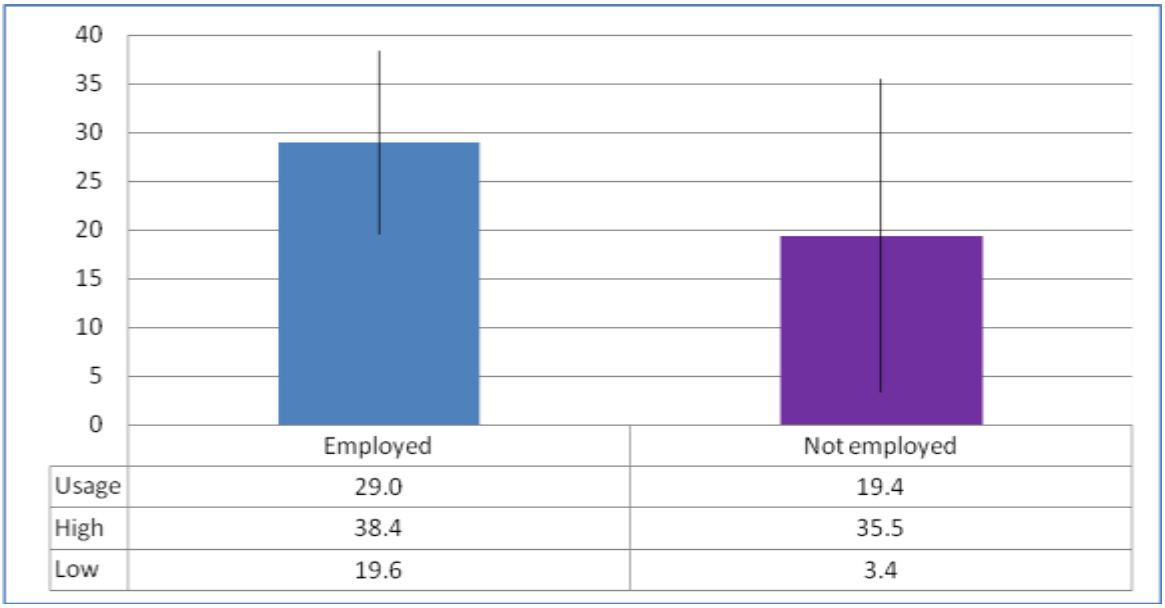
> *Some clients are also being influenced by friends to change the method being used. Also because of contraceptive duration some opt from short term family planning methods to long term or the reverse depending on the objective prioritized* ***(Community service provider Katakwi).***

> *Peer influence especially from other clients who have used these methods and have not found difficulty with them* ***(Service Provider KI Kaabong District).***

3.8.18 Employment Status

The confidence intervals which are reflected in figure 3.16 below show some relationship between employment and use of modern contraceptives; the point prevalence for those that are not employed is outside the 95% boundary of those that who are employed. That is, generally, the survey results revealed that respondents who had employment had a higher prevalence of modern contraceptives use compared to those who were unemployed. Theoretically, this finding could be related to the nature of engagement where having frequent deliveries would affect their work outputs and they are likely to be less opposed to the use of modern contraceptives. Specifically, use of contraception methods was higher among those employed (29 percent) than in those who are unemployed (16 percent). However, χ^2 statistical tests of significance showed that there is no difference in family planning use between the two employment categories (χ^2 -2.0 and p-value- 0.074). Therefore, employment is not regarded as a key determinant of use of modern contraceptives.

Figure 3.16: Contraceptive use by Employment Status



	Employed	Not employed
Usage	29.0	19.4
High	38.4	35.5
Low	19.6	3.4

3.8.19 Number of living Children among Females

It was observed that women who had more than three children were more likely to use modern contraceptives compared to those who had two or less children. About thirty percent (30%) of women with 3 or more living children are using modern contraception whereas about 21% of those with 1-2 children are currently using family planning services. However, χ^2 statistical tests of significance showed that there is no difference in family planning use across the categories of number of children possessed by respondents (χ^2 - 2.9 and p-value- 0.408).

3.9 Community Level Determinants

This section presents two categories of community level determinants including; i) the influence of some people in the community as defined by culture and ii) the provider environmental issues. The specific role of male support was discussed in section 3.8.

3.9.1 Community power and cultural Influence

The survey results show that decision making about family issues including having children go beyond the immediate family. In addition to the husband's influence, influence also was observed among the in-laws, opinion leaders who varied from setting to another and these included kraal leaders[1], warriors and Manyatta[2] leaders in the Karamoja settings who were expected to protect and preserve the culture. The power of the husband and community was further consolidated by payment of dowry which further disempowered

[1] Kraal leader:The persons in charge of where the collected heads of cattle are kept.
[2] Manyatta: A group of homesteads in one enclosure.

the females. Decisions about use of contraceptives were made collectively under the guidance of the opinion leaders like Heads of Manyatta whose decisions were complemented by community policing. Discontinuation of an FP method use was commonly reported on the discovery of the use by a non supportive community member.

The cultural value systems varied from area to area. However, the societal cultural norms were opposed to modern contraceptives and derived pride from having many children. The community opposition to use of modern family planning was more visible in the Karamoja region compared to other areas. Those supportive of family planning were stigmatized by the rest of the community and as such affecting the use of modern contraceptives. These issues are reflected in the statements below:

> *Even in our communal settlements, such decisions must be reached in a meeting chaired by the Manyatta head so that the community or your in-laws don't put the blame on you when something bad like death during birth of the baby or mother occurs, because they are in full knowledge of the situation. This is followed by community policing* ***(Non-users male FGD Kaabong).***

> *In cases where elders discover that one enrolled in FP use, they will forcefully cause that woman to terminate the method and ensure that the husband makes her conceive, this is a very common practice in Poet* ***(Community FGD Kotido).***

> *Culturally, having many children is a pride and therefore as a man, many children earn you respect. Therefore, they do not use contraceptives. Many children are also culturally believed to be a source of dowry especially for the girl children* ***(Kaabong Local Government Key informant).***

> *Some people use traditional kiganda methods of herbs. Our culture is such that a woman is brought or married to produce- nothing else; no compromise on this or else what did she come to do? Slogans like "yajja kujuza toyi" Did she come to fill the toilet (****District KI Mubende).***

> *There is stigma against those using contraceptive because they have gone against the traditionally acclaimed and accepted methods of child spacing* ***(Community Level FGD).***

3.9.2 Environmental Determinants

By definition, the environmental determinants are those external to the individuals but influence the utilization of services mainly related to service provision. These determinants contribute to non-use, continued use and discontinuation of modern contraceptives. The survey results show that the environmental factors varied from region to region depending on the service infrastructure and consumables.

In the Karamoja region, the factors observed included the limited accessibility of family planning services due to the long distances to health facilities, the role played by politicians who were not supportive of the family planning concept, some form of insecurity, low literacy rate, nomadic characteristic in the population which leads to discontinuation or non-use, limited knowledge on family planning, limited training of service providers and uncertainties related to child survival led to non use of contraceptives. Some stock-outs for particular family planning methods also contributed to discontinuation of contraceptive methods. Programme design was noted to be biased towards women as such contributing to limited male involvement. The quality of family planning services including provision of snacks also influenced the continued use of family planning services. Availability of integrated health services like FP with immunization provided an opportunity to access family planning services; this also involved men.

In addition, similar problems are experienced in other study areas and they include: limited support by the political leadership, long distance to the service outlets among other things. Whereas these factors promote non-use, some districts had more favourable conditions for use of modern contraceptives than others, especially Kanungu and Mubende districts. These factors are summed up in the statements below:

> *The other factors affecting the use of contraceptives are insecurity, the nomadism of the population and low illiteracy levels* ***(District Level KI Kotido).***
>
> *Political leadership is mainly against family planning services and discourages users; they encourage more child births and criticize family planning. However, some political leaders together with health workers have encouraged people to adopt family planning through different forums like campaigns, health meetings and other community events* ***(Community level KI Kotido).***
>
> *The nearest health facility to the village (Kathile HCIII) is very far with completely no access road to the health unit and services at facility are so poor, most of the times the facility has no operational medical personnel present to attend to clients* ***(Community Provider KI Kaabong).***
>
> *The services are readily available and even better in the town areas but the population in the rural areas is still bigger and yet they are the ones against FP use* ***(Female user FGD Moroto).***
>
> *Current policies, by laws, at national, district, local councils e.g. in health, education like punishing those who do not take all children to school are good and contribute to FP use* ***(District Level KI Mubende).***
>
> *Professional counseling that motivates enrolment for FP use, availability of service throughout, friendly nature of services providers and proper*

management of side effects. Clients have a variety of choices freely ***(Community service provider Moroto).***

3.10: Reasons for non-use of modern contraceptives

Information was sought to get the reasons for non-use of modern contraceptives at different levels. At individual level, the reasons for non-use of contraceptives were categorized as sexual behavior, fertility related, opposition to use, lack of knowledge and method related. Specifically 22% of the respondents cited need for more children followed by 12.2% who cited fear of side effects as the reasons for not using any methods. The other key reasons extended included: Having no knowledge of FP method (9.4%), culture (8.5%) and opposition by partner (7.9%). These cited reasons influenced the individuals not to use modern contraceptives. The details are presented in table 3.12.

Table 3.12: Reasons cited for Never Used Any Family Planning Method (n - 310)

Reasons cited	Number of responses	Percent
Sexual Behavior		
Not married/Don't have partner	13	2.7
Does not have sex	12	2.5
Have infrequent sex	17	3.5
Fertility Related		
Need more children	106	22.0
Menopausal/Hysterectomy	4	0.8
Cannot get pregnant	4	0.8
Menstruation takes long to come back after delivery	2	0.4
Still breast feeding	9	1.9
Opposition to Use		
Respondent does not want FP methods	13	2.7
Partner does not want FP methods	38	7.9
Friend relative opposed use of FP methods	7	1.5
Religion is against use of FP methods	13	2.7
Culture is against use of FP methods	41	8.5
Lack of Knowledge		
Have no knowledge of FP method	45	9.4
Don't know source of FP method	9	1.9
Method Related		
Fear side effects of FP methods	60	12.5
Cost of FP methods is high	6	1.2
Source of FP methods is far	14	2.9
Available FP method(s) not effective	3	0.6
Preferred FP method not available	3	0.6
FP is inconvenient to use	7	1.5
FP interferes with body's normal processes	30	6.2
Other Reasons		
Don't want FP methods/want to have as many children as God can provide	4	0.8
Periods take long to come back/naturally take long to conceive	6	1.2
Prefers the wife/partner to use the method	4	0.8
Prefers traditional/natural methods	9	1.9
Do not know why never used	2	0.4
Total	481	100.0

Note: A respondent was allowed to give more than one reason

The qualitative data also revealed some reasons for non-use and these were consistent with those in the table 3.10; they include fear of side effects, cultural, desire for a male child, illiteracy, higher status associated to having many children, regarding children as a source of wealth, opposition by religious leaders, partner opposition and failure to afford transport costs. These factors are similar to those cited as reasons for discontinuation of use of family planning methods. This is point is further reinforced by the statements below:

High poverty and illiteracy levels here at village and in many parts of the district, people are not educated and this is a big challenge in terms of access to information and acceptance of the contraceptives, hence non-use ***(Community Service Provider KI Kaabong)***

*Children are attached to property value of dowry especially for the girl children who are taken as a source of wealth, so such desire certainly affects contraceptive use. The children also build on a man or woman's social status and value (****Kaabong Local Government Key informant)*****.**

Pills can easily be forgotten and if someone did not agree first with the husband on taking using a FP method, he can easily find out. Condoms if you did not agree with the man he can even take it off during the time of ejaculation ***(Users FGD Mubende).***

Sometimes it's the woman who doesn't like them, they fear that it would get stuck in the woman and the image of a married woman with a condom stuck inside her is shameful ***(Discontinued Users FGD Mubende).***

Sometimes the clients stay at a distance from the family planning clinic; and they may have taken on family planning secretly, so it becomes hard for them to get transport to come to hospital ***(Service Provider KI Mubende).***

Continuous bleeding is a big problem, I had an experience where even after treatment at Mubende hospital, the bleeding could not stop ***(FP users FGD Mubende).***

Pregnancy is very burdensome. Even delivery is problematic – traveling on boda bodas to Bukuya to deliver is traumatic and may lead to still births. This encourages some people to use FP to avoid such traumatic situations ***(Discontinuers FGD Mubende).***

3.11: Future use of Contraception

Analysis was also done to determine the percentage of women age 15-49 who have never used a contraceptive method who intend to use it in the future (table 3.13 and table 3.14). This was done among all women and those who are currently married. In both categories of women, the results show that about half of the women have intention to use a family planning method in the future. Fifty five percent of all women and 52 percent of currently married women said that they have intention to use a family planning method in the future. This shows a positive attitude towards the use of modern contraceptives services in the future. This is also indicative of the future demand for family planning methods.

Table 3.13: Future use of contraception (All Women)

Percent distribution of women age 15-49 who have never used a contraceptive method by intention to use in the future, according to number of living children

Status of intention to use in the future	Number of living children[1]					Total
	0	1	2	3	4+	
Intends to use	66.7	80.0	84.0	52.5	36.3	54.9
Unsure	22.2	0	4.0	17.5	15.0	12.0
Does not intend to use	11.1	20.0	12.0	30.0	48.7	33.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	9	30	25	40	80	184

[1] Includes current pregnancy

Table 3.14: Future use of contraception (Currently married Women)

Percent distribution of currently married women age 15-49 who have never used a contraceptive method by intention to use in the future, according to number of living children

Status of intention to use in the future	Number of living children[1]					Total
	0	1	2	3	4+	
Intends to use	*	81.2	71.4	52.8	38.1	51.5
Unsure	*	0	7.2	13.9	17.5	13.1
Does not intend to use	*	18.8	21.4	33.3	44.4	35.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1	16	14	36	63	130

[1] Includes current pregnancy
* Suppressed due to few cases observed

3.12 Family Planning Method Maintenance/Change

The focus of this study was to establish the determinants of use and non-use of modern contraceptive methods. In this focus, method maintenance, change and discontinuation are critical. This section covers the status of maintaining, changing and discontinuing contraceptive methods. Among the sexually active women who had ever used any modern contraceptive method, it was noted that 31% had changed a family planning method while 69% reported to have maintained the same method. This is shown in figure 3.17 a.

Analysis was done to determine the significance of association between changing or maintaining a family planning method on a number of variables, and the results are summarized in table 3.16.

Figure 3.17 a: Proportion of Women who Changed an FP Method (n-166)-Structured Questionnaire

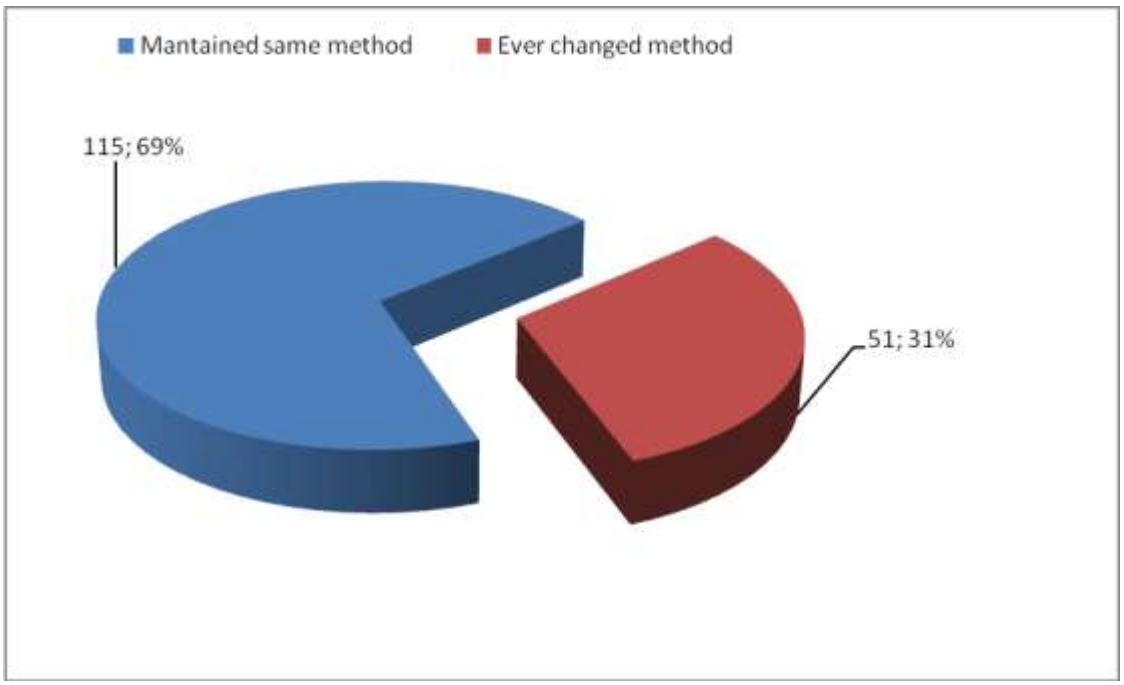


Figure 3.17 b: Percent ever changed a family planning method (n-82)-Exit Interview

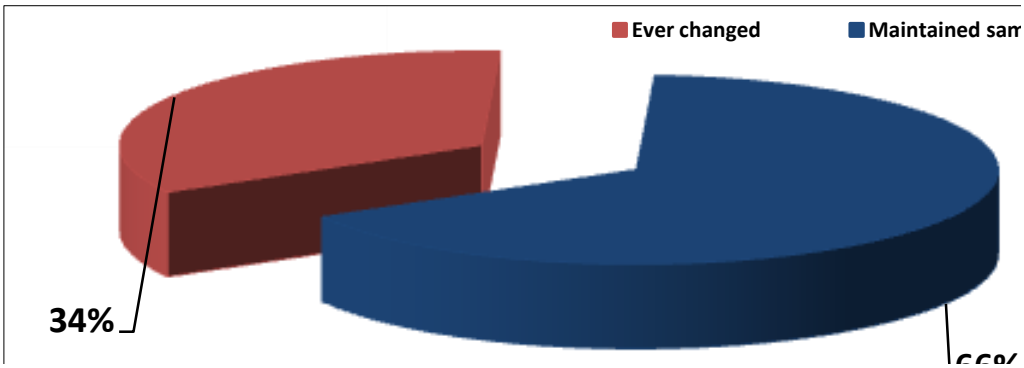


Table 3.15: Sexual activity, ever use, ever changed and knowledge of source of family planning method

Percent of respondents that have ever had sex, those who know source of family planning method, out of those that have ever had sex percent that have ever used a family planning method, and out of those that have ever used a method of family planning percent that changed method(s).

	Among all respondents:			Among respondents that have ever had sex:		Among respondents that have ever had sex:	
Category	Percent ever had sex	Percent who know source of method for family planning	Number	Percent ever used a family planning method	Number ever had sex	Percent ever changed a family planning method	Number ever used a family planning method
Male	83.7	86.9	245	38.5	205	15.2	79
Female	84.7	90.1	413	47.4	350	30.7	166
Total	84.3	88.9	658	44.1	555	25.7	245

The clients who visit FP clinics, are expected to be counseled and provided with information on the different options of contraception, their benefits, side effects and what to do in case they get side effects. Clients are also informed of alternative methods to use in case of side effects. Data from exit interviews were analyzed to assess the factors that lead to change of FP methods. The results showed that of the 82 clients that participated in the exit interviews, 34 percent reported that they have ever changed a family planning method. This proportion compares well with the proportion of 31% which was observed under the structured questionnaire interview (refer to figures 3.17a and 3.17b).

Table 3.16: Relationship between Change of Modern FP Method with Selected Variables - χ^2 Tests

Significance p-values generated when relationship is tested between women's change in use of Modern FP methods with selected variables

Selected Variables	p-value
Age	0.311
Education	0.408
Religion	0.137
Tribe	0.443
Marital status	0.396
Employment	0.355
Mobility	0.029*
Period stayed in area (for immigrants)	0.036*
Distance to former place of residence	0.008*
Number of children ever born	0.778
District/area of residence	0.620
Sexual Relationships; Regular partners	0.214
Sexual Relationship; Non regular partners	0.468
Having children	0.639
Exposure to media messages on FP	0.200
Getting encouragement from partner	0.231
Getting discouragement from partner	0.024*
Preference for number of children needed by women	0.017*
Agreement with partner regarding child spacing	0.299

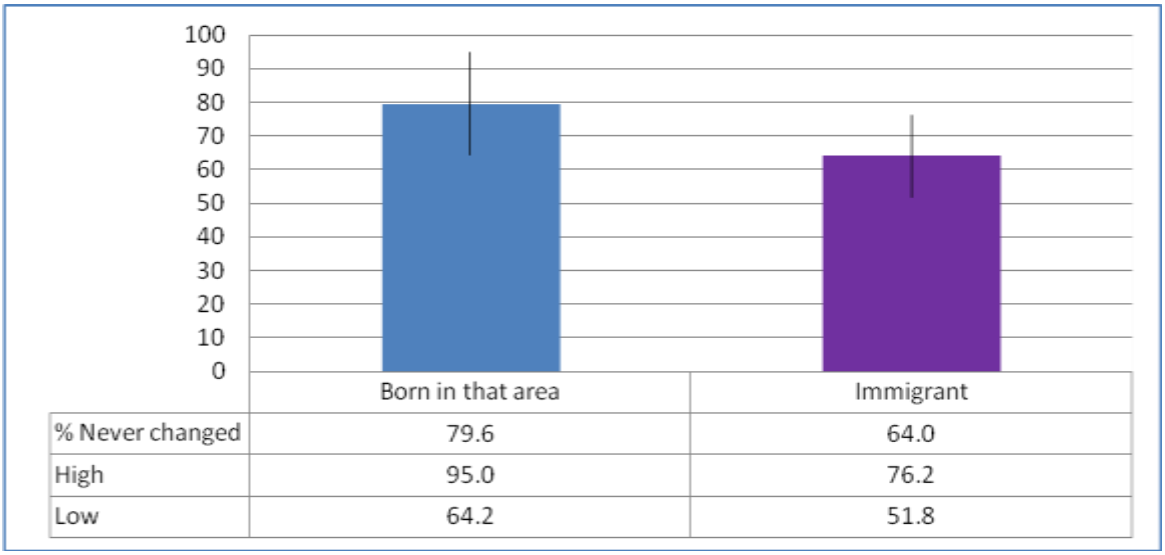
An asterisk indicates that the p-value is significant at level of significance a - 5%; that is, there is a significant difference in the different categories considered for a variable under consideration.

The analysis revealed that four factors determined change/maintenance of FP method used, these were; mobility, period stayed in area, distance to former place of residence and getting discouragement from partner. The proceeding sections present data that were generated when association between each of these factors with maintenance/change of FP methods was sought.

3.12.1 Mobility

About 80% of respondents that were continuously living in the surveyed area reported to have maintained the same contraceptive method whereas 64% of respondents that had immigrated (lived somewhere else in addition to where the survey team found them) reported to have maintained the same FP method. The chi-square test showed significant association between mobility and method change/maintenance (χ^2 -3.5, p-value -0.03). The dispersion between categories of this factor is indicated in figure 3.18.

Figure 3.18: Proportion of Women who Never Changed an FP Method by Mobility

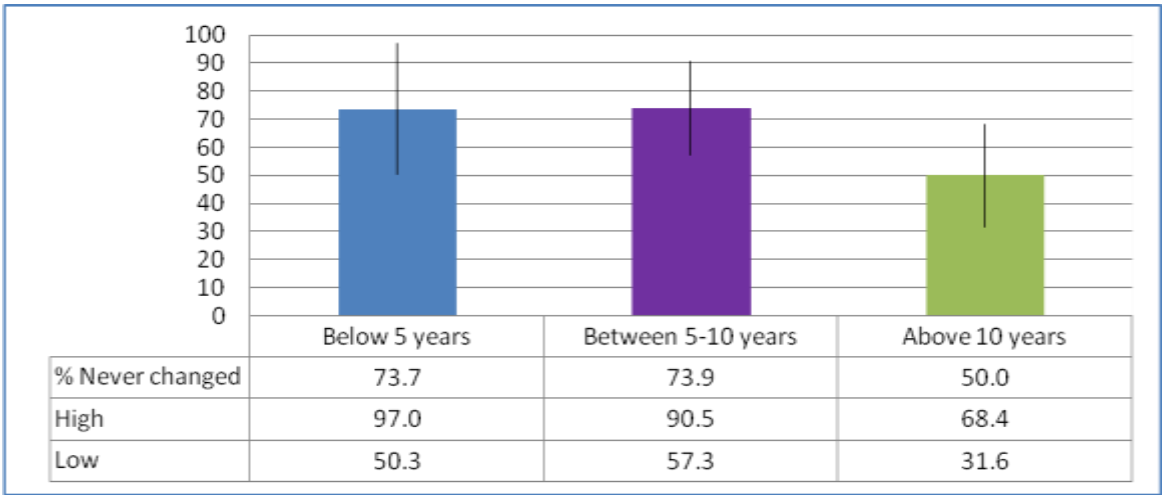


	Born in that area	Immigrant
% Never changed	79.6	64.0
High	95.0	76.2
Low	64.2	51.8

3.12.2 Period stayed in Area (for immigrants)

Immigrants that had stayed for more than 10 years in the study area were less likely to maintain the same method of contraceptives compared to those that had stayed for less than 10 years (χ^2 -6.6, p-value-0.04); the proportions that maintained the same method were 73.8% and 50% respectively figure 3.19.

Figure 3.19: Proportion of Women who Never Changed an FP Method by Period Stayed In Area (immigrants)

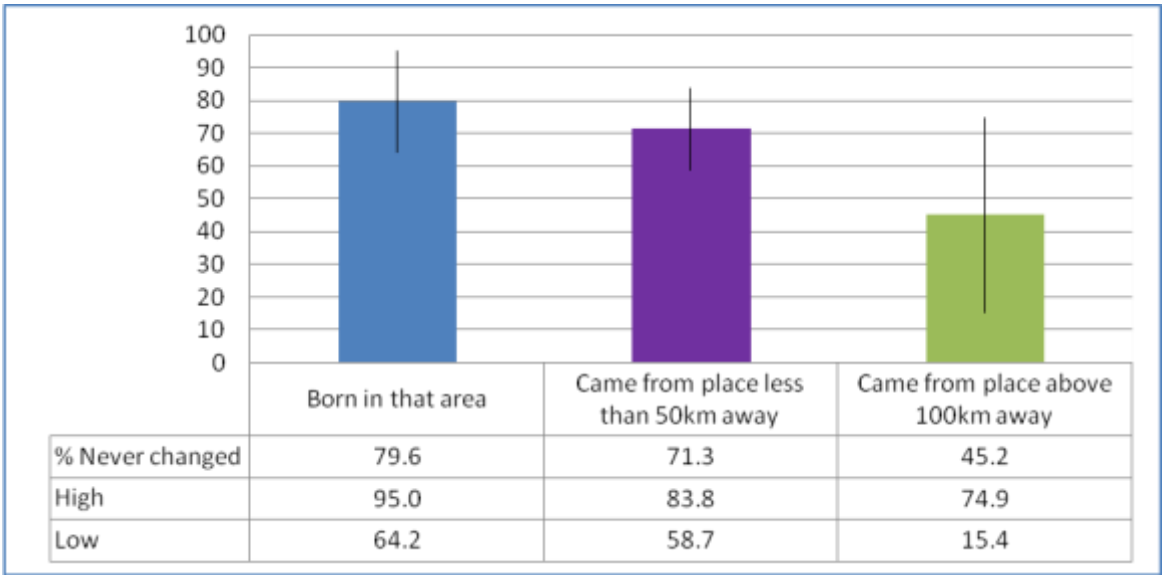


	Below 5 years	Between 5-10 years	Above 10 years
% Never changed	73.7	73.9	50.0
High	97.0	90.5	68.4
Low	50.3	57.3	31.6

3.12.3 Distance to former place of residence

As can be observed from figure 3.20 below, respondents who indicated that they came from a distance that was 100 kilometers and above away from where the survey team found them, were less likely to maintain contraceptive method (45.2%) compared to those that came from below 100 kilometers (71.3%). The chi-square test indicated significance in this association (χ^2 -11.8, p-value-0.008).

Figure 3.20: Proportion of Women who Never Changed an FP Method by Distance of Origin



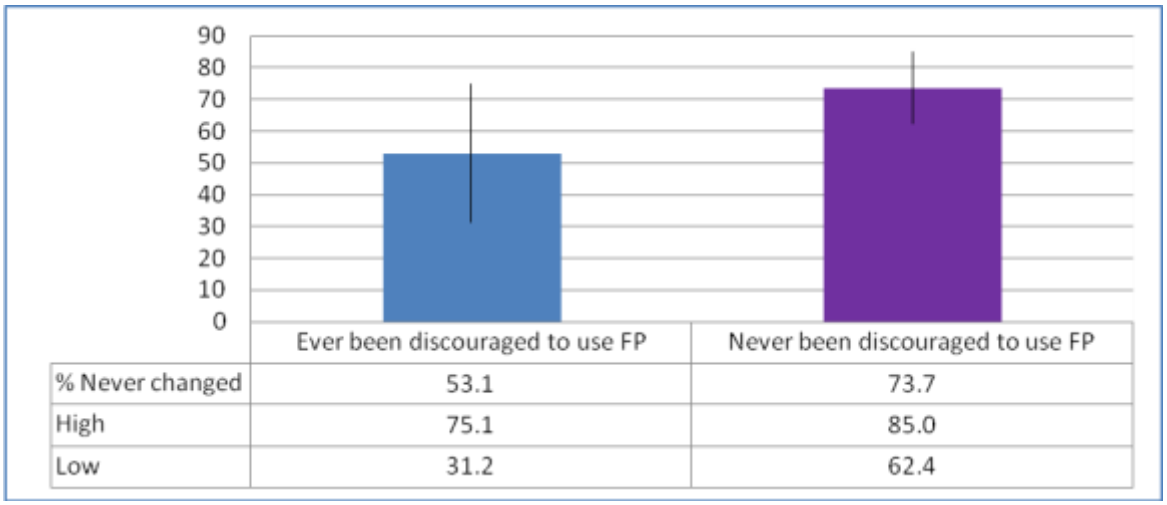
	Born in that area	Came from place less than 50km away	Came from place above 100km away
% Never changed	79.6	71.3	45.2
High	95.0	83.8	74.9
Low	64.2	58.7	15.4

3.12.4 Getting discouragement from partner

The chi-square test was made to establish the association between maintenance of contraceptive use with discouragement and encouragement of partner. The test revealed that there is no significant association between maintenance and

encouragement from partners (χ^2 -0.5, p-value-0.23). However the test revealed that there is a significant association between maintenance and discouragement from partners (χ^2 -4.0, p-value-0.02). Respondents who indicated that they have ever been stopped or discouraged by a partner to use an FP method were less likely to maintain the same method (53.1%) compared to their counterparts who said they have never been discouraged/stopped (73.7%) as seen in figure 3.21 below.

Figure 3.21: Proportion of Women who Never Changed an FP Method by Whether Ever Got Discouragement from Partner

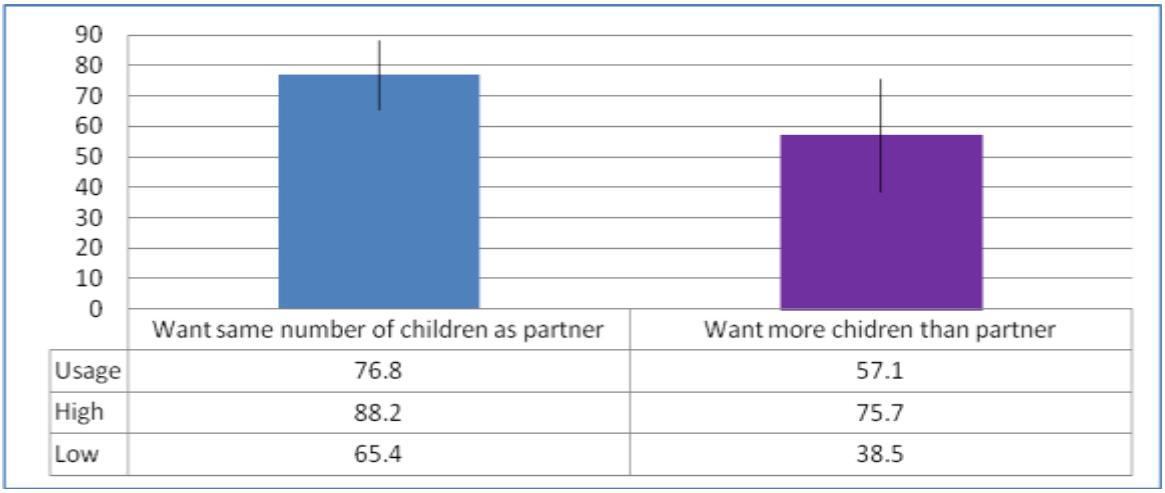


	Ever been discouraged to use FP	Never been discouraged to use FP
% Never changed	53.1	73.7
High	75.1	85.0
Low	31.2	62.4

3.12.5 Preference for number of Children needed by Women

When comparison was made between women who want the same number of children as their partners with those women who do not know the partners' preferences, the difference in maintenance of FP method used was statistically significant (χ^2 -12.1, p-value-0.017). Respondents that needed the same number of children like their partners were more likely to maintain the same contraceptive method than those whose preference (on number of children) differed from that of the partners; the proportions were respectively 76.8% and 57.1% as seen in figure 3.21 below.

Figure 3.21: Proportion of Women who Never Changed an FP Method by Preference on Number of Children Needed by Women



	Want same number of children as partner	Want more chidren than partner
Usage	76.8	57.1
High	88.2	75.7
Low	65.4	38.5

3.13: Reasons for maintaining the same method of modern contraceptives

Information was sought to get the reasons for maintaining the same method of modern contraceptives. When respondents were asked about the reasons for maintenance of the same method 26% and 25% respectively of the reasons cited were related to method being convenient and absence of side effects in the method. These cited reasons influenced the individuals not to change the methods they were using and the details are presented in table 3.17.

Similarly the top most cited reasons under the exit interviews were fear of side effects of a previous method (cited by 50% of those that have ever changed a method) and old method being inconvenient to use (table 3.18). The reasons for maintenance of each method and for the specific types of changes are presented in tables 3.19 and 3.20.

Table 3.17: Reasons for maintaining the same method in women that reported ever used any modern FP method (n - 115) - Structured Questionnaire

Reason cited	Number citing the reason	Percent
Method is convenient to use	65	25.9
Method has less/no side effects	63	25.1
Method is effective	44	17.5
Method is cheaper	29	11.6
Source of method is near	14	5.6
Partner has no objection to use of method	8	3.2
Method is permanent and it is done only once	2	0.8
Other	26	10.4
Total	251	100.0

Note: A respondent was allowed to give more than one reason

Table 3.18: Reasons for switching methods (N - 28)- Exit inteviews

Reason cited	Number citing the reason	Percent
Fear of side effects of former method	14	50.0
Former method was inconvenient to use	8	28.6
Former method was less effective	3	10.7
Former method was not available	1	3.6
Former method interferes with normal process of body	1	3.6
Partner objected former method	1	3.6
Total	**28**	**100.0**

Table 3.19: Reasons cited for using the same method of family planning in women currently using a family planning method

Among women age 15-49 currently are using contraceptives, those who reported maintaining the same method since they started using a family planning method and the percentage of those citing a specific reason for maintaining use of a particular contraception method.

Maintained Method	Percentage to total that have not changed method	Among the number of responses given per method maintained, percent contribution of those which state that:								Number of responses
		Method is convenient to use	Method has less/no side effects	Method is effective	Method is cheaper	Source of method is near	Partner has no objection to method	Method is permanent and it is done only once	Other reasons	
Female sterilization	3.1	0	0	0	0	0	0	100.0	0	2
Pill	7.8	16.7	16.7	33.3	0	16.7	16.7	0	0	6
Injection	59.4	22.0	44.0	20.0	8.0	0	4.0	0	2.0	50
Implant	18.8	50.0	18.2	13.6	0	4.5	0	0	13.6	22
Condom	4.7	0	0	0	0	33.3	0	0	66.7	3
LAM	6.3	0	0	25.0	75.0	0	0	0	0	4
Total	100.0	26.4	31.0	18.4	8.0	3.4	3.4	2.3	6.9	100
Number	115	23	27	16	7	3	3	2	6	87

Table 3.20: Reasons cited per type of change of method among respondents that have ever used a family planning method

Among respondents age 15-49 who reported changing a contraceptive method, the percentage of respondents citing a specific reason, by type of change

Type of change			Among the number of responses given for the reason per type of change, percent contribution of:					
:om:	To:	Percentage of respondents reporting the change	Fear of side effects of former method	Former method was less effective	Former method was inconvenient to use	Former method interferes with normal process of the body	Other reasons	Number of responses
Injectables	Implant	27.9	50.0	6.3	12.5	18.8	12.5	16
Pill	Injectables	24.6	73.3	0	0	6.7	20.0	15
Injectables	Pill	11.5	100.0	0	0	0	0	7
Injectables	Other*	6.6	75.0	0	0	0	25.0	4
Injectables	Female sterilization	3.3	0	0	0	0	100.0	3
Injectables	IUD	3.3	0	0	0	0	100.0	2
Injectables	Condom	3.3	0	0	50.0	0	50.0	2
Condom	Other*	3.3	0	0	50.0	0	50.0	2
Pill	Other*	3.3	100.0	0	0	0	0	2
Implant	Pill	1.6	100.0	0	0	0	0	1
Pill	Implant	1.6	100.0	0	0	0	0	1
Condom	Pill	1.6	0	100.0	0	0	0	1
IUD	Female sterilization	1.6	100.0	0	0	0	0	1
Other*	Condom	1.6	100.0	0	0	0	0	1
IUD	Other*	1.6	100.0	0	0	0	0	1
Withdraw	Pill	1.6	-	-	-	-	-	NR
Injectables	LAM	1.6	-	-	-	-	-	NR
Total		100.0	61.0	3.4	6.8	6.8	22.0	100
Number		51	36	2	4	4	13	59

Note: A respondent was allowed to give more than one reason

NR- No response. * Includes users of only family planning methods which are not listed individually in the table

3.14: Discontinuation of using a family planning method

Analysis was done to determine the proportion of men and women who reported discontinuing using a contraception method. This was done among men and women who reported that they have ever had sex and used a family planning method. As a follow up, further analysis was done among those respondents who reported discontinuing a family planning method, as well as provided reason(s) for discontinuing a family planning method. During the survey, women were also asked whether their partners have ever encouraged or discouraged them to use a family planning method.

A total of 166 women reported to have ever used a modern family planning method. Of these, 36 percent reported to have discontinued using a family planning method as indicated in figure 3.22.

Figure 3.22: Percent of women who discontinued using family planning method(s) among those who ever used contraceptives (n-166)

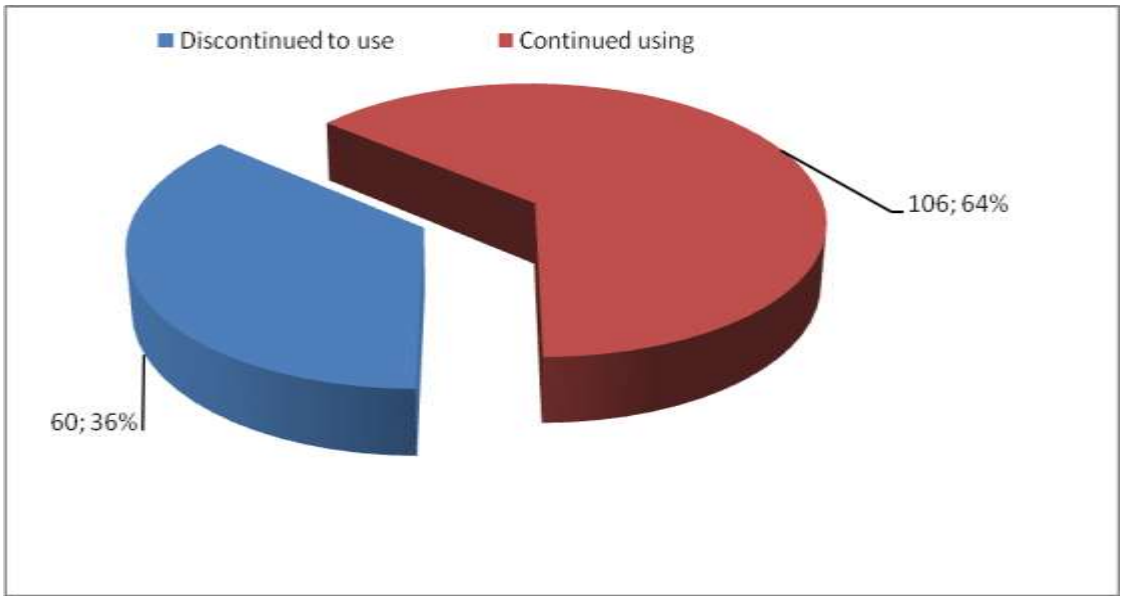


Figure 3.23 reveals that among women who reported to have been using family planning methods 88% stated that they ever discussed it with their partners. The study revealed also those women holding discussions with partners was a key determinant of continuation/discontinuation of family planning services. Family planning clients who had discussion with their partners were less likely to discontinue family planning use than those who did not discuss it with partners. Specifically 60% of those who discontinued a method never discussed with their partners while 32.9% discussed it as indicated in figure 3.24. This association was statistically significant (χ^2 - 5.6, p-

value-0.019). The other selected variables like age, religion, marital status did not show a relationship as it can be seen from table 3.21.

Figure 3.23: Proportion of Women Who Used FP Method After Discussing With Partner (n-166)- Structure Questionnaire

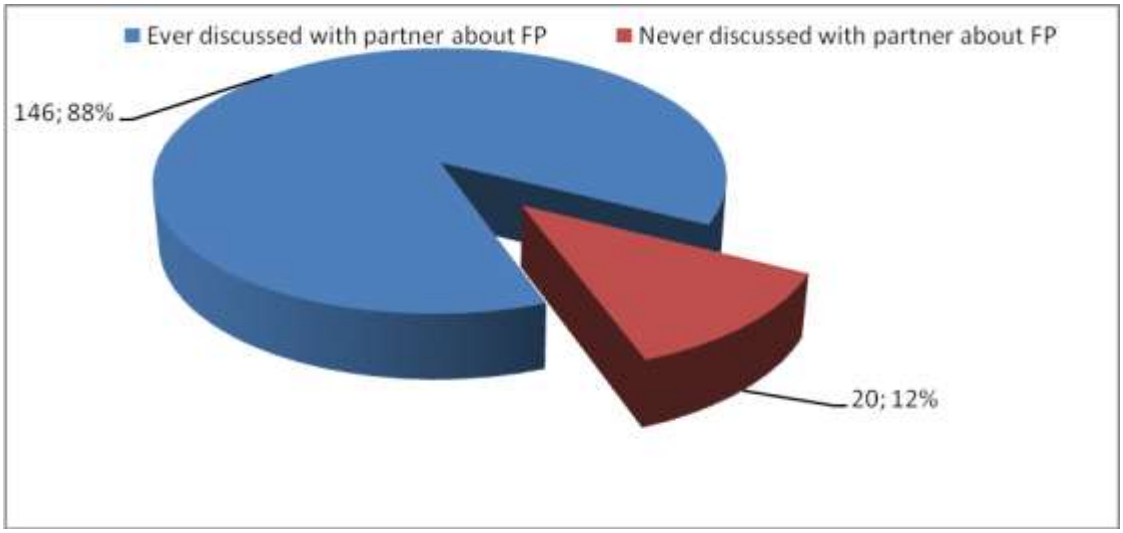
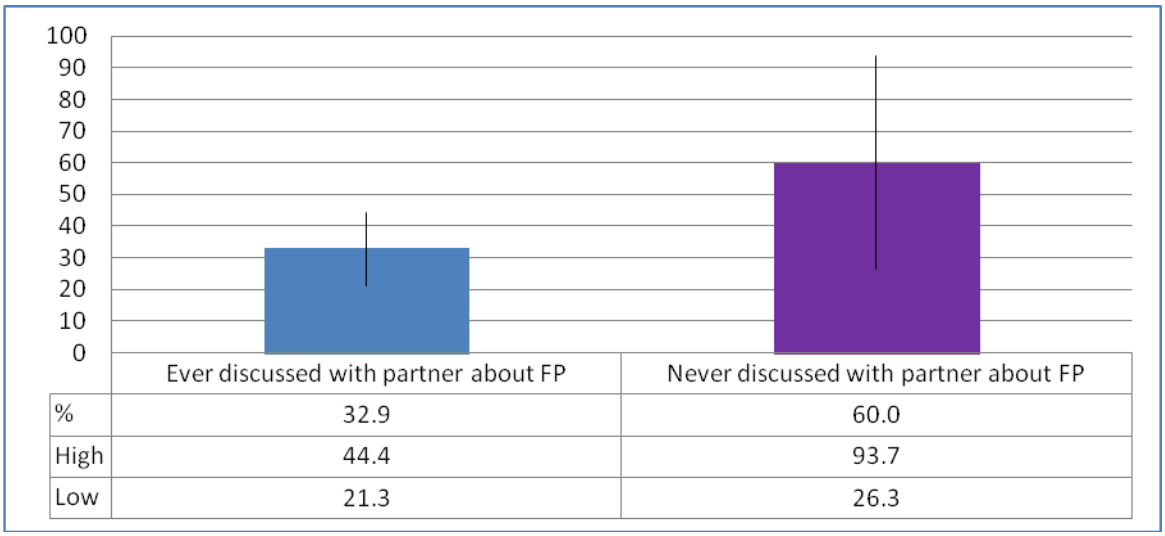


Figure 3.24: Proportion of Women who Discontinued Use of FP Method by Discussion Status - Structure Questionnaire



	Ever discussed with partner about FP	Never discussed with partner about FP
%	32.9	60.0
High	44.4	93.7
Low	21.3	26.3

Figure 3.25: Percent ever got encouragement from partner to use an FP method (N-82)- Exit interviews (EIs)

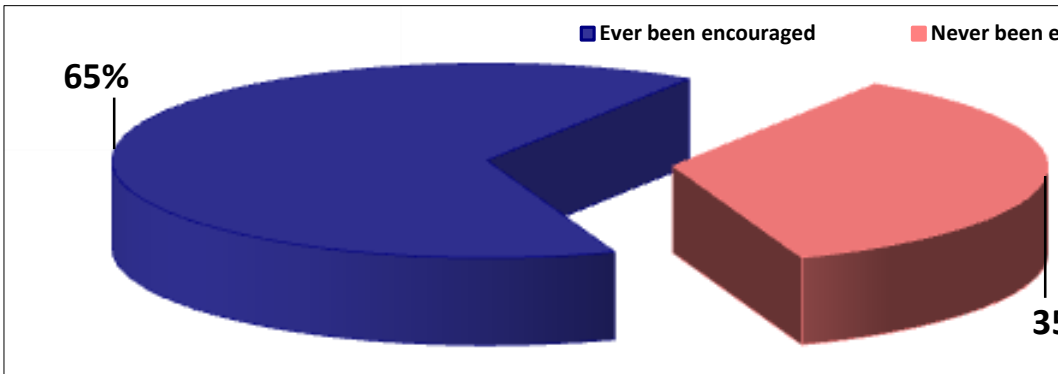


Figure 3.26: Percent ever been stopped by partner to use an FP method (N-82) - EIs

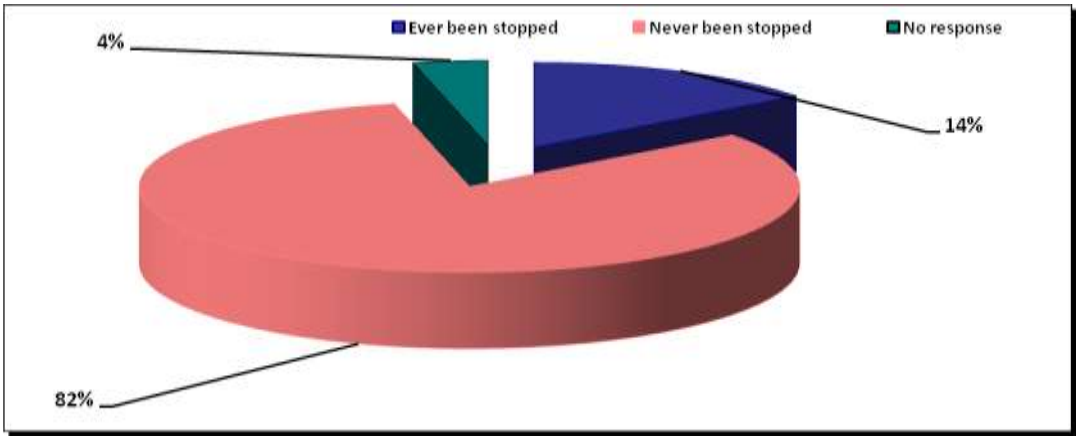


Table 3.21: Relationship between Discontinuation of Use of Modern FP Methods – χ^2 Tests

Significance p-values generated when relationship is tested between women's discontinuation for use of Modern FP methods with selected variables

Selected Variables	p-value
Age	0.292
Education	0.111
Religion	0.420
Tribe	0.285
Marital status	0.201
Employment	0.433
Mobility	0.338
Period stayed in area (for immigrants)	0.074
Distance to former place of residence	0.542
Holding Discussion with partner on issues pertaining to FP	0.019*
Getting encouragement from partner	0.213
Getting discouragement from partner	0.498
Number of children ever born	0.314
District/area of residence	0.126
Sexual Relationships; Regular partners	0.553
Sexual Relationship; Non regular partners	0.315
Having children	0.542
Exposure to media messages on FP	0.261
Preference for number of children needed by women	0.298
Agreement with partner regarding child spacing	0.455

An asterisk indicates that the p-value is significant at level of significance a - 5%; that is, there is a significant difference in the different categories considered for a variable under consideration.

A number of respondents were given encouragement by their partners to continue using a contraception method. Table 3.22 shows that percentage of men and women age 15-49 years who reported to have got encouragement from their partners to use a family planning method was 52 percent among women, 56 percent among men and 53 percent among both men and women. The rest of the respondents have either never been encouraged to use or never had opportunity to discuss family planning methods.

The survey also evaluated encouragement from partners to use any method of family planning among women age 15-49 that have ever used a contraceptive method. Those respondents who reported having obtained encouragement cited some specific reasons for such encouragement. Table 3.25 shows the percentage of respondents that cited a specific reason behind the provision of such encouragement. The reasons cited include convenience to use the method, little or no side effects of a method, method perceived to be effective, partner has no objection to use of method and method is cheaper/source of method is near.

Due to limited numbers of respondents, reasons for encouragement could only be reliably evaluated in three contraception methods, namely; pills, implants and injectables. The other methods have too small numbers to allow reliable estimation. Overall, the results show that 86 women age 15-49 who ever used a contraceptive method reported having obtained encouragement from their male partners to use any method of family planning. The distributions of the specific reasons cited for such encouragement are as follows: Injectables (56 percent), implants (16 percent) and pills (14 percent).

Examination of the specific reasons cited for encouraging specific methods of contraception (refer to table 3.25) revealed the following: Encouragement for use of pills is due to method being convenient to use (46 percent), method has less/no side effects (15 percent), and method is effective (23 percent), partner has no objection to use of method (8 percent) and method is cheaper /source of method is near (8 percent).

In the case of encouragement to use injectable contraception method, the reasons given are that method is convenient to use (29 percent), method has less/no side effects (20 percent), and method is effective (15 percent), partner has no objection to use of method (14 percent), method is cheaper/source of method is near (7 percent) and method works for a longer time (8 percent).

In the case of encouragement to use implants, the reasons given are that the method is convenient to use (25 percent), method has little/no side effects (8 percent), and method is effective (8 percent), partner has no objection to use of the method (0 percent), method is cheaper/source of method is near (8 percent) and method works for a longer time (25 percent).

Support from partners or spouses of family planning clients are crucial in promoting use of FP services. In line with this, there is a deliberate policy of male involvement in FP services. During the exit interviews, clients were asked whether they had received encouragement from their partners. In response, 65 percent of the respondents said that they have ever been encouraged while 35 percent said that they have never been encouraged. The specific support that had been received from partners were in form of moral support and giving advice/ideas (32 percent), provision of financial support (26 percent), provision of consent (24 percent) and escorting the women to the clinics (15 percent) as can be seen from tables 3.23 and 3.24.

While some clients received support from the spouse or partners on family planning, some instead received discouragement or were stopped from using FP services. As shown in Figure 5.5, fifteen percent of the exit interview respondents admitted that they have ever been stopped from or discouraged by their spouse/partners from using a family planning method. The discouragement was in various forms; for instance, the partner never consented to the use of FP method, hence the FP client was using a method secretly without knowledge of the partner (25 percent), partner talks negatively about FP (17 percent), partner says women should produce as long as God wants (17 percent), partner is afraid of the side effects of FP methods (17 percent) and partner prefers traditional family planning methods (17 percent).

Table 3.22: Encouragement from Partners on use of Contraceptives (n-245)- Structured Questionnaire Interviews

Among men and women who reported ever had sex and used family planning method(s), percent reporting that they got encouragement from their partners to use a family planning method.

Category	Number ever used family planning method(s)	Percentage reporting to have got encouragement from their partners to use a family planning method
Male	79	55.7
Female	166	51.8
Total	245	53.1

Table 3.23: Ways how FP clients were supported by their partners (N - 53) - EIs

Type of support	Number citing the support	Percent
Has been supportive; morally and in giving ideas	20	32.3
Provides financial support	16	25.8
Gave consent	15	24.2
Escorts her to health facility	9	14.5
Others	2	3.2
Total	62	100.0

Table 3.24: Ways/how FP clients were stopped/discouraged by their partners to use FP (n - 12) – Eis

Type of discouragement	Number citing the discouragement	Percent
Partner never consented for use of FP/does not know that respondent is on FP	3	25.0
Partner talks negative about FP	2	16.7
Partner says women should produce as long as God wants	2	16.7
Partner fears side effects of FP	2	16.7
Partner prefers traditional methods	2	16.7
Others	1	8.3
Total	12	100.0

Table 3.25: Reasons cited for partner(s) encouragement in using of family planning methods (n-86)

Among women age 15-49 who ever used a contraceptive method, those who reported having obtained encouragement from partners to use any method of family planning, and the percentage of those citing a specific reason for such encouragement.

		Among the number of responses given per method encouraged by partner, percent distribution of those who say that they were encouraged by the partner because:								
Method Encouraged by Male Partners	Percentage distribution of FP methods encouraged by male partners	Method is convenient to use	Method has less/no side effects	Method is effective	Partner has no objection to use of method	Method is cheaper/ source is near	Method works for a longer period	Friend/ relative/ expert client encouraged use of method	Other reasons	Number of responses
Female sterilization	3.5	0	0	0	0	0	0	0	100	3
Pill	14.0	46.2	15.4	23.1	7.7	7.7	0	0	0	13
IUD	1.2	0	0	0	0	100	0	0	0	1
Injection	55.8	28.8	20.3	15.3	13.6	6.8	1.7	5.1	8.5	59
Implant	16.3	25.0	8.3	8.3	0	8.3	25.0	0	25.0	12
Condom	4.7	0	0	0	50.0	50.0	0	0	0	2
Other (like LAM)	4.7	0	0	0	50.0	0	0	0	50.0	2
Total	100.0	28.3	16.3	14.1	12.0	8.7	4.3	3.3	13.0	NA
Number	86	26	15	13	11	8	4	3	12	92

Note: A respondent was allowed to give more than one reason
LAM; Lactational amenorrhea method, NA ; Not Applicable, FP; Family Planning

3.15 Reasons for Discontinuation of use of a family planning method

A number of women aged 15-49 who reported discontinuation of use of a contraception method provided reasons for discontinuing with a family planning method. As shown in Table 3.26 various reasons given including; desire to become pregnant/have more children, fertility related reasons, side effects/health reason, preferred method not available and partner objection, as well as method being perceived to be against religion/culture. In some circumstances, no particular reason was provided or stated.

Among users of injectable methods and implants, desire to be pregnant or get more children as a reason for discontinuing a contraception method was given by 23 and 11 percent of them, respectively. Furthermore, 35 and 11 percent of users of injectable methods and implants gave side effects/health reason as a reason for discontinuing the methods, respectively. Additionally, 10 percent of users of injectable methods and 33 percent of users of implants gave partner objection as a reason for discontinuing the methods. In case of user of the pills method, the reasons given for discontinuation are variable; side effects/health related reasons (36 percent), partner objection (21 percent) and fertility related reasons (14 percent). Due to small numbers of respondents in the other categories of contraception methods, namely; male condoms, female condoms, rhythm/moon beads and LAM, the reasons for discontinuing the methods could not be reliably evaluated

Table 3.26: Reasons Why Women Discontinued Using Family Planning Methods (n-60)

Among women aged 15-49 who reported discontinuation of use of contraceptives, percentage distribution according to methods discontinued and according to a particular reason given for discontinuing with a family planning method.

		Reason for discontinuation						
Method Discontinued	Percentage distribution of women reporting discontinuing with the method	Desire to become pregnant/ have more children	Fertility related reasons[1]	Side effects/ health reason	Preferred method not available	Partner objected/ method was against religion/ culture	Reason not known /stated	Number of responses
Pill	23.3	0	14.3	35.7	0	21.4	28.6	14
Injectables	50.0	22.6	9.7	35.5	3.2	9.7	19.4	31
Implants	15.0	11.1	22.2	11.1	0	33.3	22.2	9
Male condom	5.0	0	50.0	0	0	50.0	0	2
Female condom	3.3	100.0	0	0	0	0	0	2
Rhythm/Moon beads	1.7	0	0	0	0	0	0	1
LAM	1.7	0	100.0	0	0	0	0	1
All methods	NA	16.7	15.0	28.3	1.7	16.7	21.7	NA
Number	60	10	9	17	1	10	13	60

[1] Includes infrequent sex/not married/have no partner, still breast feeding, difficult to get pregnant/menopausal, and not yet

menstruated since last birth

The survey further revealed that information which emerged from the qualitative data also showed similar reasons for discontinuation of contraceptive methods. However, the most common factors cited were the existence of side effects, negative peer pressure, stock outs, misconceptions, desire for more children, high mobility of clients for Karamoja region and discovery by spouses. The statements below provide insights to the above revelation.

Sometimes the clients come for their monthly refills/appointments and find that certain contraceptives are not available e.g. the oral pills because the clients using them are very few, they sometimes expire unused, so we encourage them to try other available methods like condoms and injectables or at times weight gains ***(FP Provider KI Kaabong).***

Some clients are also being influenced by friends to change the method being used. Also because of contraceptive duration some opt from short term to long term or the reverse depending on the objective prioritized ***(Community service provider Katakwi).***

Pills can easily be forgotten and if someone did not agree first with the husband on taking on F,P he can easily find out. Condoms if you did not agree with the man, he can even take it off during the time of ejaculation ***(Users FGD Mubende).***

Sometimes it's the woman who doesn't like them, they fear that it would get stuck in the woman and the image of a married woman with a condom stuck inside her is shameful ***(Discontinued Users FGD Mubende).***

3.16: Client's satisfaction and Challenges affecting FP service delivery

This section provides successes and e key challenges affecting the delivery of modern contraceptives in the study area. These challenges are presented from the perceptive of the key informants at different levels, and data generated from both structured questionnaire and exit interviews. A number of successes challenges were registered.

Through use of a structured questionnaire, current users of modern contraception methods were asked a number of questions to determine whether they received information to aid their decision making on choice of modern contraception methods to use. They were asked whether they were informed about side effects of modern contraception methods, whether they were informed of what to do if side effects occur and whether they were informed of what alternative modern contraception methods are available to, and what to method to use in case they get side effects for a particular method in use.

The results also show that, a total of 71 women who started the last episode of modern contraceptive method within five years preceding the survey reported that they are current users of modern contraception methods. Of these, 72 and 100 percent said they were informed of side effects of injectable FP methods and pills, respectively. Furthermore, 100 percent and 76 percent of women who started the last episode of IUD and implants within five years preceding the survey; and are current users of modern contraception methods said that they were informed of side

effects of IUD and implants, respectively. From above, it can be seen that every women who started the last episode of pill and IUD within five years preceding the survey reported that they received information on method specific side effects.

In regard to general information on what to do if side effects occur, the proportion of users who was informed of this is 100 percent for pills, 100 percent for IUD, 67 percent for injectables and 68 percent for implants. The results further show that a good proportion of FP users are informed of the alternative methods of modern contraception to use in case they get side effects. Seventy two percent of users of implants, 77 percent of users of injectables, 80 percent of users of pills and 100 percent of users of IUD received this information.

Overall, the results show that among current contraception methods users age 15-49 who started the last episode of use within the five years preceding the survey, the percentage who were informed about possible side effects or problems of that method is 76, the percentage who were informed about what to do if they experienced side effects is 70 and the percentage who were informed about other alternative methods they could use is 76.

The survey further reveals that the EI clients had received a variety of information from the FP clinics which they had visited. Specifically, information was received on the following prompted topics; safer sex options (38 percent), prevention of HIV, STIs and unwanted pregnancy (76 percent), contraception (how it works, side effects, etc) 83 percent, emergency contraception (34 percent), relationships and sexual enjoyment (17 percent), other concerns such as body image and sexual hygiene, menstruation, masturbation (44 percent), wet dreams and where to get services which the clinic does not provide (51 percent). Therefore, as expected and since the respondents were from FP clinics, the majority (83 percent) had received information on contraception.

Right to access FP services was assessed during the exit interviews, as defined earlier; family planning is the right of an individual to receive adequate information about the method of family planning of their choice and to determine responsibly and freely the number of and spacing of children. In line with this concept, this survey assessed the right to access FP services in a number of areas, namely; convenience of opening hours of the clinics, affordability of cost of service, getting the service for which had come for, services received were free from problems/difficulties, service providers ensured confidentiality, spent the right time at the clinic, waiting room is comfortable, clinic staff were friendly, client were given chance to express their own opinion, clients were informed of when to return for follow up visits and clients were informed of the right to return in case of problem.

As shown in Table 3.27, the results generally show that the rights of the FP clients were being met. Eighty four percent of respondents said the FP clinic opening hours were convenient while 85 percent said the cost of services is affordable. The right to choice of a family planning method is almost universal (99 percent) because these clients said that they were able to secure the services they came to get from the

clinics. Right to continuity of care was also being reasonably met; ninety two percent of clients reported that they were informed of when to return for follow up visits. Furthermore, 82 percent of EI clients reported that they were informed of their rights to return in case they experience any problems or side effects. The results further show that 4 out of 10 clients felt that the services received were free from problems/difficulties; and that the services providers ensured confidentiality of client's information. Eighty five percent of EI respondents said that the clinic staff were friendly, 60 percent said that the time spent at the clinic is right and 56 percent felt that the waiting room was comfortable. Furthermore, 54 percent of the respondents said that they were given a chance to express their own opinion.

Table 3.27: Client's right to access, choice, safety, privacy, dignity, expression of opinion, and continuity of care (n - 82)-Client Exit Interviews

Among clients visiting the FP clinics percent accepting to have received their rights under the following areas assessed during the study, by type of facility visited

Assessed Area	Private (n - 25)	Government (n- 57)	All (n-82)
Right to access			
Convenience of opening hours	100.0	77.2	84.1
Affordability of cost of service	88.0	84.2	85.4
Right to choice			
Securing the services one came for	100.0	98.2	98.8
Right to safety and confidentiality			
Services received were free from problems/difficulties	60.0	59.6	59.8
Service providers assured client confidentiality	76.0	59.6	64.6
Right to dignity and comfort			
Spent right time at the clinic	68.0	56.1	59.8
Waiting room was comfortable	60.0	54.4	56.1
Clinic staff were friendly	100.0	78.9	85.4
Right to expression of opinion			
Client given chance to express own opinion	60.0	50.9	53.7
Right to continuity of care			
Client informed of when to return for follow-up visit	88.0	93.0	91.5
Client informed of the right to return in case of problem	80.0	82.5	81.7

Note: Each of the areas was assessed for every client.

Table 3.28: Client's right to information (N - 82) -Client Exit Interviews

Among clients visiting the FP clinics percent accepting to have received information on the following prompted topics during any visit, by type of facility visited

Topic	Private (n - 25)	Government (n- 57)	All (n-82)
Safer sex options	20.0	45.6	37.8
The prevention of HIV, STIs and unwanted pregnancy	68.0	78.9	75.6
Contraception (how it works, side-effects, etc)	84.0	82.5	82.9
Emergency contraception	8.0	45.6	34.1
Relationships and sexual enjoyment	4.0	22.8	17.1
Other concerns such as body image, genital hygiene menstruation, masturbation, wet dreams, etc	20.0	54.4	43.9
Where to get services which the clinic does not provide	52.0	50.9	51.2
Others	0.0	7.0	4.9

Note: A respondent was asked if he/she received information on each of the topics

When comparison between private and government facilities is made in regard to all the FP service variables, the results show that private facility clients expressed better satisfaction in all of them except for the right to continuity care where they were better satisfied with government facilities. This was established during client exit interviews.

Since clinic environment is very crucial in service delivery, the 36 clients who said that the waiting rooms are uncomfortable were probed to find the reasons behind this; in response, the majority (36 percent) reported that the clinic room is too crowded while 14 percent said that the room does not have chairs. Additional reasons were given by a few clients; they included absence of a waiting room, room is too busy, room is untidy/dirty and room is in the open.

During the exit interviews, 64 clients cited specific reasons for liking the services being provided by the clinics. Table 3.29 shows that 46 percent of these respondents said they were satisfied because the staff/client relationship is good or that staff members are kind and not rude, as well as give them the required information. Other reasons for satisfaction include availability of medical equipment/ supplies (18 percent), staff members are time conscious/committed to their work (13 percent), service delivery is fast/good with short waiting time and clinics have enough staff (6

percent0, clinic opens early and closes late and therefore clinic hours are convenient (5 percent); and the clinics are clean/have a variety of methods (2 percent). Figures 3.27 and 3.28 reveal that most of the FP clients (60%) were satisfied with time spent at the clinic and almost all of them (99%) would recommend a friend to come for FP clinic in the same clinic where the survey team found them. From figure 3.29 78% of the FP clients indicated that they had something good they liked about the clinic they had visited.

On the other hand, from figure 3.30, about 33 percent of clients said that they disliked some things at the family planning clinics. On probing these clients to find out the reasons why or what they disliked, the specific reasons included shortage of medical equipment and supplies (25 percent), staff relationship is bad and staff waste a lot of time or do not want to work or are rude (18 percent), Clinic has many services and time is wasted/Services are very slow/waiting time is long (15 percent), Clinic does not have enough staff (13 percent) and lack of variety of services (8 percent), Staff do not provide health education (6 percent), clinic opens late and closes early and thus, clinic time is not convenient (6 percent) and clinic/facility/toilet is dirty (4 percent). A few respondents (4 percent) did not state any specific reasons for disliking the family planning clinics (table 3.30).

Figure 3.27: Percent distribution of how clients felt about time spent at clinic (n-82)

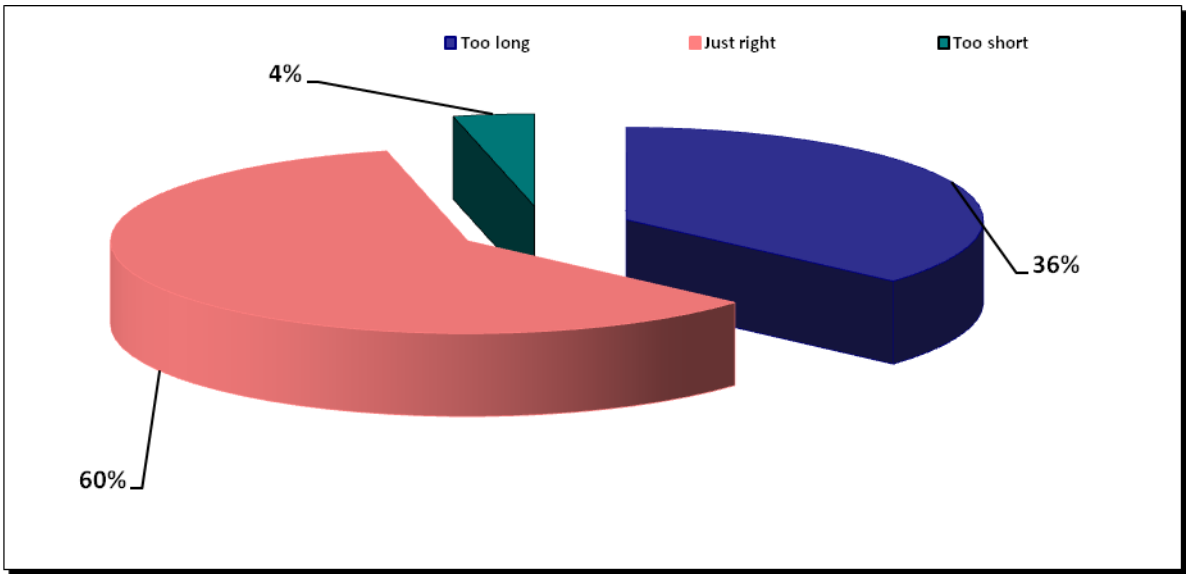


Figure 3.28: Percent who will recommend a friend/relative to come to the same clinic

(n-82) - Els

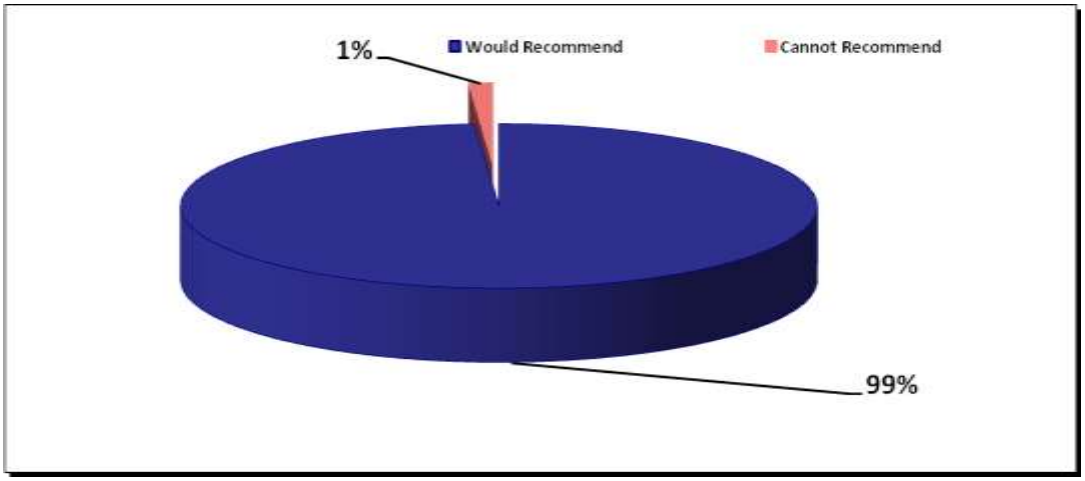


Figure 3.29: Percent who liked anything in particular about the FP clinic (n-82)

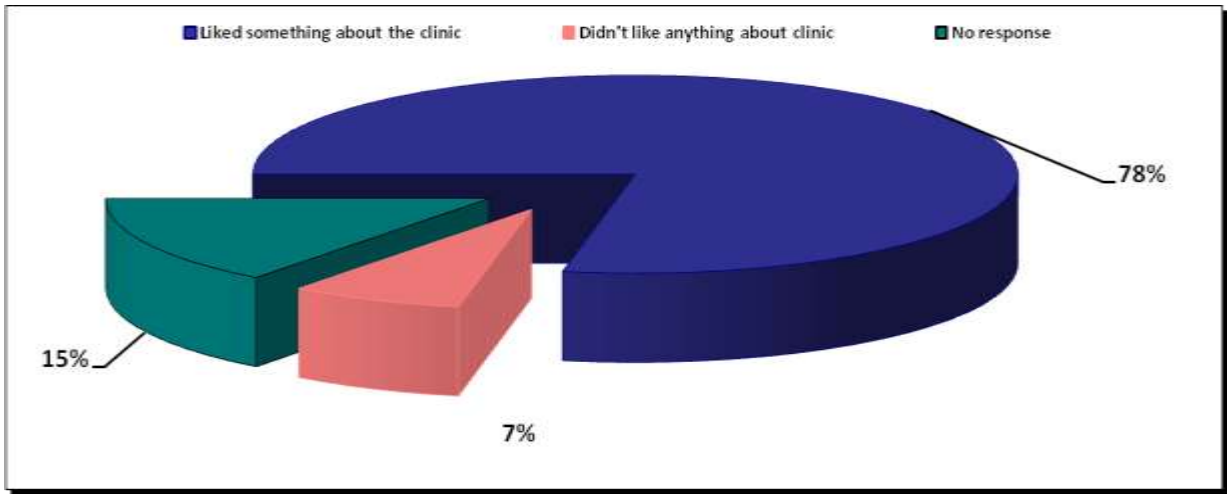


Figure 3.30: Percent who disliked anything in particular about the FP clinic (N-82)

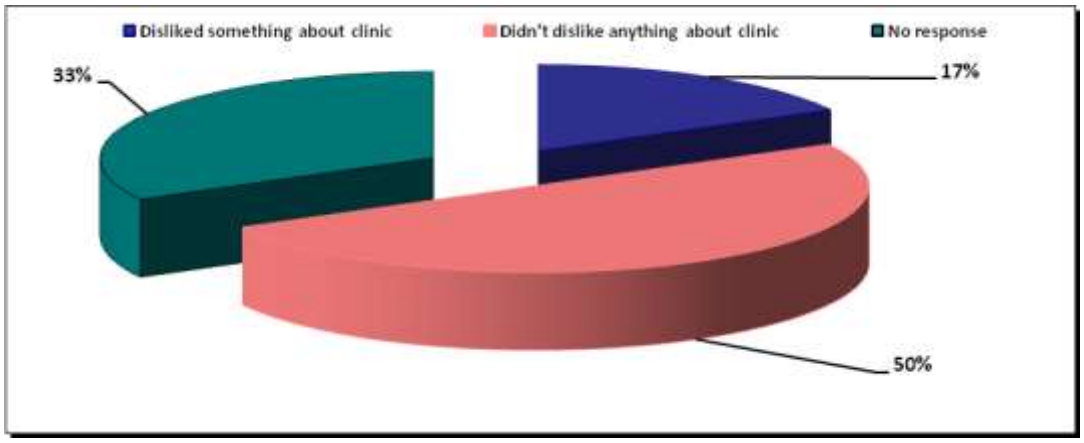


Table 3.29: Items liked about the clinics by FP clients (N - 64)

Item liked by clients	Number citing the item	Percent
Staff patient relationship is good/Staff are kind/not rude/explain well	38	46.3
Availability of medical equipment/supplies	15	18.3
Staff are time conscious/committed to work	11	13.4
Services are faster/good/waiting time is short/Clinic has enough staff	5	6.1
Clinic/facility opens early and closes late (time is convenient)	4	4.9
Clinic is clean/has a variety of methods	2	2.4
Others	7	8.5
Total	88	100.0

Note: A client was allowed to give more than one item

Table 3.30: Items Disliked about the clinics by FP clients (N - 41)

Item disliked by clients	Number citing the item	Percent
Shortage of medical equipment/other supplies	12	25.0
Staff to patient relationship is bad/Staff waste time/do not want to work/Staff are rude/shout at clients	9	18.8
Clinic has many services and time is wasted/Services are very slow/waiting time is long	7	14.6
Clinic does not have enough staff	6	12.5
Others like lack of variety of services	4	8.3
Staff do not provide health education	3	6.3
Open late and close early/time is not convenient	3	6.3
Clinic/facility/toilet is dirty	2	4.2
Not stated	2	4.2
Total	48	100.0

Note: A client was allowed to give more than one item

Table 3.31: Reasons cited as to why clients found the waiting room uncomfortable (N - 36)

Reason cited	Number citing the reason	Percent
Room is too crowded	13	36.1
Room does not have enough chairs	5	13.9
No waiting room	3	8.3
Room is very busy	2	5.6
Room is untidy/dirty	1	2.8
Room is in the open	1	2.8
Others	4	11.1
No reason given by respondent	7	19.4
Total	36	100.0

Table 3.32: Suggestions cited by FP clients on how to improve FP services (N - 82)

Type of support	Number citing the suggestion	Percent
More staff should be recruited	17	20.7
More FP methods should be provided	15	18.3
Improve on IEC about FP	10	12.2
Staff should come early/be more committed	6	7.3
Hours of service should be extended	4	4.9
More clinic days should be provided	4	4.9
Talk to men about the services	4	4.9
Staff should be kind/not be rude	3	3.7
Staff to patient relationship should improve	3	3.7
Staff should be faster	2	2.4
Others e.g. improve sanitation	2	2.4
Not stated	12	14.6
Total	82	100.0

In order to get ideas from FP clients on how to improve services, suggestions were sought from exit interview clients on how family planning services can be improved. As shown in Table 3.32, of the 82 exit interview respondents, about one fifth of them (21 percent) suggested that more staff should be recruited. Furthermore, 18 percent said that more FP methods should be provided by the clinics and 12 percent said that there should be improvement in information-education-communication (IEC) for family planning services. The other suggestions which were given by a few clients are; staff members should come early and be committed to their work, clinic service hours should be extended, more clinic days should be provided, talk to men about FP services, staff members should be kind and not rude, there should be an improvement in the staff/client relationship, staff members should be fast in service delivery and clinic sanitation facilities should be improved.

3.17: Key Lessons Learnt

The study shows that the injectables were the most preferred method in the entire study region but the method preferences varied with age. There was a tendency for the younger groups to prefer condoms and pills which were found to be less

permanent. This therefore calls for age appropriate programming for effective family planning interventions.

This study reveals that higher education leads to greater awareness and knowledge and increased use of contraception. However it should be noted that higher educational attainment does not automatically ensure that all sexually active men and women who are educated will enroll and sustain use of modern methods. In a more positive light, results show that more educated women tend to choose more effective methods.

Availability of free services does not automatically mean increased uptake, does not ensure sustained use and effective use. This study found that even when contraceptives are provided free of charge they expire in some health facilities even when some people in the community are aware of their availability. This implies that promoters of modern methods need to do more in promoting the purpose and usefulness of the services other than their availability for free. This study shows that efforts to identify those individuals who are in need of family planning services and to make services more accessible to them can lead to more productive outcomes. This scenario was more manifested in Karamoja region.

Absence of Partner support and Spousal communication on family planning affects the decision on whether to continue using a method and promotes stealth usage. It was observed that frequent discussion of family planning issues between husband and wife increases the chances of sustained use and lessens the chances of discontinuation. Likewise, disagreement between couples about the desired number of children increases the probability of discontinuation. Greater efforts should be made to promote spousal communication on reproductive health matters and male involvement in the family planning programs. Spousal support among users was more prevalent than the common notion that it is lacking as this study reveals that about 65% of the current FP users had spousal support.

Whereas exposure to messages was noted as a key determinant of use of modern contraceptives and knowledge of any family planning methods was universal the misconceptions remained common and affecting the use. Therefore use of media approaches that dispel romours and misconceptions would be more appropriate.

Experience and fear of side-effects was a deterrent to use of modern contraceptives as revealed by the study in all the study districts. This calls for need to effectively manage the side effects as they emerge.

Existence of strong traditional community structures can negatively influence healthy seeking behaviours as noted in Karamoja region where the use of modern contraceptives was effectively resisted by the traditional community leadership. Therefore the success of any programme is dependent on how well these structures are harnessed.

Chapter Four

4.0: DISTRICT BASED QUALITATIVE SURVEY RESULTS

Introduction

The aim of this chapter is to present district based data. During the survey, qualitative data was generated using a combination of research methods, namely; Focus group discussions (FGD), key informant interviews (KI) and exit interviews conducted at health facilities and family planning clinics. The data analysis which followed culminated into summaries of key findings for every district; as well as information at individual and community level. Given that the survey did not provide quantitative data at district level, this chapter has been dedicated to district level qualitative data. The sections that follow therefore present qualitative findings from all the individual study districts except for those in the Karamoja region which are presented as for one region categorised as a domain.

The presentation is made according to the emerging key themes, namely; knowledge of family planning and determinants of use and non-use of family planning. The other factors considered are socioeconomic variables such as religious, cultural factors, health environmental, as well as power and gender dimensions. Key findings are also presented for two of the major sections.

4.1 Karamoja Region

Key Findings related to Karamoja region

- Family Services are available in most public health facilities in Karamoja region and Marie Stopes Uganda is a key partner provider in the region.
- Bad road network especially in the rainy season affected accessibility for family planning services since transport costs were very high.
- Family planning knowledge was evidently demonstrated to be high.
- Preferred methods of family planning were the injectable and implants in the Karamoja region because of privacy and convenience.
- Traditional FP methods preferred by the community gate keepers like Manyatta heads
- Many children taken as a source of future wealth and pride affecting use.
- High dependency of women on men negatively affecting uptake of FP services.
- Decision making bestowed on husbands in homes, Kraal leaders and in-laws at community level yet not supportive of family planning use.
- High resistance by the catholic institution in Karamoja including not providing services at their institutions affected use.
- Desire to stop child bearing and benefits like healthier families, better bonding of babies to mothers positively influenced the use.
- The side-effects like nausea prolonged menstrual periods and delayed fertility led to none-use and discontinuation of modern contraceptives.
- The nomadic characteristics, low literacy and limited male spousal support negatively affected use of modern contraceptives.
- Peer influence contributed to initiation and continued use of modern contraceptives.
- Provision of friendly FP services influenced initiation and continued use of contraceptives.
- Understaffing and limited training of VHTs affected modern contraceptive service provision.
- Large family sizes are promoted to ensure adequate security for the family.

4.1.1: Knowledge, Preference, and perceptions

This section presents the issues related to the level of knowledge, the method preferences and perceptions related to family planning. It focuses on the understanding of the concept of family planning, the methods, the common

choices preferred at the different levels and the attitudes of the users and non-users towards contraceptive use. Thoughts on these issues were solicited from different individuals and groups and these views were compared.

Knowledge

Overall, the study participants demonstrated an understanding of the family planning concept and were able to mention the common contraceptive methods. The knowledge levels on family planning seem to vary according to proximity to the urban areas with the people in semi urban and urban being more knowledgeable on family planning as opposed to the rural populations. Nonetheless, even the non users had some basic knowledge of family planning especially its primary objective of child spacing. The knowledge was observed to be lower among the male population compared to the female population. This is illustrated in statements below:

> *We hear of medicines that government and the health workers have come up with so as to help the women stop producing, but we are not part of this confusion, the women and health workers have connived to stop producing using these medicines****(Non user male FGD Moroto).***
>
> *This is when two partners agree when to and when not to have children. It's reducing the rate of producing or giving birth to children through using contraceptives that allow you to space the births* ***(Male user FGD Moroto).***
>
> *This is when a child has grown up and is able to walk and even fetch for his parents drinking water, then a woman is ready to conceive again and her menstrual periods have returned (Female non user FGD Moroto).*
>
> *It's a way of spacing children. It's planning of child births which require women to go and produce in hospital. The Methods include injections, Pills, Implants, female sterilization, IUD, Beads, condoms, Male sterilization and breast feeding* ***(Community Level KI Kotido).***
>
> *The men/husbands are totally not informed on family planning and contraceptives and due to ignorance they are against contraceptive use, further the longer the relationship, the more the faithful and trust in the couple, so they are satisfied with their traditional way of child spacing hereby not giving any chance to contraceptive use****(Community provider Kaabong).***
>
> *Family planning is when you wait for your child to attain a certain age like 2 years or more before the woman conceives again. It is when a woman goes to hospital and she's given the modern contraceptives as a way of delaying birth as the child grows. It involves the use of condoms, swallowing of pills, female sterilization, and breast feeding* ***(Non-users FGD Kaabong).***

Method Preferences

Understanding of contraceptive preferences is very critical in informing family planning programming. Preference was expressed for the injectables and implants in the entire Karamoja region and this was attributed to privacy and convenience associated to the methods. The injections and implants provided the privacy and confidentiality that enabled female users to have the services without their spouse's knowledge. In addition to privacy, some users found these methods convenient because they did not have the burden of swallowing daily pills associated to oral contraceptives. Adherence to daily taking of oral contraceptives was made worse by consumption of alcohol which was a common trait in the Karamoja region as such influencing the method preferences. Preference for the traditional methods, use of safe days and condom use for males was also expressed by some of the study participants. The above is expressed in statements below:

> *Implant takes long, it's convenient and you do not have to bother with frequent visits to the health unit. Some of us have lost children due to poor spacing and the children keep getting sick and you are always in hospital* ***(Female user FGD Moroto).***
>
> *We separate ourselves from the women until the child is 2 years or older using the fire place, no man is to cross the fire boundary when the child is still young. A woman would make an alarm if the man crossed before time and the neighbours would come to the rescue of that woman, that man is disciplined by the clan elders* ***(Male non user FGD Moroto).***
>
> *Depo provera is preferred especially in cases where the male support is lacking on family planning because an injection is taken in secrecy. Implants are long term methods and once initiated, it does help you to properly space the next birth from the previous ones and it's also a very private method* ***(Service Providers KI Kotido).***
>
> *Most women prefer injectables and implants because of the convenience unlike swallowing pills which is not easy, most women take alcohol hence the chance of forgetting to swallow when drunk****(Satisfied user Kotido).***
>
> *We are also comfortable with counting days. This creates a bias to any modern family planning method* ***(Non users FGD Kaabong).***
>
> *Condoms are used usually by the men and because they are allowed to have multiple partners whom they use them with. They are commonly available and depending on the population around for instance the soldiers prefer condoms and pick them in large amounts (Kaabong Hosp & Lolelia HC III). The women who use depo-provera have associated it with being so effective for them than condoms because some of the*

men do not want to use them and this safe guards them from getting pregnant ***(FP Service Provider KI Kaabong).***

Perception and Misconceptions

Generally, a number of misconceptions and perceptions were noted and brought forward. Some of the notable ones include modern family planning being used as remedy for those who are weak and lack sexual control especially after birth, Children born by women using family planning are not healthy and bright because the users are usually conditioned to give birth from the hospital and they never know where the placenta is thrown i.e. placenta is traditionally buried and it's believed to be the an everlasting connection between the child and his ancestry. The other issues were contraceptives destroy the ovaries and causes women to have wounds in the uterus which eventually makes women become barren or give birth to abnormal children who are with no limbs and hands, government ploy to make the population extinct, FP as an urban well to do service, a method of HIV transmission, an enhancing factor to promiscuity. The discussions are further detailed below:

Also family planning is taken as a service only for the well to do families especially for the urban and semi-urban population believed to be the educated class of persons ***(Community member KI Moroto).***

Negative attributes from opinion leaders, as some believe that's its one way of introducing HIV in the body especially through the injections methods ***(Community member KI Moroto).***

They say that family planning makes women barren, it's a form of witchcraft aimed at child and it's a form of murder of the unborn. Family planning use is taken as a form of murder which works against the Bible conception of producing to fill the earth. There is an inner built fear among other people fearing to come for family planning services ***(Kaabong Local Government Key informant).***

Contraceptive use is associated with promiscuity, so this is a discouraging factor hence non use. There is a misconception that family planning use stops women from bearing children. This misconception brings a fear among the society that the women will stop bearing children yet among the Karimojong children are given value as a source of wealth, labour during old age and a source of security ***(Non users FGD Kaabong).***

4.1.2: Socio-economic Determinants

Combinations of economic and social factors tend to affect utilization of health services and contraceptive use was found to have no exception to this phenomenal. In the context of the study region these factors included poverty

leading to inability to afford transport & service costs, high economic dependency on men and evidence of economically empowered and educated urban based women accessing more family planning services compared to the rural counterparts. The other socio-economic factors affecting the use of modern contraceptives include: having many children was taken as a source of future wealth /status nature of female relationship whether single or married where the singles in unstable relationships reported more use of modern contraceptives and as an opportunity for better package of handouts from relief organizations like WFP, priority setting by individuals, FP service taken as an opportunity for a meal for poverty stricken families. Peer influence contributed to both initiation and continued use of modern contraceptives. The women starting up new relations may be influenced to discontinue a method for a desire to produce children for the new relationship. This is reflected in the scenarios below:

> *The women with economic independence and educated are able to use family planning freely and even some of them visit the health facility for service as a couples but this is only witnessed here in Kaabong town where most of the users are educated workers who are only here to work but not natives of Kaabong* ***(Kaabong Local Government Key informant).***
>
> *As earlier mentioned, children are attached to property value of dowry especially for the girl children who are taken as a source of wealth, so such desire certainly affects contraceptive use. The children also build on a man or woman's social status and value and this is responsible for the desire of more children for respect in the communities. The more the children, the bigger the handouts from the relief and humanitarian organizations like WFP, and this is highly appreciated in the community as the bigger numbers are perceived to be the wealthy ones* ***(Kaabong Local Government Key informant).***
>
> *Family planning services are offered to clients free of charge by all government health facilities so the cost of the service should not be a challenge to contraceptive use. The service is much nearer to the community levels now with VHT and H/C at parishes and S/C level, so people have access to the* ***service (Local Government KI Moroto).***
>
> *Peer influence especially from other clients who have used these methods and have not found difficulty with them .Also among the enlightened population here, they have realized that child education is beneficial however educating many children is costly and therefore they have started managing their numbers using contraceptives* ***(Service Provider KI Kaabong District).***

Clients also discontinue when they are changing couples for instance a woman will get another man who wants to have children and therefore she has to discontinue ***(FP Provider KI Kaabong).***

4.1.3: Religious Determinants

The uptake of modern Contraceptives is said to be influenced by religious beliefs, values, principles and affiliations. Human beings tend to adhere to these values and principles. Within the community setting religion is a dominant influence to individual decision making. Specifically, in context of Karamoja region the Catholic Church was noted to have well established religious institutions and a very strong correlation between the catholic religion and the Karamojong culture as both are strong advocates for the promotion of natural contraceptive methods.

In the catholic managed health facilities modern contraceptives apart from permanent methods were not provided to the community as such depriving the potential clients from accessing information and services. The other exceptions to this opposition were the condom use in discordant relationships. This exemption only featured in Karamoja region. The catholic beliefs regard contraceptive use as a form of murder and hold the biblical belief of "produce multiply and subdue the earth". These are common and as such negatively impacting on the use of modern contraceptives. The other religious dominations like the Protestants did not show any opposition to the modern contraceptive use. In the study community these issues could be reflected in the statements below;

Children are blessing, and you produce many because, God takes away some when they are still young, so you have to keep producing to replace those lost ***(Non users FGD Kaabong).***

Catholics and the catholic church has its establishment in Kaabong and even some of the services like health are run by the church which has a very conservative view towards modern contraceptive use and is rather promoting and advocating for the natural methods which are consistent with the traditional child spacing cultural methods among the Karamojongs. The Biblical concept of produce, multiply and subdue the earth is a strong hold here used so much to fight the contraceptive use and family planning new enrollments ***(Kaabong Local Government Key informant).***

The catholics promote the traditional methods and denounce the artificial ones. Even in the Catholic health centers like Loputuk, contraceptive services are not provided. The Anglican Church rather seems more neutral on the contraceptive use especially through their

promotion of monogamous unions and proper child spacing ***(Local Government KI Moroto).***

The use of emergency contraceptive pills even in cases of rape is not acceptable and the use of condoms in cases of discordance is acceptable but only as a means of preventing infection but not as a contraceptive tool ***(Local Government KI Moroto).***

The permanent methods of male and female sterilization are also promoted in the health center and some successful surgeries have been carried out in Matany Hospital Napak the largest Church mission run hospital in the region ***(Local Government KI Moroto).***

4.1.4: Power and Gender Dynamics Determinants

In traditional African settings roles and responsibilities are defined by the community values and the socialization process. Most of which were still common in the Karamoja region. Whoever holds power within a family and community setting influences the key decisions including utilization of services. In the context of sexual reproductive health and family planning, it is critical to understand the power dynamics of the community as these influence uptakes of services. It was observed that at family level decision making was bestowed on the husbands while at community level decisions were made by opinion leaders who included kraal leaders[3] and Manyatta[4] leaders who were expected to protect and preserve the culture. The other community members who wielded power in decision making regarding to family planning are the mother in-laws, the church and the warriors. It was observed that individual women did not have full rights about their reproduction and the centres of power in the decision making were mainly the elders and the household heads who are men. The power of the husband was further consolidated by payment of dowry which further disempowered the females. Decisions about use of contraceptives were made collectively under the guidance of the Manyatta head which decision was complemented by community policing. Since most of the men and those who hold power don't support family planning initiatives the service turnout in communities is very in this region. Discontinuation of an FP method was commonly reported on the discovery of the use by a non supportive male spouse. Where women independence is reported there was a higher likelihood of use of modern contraceptives. These issues reflected in the statements below:

Even in our communal settlements, such decisions must be reached in a meeting chaired by the Manyatta head so that the community or your in-laws don't put the blame on you when something bad like death during birth of the baby or mother occurs, because they are in full

[3] Kraal leader: The persons in charge of where the collected heads of cattle are kept.
[4] Manyatta: A group of homesteads in one enclosure.

knowing of the situation. This is followed by community policing ***(Non users male FGD Kaabong).***

The husbands are the household heads here and the decision to use family planning is dependent on them, and with the biases they have on family planning as way of stopping us women from producing, some of us have been threatened with death if we ever try ***(Non users female FGD Kaabong).***

Some of the women have spouses with many partners so this kind gives us the independency to enroll for family planning and also choose the method. Some of us we actually convinced by the spouses to enroll for family planning as an option for planning to the family ***(User female FGD Moroto).***

When partners disapprove of use, they forward women to remove or stop the method (especially local communities) ***(Community service provider).***

The status does matter a lot in Karamoja because here, something is decided by the opinion and kraal leader, therefore the wife of a kraal leader or opinion leader can't use modern family planning even if she wanted because, the kraal / opinion leaders are seen / known to preserve / protect the culture and interests of the Karamojongs ***(Community level Key Informant Kotido).***

*The Jie as warriors don't allow their women to be contaminated with contraceptives, because it will affect the next generation of warriors that will be produced, literary the word Jie means fighters so this argument does have a strong effect even at the household and manyatta levels where this has to be upheld(****Community FGD Kotido).***

In case where elders discover that one enrolled they will forcefully cause that woman to terminate the method and ensure that the husband makes her conceive this is a very common practice in Poet ***(Community FGD Kotido).***

4.1.5: Cultural Determinants

Cultural values vary from community to community and are usually passed over from generation to generation. The Karamoga region in particular is highly a traditional society which cherishes its value system strongly. Usually, the custodians of cultures and value systems are elders who are predominantly men and include Kraal and Manyatta heads that were not interested in modern family planning and preferred their traditional family planning approach. The big family sizes were valued

and a source of bride wealth in the community. Those not promoting these values are stigmatized and taken to be against the expansion of the tribes. There is still a belief that the modern contraceptives are not necessary since the men usually leave for a long period to allow the child grow up or would get sexual satisfaction from another wife as the babies grow-up. The societal norms also derive pride in having many children and regard delivery of many children as a compensation provided for the big dowry provided. Overall, most of the cultural norms in the Karamoja region were opposed to the use of modern contraceptive services. This is illustrated in statements below:

> *Culturally as Karamojongs, we have our traditional birth spacing methods like the man going to the kraal for a long period until when the child has grown up. Our forefathers instilled in us the value of children especially having many children as this made a woman with many children the husband's favourite because she was strong and the children would also take on the strength of their mother. Men are allowed to marry more women to allow the children attain an acceptable age* ***(Non users Male FGD Kaabong).***
>
> *Most men say women are married with many cows and so they are conditioned to produce many children as a compensation for the dowry lost to her relatives* ***(Kaabong Local Government Key informant).***
>
> *Culturally having many children is a pride and therefore as a man, many children earn you respect therefore they do not use contraceptives. Many children are also culturally believed to be a source of dowry especially for the girl children (Kaabong Local Government Key informant).*
>
> *There is stigma against those using contraceptive because they have gone against the traditionally acclaimed and accepted methods of child spacing* ***(Community Level FGD).***
>
> *Culturally, the fire place is also used in Karamoja as a way of keeping a man away from his wife sexually when the child is still young, the sleeping places in the Manyatta are separated by a fire and the man was not allowed to crossover to the woman's side until the child came of age, however if the woman crossed then it signified that the child had grown* ***(Non user male FGD Moroto).***
>
> *Cultural pressure, the women are supposed to produce as many children as possible so there are users who are forced to discontinue due to traditional pressure from community regards to children* ***(Family Planning Provider Kotido).***

4.1.6: Health /reproductive health methods related Determinants

This section provides information on the factors influencing use and non-use of contraceptives related to health generally and modern contraceptives in particular. Specifically, it was observed that the clients using services were motivated by the benefits like, desire to stop having children totally and conveniences related to contraceptive methods. The other motivating factors included healthier families, better bonding between mother and child, better upbringing for the children, adequate time for the mother to regain strength and heal.

However, the non use and discontinuation were influenced mainly by the risks and side effects related to specific methods. The side effects mentioned included, nausea, dizziness, loss of weight heavy, delayed, painful and irregular menstrual flows among clients. The other factors which have influenced non-use are improper management of methods like the IUD and implants, method side effects and related method procedures especially requiring exposure of private parts like IUD. These scenarios are reflected in the statements below:

> *It gives you enough time for yourself and your children. Ability for the women to regain all the strength lost during child birth and also gives the womb the time to properly heal. The sickness syndrome is reduced in the family as the immunity of the children is boosted through prolonged breast feeding and proper care and love* ***(Satistified user KI Kaabong).***
>
> *Many women have dropped out because of excessive bleeding even after trying several methods. General body weakness which comes with nausea and dizziness. They have been complaints of vomiting and loss of weight especially those on implants. Breast tenderness and sensitivity is also common all leading to discontinuation. However, the issues arising with depo are that it affects the menstrual cycle some can take up to 6 months without menstruating and others have it more frequently which is rather a big inconvenience for them* ***(District level KI Kaabong).***
>
> *The family planning figures in Kaabong are very unstable due to such misconceptions with many drop-outs because of poor management of side effects and sensitization on the hearsay and misconceptions. We have not have heard of the health benefits of contraceptive use, however some of the risks we hear of are that it causes women to bleed and lose a lot of blood thus they became thin and small with very little energy that some of them can't give birth again* ***(Non users FGD Kaabong).***
>
> *Women with more births and desire to stop child births enroll/seek for contraceptive services which are usually long term such as Tubal ligation*

and implants. Improper administering of the method for example IUD, has actually built a fear for the use of this method among the women ***(Community FGD Kotido).***

4.1.7: Environmental Determinants

The environmental determinants are those external to the individuals but influence the utilization of services. These determinants do contribute to non use, continued use and discontinuation of modern contraceptives. In the Karamoja region the factors observed were the limited accessibility of family planning services because of the long distances to health facilities, the role played by politicians who were not supportive of the family planning concept, some form of insecurity, gender Based Violence related to discovery of the use of a method by the husband, low literacy, nomadic characteristic in the population which leads to discontinuation or non-use, limited knowledge on family planning, limited training of service providers and uncertainties related to child survival led to non use of contraceptives. Some stock-outs for particular methods also contributed to discontinuation of contraceptive methods. Programme design was noted to be biased towards women as such contributing to limited male involvement. The quality of family planning services including provision of snacks also influenced the continued use of family planning services. Availability of integrated health services like FP with immunization provided an opportunity to access family planning services and as well involve men. These factors are summed up in statements below:

There is limited knowledge of family planning which generally affects the use of the services. The services are very far and distance discourages them from using Family planning services. There are no trained medical Family planning personnel who extend services to village levels .Most staff are nursing assistants ***(Community FGD Kotido).***

The other factors affecting the use of contraceptives are insecurity, the nomadism of the population and low illiteracy levels ***(District Level KI Kotido).***

Political leadership is mainly against family planning services and discourages users; they encourage more child births and criticize family planning. However some political leaders together with health workers have encouraged people to adopt family planning through different forums like campaigns, health meetings and other community events ***(Community level KI Kotido).***

The family planning programme design concentrates so much on women contraceptives and very limited methods for men which accounts for less involvement of men in direct contraceptives use or in supporting their spouses in enrolling for family planning ***(Community level KI Kotido).***

There are still challenges especially in areas where main health facilities are privately owned by church foundations like Loputuk, these health units have not supported contraceptive use and don't offer the services in their health unit, to a large extent its challenging and responsible for the high level none use of the service in such areas ***(Local Government KI Moroto).***

Family planning information and services are free and can be accessed daily as and when one wishes with no strings appended to the delivery of the service. There is a high level of confidentiality with some of the methods like the injectables and implants which does encourage even the non-users to initiate the use. Well trained medical health staff offering the services especially in counseling about the benefits and proper management of the side effects ***(FP Service Provider Kotido).***

Professional counseling that motivates enrolment for F/P use, availability of service throughout, friendly nature of services providers and Proper management of side effects. Clients have a variety of choices freely ***(Community service provider Moroto).***

*Sometimes the clients come for their monthly refills of appointments and find that certain contraceptives are not available e.g. the oral pills because the clients using them are very few, they sometimes expire unused, so we encourage them to try other available methods like condoms and injectables or at times weight gains****(FP Provider KI Kaabong).***

4.1.8: Challenges

Specifically, some of the key informants were asked about the challenges which affect the use of family planning services in the community. In response it was noted the human resource challenges like inadequate number of trained staff and related overload were noted. The other factors included inadequate FP training and facilitation for the VHTs, long distances to health facilities, inaccessibility of health facilities during the rainy season and limited resources for outreaches and follow-up. These factors are reflected in the statements below:

Under staffing, we have to handle other patients as well as the FP clients, so this is divided attention. In addition Staff are not well trained on provision of family planning service and they few staff trained are not always readily available, for instance, sometimes we have to ask the clients to return for the implant or IUD initiation if the in-charge is not available. Lack of resources to mobilize, sensitize and follow-up clients who drop out and don't feel the pressure since lacking FP is not a disease ***(FP Service Provider KI Kaabong).***

The VHTs are not adequately trained to handle family planning services. The distances between the communities and the health units are usually very long for the clients. The literacy levels are also still very low and therefore it's hard for people to conceptualize some of these FP issues ***(FP Service Provider KI Kaabong).***

The main challenge is the poor mobilization in the catchment area. E.g mostly it is VHTs doing mobilization for Marie stopes, but they are not performing most probably due to high illiteracy levels among VHTs ***(Community service provider).***

Limited space as you can see the FP unit is within the ANC unit, so once our clients come, they have to wait from outside. The limited number of staffing in the unit, here the same nursing assistants attending to the mothers in the maternity are the same who provide the FP services, so sometimes the clients can come when we are very busy in the theatre and after long wait they leave minus the service ***(Community service provider).***

Difference in interest of the staff, for instance there are those who are interested in handling only PMTCT and ANC cases and may not be interested in handling FP services ***(Community service provider Kotido).***

Cultural interferences where people believe that they will not be able to have children if they use family planning so a lot of time and resource is spent counseling them ***(Community service provider Moroto).***

Key findings from Katakwi, Mubende, Kanungu, Yumbe and Oyam Districts

- The knowledge of the family planning concept and methods was generally high in all the study distr with limited information on implant and IUD in Mubende district.
- Misconceptions like family planning making women prostitutes, leading to production of children with abnormalities, taken as form of murder, initiation of an FP method requiring a blood test and IUD disappearing in the body were common in all study districts.
- The high cost of transport affected service access in some instances as high as over 40,000/-.
- Failure to meet basic needs for big families influenced uptake of modern contraceptive services.
- Higher education and better income led to better use of modern contraceptives
- Existence of safety social nets - Grandparents etc encouraged young people to have children
- Many children were also taken as a source of family labour in the rural setting.
- The common belief among some religious groups is that God commanded the human race to reproduce and fill the earth and this is propagated by religious leaders especially the Catholics, born-again Christians and the Muslim groups.
- Muslim leaders believe every child comes with his or her own luck while some Christians believe in producing to fill the entire earth common mainly in Yumbe district which is predominantly Muslim.
- The decisions on whether to start or continue using are influenced by husbands.
- The in-laws played a role in influencing their sons in making decisions against the use of family planning services.
- Competition among co-wives led to none use of contraceptives among women in some communities.
- Desire for especially the male children led to none use of contraceptives.
- Big family size associated to community respect among men was noted as a breeding factor for non use of contraceptives especially in Yumbe district.
- The cultural values promote bigger family sizes and especially the boy child as a means of promoting the family lineage.
- The culture promotes child bearing as the principal role of women and which is expected to continue without any interferences.
- Health risks or side effects Continuous bleeding, experiencing high blood pressure, loss of libido, loss of weight leading to HIV infection association, delay in regaining fertility, "dryness" among women users and failure to have menstruation periods contributed to discontinuation
- Risks related to pregnancies were also taken as a factor encouraging the use of contraceptive services.
- Some areas had services while others lacked family services leading to use and non use respectively.
- Political support for family planning use this also varied from area to area in areas the political leadership was Supportive while in others they weren't supportive.
- The implementation of the UPE and USE programmes were noted to have affected negatively the use of family planning services because families are assured of free education.
- The byelaws which punish those who don't educate and care for their children have also encouraged the use of contraceptives.

- The young people started uses of contraceptives to enable them enjoy life without the risk of pregnancy.
- Minimal side effects facilitated continued use and less durations taken to regain fertility after use of a method encouraged people to continue using particular methods.
- Some stock outs were reported in some districts like Kanungu as such leading to none use and method change.
- The influence of friends and peers led to either use or none use of modern contraceptive methods.
- Low male spousal support led to none use of modern contraceptives.
- Poor management of side effects and poor staff attitude led to method discontinuation.
- Inadequate facilitation of service providers to conduct outreaches affected service accessibility.

4.2: Katakwi District Findings

4.2.1: Knowledge, Preferences and perceptions related Family planning.

Knowledge

Comparatively Katakwi community had better knowledge of contraceptives compared to the neigbouring Karamojong communities. The knowledge level of family planning among the different communities in Katakwi is quite high with people being able to differentiate clearly between the traditional and modern family planning methods. The role played by health practitioners in the initiation and delivery of family planning services was understood by the communities as well.

> *Family planning is the spacing of children with medical help. Birth control using contraceptive medicines* ***(Community satisfied user).***
>
> *Family planning are two people i.e. husband and wife in a household who come to agreement on how to space up their children. Family planning is birth spacing of children (****User male FGD Katakwi)****.*
>
> *This is when you give birth to a child and you take of sometime from 2 years and above before you give birth again(****Discontinued user FGD Katakwi).***

Method Preferences

Understanding contraceptive method preferences among communities is valuable in informing family planning programme design. In Katakwi district the community response indicated that they preferred injectable methods, implants and tubal-ligation. These were preferred mainly because of the associated convenience and the long term effect. However the method preference among the young and cohabiting population were the oral pills and condoms.

This helps you to absolutely stop producing once you have reached the desired number of children and you don't experience the side effects like other methods ***(Female user FGD Katakwi).***

It's sometimes upon the agreement of the spouses and sometimes once the children are many, you decide to use tubal-ligation to avoid the risk of getting pregnant again because here in Ominya we have challenges of land and poverty, you find a household where there are eight children having only about two acres of land and yet this is their only means of survival ***(Female user FGD Katakwi).***

Implant; because it takes a long time and you do not have to worry over unexpected pregnancies ***(Community satisfied users Katakwi).***

*Pill are mainly taken by the cohabiting, educated girls not yet in marriage since they have not yet established the fate of their relationship and trust of having a child****(community satisfied users Katakwi).***

Condoms are commonly used by youths and most men as well because they are easy to use, don't have any side effect, portable and accessible ***(Community service provider).***

Perceptions and Misconceptions

Existence of misconceptions related to a service inevitably affects utilization of the service. Like in many Ugandan communities misconceptions were manifested in Katakwi district. These were evident in both rural and urban settings. Those commonly mentioned included: Contraceptives causing cancer, male impotence and deformities among babies. There were beliefs that condoms can get stuck inside women and contraceptives being associated to promiscuity among users. Family planning was perceived by some as a service for those who already have many children.

Bleeding can cause cancer to women. To Catholics family planning is murder of the unknown children. Pills when swallowed accumulate in the stomach leading to cancer. Men think vasectomy leads to impotence. They believe, children produced with deformities results from contraceptive usage and most caesarean births are family planning results ***(Local government KI Katakwi).***

There is no enjoyment with condom use and these Condoms remain inside the women after sex. Family planning has affected and spoilt many women as it is responsible for the adulterous and promiscuous nature of women ***(Non user male FGD).***

*Most young girls who are still studying, it is advisable that they use pills not implants / injections as the later will affect the production of the female egg and reduce their chances of conception later****(Male user FGD Katakwi).***

Family planning is for people who have many children like eight and more and have experienced the burden of managing these children and not for everybody ***(User female FGD Katakwi).***

Girls who use family planning before marriage are believed to be prostitutes and will never give birth ***(Community member KI Katakwi).***

4.2.2: Socio-economic Determinants

In Katakwi district the factors leading to non-use included the high cost of transport and services in some instances which some people could not afford. This factor of cost is not wholly applicable as services are free in all public health facilities while outreaches are also common.

The high cost and burden of maintaining especially big families, higher education levels especially among women, family drive for better health and independence in decision making were associated factors for initial and continued modern contraceptive use. The influence of individual and family friends also positively contributed to use of contraceptives. This is illustrated in statements below:

Marie stopes goes up to the lower units (HCII) to extend services to people, so it is not true that cost and transport is a reason enough for people not to use family planning. The services are readily available right from the VHT /CMD (Community Medicine Distributors) levels where oral pills and condoms are available and people can do the refills ***(Local government KI Katakwi).***

Husbands only succumb to the use of family planning once there are emergencies and difficulties like during birth and difficulty at labour period ***(Local government KI Katakwi).***

Some clients are also being influenced by friends to change the method being used. Also because of contraceptive duration some opt from short term to long term or the reverse depending on the objective prioritized ***(Community service provider Katakwi).***

Those who are well educated and have seen the need for fewer children and child spacing and are planning according their resources are the ones to go for contraceptives; however it's the poor who desire more children do not consider enrolling for family planning ***(Female user FGD Katakwi).***

*Even economically independent women and girls visit the same health facilities because the service is usually free only that they may access some methods which some married women don't know or fear to use****(Discontinued user KI Katakwi).***

Transport to the health facility is very challenging, sub county HC is very far and they walk long distances to access the services where at times they fail to get preferred methods and are referred to the district hospital which is about 10kms far ***(Community satisfied user Katakwi).***

*There are cases where clients have been urged to pay some money for removal of implant. These cases have been reported in Katakwi hospital, where the implants were initiated by Marie Stopes and some clients have experienced serious side effects and have wanted to remove the implant, they have been urged to pay Ugx 10,000 for removal or wait until the next Marie stops clinic day (****Local government KI Katakwi).***

4.2.3: Religious Determinants

The beliefs and values of given religions at times influenced decision making for services. In Katakwi district the predominant religious groups were the Catholics who are opposed to contraceptive use and the Anglicans who expressed liberalism. The Anglican church is liberal on the contraceptive use among its folk and while their counter parts the Catholic church have openly destroyed contraceptives and banned any contraceptive programs in any of its premises. The Catholic believers take the use of modern methods of family planning as being against their faith and biblical wisdom which is more of interfering with God's creation plan. The catholic clergy were reported to preach against family planning whenever they could get opportunity to do so. However, the individuals make personal decisions according to their challenges and needs without much consideration of the teachings. This is reflected in statements below:

Religious leaders are not in for family planning, they preach against family planning in churches especially the Catholic Church. There was an incidence in USUK Health Centre II a Sister burnt boxes of condoms that were sent by PACE ***(Local government KI Katakwi).***

Condoms are totally discouraged by Catholic Church even when it is the case for discordant couples; in Health Centers run by the church for example St Kevin HCII, Omodoi sub-county and St Ann HCII in Usuk do not offer family planning ***(Local government KI Katakwi).***

The religious leaders have misinformed people of family planning for example; a parish priest here once preached that " family planning makes the children dense and to give birth to children with deformities"and this is what our catholic priest tells the congregation here (Ominya-Toroma) ***(Male user FGD Katakwi).***

*The Anglican Church is urging couples to as much as possible produce children that they can manage properly and space them using family planning(****Discontinued user FGD Katakwi).***

The religious beliefs say it is a form of murder because the fertile eggs inside the woman's body / reproductive system are being destroyed The religions believe that it's an abuse of nature it's responsible for high immorality in the community ***(Non user female FGD Katakwi).***

4.2.4: Cultural Determinants

The cultural norms and values in Katakwi district related to family planning were not strong .With the onset of economic challenges and developments there is a stronger passion for the use of modern contraceptives as opposed to the support for the bigger family sizes.

The reasons extended for large family sizes and limited contraceptive uses were: need to have future economic security, continuity of the family lineage and need to utilize the extra free land. The ateso culture promoted early marriages whenever a girl developed breasts she would get married and produce children without using contraceptives.

Some cultural values also promote the concept of family planning like married girl should not continue producing when cows used to pay the dowry have stopped and so long as a woman is breast feeding she is expected to transfer to the in-laws until she stops. This is illustrated below:

We also have a tendency of producing children because we hope to depend on them in the future when they grow up and we are older, this mentality therefore drives us to have many children with the hope that they will be able to help their parents financially ***(Community Satisfied users Katakwi)***

In Iteso once a girl gets breasts she is ready for marriage and once a girl is married at a tender age she is likely to produce very many children and previously culture was discouraging this because cows paid during bride price can't continue producing when the woman is not producing. However, this is no longer a major issue ***(Local government KI Katakwi).***

*Most families are now independent regards to family planning so culture has very little or no impact on use or non-use (****Community member KI Katakwi).***

The older generation (grandparents), advocate for more children and a woman married has to continue the family lineage by producing children who will be named after the deceased clan/family members ***(Male non user FGD Katakwi).***

In our culture, our forefathers practiced family planning. Once a woman was breastfeeding, she moved to her mother-in-law's hut until that child came of age, which is when she returns to her husband's hut ***(Female non user FGD Katakwi).***

Once the child is able to bring you drinking water then that child was off age and the parent ready to have another one. The culture issues surely say a women's roles is to give birth however due to the hard times the cultural traditions have been overrun by the desire to survive and manage smaller families ***(Discontinued user FGD Katakwi).***

4.2.5: Power and Gender Dynamics Determinants.

The power to make Sexual and Reproductive decisions in Katakwi district remained mainly that of the husband and Katakwi district was no exception to this to an extent. In addition to husbands the mother in-laws and family members had a say in the direction of use of family planning services. Experience from Katakwi district was a mixed one while some men were quite supportive of the use of modern contraceptives and could either consent or even escort their spouses the others were not. The current users of family planning services contributed to influencing men to have a positive attitude towards family planning. There were also cases of discontinuation and threat for violence by some male spouses whenever they found out that their wives were using modern contraceptive methods. This is expressed in the statements below:

Most men are scared of family planning they believe that women can leave them since there would be no young children to hold them back ***(Discontinued FGD Katakwi).***

The family members think it's a waste of resources like dowry as a woman has to produce to accomplish the reason to why she was married and a woman who delays to give birth is not in the good books of her in-laws. The relatives / family members think that women in family planning stop the family and clan from growing and that women only come to eat ***(Female non user FGD Katakwi).***

The family trend here generally is that most men are supportive and give a go ahead for women to enroll for contraceptive use on consent although there are cases of a few who seem not to give support ***(Community member KI Katakwi).***

Mothers in law want grand children and they want their daughters to give birth and they believe family planning methods may lead to barrenness.

Husbands only succumb to the use of family planning once there are emergencies and difficulties like during birth and difficulty at labour period. The family members and relatives are encouraging proper spacing and fewer children due to the limited family / clan land for settlement and agriculture ***(Community service provider Katakwi).***

4.2.6: Health /reproductive health methods related Determinants

This section presents the motivating and de-motivating factors related especially to the modern contraceptives it covers the benefits and side-effects which contribute the discontinuation of contraceptive use and none use.

The study participants mentioned benefits like reduced stress, better health and improved feeding for the mother and child. The proper handling of side effects and fear of pregnancy especially among the young led to continued use and motivated others to start to use methods.

On the other hand the method related side effects included over bleeding, irregular menstrual cycles, nausea, loss of libido and hypertension as such negatively affecting the use. The desire for children led to nonuse or discontinuation of an FP method. These issues are further illustrated below:

> *Women are stress free with no fear of getting pregnant again. Women enjoy better health and so do their families* ***(Community satisfied user Katakwi).***
>
> *Proper and timely handling of cases reported method related side effects in the areas of use has led to more enrolment of contraceptive use* ***(Community Satisfied user KI Katakwi).***
>
> *Caesarian mothers use family planning methods to space child birth and the mother has to rest in birth in between the pregnancies. There is proper planning and health for the children* ***(Local government KI Katakwi).***
>
> *The rate of which children fall sick has reduced (trips between home and hospital have also reduced)* ***(Female user FGD Katakwi).***
>
> *Low libido (sex urge) for women on contraceptives, hypertension and diabetic cases may not be able to use these methods. Some male organs are reported to reach the copper IUD during sexual intercourse* ***(Local government KI Katakwi).***
>
> *Body weakness, over bleeding, very irregular menstrual cycles associated with Depo provera* ***(Community satisfied user Katakwi).***
>
> *Fear of early pregnancies and fear of miscarriages especially among the youth and newly cohabiting couples have led to use of contraceptives* ***(Community service provider Katakwi).***

4.2.7: Environmental Determinants

In Katakwi district these external factors affecting contraceptive use included high level of mobilization by the VHTs and political leaders, improved economic fortunes for families practicing family planning serving as a motivation for the nonusers to initiate. The other facilitating factors for contraceptive use observed included the availability of free services, promotion of child rights by the district local government

and expansion of the integrated service delivery outlets including VHTs. On the other hand the negative attitudes by service providers especially as a result of overload negatively affected service uptake. This is noted in statements below:

> *The VHTs and L.Cs are also working hard in mobilization and sensitization of the community on family planning activities like the Marie Stopes clinic days in Toroma H.C. IV* ***(Female user FGD).***
>
> *Politicians at the district level are involved in radio talk shows to sensitize the masses about family planning, however some politicians are against family planning attributing it to the cases of Kony rebel attacks and the Karamojong invasions that left many lives dead, so they advocate for more children to replace the dead* ***(Local government KI Katakwi).***
>
> *The fact that people are now able to save some money realized from sale of surplus foods and put it into productive use and not as it were before where they spent on treatment after child falling sick in the home is a motivation here for many enrolling households on contraceptives* ***(Female user FGD Katakwi).***
>
> *All heath facilities in Katakwi have stocks of contraceptives and it's rare to find a facility running out of contraceptive, so availability has increased use especially by voluntary method involving clients who willingly come to health facilities to seek the free service* ***(Local government KI Katakwi).***
>
> *Attitude of health workers towards the beneficiaries especially when they are over loaded with work is not good and this has demotivated many people from enrolling for contraceptives. Limited number of personnel in Health Centre leads to potential crowds waiting for long hours for the service and some even get tired and leave without being attended to. Generally the recent policies have extended health services to village level through VHTs, CMDs and frequent outreach programs such as the Marie Stopes visiting team, this has led to more support and use of contraceptives here* ***(Community service provider).***
>
> *The population policy is promoting the use of family planning under the UNFPA where people are encouraged to produce what they can manage and discourages abortion. The National Heath policy supports the use of family planning among individuals, youth and family. The District Local Government education policy advocates for every child's right to education, feeding, health and these can only be realized through proper child spacing* ***(Local government KI Katakwi).***
>
> *Also many people are now going to the hospital not only for family planning but also for other services like immunization and antenatal care and use this chance to get family planning services* ***(Community service provider Katakwi).***

4.2.8: Challenges

In Katakwi from the context of service provision the challenges observed included inadequate staffing, the late receipt of outreach allowances affecting the morale, the long client waiting time, crowded health facility environment, inadequate facilitation of VHTs and high illiteracy levels affecting honouring of appointments. The other challenge is lack of vehicles for outreaches. These challenges are expressed in the statements below:

> *Inadequate staffing also affects the delivery of family planning services to the catchment area, for example clients outnumber the medical personnel leading to over waiting for service at health facility* ***(Community service provider Katakwi).***
>
> *Due to shortage of vehicles, the hospital is forced to integrate the programs i.e. if they are going to immunize, they also need to fix family planning programs* ***(Community service provider Katakwi).***
>
> *Delays of motivation allowances for example, outreach teams spend 2-3 months to receive their money and this kills morale of working* ***(Community service provider Katakwi).***
>
> *Inadequacy of methods within some service provider areas for example the youth corner has very limited methods i.e. condoms and oral pills to offer and does not meet the choice needs of clients* ***(Community service provider Katakwi).***
>
> *Inadequate skills to administer some of the methods and during the out reaches the community members ask about the long term or permanent methods, for instance they have very few knowledgeable staff to administer the IUD* ***(Community service provider Katakwi).***
>
> *The facilities are very far and too crowded with less staffing. This has demotivated family planning usage in their village. E.g. clients over walk to access facility and can sit for long hours waiting for service and at times nurses say they are tired and ignore them* ***(Community Member KI Katakwi).***
>
> *Limited level of education and illiteracy whereby some clients are not vigilant with following up their appointment dates* ***(Female user FGD Katakwi).***

4.3: Mubende District

4.3.1: Knowledge, Preferences and Misconceptions

Knowledge

Knowledge about a service contributes to utilization so the study sought information on the levels of understanding of the family planning concepts and methods. It was observed that in Mubende district the community had a good understanding of the family planning concept. However, they had limited knowledge of some of the contraceptive methods like the IUD and implants. Most of the categories of study participants knew the family planning concept and the contraceptive methods. The understanding of the family planning concept and methods is demonstrated in the statements below:

> *Family planning is the way one can control his/her birth rate and take good care of them i.e. Controlling the production of children one can take care for, even when marrying wives, one must be aware that he can provide for them. Human beings are not supposed to be like pigs* ***(Elders FGD Mubende).***
>
> *Family planning is producing few children that one can take care of, provide the basics of life like feeding, accommodation and schooling* ***(Family planning users FGD Mubende).***
>
> *In actual sense we don't know what it really means, but we simply just take injections and I cannot lie to someone that FP is this or that* ***(Users FGD Mubende).***
>
> *The methods we know are the IUD "Kaweta", the pills, the implant, jelly/foam, injections and sterilization. The implants have just been introduced so many people don't yet know them* ***(Youth FGD Mubende).***
>
> *We know the pills and injections .We have heard about the coil but we have never seen it .There are capsules/norplant which they put in the hand* ***(Discontinuers FGD Mubende).***

Method Preferences

The information generated on method preferences is important in informing family planning programmes. The study participants were therefore asked about the preferred family planning methods and the reasons for preference. In response, most of them said that the preferred method was the injection because of the convenience of use and availability. Those who did not prefer oral pills indicated that it had a burden of taking it daily giving room for forgetting. The IUD had some misconceptions like stress creation which negatively affected its preference. The youth however preferred the oral pills compared to other methods indicating it is more accessible to them. The other reasons extended for injection preference was

the possibility to use it without knowledge of an opposing husband. These issues are echoed in the statements below:

> *The preferred method in the community is an injection because it is deemed easy. It can be obtained from every clinic and health centre available .Another method that is preferred is the oral Pill. These are also preferred because they are readily available and can be obtained from every health centre. The method is also cheaply obtainable than any other* ***(Elders FGD Mubende).***
>
> *We prefer the pills because we can easily get them. We have little information on the implant and the IUD so we can't compare* ***(Youth FGD Mubende).***
>
> *The pills can be forgotten and injection can be hidden from the husband if there was no consensus between the couple. Implant is preferred since it can delay conceiving for a longer period* ***(Non Users FGD Mubende).***
>
> *At first I used an injection, but I bled until the end of the 3 months, took another injection for 3 months but the bleeding couldn't stop, I gave up and started on using pills which never had any effect on me, hence I went on to use pills because they were acceptable in my body* ***(Discontinuers FGD Mubende).***
>
> *As for the coil if it is inserted, you are not supposed to stress yourself with hard work yet for us in our village we have to dig, so we use pills and injections. You also need to eat and feed well* ***(Discontinuers FGD Mubende).***
>
> *Natural methods (moon beads) are the best methods to use. It is a matter of counting off the risky seven days in a month. They also help to avoid the effects of other modern FP methods* ***(Elders FGD Mubende).***

Perceptions and Misconceptions

Possession of inadequate information and negative beliefs tend to affect service uptake. Therefore, an effort was made to establish the perceptions and misconceptions among the study participants.

The commonly mentioned perceptions and misconceptions were that those women using contraceptives were prostitutes, pills pile in the body and cause cancer, a mode of murder of the unborn, that the contraceptives lead to delivery of children with deformities, the disappearance of the IUD in the body leading to death and need for blood tests before an FP method is initiated. The existence of these misconceptions contribute to none use and discontinuation of contraceptive use. These are reflected in the statements below:

> *Some men don't want their wives to go for FP because they believe that women on FP are prostitutes. They have a belief that once a woman is*

not expecting to get pregnant at any time, she could easily opt out for other men ***(Elders FGD Mubende).***

Most of the time when one uses FP he/she can get problems, like tumours on the uterus , produce children with broken limbs, with deformities or producing more than five children at ago, which is not allowed by the law. The contraceptives also makes a woman become sickly, becomes unhappy in life, amongst peers ,becomes slim and even look ugly ***(Youth FGD Mubende).***

*One of the factors affecting contraceptive use is getting FP use without first testing blood compatibility with the type of the method so as to avoid/limit side effects, family disharmony, misconceptions, etc (****Discontinuers FGD Mubende).***

The pills pile in the stomach and it causes cancer and other problems. The coil can dissolve into the body and later cause problems. Some contraceptive methods cause harm to men during sex e.g. the coil ***(Community level KI Mubende).***

4.3.2: Socio-Economic Determinants

Social and Economic dimensions in a community affects service utilization. In respect to the use of contraceptive services in Mubende district the study participants noted that cost of transport to the tune of UGX 40,000/- affected the use of services especially among the poor. On the other hard economic challenges like meeting the basic needs for big family sizes was also noted to influence decisions to take up family planning services. The education levels and better income were reported to be associated with higher utilization of contraceptive services. Some people especially young people wouldn't care about the number they produce because they knew parents and grandparents would take responsibility .The many children were also taken as a source of family labour in the rural setting. There were also allegations that contraceptive users tend to be weaker and less productive in undertaking manual work. The young girls used contraceptives out of fear of pregnancies. These are illustrated in statements below:

The cost of transport to health facility in Mubende town is 40,000/- and since we are poor we can't easily afford this cost ***(Elders FGD Mubende).***

Some young girls who are not yet ready for responsibility of child bearing and rearing and still want to enjoy life continue using it. Many/most rural men do not care for their children and leave the burden to the woman which prompts them to limit the number by continuously being on family planning ***(District level KI Mubende).***

There is poverty, high cost of living, and lack of children's basic needs like food, accommodation and medical care. The only solution however is to go for FP in order to have few children. The cost of transport is

sometimes high and they would find it hard to reach the FP clinic during the prescribed time. For the services they are free at the government health centre and with a small charge in the private clinic ***(Users FGD Mubende).***

Transport costs to the health centers for FP are no longer a problem and can be accessed by all, be it the rich or the poor irrespective of one's status. There is no need transport money to get the FP services ***(Non User FGD Mubende).***

The services are used mainly by those people of the high social class, the poor and the less educated don't know how to use the services. However since the area is almost isolated the use of the services is still lacking because of the high cost to reach Mubende town ***(Youth FGD Mubende).***

Some families want children as a source of labour in their gardens and security for their parents in old age. This has encouraged the production of more children and discouraged the use of FP services ***(Satisfied User FGD Mubende).***

4.3.3: Power and Gender Dynamics

Decisions on sexual and reproductive health in the Ugandan setting are commonly bestowed with the husbands and Mubende district was no exception to this arrangement. The decisions on whether to start or continue using family planning are mainly influenced by husbands. In addition, the in-laws played a role in influencing their sons in making decision against the use of family planning services. The competition among co-wives, the desire for the male children and big family size associated community respect among men were noted as breeding factors for non use of contraceptives. The decision making power was also used to support the use of family planning services. This is reflected in the assertions below:

If the man has more than one wife, there will be competition on who produces more than the other. The first wife would perhaps want to stop when the second wants to edge out the first one on the number of children she has in the family ***(Elders FGD Mubende).***

Some men encourage their wives to go for FP especially those who have been with their partners for a longer period of time and they already have children ***(Users FGD Mubende).***

*You may sometimes agree with your husband that you are going for FP, but when the in-laws hear about that they influence the husband to reject it because for them they only need to see grand children in the home****(Discontinuers FGD Mubende).***

We just hide from our husbands to use contraceptives. They insist that we should produce because they say they brought us to produce, yet we

are working, feeding the family and being pregnant at the same time. That is why it is a secret between me and the health worker. I left FP because my husband was quarreling and my child had grown up. It is my husband who caused me to leave it ***(Discontinuers FGD Mubende).***

Men sometimes threaten their wives that if that if their wives go into FP they will marry other wives who can produce. In fear of the co-wife, they resort to producing for the man who wants children ***(Non Users FGD Mubende).***

Family members influence on use and non use of FP in various ways; Men are always in for continued delivery/many children and prevent women from taking contraceptives. In some families women are chased out of home for not producing children thus preventing them from taking contraceptives ***(District level KI Mubende).***

4.3.4: Religious Determinants

The religious beliefs that people have influence the use of some services. The family planning services are among those which are affected by such religious beliefs. The common belief among some religious groups is that God commanded the human race to reproduce and fill the earth and this is propagated by religious leaders especially the Catholics, born- again and the Muslim groups. The use of contraceptives is instead regarded as murder and every child taken to be born with their own luck. Some religions were however supportive of family planning services. These issues are reflected in statements below:

Some experts say those going for FP are right and others say they are not right because God commanded man to produce and fill the earth and that means that using FP is an act of murder. They thus believe that FP control can only be done by God ***(Elders FGD Mubende).***

When pastors and other religious read the bible, they quote it saying that it is out of order for someone to control pregnancy, because in the bible God said that produce and fill the earth. The pastor cannot therefore change and preach against the teaching. They end up discouraging it ***(Youth FGD Mubende).***

Some churches support family planning especially the natural methods such as moon beads since they don't involve killing the ovary but very difficult because it involves counting days and one can forget ***(Users FGD Mubende).***

Muslims, Catholics and born-again discourage their followers from using family planning because it is looked at as murder especially by Catholics. The Protestants seem to be more liberal on family planning but have never clearly indicated their stand ***(Community service provider KI Mubende).***

Religious beliefs have influence on the use of FP in the community. Some people who don't use FP say that, "Katonda alikubuuza nti amaggi geyakuteeka munda gakoola ki?" literally meaning that 'One will have to give an accountability of the ovaries that God gave her If God has created you to have like four and you 'kill' two of them during the FP process, then you will only have two; which are not enough ***(Satisfied User KI Mubende).***

4.3.5: Cultural Determinants

Communities pass over institutional values from one generation to another especially through elders and these cultural beliefs may not be supportive of the technological advancements like the use of modern contraceptives. The cultural values promote bigger family sizes and especially the boy children as a means of promoting the family lineage. This belief was common in Mubende district as well.The culture promotes child bearing as the principal role of women and which is expected to continue without any interferences. Overall, in Mubende the cultural system negatively affected contraceptive use in the community. These issues are reflected below:

The culture is supportive of a family having children of both sexes the boys to service as the heirs and to promote family lineage and the girls as a source of bride wealth ***(Youth FGD Mubende).***

Women who come from large families and support culture don't approve having few children. If our own mothers produced us in large numbers, why produce fewer children. As long as land is available, they can have more children ***(Youth FGD Mubende).***

Culture was there before FP so the elders/grandparents are not supportive and cannot be convinced about the use of FP. Even the spirits (jjaja's) don't like it ***(Users FGD Mubende).***

*Some people use traditional kiganda methods of herbs. Our culture is such that a woman is brought or married to produce- nothing else; no compromise on this or else what did she come to do? Slogans like "yajja kujuza toyi" Did she come to fill the toilet (****District KI Mubende).***

Kiganda and Kinyakitara cultures believe that only boys can inherit property from the parents so people strive so hard to ensure that they have sons. In cases a family has no boy; they would not try to use family planning at all because this would not help them get what they are looking for ***(Community Service Provider Mubende).***

4.3.6: Health/Reproductive Health and Method Related Determinants.

The use of modern contraceptives is associated with benefits and risks which affect the sexual reproductive health of the users. The study participants were asked about

the experiences related to the different services. In response the study participants indicated that that the users appeared good looking and healthy. On the hand the health risks or side effects were mentioned as to be negatively affecting service uptake these include continuous bleeding, experiencing high blood pressure, loss of libido, loss of weight leading to HIV infection association, delay in regaining fertility, "dryness" among women users and failure to have menstruation periods. In addition to the side effects the bother related to method like daily taking of pills led to either change of method or discontinuation. The risks related to pregnancies were also taken as a factor encouraging the use of contraceptive services. Some clients were prompted to start using family planning services after establishing they were HIV positive and after experience of individual complications. These issues are reflected in the statements below:

> *When some people use family planning, they eventually look healthy, gain weight and this attracts others to also use the FP services. They look good and healthy while on FP and so they continue using it* ***(Elders FGD Mubende).***
>
> *Many users experience losses of sex appetite and dryness during sexual intercourse which makes the man to hate having intercourse with you and may eventually go for other women who are sexually active. Some users lose weight, become tiny and look as if they are sickly prompting people to brand them HIV victims while others are unable to regain menstruation periods****(FP Users FGD Mubende).***
>
> *I left FP because of over bleeding and my husband got tired of the situation and overspending on treatment. He had at first accepted to use FP.A few women and men have had sterilization from Mityana and they are healthy. The older women are more likely to accept sterilization than the young ones. One disclosed that she had a sister who has had sterilization but the husband complained of coldness during sex* ***(Discontinuers FGD mubende).***
>
> *Pregnancy is very burdensome. Even delivery is problematic – travelling on boda bodas to Bukuya to deliver is traumatic and many lead to still births. This encourages some people to use FP to avoid such traumatic situations* ***(Discontinuers FGD mubende).***
>
> *In my opinion mothers benefit by giving birth to few children and hence their health is good and free from exploitation, laborious responsibilities and free from associated risks* ***(District Level KI Mubende).***
>
> *The people fear family planning because it makes women lose sex appetite and become very cold during sex. This may make them lose their husbands. They also say every child comes with his or her luck on earth* ***(Elders FGD Mubende).***

They may start use because of the experience of the previous delivery if an individual had a complication. The poverty, increasing age and minimal side effects with proper sensitization influences them to initiate a method ***(Service Provider KI Mubende).***

HIV positive persons may not want to give birth, let alone to get pregnant, because of health reasons ***(Service Provider KI Mubende).***

4.3.7: Environmental Determinants

The study focused on those factors external to the individual which influence use of family planning services in among Mubende residents. Through the interface with the study participants it was established that the situation wasn't uniform in the entire district. In some areas the family planning services were available and accessible yet it wasn't the case in others as such the effect was different. Regarding the political support for family planning use this also varied from area to area. In some of the areas the political groups had total support while in others they weren't supportive and the same time not serving as models. The existence of FP promotional programmes in some of the areas accounted for the difference in community support. Some influence from religious leaders was also observed for instance the Muslim leaders believe that every child comes with his or her own luck while some Christians believe in producing to fill the entire earth. The implementation of the UPE and USE programmes were noted to have affected negatively the use of family planning services because families are assured of free education. The byelaws which punish those who don't educate and care for their children have also encouraged the use of contraceptives. These scenarios are illustrated in the statements below:

In this community we have a man who moves from house to house educating people about family planning though he is not welcomed in other homes. We also don't have a health centre so getting some family planning services is difficult ***(Elders FGD Mubende).***

With the new health centre offering free services everybody can access services without trouble including those who have not got consent from their husbands. So the number using the services has increased ***(Non Users FGD).***

You tell the truth, whether sub county chairpersons, be it the village local councils, no one has ever come up to talk about FP use. It is not an issue to them. Our Chairman who would have directed us to use FP is instead the one with more children. So how can he guide us to use FP? Other just put on FP T-shirts, but they say nothing about FP ***(Elders FGD Mubende).***

Our political leadership has helped in focusing the use of FP. The Local Government Councilor has been instrumental in encouraging her fellow women to go for the FP instead of just producing for the sake ***(Family Planning Users FGD Mubende).***

Some politicians have done a good job in advocacy and mobilization. We work through/with them. We are given a platform during their different fora to say something as a district to address family planning issues e.g. during budget conferences ***(District Level KI Mubende).***

Current policies, by laws, at national, district, local councils e.g. in health, education like punishing those who do not take all children to school are good and contribute to FP use ***(District Level KI Mubende).***

*FP service availability determines if one should take them on or not. There are services that are not available in some health centers. There is stigma associated with FP in some communities which affects its use (****Community Service Provider KI Mubende).***

4.3.8: Challenges

This section presents challenges from the perspective of service providers. The challenges observed included lack of transport for facilities to undertake outreaches, inadequate staff allowances for outreaches, inadequate service provision FP supplies, lack of preferred methods at some facilities especially in private facilities, limited training for staff and staff overload. This is reflected in the statements below:

We need transport for getting equipment from Mityana diocese and also for outreaches within the community. We buy our own pregnancy test kit but we do not charge separately from the charge of 2000 which we eventually charge when giving out a method. We need such tests and HIV tests too. Some people want methods I don't have such as the coil and yet the HC IV at Kiganda is far and people find it difficult to go there ***(Private FP Service Provider Mubende).***

People's incomes are low. Being private, I charge 1500/- but some cannot afford. I get the method from Indian pharmacies in Mityana. It is far and costly in terms of transport compared to profit or charge I levy. Yet others get services on credit and take long to pay or default ***(Private FP Service Provider Mubende).***

Having clinic days daily affects the family planning service delivery, especially when one comes and the nurses are busy. It is hard for one to be attended to because there are other emergencies which need immediate response. Women also come in with their minds made up on the choice of method they are going to use, this makes it hard for one to convince them to use a different one .Preferred methods are not available sometimes such as IUD, TL, implants. ***(Public FP Service Provider Mubende).***

4.4: Kanungu District

4.4.2: Knowledge, Method Preferences and Misconceptions

Knowledge of Family Planning

Knowledge on a particular service has a bearing on the utilization so information was sought on the understanding the family planning concept and the methods. It was observed that overall the family planning concept was understood by most of the groups though some level of misunderstanding was noted among the none users who took it as the killing of over among the child bearing mothers. These issues are illustrated in statements below:

> *It means the way of controlling birth, stopping or increasing the production of children using various ways like condoms. Family planning is the way to sit down as a man and woman and see how many children to produce* ***(Elders FGD Kanungu).***
>
> *Producing children you can care for with the resources you have. Not to produce twins* ***(FP user FGD Kanungu).***
>
> *Family planning means killing eggs (ova) in the children bearing mothers* ***(Non users, Kanungu)***
>
> It is spacing children using injections, oral pills, sterilization, implants, moon beads and breast feeding **(Users FGD Kanungu).**

Method Preference

The information on the preference of methods is important in informing the design of family planning programmes. Therefore information was sought on the methods most preferred and the reasons behind the preferences. The most preferred method was the injection and the reason for the preference was mainly convenience and accessibility. The other factors influencing preference were peer influence, cost, the side effects, age, level of privacy and the information provision by service provider .The older people had more preference for long term and permanent methods while the young ones preferred the short term methods like the pills and condoms. This is reflected in statements below:

> *Convenience and availability of certain methods lead to high/low chances of it being used e.g. condoms can be accessed from nearest shops and are always available. Some people/ partners prefer using certain methods because they are not costly (cheap) especially in private clinics. They may be preferred because of less side effects and influence of other users* ***(Elders FGD Kanungu).***
>
> *With pills you can forget and also one may not like taking drugs and prefer injection…..and at times you would like to take long to produce so you prefer methods like coil and Norplant* ***(Users FGD, Kanungu).***

Injections are convenient to some people especially those hiding from their spouses. It is done once. The common methods like injection and pills are preferred unlike diaphragm which is unknown. People are price sensitive. They will prefer cheaper methods like injections and pills .Some methods are more preferred by mature people such as female sterilization ***(Non users, FGD, Kanungu).***

*Injections are convenient to use. It can be administered once in three months unlike pills which you have to swallow every day. It is also effective. On the Negative side injections cause excessive bleeding….. Cannot easily be withdrawn from e.g. when you decide to have children before the time of injection ends…. They cause other diseases such as high blood pressure, dryness etc (****Non Users FGD Kanungu).***

The old ones who are no longer interested in children can even go for permanent sterilization- vasectomy/ tubal ligation ***(Youth FGD Kanungu).***

The injections are preferred because they are easy to use because someone cannot forget to use it ***(FP Service Provider KI Kanungu)***

Beliefs and misconceptions

The existence of wrong beliefs and misconceptions in the population would negatively affect service use. Therefore study participants were asked about the common beliefs and misconceptions in their respective communities. The common beliefs sighted included: The number of children was taken as a source of wealth, family planning associated with prostitutes and HIV with multiple sex, leading to delivery of abnormal children, loss of energy and fertility. These are reflected in the statements below:

Family planning services is a way to prostitution and cheating on their partners. Belief that having many children means more wealth, hence, no need to use family planning services ***(Elders FGD Kanungu).***

Family planning leads to deformed children's bodies and loss of energy ***(Youth FGD Kanungu).***

Family planning is said to make people barren, cause blockage of fallopian tubes and growth of fibroids ***(Users FGD Kanungu).***

These beliefs and others we may not be aware of cause or discourage some people from using family planning or dropping out. But here it is very minimal because of the level of sensitization about the advantage of family planning in relation to good family life (Users FGD, Kanungu).

4.4.3: Socio Economic Determinants

The study assessed how the social and economic factors affected the use and none use of contraceptives. In response it was observed that these factors include the availability of money to afford the cost of the service facilitated the use. The failure to meet the family needs encouraged especially the poor to utilize modern family planning services. On the other hand the educated, economically independent and rich people were more knowledgeable on family planning services and utilized services more compared to the less educated and poor. These groups were associated with better affordability of the services and management of side-effects. These issues are reflected in the statements below:

> *Most of the time women rely on their husbands to give them money to access family planning services in terms of transport and payment. This implies higher likelihood of failure to raise the needed funds yet long distances to the health center is tiresome. As a result many people can't afford accessing the family planning services* ***(Elders FGD Kanungu).***
>
> *Cost of the different, methods is another factor. For instance if one is on injection and it becomes unavailable in time, she will switch herself to pills which cost 500/- compared to injections at 2000/- from local clinics who mostly mind about business not continuity of a method* ***(Service Provider KI, Kanungu).***
>
> *It is good for the rich because for them they can afford the costs involved i.e. can go for the best hospitals in case of any complication. It is convenient for them because for the rich, they do not do these hard jobs which the poor do. (they hire other people to dig for them) this is because some family planning methods weaken you to the extent that you can no longer dig or do any other difficult job* ***(Non users FGD, Kanungu).***
>
> *The educated people seek family planning services more because they are knowledgeable and can afford any method of their choice; afford transport to the health centers and in case of any urgency they are attended to very fast compared to the poor* ***(Elders FGD Kanungu).***
>
> *The social status of an individual affects the use or non use of family planning. For example the educated people in the society are assumed to be more informed than the uneducated. Therefore with this information they can easily go for family planning services unlike the uneducated* ***(Satisfied user, Kanungu).***
>
> *Most families in the area depend on agriculture. So the more children you produce, the more cheap labor you get for farming* ***(Community Service Provider KI, Kanungu).***

4.4.4: Power relations and Gender Dynamics

The decision making related to utilization of family planning services is not only bestowed on the users but other stakeholders involved in influencing decision making processes. In the context of the Kanungu district the key influencers to decision making were the elders, grandparents and in laws from the man's side. The husbands were secondary to these other family members. In most instances this influence led to either non-use or discontinuation of a method since those holding power were not supportive of modern family planning interventions.

> *Some families discourage family planning use. The elder people in the family like parents of the couple can dictate family planning usage or non* ***use (Elders FGD Kanungu).***
>
> *Significant people like mother/father in law influence the use of family planning methods since they are considered to be knowledgeable and have experiences. However such people, may not be considered in decision making since some seem to dwell on traditional beliefs e.g. more children more wealth* ***(Youth FGD, Kanungu).***
>
> *The mothers in law look at family planning as a taboo and if you talk about it she discourages you from doing it. Giving many births in big families is used as competition tactic to get the love of the husband* ***(Discontinuers, Kanungu).***
>
> *Family members can play a big role as they remind the partners about the importance of family planning. Children who are educated can influence decision making since they know most of the side effects associated with using certain methods of family planning (****Youth FGD Kanungu).***
>
> *The men are the decision makers or else the women have to hide. If the husband wants more children, it is very difficult for the woman to practice family planning. The elders also advocate for more kids and are not supportive of contraceptive use* ***(Community Service Provider).***

4.4.5: Religious Determinants

Religious beliefs and values are known to influence decision making on health including family planning. The study established how religious beliefs were affecting the use of modern contraceptive services. The common belief propagated by the Catholics, Pentecostals and Muslims is the call to produce and fill the world .Such beliefs influence the Faithfull to ignore the use of modern contraceptive services. This is echoed in statements below:

> *The leaders encourage us to use it so as to have manageable families and better quality of life. The religious belief is now about producing what you can manage not just to 'fill the world* ***(Elders FGD Kanungu).***

Pentecostals believe in non use of contraceptives since children come from God and so the bible condemns having few children. They believe in producing and filling the world according to the bible. Muslims mostly marry many wives and so have many children which bring about none usage of family planning ***(Elders FGD Kanungu).***

Whereas some religions oppose family planning the others like the Anglicans encourage use of family planning ***(Youth FGD, Kanungu).***

Catholics don't support the use of artificial family planning methods and equate it to murder which the bible condemns. Therefore true Christians should not use family planning ***(Non Users FGD Kanungu).***

Basically it's the Catholic Church that does not provide for modern family planning and strongly opposes any form of scientific family planning methods. It only promotes natural ones. Other religious sects (Bisika group in Fort portal and the Pentecostals) discourage family planning up take. Many people believe them and follow their advice. Some even discourage use of any modern medicines ***(District Level KI Kanungu).***

Among most religions like Islam and Catholics the practices of modern family planning methods are seen as a sin against God. It's taken as murder. They discourage it totally. The Protestants are more liberal but do not support it openly ***(Community Service Provider, Kanungu).***

4.4.6: Cultural Determinants of Contraceptive Use

Communities usually promote cultural values from generation to generations and it is usually the elders who are the custodians of culture. These cultural values influence individual behaviours including health seeking behaviours. Specifically, in Kanungu district it was noted that the value system promoted the boy child as the beneficiary to family inheritance and in promoting clan and family lineage. The dead are said to live through the children born as such promoting non-use of contraceptives. The individuals with bigger family sizes were more respected compared to those who had small ones. This led to non-use and even discontinuation of particular contraceptive methods. These issues are cited in statements below:

Single sex in some tribes is seen as a misfortune calling for the need to produce the opposite sex which limits the use of contraceptive. There is need for inheritance of father's property and to get heirs of their clans e.g. If they only produce girls who get married and leaves the family, then the future of the tribe is at stake. This leads to people producing many children limiting the use of family planning ***(Elders FGD Kanungu).***

Elders of the family like grandmothers and fathers in most African traditional societies, believe that if their sons have many children they expand the clan and bring prestige to the family…… that the dead keep on to live in

*the new born children of the family who are renamed in the names of their ancestors. Culturally the 'Basigi' don't support contraceptive use. The belief is that God cares for everybody. If birds are fed by God, what about people****? (Community Service Provider KI, Kanungu).***

4.4.7: Health/reproductive health and methods related Determinants

This section provides information on how the total wellbeing an individual affects contraceptive use. The emerging issues show how associated benefits facilitate family planning utilization and health risks/side effects which show how family planning uptake is limited as a result of these effects. The common side effects reported include excessive bleeding associated to injections, irregular menstruation, dizziness, loss of libido and nausea. In addition there were some health related misconceptions which were reported and these included deformities of babies and cancer. A reaction to rubber by inching among some men affected the use of condoms. These factors contributed to either none use of discontinuation of a method.

The reported benefits promoting use include improved health, love for the children and income for the family. These scenarios are reflected in statements below:

With injections some people finish four years without having their periods which is not healthy. Some women put on weight while others reduce which causes high blood pressure. Some men are allergic to rubber so if used it itches their bodies. This leads to discontinuity. Pills bring about dizziness and vomiting or nausea which discourages the use of such method. Withdrawal limits a woman from getting nutrients that are in sperms and leaves men wanting and dissatisfied ***(Elders FGD Kanungu).***

It causes cancer of the uterus; IUDs/ implants can sink into your body and this can be fatal; Brings dryness in bed(when having sex); Excessive bleeding; Irregular menstrual periods/having none ***(Non Users FGD Kanungu).***

Injections, pills, implants are associated with side effects such as excessive bleeding, dryness during sex, loss of sex appetite, deformities among new borne babies leading to husbands stopping their wives from using family planning; Some discontinue because they need more children or due to inadequate FP services due to long distances to where they are provided, Loss of partners due to death, divorce or separation, When someone changes to a religion which does not like family planning e.g. Catholics ***(Elders FGD Kanungu).***

Family planning Increases family income to cater for basic needs…….Health growth of children…….Love for the children is maintained since they are few in number……Body fitness on the side of the mother and they take long to get old. It gives the husband chance to

produce the exact number of children they want….Reduces unwanted pregnancies ***(Youth FGD, Kanungu).***

Family planning helps in having healthy babies…..Mothers stay healthy and young because they get time to look after themselves…..It does not bring stress in the family unlike when you have many children, it can be stressful…. It promotes love in the family because the man and woman get time for each other ***(Non users, FGD Kanungu).***

Most of the village folks limit contraceptive use because of the desire for many children or a certain sex if not yet got. But those who do not want to produce a lot of children especially the rich stick on using contraceptives ***(Elders FGD Kanungu).***

4.4.8: Environmental Determinants

These are factors external to the individual which affect the utilization of family planning services. These factors would either enable or disable the utilization of contraceptive services. The favourable factors mentioned in Kanungu were availability of services, supportive political leadership, and favourable policies like health policy and by laws which encourage utilization of the services. However the unfavourable factors to use of family planning services included common stock outs and policies like UPE and USE which reduce the child education burden leading to limited use of modern contraceptives.

Here health centers don't offer some services e.g. female/ male sterilization which leads to non use or travelling to far places looking for it. Services are always there but being too far and tiresome to reach while footing. Many people don't go there for family planning or discontinue using it. If people know that certain services are never there in a specific health centres or clinics they don't go there for contraceptives….Condoms are available in shops but most of them are expired and so we do not use them ***(Elders FGD Kanungu).***

Stock-outs affect women who miss methods and get pregnant. Secondly, if you don't have money you miss out if free ones are out of stock and you end up getting unexpected/unwanted pregnancy. Thirdly, we are using only the 3 methods (Pill plan, injecta plan and condoms) and those who cannot use these, lack the service ***(Users FGD Kanungu).***

Political and religious leaders educate / mobilize and sensitize us about a manageable family size in order to develop oneself and the community generally. Secondly they work to ensure that methods are available in the health units. They have educated community based health providers who also distribute method and refill 'supply'. These are spread in the village i.e. community based service providers ***(Community level KI, Kanungu).***

Some new policies like 'UPE' (universal primary education) have encouraged most people to produce many children because of the free education ***(Community Service Provider, Kanungu).***

4.4.9: Challenges

The challenges observed from the service provider's view were contraceptive stock-outs, inadequate service provision equipment, limited staff training and low involvement of VHTs in mobilization at different levels. Some of these are outlined in the statements below:

> *Stock outs should be dealt with. There are insufficient logistics/materials to facilitate service delivery e.g. equipment (BP machines to take the BP before initiating clients on IP and PP)…..Limited range of methods* ***(Service Provider, Kanungu).***

> *We do not have capacity at this clinic to offer all family planning methods and therefore our clients do not have a variety of options .Secondly there is lack training on updates e.g. about micro pill which has 35 tablets which we are not familiar with* ***(Service Provider, Kanungu).***

> *In the private clinic they also experience a low turn up of family planning users. Some of our clients cannot afford to raise the money we ask for. There are also challenges of clients discontinuing use of the family planning methods/services. The majority of our local people are not sensitized about family planning services and this negatively affects its use* ***(Service Provider, Kanungu).***

> *All these call for health education through mediums such as radio talk shows to continue on family planning mainly targeting men. VHT should be involved in health education on family planning methods as well* ***(Service Provider, Kanungu).***

4.5: Yumbe District

4.5.1: Knowledge, Contraceptive Method Preferences and Perceptions

This section covers the knowledge status, the method preference and perceptions as they emerged from the different study categories in Yumbe district.

Knowledge on Family planning

The study participants demonstrated an understanding of the family planning concept and the common methods. However, the family planning knowledge

seems to have been lower among the elderly group. The rest had clear knowledge of the contraceptive methods which included the injections, tubal ligation, the contraceptive pills and implants whose source they indicated were local health facilities.

> *Family planning is spacing children i.e. to get another child when the one you have is 3 years old the methods are natural methods, that is moon beads and artificial methods where you can use pills for adolescents the method used is abstinence and use of condoms* ***(Youth FGD Yumbe).***

> *Family planning is spacing of children, meaning the child should reach 3 years before getting another and the modern methods are contraceptive pills, IUD, injections implant, moon beads, female sterilization* ***(Male users FGD Yumbe).***

> *We know the injections but we are ignorant about other methods which are mainly for the young people* ***(Elderly FGD Yumbe).***

Contraceptive Method Preferences

The method preferences and the reasons behind the preferences are important in informing programming. In Yumbe district it was the injectables and implants that were the most preferred methods especially among the middle aged married individuals because of the associated privacy especially from men and convenience of one prick in three months. However, the condoms and pills were preferred among the young people. Equally the men had preference for the condoms. This is reflected in the statements below:

> *I do not like pills because you can easily forget to take especially when you are busy with household chores so I prefer injection* ***(Satisfied User KI Yumbe).***

> *I prefer injections because I do not want my husband to know that I am using contraceptives," he no longer provides for us because he got a new wife* ***(Satisfied User KI Yumbe).***

> *We prefer condoms because they are easily accessible. However some women fear implant because of the misconception that it can disappear into your body so they prefer injections and pills while others don't like pills because it's easy to forget taking it daily* ***(Users Male FGD Yumbe).***

Implants are preferred due to the long duration it takes hence it can be used by the most forgetful person ***(Discontinuer FGD Yumbe).***

Pills are not preferred, by women who are using the method secretly for example one time a man found pills in the wife's bag, he wanted to kill her because he thought she was being promiscuous ***(None user FGD).***

The reason why women are using injectables commonly is because they are using it secretly. Men believe that the coil will discomfort them while having sex .Injection is secret women prefer it because the husband will not know or see ***(Users FGD Yumbe).***

Implant is convenient e.g. women who are busy, they do not have to come to the facility frequently. Injectaplan once given nobody will know that you received it. The duration of 3 months is convenient; it creates no suspicion ***(Satisfied User KI Yumbe).***

Perceptions and Misconceptions

The existence of negative perceptions and misconceptions about contraceptives tend to affect utilization of contraceptive services. Yumbe district residents were no exception and were asked about the common perceptions and misconceptions. The misconceptions mentioned include how contraceptive use leads to foetal abnormalities, cancer, loss of weight, family instability, and impotence among men and infertility among users. The users were taken to be creating a bad name, against Gods plan and the Muslim faith. The key misconceptions are presented below:

We hear use of contraceptives makes a woman sterile, promiscuous, never to enjoy sex and all her ova to die. Muslims believe those contraceptives were introduced to reduce their population because in their religion there are many followers. We hear that when you use implant it can disappear into your body and you will never have children again ***(Youth FGD Yumbe).***

Those who are using contraceptives are healthier and have better living conditions than those who are not using .Those who are using family planning are Christians, for us Muslims we don't use contraceptives ***(Non user FGD).***

I thought I would not have another child after stopping the use because of the beliefs that it makes one to become infertile but I am pregnant now ***(Discontinuers FGD Yumbe).***

We fear using condoms because of the fear that it can remain in a woman and they will not have children again. When a woman starts

using contraceptives she will be relieved of child care burden and look younger, this will make other men to start admiring her so I cannot encourage the use instead I love to suffocate her with children so that she does not have any breathing space ***(Elderly FGD Yumbe).***

A condom can remain in a woman, the women do not want us to use them and they even say that sex is not enjoyable when using a condom ***(Male Users FGD Yumbe).***

On Vasectomy there is none response so far at the hospital, they think it makes men impotent ***(Users FGD Yumbe).***

4.5.4: Socio-economic determinants

This section presents the economic and social problems affecting the use of modern contraceptives in Yumbe district. The economic and social factors have a two-way effect that is affecting the use of contraceptive services positively and negatively. It was reported that poverty led to current clients and potential new clients fail to afford transport costs and basic clothing like under garments which are viewed by health workers during examinations despite free services in all government aided health facilities. At the same time poverty has encouraged many families to take-up modern family planning as a way of reducing the burden of raising children. Family disagreements emerging from extra marital relationships also led women to initiate modern contraceptives.

Women fear any examination to do with private parts because they fear to come without underwear's since they are poor. The living conditions of our community are not ok, we don't have money for treatment in case we get complications due to use of contraceptives and even for transport to the health facility ***(Female User FGD Yumbe).***

Because of hard economic times we agreed with my husband to have minimum number of children we can offer to take care of. Since times are "hard" people learn their own lessons and go for child spacing without anyone forcing them .For sure I am now using contraceptives because of economic conditions after failing to feed 6 children ***(Users KI Yumbe).***

I used to tell my wife I don't have brothers and sisters. I have to produce many but after experiencing the burden of 6 children, we are now using injections and she is ok with no side effects ***(Male user FGD Yumbe).***

Family disagreements with their spouses e.g. when a man impregnates another women outside or gets another wife they resort to use of family planning because the man is no longer reliable ***(FP Service Provider Yumbe).***

4.5.5: Power and Gender Determinants

The study sought to establish the power centres in decision making for use of modern contraceptives and it was established that these lay at the hands of the husbands as family heads, parents and the in-laws. In some instances in the case of polygamy women would compete for the husband's favour in terms of who among them is more fertile. These factors have a lot of influence on women's capacity to make own decision about family planning amidst competition from their spouses. The male counterparts are the ones who give a go ahead for services and would determine continuity especially if they are aware of the service. Those holding decision making power would determine the use, discontinuation and even the choice of contraceptive methods. This situation is illustrated in the statements below:

> *We rely on the men for decision making so we don't just go for it, I asked him to use contraceptives and he was threatening to divorce me. A hajji's family will not allow his family members to go for family planning because the Quran is against it* ***(Non Users FGD Yumbe).***

> *Those who come without consent so when he gets to know she is stopped. When the men find the wife is using contraceptives, they stop them e.g. last year there was an incident where a man found out that the wife had an implant on the arm, and tried to remove it with a razor blade, the issue was in police****(Service Provider Yumbe).***

> *Obviously the men are the ones making the decisions in a home but if you go for these methods secretly you can use it, he will realize when it is too late. My husband threw away the pills when he found them; it's because of him that I stopped using them* ***(Discontinuer FGD Yumbe).***

> *When you are using contraceptives without the consent of the man and he gets to know about it he will not trust you again, he might even accuse you of being promiscuous* ***(Non Users FGD Yumbe).***

> *I started using contraceptives when I had two kids and my in-laws started complaining, they influenced my husband to get another wife who can give him many children. I had to stop now I have five* ***children (Discontinuer FGD Yumbe).***

> *My wife was negative about use of contraceptives but I had to take her to the health facility myself and after the nurses talked to her she accepted* ***(Youth FGD Yumbe).***

> *If we want to have children, they should be of a manageable number and they should be properly spaced, but our men do not want to know*

about that all they want is to have more and more children ***(Discontinuers FGD).***

4.5.6: Religious Determinants

Religious beliefs and values are known to influence behaviours including health seeking behaviours. In Yumbe district being predominantly Muslim community, the users of FP methods use them secretly knowing it's a sin against God. It is also preached that Family planning is not provided for in the Quran and Allah forbids any one stopping women from giving birth.

In addition, the Quran allows Muslims to have more than one wife which encourages competition among women on who produces more children for the husband and as such affecting the use of modern contraceptives. Among Muslims they also believe that family planning is for Christians yet the Catholic Church is also totally against use of contraceptives to control child birth. These issues are reflected in the statements below:

> *There are few Christians in this community and the Quran does not allow the use of contraceptives. If Allah has refused we cannot use it, though I would want to use it, I fear the repercussions* ***(Non Users FGD Yumbe).***
>
> *Catholics say the use of contraceptives is a sin, its being discouraged. Our religious leader says using contraceptives is wasting the chance God gave you to have children* ***(Users FGD Yumbe).***
>
> *Muslims believe that contraceptive use is a sin and they believe in whatever the IMAM tells them that is why most Muslim women do not use contraceptives. Early marriages are encouraged in Muslim faith for example after a girl's first menstrual period, the second one should not come, it should be a child, so a girl will start producing at 15 years and continue having many children since contraceptive use is not allowed in Muslim faith and the older men they marry dictate on them like their own father* ***(Youth FGD Yumbe).***
>
> *Since this is a missionary founded facility, we do not offer family planning services but we counsel mothers, and refer them for family planning other health facilities* ***(Service Provider KI Yumbe).***

4.5.7: Cultural Determinants

Communities have varying cultural systems and values which are passed on from one generation to another using especially elders. In Yumbe community the cultural values were not supportive of the conceptive of family planning. The predominant belief was once bride price is paid, then a woman is expected to produce until menopause stops you naturally and it's believed that this is a way of paying back for their cows (Bride price). Culture demands that clans can only grow through promoting large families and giving birth to many children. The women without children were regarded inferior. The above is expressed in statements below:

Culturally in our community having many children is a prestige, so contraceptive use is not common. When dowry is paid, the woman should produce until her eggs are over ***(Youth FGD Yumbe).***

Culturally they encourage women to produce as many children as possible because they want many children so for us who are using contraceptives and have two kids, they call us useless. The primary role of a woman in a home culturally is to produce children, so women do not want to use contraceptives because it will limit the number of children ***(Users FGD Yumbe).***

*I would like to go for these methods at the facility but, since culturally a man is the decision maker in the home, I cannot go for it because my husband is against it (****Non users FGD Yumbe).***

In the past our mothers gave birth to too many children, by then family planning methods were not yet introduced. So our husbands object to the use of these methods because they want to emulate the ways of their fore fathers ***(Female Users FGD Yumbe).***

Culturally a woman without a child is not a real woman so they cannot use family planning ***(None user FGD).***

4.5.8: Health /Reproductive Health related Determinants

This section presents the health related advantages which promote use and the disadvantages which promote discontinuation or none use of modern contraceptives. It was observed that in Yumbe the health related benefits mentioned included a healthier wife, more attractive wife more engagement in productive work improved family relationships, dual protection from HIV and pregnancy. These have influenced people to start using contraceptives.

On the other hand the risks or disadvantages related to the health and contraceptive methods included method side effects like abdominal pain, loss of weight, prolonged menstruation, delayed regaining of fertility and condom inconveniences like changing and inserting of the female condoms. These issues are discussed in statements below:

They mainly stop due to side effects especially over bleeding, Persistent spotting. Some mothers fail to get health services due to long distances and other commitments they have at home e.g. house hold chores, child care and farming, so they get discouraged. When the child makes one year, they stop because they want to get pregnant ***(Service Provider Yumbe).***

Contraceptives have side effects like lower abdominal pain and prolonged bleeding, some women abandoned the use, and others only hear about it and fear using contraceptives. Family planning

encourages good relationship among couples, stronger healthier wives and improves sexual frequency ***(Male users FGD Yumbe).***

There are no health risks instead the use of contraceptives will improve your living standards ***(User FGD Yumbe).***

Using family planning methods becomes socially risky when it breaks your family e.g. divorce. When people hear complaints from those that are having bad side effects like loss of weight, vomiting and prolonged menstruation, they get discouraged ***(Discontinuers FGD Yumbe).***

Sometimes women take long to gain their fertility especially after injections so they fear. Some of these methods have bad side effects like weight loss so it discourages women from using e.g. implant .The use of pills is risky because if you miss taking for a day and you have sex, you can get pregnant ***(Non user FGD).***

Condom use has two functions; it protects against STI's and prevents unwanted pregnancies ***(Youth FGD Yumbe).***

Men don't like female condoms that they are noisy and think changing condoms after every round is inconveniencing ***(Female Users FGD Yumbe)***.

4.5.9: Environmental Determinants

This section provides the influences external to the individual affecting the utilization of modern contraceptive services in Yumbe districts. The facilitating factors include availability of modern contraceptives, availability of support, human personnel, the use of mass media for awareness creation and health infrastructure. The support available was from UNFPA and this was made effective through local health personnel including VHTs. The barriers noted in the environment were periodic stock-outs of some modern contraceptives and the supply chain policy challenges.

We appreciate UNFPA & MOH on their continuous supply which has increased access to mothers. They have enabled VHTs to learn about the methods and distribute them ***(District KI interview Yumbe).***

It's not that people are not using these services because they are not available, no these services are always available there, people are just negative about them ***(Discontinuers FGD Yumbe).***

Due to relative provision of services at our nearby health facility many women can now easily access them without being affected by transport costs. These drugs are there at health facility but we are not utilizing them due to a number of reasons ***(Non User FGD).***

Stockout of drugs affects enrolment and consistency e.g. for 3 months now, we have run out of stock leading to dropouts because there will be no consistency in use ***(Community Provider KI Yumbe).***

Policies of National Medical Stores in their supply chain, they may not give you all the drugs you need hence some health facilities run out of drugs this affects consistence use in case of stock out. The policy of recruiting and training VHTs have been useful, they have increased access and awareness. Use of media e.g. talk shows has helped ***(District KI Yumbe).***

4.5.10: Challenges

From the perspective of Family Planning Service providers in Yumbe district the major challenges were, stock-outs, inadequate transport for outreaches/follow-up, and long distances to health facilities, inadequate equipment resistance to family planning from religious leaders and the males. This is illustrated in the assertions below:

Some equipments like forceps, trackers, gloves syringes sometimes may not be available so we are forced to tell the clients to buy from outside. Hence when they do not have the money they may not come back for ***services (Service Provider Yumbe).***

Clients who come for services and want it on the same day and find that it not available they blame us for not providing the services and sometimes go away for good. Some men do not like these services in the community; they insult us when we go to outreaches ***(Service Provider Yumbe).***

If a man finds it in the house he will chase the woman and it becomes our problem because they sometimes tell them to go to the VHTs home. When we talk to non-users who have poor child spacing sometimes they start abusing you together with their husbands ***(Service Provider Yumbe).***

Capacity building of the staff; Knowledge gap among the staff because when you don't offer the services you will not know much about it and some of us have never seen some of these modern methods. Understaffing, hence we are overwhelmed with work ***(Service Provider Yumbe).***

Lack of transport; sometimes clients call you anytime to deliver services but due to transport problem, we are inefficient because the village is big. When we run out of drugs, we may not be able to pick them in time due to lack of transport and this affects consistency for pills ***(Community KI Yumbe).***

4.6: Oyam District

4.6.1: Knowledge, Method Preferences and Misconceptions

In Oyam district the knowledge of family planning concept and methods was quite high. The study participants were able to state their understanding of a family planning concept and as well mention family planning methods. The different groups including the none users knew both the FP concept and the methods .This is demonstrated in the statements below:

> *Family Planning is understood as producing children that a couple can take care of which is a decision of both a man and a woman* ***(None users FGD Oyam).***
>
> *It is producing children whom you can take care of and avoiding them to become thieves* ***(Youth FGD Oyam).***
>
> *It is spacing children and looking after them in the right way* ***(Users FGD Oyam).***
>
> *Family Planning methods commonly known are: Safe days/ moon beads, Pill/ pill plan Condoms ,Male/ female sterilization, Implants and IUD (****None users FGD Oyam).***
>
> *We know both the male and female condoms, the pills, implants, injections and sterilization* ***(Youth FGD Oyam).***

Contraceptive Method Preferences

In Oyam, the most preferred the method was the injectable especially among the adult population. The reason for preference was mainly convenience of the method.

Users' preference for a given method ranged from cost of service and accessibility, to safety and effectiveness of the method. Participants expressed a general desire to change current method to more long lasting methods. Some preferred a method because of the less side effects associated with it.

Since a number of women use FP without the consent of their husbands, it was noted that there is a preference for long term methods, than the short term methods. However, often long term methods are not accessible for the economically unprivileged and rural households. Condoms are cheap but women have limited control of its use, it can only be effective if the man is the one with the desire for child spacing. The supportive statements are below:

> *Pills are associated with fatness, injectables are associated with birth risks; diaphragm is associated with safety at birth without any serious side effects on the body. So, some of these methods depending on their perceived*

effects determine use of a particular method. The use of a particular FP method depends on the attendant outcome of the method ***(District level KI Oyam).***

There is a big preference for long term methods like implant but these are not usually available which leads to most mothers staying away from FP units which later affect FP use negatively ***(District level KI Oyam).***

I have ever used injections and I had a prolonged bleeding for almost one month which caused me health problem thus I discontinued ***(Discontinuer's FGD Oyam).***

I am tired of frequenting the hospital for FP, I wish to go for an implant because I was informed you spend 5-10 years without visiting the hospital ***(User FGD Oyam).***

I often forget taking pills so I want to change to a permanent method (User FGD Oyam).

I would like to abandon the injection and go the IUD because I experience back pains during menstruation ***(User FGD Oyam).***

We get access to free condoms even when we wish to buy they are cheap and every one can afford ***(User FGD Oyam).***

Common beliefs and misconceptions:

It was indicated that prior to ongoing sensitizations on FP in the districts, modern family planning methods were associated with; Bareness, leading to users giving birth to abnormal children or causing deformity in babies at birth, causing Caesarean-section child birth which weakens women in the long run, and was believed to be a women business. FP is believed to; cause female eggs meant for child birth to collect in the users stomachs which in the end causes death, Women Users to become Promiscuous, causes cancer of the cervix, causes caesarean section child birth. It is also believed that FP can be used to reduce on land wrangles, men who accept FP are under the influence of their wives, users are shying away from responsibility of looking after children.

The misconceptions contribute to rejection of the services especially by men who forbid their spouses from taking up the services. Misconceptions were found to have proved a difficult huddle to skip by contraceptives service providers as they face a lot of rejection. These are reflected in statements below:

Family planning methods cause barrenness in women, some people in the community say once a woman joins any family planning method, she will never give birth ***(Community level KI Oyam).***

Some say, that family planning use causes deformity in babies, for example of recent a woman gave birth to a baby with a very big head and later on died ***(Non Users FGD Oyam).***

Women on family planning use will never give birth normally; they will go under Caesarean section which weakens the woman in the long run and at the same time that it also stops delivery ***(Non Users FGD Oyam).***

*That since eggs are not being replaced, they collect in the abdomen an example of a women in the community who was a user of FP and the talk was that she died because eggs collected in her abdomen (which was very big) and lead to her death****(Service Provider KI Oyam).***

Contraceptives make one lose weight and blood. So, one needs to go for blood transfusion to be healthy ***(Non Users FGD Oyam).***

4.6.2: Socioeconomic Determinants

It was found that generally in rural areas of Oyam there is a low health seeking behavior. People only seek for health care on serious cases that are life threatening. FP is taken as a secondary health requirement hence, except if it is brought as close as possible to the beneficiaries, most people were not likely to spend on transport and lunch to go for distant health units for FP alone. This scenario means, the in areas where the HCII are a distant place (hard to reach areas) and there are no outreach sites, contraceptives use is only heard about in households which are economically privileged (Which can afford travel costs).

It was also discovered that economically privileged households had better chances of having access to information through owning a radio, attract services of community health workers and capacity to read IEC materials because of access to education.

Most households in the district are patriarchal were women solely depend on men for their survival. Decision making on finances and health in the household are done by the husband. With exception of a few women who are economically liberated most women find a lot challenges to convince their spouses to give them money especially for purposes of contraceptives use.

The study team was informed that, free services provided at health facilities sometimes have been found not to work effectively well for some women,like the implant and often the methods that would have worked for them are provided at a cost. Given the poverty levels in Oyam some people are left out because they cannot afford.

It was also found that because of the inability to go to trained FP service providers, some women resort to going to nearby drug shops (clinics) with limited capacity and

no experience to offer the service. In the end wrong methods are prescribed, side effects are enormous causing more users to reject FP. Supportive statements are as below

> *Poverty is not an excuse for none-use of Family Planning if one knows what they want from FP use. One rather goes for FP service and waits to reap the perceived gains in future* ***(District level KI Oyam).***
>
> *FP/Health care services are free at government Health facilities. So, no cost element is involved that hampers access to the service. Even when the Family Planning service is at a cost at private health units, it is affordable provided one wants the service to meet a need now and in future* ***(District level KI Oyam).***
>
> *People of high status are more likely to access health-related information because they are learned while people of very low status cannot* ***(Community level KI Oyam).***
>
> *Women and girls in rural areas mostly depend on men and cannot make their own decision to go for family planning service meanwhile women in urban areas do not entirely depend on men, they make their own decisions since they know the benefits of FP****(Users FGD Oyam).***
>
> *If cost is involved in accessing FP services in terms of transport facilitation and the cost of the actual services, clients find it hard to access FP* ***services (Service Provider KI Oyam).***
>
> *Most times the most poor people in the community tend to be less educated with illiteracy FP use is usually very low and these also believe the more children, the more labour force so they no need of its use. Women and girls in urban centres are more knowledgeable about FP so they are informed on the different choices one can make* ***(Community Provider KI Oyam).***

Women dependency on men for key decision and financial provisions was a key reason for making it hard to seek or access FP services while economically and socially independent women have taken up FP without fear of coercion from their spouses. Level of education was also found to have an influence on information reception, and decision making on family planning. In fact it was originally believed that FP was for educated people.

> *Most people who are well-to-do know the benefits of FP use so they usually make informed decisions. Most women and girls are now independent or do not fully depend on men for everything, thus making their own decisions as regards FP* ***(Community Provider KI Oyam).***
>
> *Literate people prefer to use contraceptive because of the knowledge they have about FP methods, products and results given the level of*

exposure so this makes them plan for a reasonable family in line with their resource capacity ***(Service Provider KI Oyam).***

Poor people do not get information on family planning because they are always in remote places and most of them are not learnt, they cannot read information on family planning ***(Community Provider KI Oyam).***

If you depend on a man, he will not support you in terms of money in buying pills or supplementing hospital bills or in terms of transport, like refusing to give you bicycle to go to the hospital. Women who depend on their spouses economically find it very hard to obtain FP services, while women who are economically independent are able to obtain the FP services ***(Users FGD Oyam).***

4.6.3: Power and Gender Dynamics

It was mentioned that to protect a woman from promiscuous behaviors, mother in-laws and husbands prefer that the wife they have is either pregnant or carrying a baby. It was also mentioned that husbands and mother-in-laws with nucleus family backgrounds often want the wife to give birth to as many children as possible. So FP comes in as a threat to their mission

Husbands being the key decision makers they often consult their mothers about suggestions on reproduction. Once an obstacle from the husband comes it was discovered that women opt for secretive methods without husband's knowledge. But when husbands finds out women are ordered to discontinue methods immediately.

In households where discussions and common agreement on family planning was sited, but secret consent is treated as defiance and often have led to family feud and separation.

However it was mentioned that when the husband and wife agree on use of FP family members have limited impact on influencing use of FP.

I went to the health unit without the consent of my husband and family members because it is me who takes care of the children and not those family members who oppose the practice of FP ***(Discontinuer FGD Oyam).***

There was a case that was reported that the husband found out that the wife had an implant and the wife was sent packing with one condition removing the implant ***(District Level KI Oyam).***

We agreed with my husband, we do not care even if the family members talk ill of me using FP, after all those family members do not provide for the welfare of these children ***(Community Service Provider Oyam).***

I used Family planning stealthily but later my husband learnt about it and he was supportive after seeing the benefits of spacing our children ***(Users FGD Oyam).***

When spouses use any FP method in their H/H, their decision has to be respected by other extended family members. But, in some cases, other family members impose themselves on such H/H to use or not to use any FP method, especially when couples have not stayed in marriage for many years. Some husbands object to FP use by their spouse upon consulting their parents not to use any FP method ***(District level KI Oyam).***

*Husbands being heads of families most times especially in rural areas always have the last say on whether to use or not use FP and their decisions are normally final for example where a lady decides to go for the implants but when the husband learnt about it she was ordered to go back and have them removed if not, she was not to return home****(District level KI Oyam).***

4.6.4: Religious Determinants

In Oyam it was mentioned that religious leaders have not played any role in promoting contraceptives use rather they have discouraged it among their followers. Catholics and Born Again Christians were mentioned to use statements like FP is 'murder of the unborn' and the bible says 'though shall not kill'.

Most religious leaders mind the numbers of their followers, so they encourage followers to give birth to as many children as possible as a way of multiplying their numbers so FP is a threat to this objective.

Although they encourage their followers to look after their children well, Christians maintain many biblical teachings that deter some women from using FP. Moslems believe in polygamy and polygamy makes women compete with one another on who produces the highest number of children for the husband. Religious leaders have not come out to advocate for FP, they often preach against it.

However it was mentioned that some Christian leaders with families also use modern FP methods to space children encouraging kin followers to use them also against the biblical teaching.

The Catholic religion does not accept modern family planning methods; they only accept the natural methods which have high failure rate. On days that a woman is not safe, she will want to have sex. They equate Family Planning to murder and hence castigate the practice ***(District level KI Oyam).***

Both the Anglican and Catholic Church maintain the biblical dictate that "be fruitful, multiply and fill the whole world". But on the other hand, they advocate for having a sizeable family that one can afford to take care of,

claiming that producing many children whom one cannot take care of is a punishment to these children ***(Non users FGD Oyam).***

The Clergy in the Anglican congregation and their spouses are also using Family Planning methods to space their children. So they should not preach what they do not practice i.e. "talk the walk and walk the talk ***(Non users FGD Oyam).***

The Moslem Community out rightly advocates for polygamy and having many children which are a blessing from Allah ***(Non users FGD Oyam).***

Some religious leaders are now openly calling for having a sensible family though God blessed the human creature to be fertile, productive and fill the whole world. They maintain that having many children when one cannot afford to take good care of is a punishment to the children with decent upbringing that will solve problems of prostitution, theft, destitute, street children and other crimes ***(District level KI Oyam).***

4.6.5: Cultural Determinants

In Oyam children are seen as assets to the clan and extension of family lineage, so the higher the number of children the bigger the clan and the family implying that Contraceptives are rejected. There is a lot cultural ties to bride price paid to families with girls, so FP is a threat to giving birth to female children hence loosing wealth. It should be noted that in recent years elders have witnessed overcrowding on land and land wrangles as a result many children hence they have begun encouraging FP.

Culturally, FP is perceived as killing the whole clan yet the strength of a clan is her people in terms of food, security (Labour force for production) and human security against external disturbances. Culture thus, discourage FP use. Children are a sign of prestige in Oyam hence men who allow their women to use FP methods are thought to be under the control of their wives hence despised in the community ***(Users FGD Oyam).***

Some cultural leaders who are knowledgeable about FP are in support of the practice because they claim land and other resources are not enough to support the ever increasing population but those who are not knowledgeable oppose FP use on grounds that children are a blessing in terms of prestige, respect, defense and wealth ***(Discontinuer FGD Oyam).***

Culturally, people should produce as many as they can because children (male) are looked at as security in a family against external attacks and female children are looked at as wealth in terms of bride price. But elders now have come out openly to advocate for modern FP use to avoid the ever increasing land wrangles, saying there is shortage of land for cultivation, hence the need for FP ***(District level KI Oyam).***

Some cultures dictate on women, once a woman is married, she is to produce many children to make the clan's name sound. That a man marries because of children not because of a woman. The more children one has the more wealth he has ***(User FGD Oyam).***

4.6.6: Health/Reproductive Health Related Determinants

It was noted that families with well spaced children have healthier looking children, well nourished; parents can afford medical care and the general welfare. In addition it was indicated that mothers on FP were generally looking healthier than those that may be stressed and stretched by looking after many children.

It was indicated that in the process of trying to identify which method works best for an individual, a lot of health side effects have discouraged FP use for those who do not try several methods. Key side effects noted included; heavy bleeding, loss of desire for sex, weight gain or loss among others, non-stop headache, heavy flows or over bleeding, slimming which people misinterpret as HIV and AIDS discourage contraceptives use

It was also indicated that sometimes contraceptives are administered by unqualified individuals, with limited capacity to administer and advice users on best use and administration of a given contraceptive. As a result the method failure is registered and side effects are adverse.

Some users have responded well and FP methods have made them look healthier than before when they were stressed by non spaced children. Respondents held the view that mothers with well spaced children are not stressed and they look healthier than those stressed with children

Maintenance of family health, people with few children always take good care of their children while those with many children cannot at times afford school fees, clothing, food and medical care ***(District level KI Oyam).***

The need to have a few but healthy children capable of good upbringing in terms of their welfare needs now and the future. This then calls for modern FP use for safe motherhood and childhood for a healthy population ***(District level KI Oyam).***

My friend may encourage me to use FP because she looks younger, she has reasonable size and she generally good because of the method she is using ***(Non User FGD Oyam).***

Health risks associated with modern FP use discourage FP use as users attach obesity, High Blood Pressure, abortion, miscarriage and other reproductive health complications such as still birth, caesarian section, long and painful periods to modern FP use ***(User FGD Oyam).***

When the risks are many or alarming, this encourages dropouts and non use example with injectables, ladies normal experience too much blood out of the ordinary so they always take long to return to fertility, thus discontinue the use of FP services ***(District Level KI Oyam).***

They was a case were female sterilization was do done incorrectly at the health centre the woman conceived, which impacted negatively on FP. This case arises from the case that the right person (Doctor) is not available to offer the services ***(District Level KI Oyam).***

If particular methods are risky to personal health and hygiene, such methods are discouraged to be used by clients who report health risks to service providers. Equally, if certain methods give rise to certain health benefits, then these methods are encourage for use by clients ***(Elderly men FGD Oyam).***

Desire for children and contraceptives use.

When communities are sensitized on FP the number of children in a household was not seen as the guiding principle. Youthful families with few children often want to have more children hence they often tend to think that FP is for future use. Families without children can hardly use FP. Families with many children are more willing to go for FP because of the burden children press on the parents.

Men want many children; this causes them not to encourage their wives to use contraceptives since children are a sign of prestige and they help in growing the clan. Such families only consider contraceptives when children have become a burden to the man.

It was indicated that women in polygamous families in Oyam tend to compete on who gives their husband the highest number of children. Due to polygamy men use pregnancy and children as a way of protecting their wives from promiscuous behavior.

*The desire for children in the community is still high thus less use of FP methods. Usually the clan demand family members like husbands and among co-wives the more children, the more status one commands in that home (****District Level KI Oyam).***

The desire for children affects contraceptive use in this community in that couples who have few children cannot adopt any modern FP method not until

they have enough children, then they consider contraceptive use in future ***(District Level KI Oyam).***

*Everybody needs to produce. A woman with no children will never have peace, the desire to have children is really much if they are few or not there and such a woman will never want to use contraceptives (****District Level KI-Oyam.).***

Men want more children than women and will not encourage their wives to use contraceptives, hence affecting family planning use ***(District Level KI Oyam).***

*The desire for children affects contraceptive use in that couples with fewer or no children would want to produce so that they may re-consider using Family Planning in the future while those with many children may be encouraged to start using FP (****Non users FGD Oyam).***

4.6.7: Environmental Determinants

Access and availability of FP methods and their impact on use and none use

Sensitization on the benefits of FP has created demand for modern family planning methods; availability of services at the local health facility and through outreaches has promoted effective demand for contraceptives. In facilities where the service is often not available many potential clients are discouraged even to demand for the service.

Availability of services ensures that those who learn about the need to take-up FP will be in position to receive the service when they make inquiries. Stock outs and absence of qualified health workers to provide the services discourages new and unsatisfied users.

*People will only demand for FP services if they are available and if not, they are discouraged. But when the services are available, high demand will be created, hence encouraging family panning use (****District Level KI Oyam).***

*Availability of FP services in terms of expanding outreaches makes FP accessible to users & if services are scarce and far from reach of users, clients are bound to relax to use FP services in the community (****District Level KI Oyam).***

If FP services are available and within reach of the population, clients will easily access the service and this encourages other potential users to take advantage of the available Family Planning services. But if Family Planning

*services are scarce, then clients are discouraged from using the service (N**on User FGD Oyam).***

The influence of Political and religious leadership

Politicians are always lobbying for social services, in situations where they have been involved and educated about the benefits; they have been instrumental in mobilizing citizens to take up FP services. People often listen and follow what they say. Local leaders have been instrumental in supporting sensitization efforts each time people consult them before they make decisions about FP. They are doing this because they have been sensitized about the impact of a large population on land and other social services; primary health care, food security and other welfare needs of the community.

Religious leaders, because they shun contraceptives use, have been hardly involved and convinced about the benefits of FP yet they have significant populations who follow them and listen to what they preach. They have encouraged natural methods in their preaching and some are totally against birth control measures.

*They are also representatives of the community, people follow what they say. If they oppose contraceptive use, people will not want to use FP, hence affecting family planning use (**Discontinuers FGD Oyam).***

*Politicians lobby for social services. If FP Services are good, that way people will be encouraged to use FP, but if it's risky, they will not use FP (**Discontinuers FGD Oyam).***

*Religious leaders always deal with large congregation on Sundays and if they preach against contraceptives, e.g. "God does not want people to kill", hence discouraging family planning (**District level KI Oyam).***

*They encourage us to produce few children so that we can take care of them and feed them well. Because resources are few, we should produce few children (**District level KI Oyam).***

*They encourage us to produce few children so that we can take good care of them because resources are scarce we should produce few children **(District level KI Oyam).***

Local leaders say that many children lead to prostitution and other bad vices because its hard to take care of them as they grow, people should produce few children thus they should use FP (***Users FGD Oyam).***

The influence of prevailing policies on contraceptives use and none use.

Current policies within government and the civil society have promoted awareness campaigns that advocate for modern FP use because they are safe, free and effective in child spacing and against unplanned pregnancies. Oyam local government in partnership with other stake holders has come out to mobilize and sensitize the community on modern FP use and benefits associated with the modern FP services.

*Current policies within government and the civil society advocate modern FP use because they are safe, free and effective in child spacing and against unwanted pregnancies. The local government in partnership with other stake holders has come out to mobilize and sensitize the community on modern FP use and benefits associated with the modern FP services. They blame continued land shortage for cultivation and associated land wrangles, child labour, prostitution, theft, destitution among others as a product of none use of modern FP services (**District Level KI Oyam).***

*There is a lot of awareness campaigns by the government on FP, thus increase in use however Policies in place where lower health facilities are not allowed to request for items, end up being punished to use methods that are available which may not be preferred like the pills (**District Level KI Oyam).***

Other Factors that have affected contraceptive use/none use

Sensitization has promoted use and has increased demand for contraceptives, outreaches have increased accessibility for hard to reach areas and regular supplies at local health centers encourages people to use the service without fear that in case they want children after they can fail to get a medical personnel to help them.

It should be noted that a reasonable population are not yet reached with FP messages because they have no access to the radio because of poverty and they are illiterate they cannot read and understand IEC materials pinned in the community.

Community Stigma on users both male and female as a result of misconceptions like slimming which may refer to as HIV/AIDs, that FP leads women to be promiscuous and loss of manhood "*if a man goes for vasectomy people will say he is no longer functioning sexually and if a woman slim as a result of an implant or pills people will say she caught HIV*"

As already indicated most men discourage their wives from use, yet many women have gone ahead to secretly take up contraceptives. When discovered the results are often violence against them, and sometimes separation and the related problems of men marrying other 'loyal' women. When other women learn about the repercussions of secretive contraceptives use they often give up on the methods. Absence of qualified medical personnel in rural communities has affected use of long term methods

> *NGO's have made a big contribution to the use of FP. They have lots of outreaches sponsor workshops and training of VHTs. The NGO's work hand in hand with hospital staff and this has increased use of FP. District Level (**District Level KI Oyam).***

> *Non availability of other methods of FP makes turn up very low or there would be use give up on ever using FP. Most times pills are available but not preferred, so they end up expiring (**District Level KI Oyam).***

> *Violence against women and children are to blame for both contraceptive use and none use in the community. Women who use contraceptives without consent of their spouses are vulnerable to violence against them. Similarly, violence against children is a product of violence against women by their spouses as a way of retribution (vengeance). These two edged violence therefore affects contraceptive use both positively and negatively (**District Level KI Oyam)***

> *To a small proportion, VHTs do not have the required knowledge and expertise to educate the masses on modern FP services/ methods but have continued to mobilize the masses to go for FP services within their reach and this has increased awareness about FP services available to them, thus stepping up campaign about FP use in the community (**Users FGD Oyam).***

> *Other factors like disorientation in the minds of the local people who see modern FP methods as unhealthy, and FP as a preserve of some particular class of well- informed and affluent lot in society and not fit for the ill-fated villagers. They also like the FP practice to prostitution and irresponsible junior or second class citizens (**Discontinuers FGD Oyam).***

4.6.8: Challenges

Limited participation and support of FP by men, Failure of clients to honor appointment dates, limited availability of reproductive health qualified staff that can work in rural areas, polygamous families where wives compete in producing children, culture of the Langi that encourages men to have many children

Religious leaders that discourage use and that encourage their followers to give birth to as many children as possible because they believe that "*children are a gift from God*" and that "*each child has own blessings*". In addition many people have not been reached with proper messages of FP so they still hold onto the misconceptions they have about FP.

> *Misconception and some belief in the community for example; that girls or young people should not use family planning, "it's only for elderly people* ***(Service Provider KI Oyam).***

> *The misinformation about family planning in the community for example "a man is considered wealthy if he/she has many children* ***(Service Provider KI Oyam).***

> *Some clients join without spouse's knowledge, making it difficult to provide the services. Few number of clients, clients come in very low number that make some methods stay for long, example pills, hence expiry* ***(Service Provider KI Oyam).***

National Key Informant's interviews

Key findings

- The leading service provider was government complemented with MSU,RHU and UHMG.
- Limited allocation of resources for family planning affected usage.
- The national investment in health far less than the 15% of the national budget according to the Abuga declaration.
- Limited male support and involvement affected usage.
- High cost of the family planning services in some private outlets affected the use.
- Religious influence wasn't regarded as a major barrier to use apart from denial of modern contraceptives of individuals in the catchment areas of catholic founded health facilities.
- Culture was not supportive of use of modern contraceptive.
- Experience and information of side-effects of modern contraceptives lead either none use or discontinuation of methods.
- Opposition from politicians contributed to non use of modern contraceptives. The national population policy was noted not to be very proactive as opposed to other countries. In addition taxation on some contraceptives contributed to high service cost.
- The media was noted to be generally opposed to the use of family planning use.

4.7: National Level Perceptive

4.7.1: Coverage of family planning services in the country

National level KIs held the opinion that although much has been achieved in the area of FP much remains to be desired. In the national framework most of the reproductive health work is taken on by NGO's (such as MSU, RHU, UHMG) to train FP providers and even the distribution of modern FP methods. They held the opinion that FP is still inadequate countrywide especially if it is seen from recent studies that have put the contraceptives prevalence rate (CPR) at 24%. The RH commodity security coalition is mainly bent on ensuring that there is sustainable provision of diverse RH services including FP methods country wide. They noted that there is a lot of knowledge on FP services not matched with usage especially amongst the poor, the marginalized, socially excluded and the underserved population like slum

dwellers, IDP Camp, rural sites, mountainous areas, Islands etc. The limited coverage is expressed in the following statements.

> *Family Planning starts from VHT and HCII up to referral hospital level. It is as wide as the system goes- about 1600 facilities. All from HCII upward are expected to offer FP but to some extent actual services provision may vary at different levels. 79 % of households is within 5kms radius of health facilities.*
>
> *Uptake is affected by availability of services. CPR is the only reliable measure .It is now 24% for modern methods which is still quite low.*
>
> *It starts from policy level i.e. budget allocation to health and in turn to RH is not comprehensive because of prioritization that tends to favour other health needs as compared to provision of FP services.*
>
> *Media – this 4th arm of Government has not been comprehensively trained or equipped with SRH information in order to give it its due regard in coverage /advocacy/sensitization/mobilization i.e. in adequate depth.*
>
> *Procurement and distribution; The modus operandi is not consistent and sustainable contributing to high unmet need for FP services especially in government Health Centres e.g. stock outs, lengthy, delayed deliveries upon requisition etc-The entire system.*

4.7.2: Economic Determinants

It was observed that at national level limited resources are allocated to health services in general and family planning in particular and this eventually affected accessibility. At individual level there are other competing priorities which affect individual capacity to effectively demand services where failure to use family planning is not associated with any life threatening challenges. In addition, the user fees are quite high at private facilities who charge as high as 15,000 for a method. This is reflected in statements below:

> *Some commercial clinics really hike the prices of FP methods E.g. morning after plus pills – between 10,000+ and 15,000 yet at RHU they are 1000 – 2000/-. At macro level it affects FP commodity supply, services and uptake. There is a big problem in developing countries of limited investment in health and FP services claiming that we don't have enough money to invest in health as stipulated in the Abuja declaration requiring minimum budget allocation to health to be not less than 15% of National budget - Uganda is between 8% - 9%.*

At micro level, travel costs to seek FP services may be a hindrance. Can the family budget be allocated to contraception against other competing priorities in the home? Of course FP is not a priority!

4.7.3: Religious Determinants

Although national level KIs acknowledged the negative influences religion may have on consumption of modern FP services, they held the opinion that unplanned pregnancies cut across religious boundaries. Hence they held the opinion that although religious beliefs may deter usage it's not a major cause of non-use and accounts for only 0.3%. The effect on use was noted by the policy among catholic institutions where family planning services are not offered as such affecting the potential utilization in their respective catchment areas. These issues are expressed in the following statements.

Irrespective of one's religion once men indulges in unprotected sex with women who have ovulated, the sperms will not respect our religion yet the Catholics don't support usage of modern FP methods which hinders access and utilization.

Places of worship are very ideal for mobilization/sensitization and event specific integrated service provision/points. But if the preachers are biased, the effect is totally opposite-very negative and leads to low uptake & utilization.

Most of the time in our country people exist on a double loyalty/identity- when they are near church or priests, they tend to bring up front the religious side. This may influence their decisions. But the influences outside religion are more powerful.

Religion has specific barriers e.g. availability. If the only health facilities in the area are catholic, it affects FP uptake and use since they are the only supplier. Access is denied because of the policies of the religion that offers the health services. So you have to go long distances to get the services; Citizens nearer e.g. a convent are more likely to be non-users because the influence of religion is concentrated.

People tend not to follow religious teaching but know what to do. Side effects affect more than anything else according to studies taken on barriers to use or uptake –UDHS.

4.7.3: Cultural Determinants

At national level recognition was made to the effect that culture affects utilization of modern contraceptives. Culturally there was preference of many children for lineage and security of the families. Widow inheritance is also a common feature

with affects utilization of services. Culture also promoted male dominance which is not supportive of family planning services. This is reflected in statements below:

> *We are a patriarchal society that is male dominated and men are supposed to "Sajjalata". The more women and children one has, the more powerful and respectful /authority he has in society.*

> *Kingdom/clans/tribes strength and power is largely defined by the numerical strength in number of peoples. So they encourage producing more kids and hence negating FP use.*

> *The line between culture and religion is very thin. The important factor in culture is how it shapes our norms and values. If a culture sanctifies large families e.g. status of men depends on no. of children, this influences the number of kids and hence use of FP. Culture is a big factor because of our norms and values which define our very existence as a people.*

4.7.4: Health /Reproductive Health & Method related Determinants

It was noted that among the respondents that good health influences the attainment of MDGs and this can be easily attained with family planning use. The benefits like health life for mothers, healthy children and capacity to look after children was noted to contribute to use. Risks associated to pregnancy also affected use. However side effects led to none use and discontinuation of modern family planning serves. The desire for children also led to use of services. These issues are reflected in statements below:

> *Look at all the MDGs, with a healthy person/people you will achieve all these as a nation e.g. fewer pupils in UPE; empowered/employed women; low infant mortality; reduced MMR by 70% with good planning; reduced unwanted pregnancies.*

> *Research has shown that many women don't reach orgasm because of due to the fear factor of getting pregnant. So if on FP the fear will reduce. They will not be in position to attain, satisfying and pleasurable sex affecting marriage tranquility and peace.*

> *Ensures proper upbringing and spacing of kids because the basic needs will be adequate. Over bearing children contributes to the chances of women getting cancer.*

> *Frequent pregnancies drain the women. Producing underweight children etc other medical health benefits. And all other benefits that I can think of from the medical point of view.*

Female condom:- takes a lot of time/ procedures and are not readily available in HC, but it is also good for protection against STIs.

Depo povera:-It is convenient and can be used without knowledge of the husband and it is used once in 3months which may explain why it is the most popular of all method. But then it has problems such as spotting (bleeding on and off), heavy bleeding/prolonged periods, loss of libido and other side effects. That may make users to drop the method.

This is true for all hormonal methods (i.e. side effects). In addition pills need to be taken every day which is a big inconvenience that discourages very many people. It forces one to think sex every day-sex since the entire exercise is about sex without pregnancy.

This is exaggerated except for the peer/family pressure ---that is living among people "thinking children". In reality the desire for children is over exaggerated. People don't necessarily go for large numbers

4.7.5: Environmental Determinants

At national level it was observed that there were factors within the environment that may lead to none use, discontinuation or continued use of modern contraceptive services. The influencing factors mentioned included stock outs of FP service supplies, limited service points especially for hard to reach communities, opposition from politicians and media. It was observed that the Ugandan population and family planning policies were not very proactive as compared to other countries where the policy is very strong and proactive. Overall, most of the factors in the environment were contributing to none use and discontinuation of modern contraceptive services. These issues are reflected in the statements below:

Method mix/Promotion of particular brands: if they are out of stock people drop out and cannot easily change e.g. protector condoms/ branded condoms verses non-branded. This affects uptake and continuity.
Imposed taxes on FP contraceptives directly affects available in terms of quantities and cost to users.

There is limited advocacy for increased budgeting and allocation of resources for RH services, limited sensitization of voters, limited prioritization of FP in their manifestos because FP advocacy may actually de-campaign them.

Recently Parliamentarians (Social Services committee, NAWP etc), have strongly advocated for RH for the youth. They have contributed to mobilizing funds for RH at various levels but this is not strong enough/adequate.

Media advocacy by some politicians is done, some political training schools E.g. Kyakwanzi have RH progranmmes in their training.

Our president for instance advocates for high population for economic reasons/mkts/consumers or political capital. This is counterproductive.

Within the political leadership, others are lobbying and increasing money/budget to buy contraceptives while others do not see it as a necessity.

The District Chairman of Luweero district (Naduli) is prominent for his negative campaigns or advises which are counterproductive to FP use and yet he has a large following.

The policies are there but their ideal application is still wanting. The policies are very many in health, local and in other sectors. Limited dissemination of the policies in different languages is still barrier to their application. Limited resources to disseminate, for example, print these policies for use.

The constitution is not very specific but our policies generally promote FP. As Uganda we just promote FP generally. Others like the Asian tigers and Tunisia, have been more aggressive and even put numbers, 1 child in China, Tunisia started with 3 then 2 and they have economically grown as a result

Inadequacy of role models in all aspects of life e.g. an inspiring person who has say only 2 children and they are admirable, to serve as a reference/rallying point.

Chapter Five

5.0: DISCUSSIONS, RECOMMENDATIONS AND CONCLUSION

5.1: Discussion

The study has unraveled invaluable information on modern contraceptive use and nonuse. Information discussed is on the current status of the service indicators including knowledge and determinants of use. Comparison is made of similar studies especially the UDHS.

The study shows that awareness of a contraceptive method is almost universal in the study area. Ninety eight percent of all the respondents have ever heard of a contraceptive method; the most commonly heard of method is male condom (92 percent) followed by pill/injectable method (87 percent).This is consistent with the UDHS 2006 where knowledge on any method was 97% of all women and 98% of all men aged 15-49 years.

The study revealed that radio is the single most common source of FP messages cited by both men and women and that newspapers/magazines are the second most common source of FP messages. This finding is consistent with that of the UDHS 2006 where a similar pattern was observed.

On the current use about a quarter (27%) of women in the study area are using some contraception methods. This compares closely with 26% of women using modern contraceptives in UDHS (2011 Preliminary report). The use varied by district where use was found to be highest in Kanungu (57.1%) and lowest in Karamoja region with 9.9%. However compared to the UDHS 2006 it shows an improvement on current use from 26.8% in southwest region where Kanungu belongs and less than 1% in the Karamoja region.

The study also shows that injectable methods are the most commonly used modern contraception methods across all age groups except for the 15-19 and 45-49 age groups and that most of the clients get their modern contraception methods from two main sources, all of which are Government facilities. Since Reproductive Health Uganda works through strengthening Government clinics, RHU Health Centres/Clinics were not cited as sources for any modern methods of contraception. Moreover, injectables and implants are the two most consistently used methods of contraception. Arising from above findings, there is need to strengthen Government health facilities to provide family planning services. Clinics should also stock the family planning methods which are commonly used by the clients.

Some of the clients reported success in use of family planning methods. On the other hand, some respondents reported failures. Additionally, some women intend to use family planning methods in future. For instance, 35 percent of women who are currently pregnant or got pregnant sometime back said that their current pregnancy or their last birth (for non pregnant women) was mistimed/unwanted. The proportion of women who are currently using a family planning method who say that the last time they became pregnant they wanted to become pregnant then is 15 percent. Fifty five percent of all women and 52 percent of currently married women said that they have intention to use a family planning method in the future. The above findings show both the need and unmet need for family planning services.

Misconceptions on family planning can affect use of services. The study revealed that some misconceptions about use of contraception methods exist. Among sexually active men age 15-49, 22 percent believe that contraception is a woman's business. Twenty six percent these men believe that women who use contraception may become promiscuous. The other misconceptions observed included: Contraceptives leading birth to abnormal children, a feeling that pills pile in the body leading to cancer, disappearance of IUD into the body leading to death and family planning regarded as a form of murder. In view of above, action should be taken to address the misconceptions.

Comparison of the findings also show that there are some trend changes when comparison of some indicators are made between the UDHS 2006 and the current survey. However, in some indicators, there is no change. There has been improvement in knowledge of fertile period of a woman. This is encouraging because it can facilitate use of the rhythm method. The proportion of respondents who heard of at least one method has remained more or less the same at around 90 percent.

Comparison has also been made between UDHS 2011 and the current survey in terms of the age distribution of curent users of a family planning method. The results show that although contraception use is lowest between the age of 15 and 29 years, users of contraception are generally younger in the present survey than in UDHS 2011. While the usage of contraceptive users peaks at the age of 30-34 in the current survey, it does so at the age of 35-39 in UDHS 2011.

Efforts were made to establish the determinants of family planning use and non-use of family planning in the surveyed districts. Through corroboration of findings from both the quantitative and qualitative elements of the survey, a number of key determinants of family planning use and non-use were identified.

After testing for significance the key determinants of use of modern contraceptives in the study area were: Education, religion, exposure to media messages on family planning, agreement of partner regarding child spacing, need and demand for family planning services, tribe and knowledge of source of FP methods. A similar observation was noted in UDHS 2006 where contraceptive use increased with educational attainment.

In addition to the key determinants, other factors influencing use and non-use were noted at individual and community levels .At individual level peer pressure, spousal support, fear of side effects and holding misconceptions affected the use while at community level the opposition by cultural leaders, support by significant others like in-laws, easy service access, service cost, poverty, poor transport infrastructure, availability of friendly services especially those managing side effects well affected the use.

However, Igwegbe and colleagues observed in their paper that in spite of high awareness among women, there was still a high unmet need of family planning. Unmet needs for family planning brings together 2 concepts one if most of the demand for FP cannot be met with supplies and services, then contraception use would fall and fertility would increase. The above researchers also found out that husband's disapproval and fear of side effects were key determinants of family planning use (Igwegbe et al). Therefore, the strategies should be such that they are holistic to address different aspects of determinants. Indongo and Naido

showed in their study that support from family members was a key determinant of family planning use; young women who discuss family planning with their mothers were among those who had a very high probability of using contraceptives (Indongo and Naido). Furthermore, in the neighbouring Kenya, a family planning study found the following factors to be associated with family planning use; age, number of living children, low or higher level of education, household wealth, current work status, exposure to media messages about family planning and discussion with the partner about family planning were associated with unmet need of family planning (Ogata 2009).

Another similar study by C.Okech et al (2011) in Kenya published in the International Journal of Business and Social science which conducted regression analysis as well revealed that partner approval, religion, knowledge of family planning services, friendliness of family planning staff and proximity to the facility are determinants of contraceptive use. These findings are fairly consistent with this study.

Another study by Buyingo and PSI-U in 2005 in Uganda on determinants of use and nonuse revealed that individual positive attitudes like a method having fewer misconceptions, social support and knowledge of the source of FP service influenced use and nonuse.

It should be noted that the figures used are for UDHS 2006. The final results of UDHS 2011 are not yet out, thus, there are no new figures for some indicators.

5.2: Recommendations

5.2.2; Address community and health facility related factors.

5.2.2.1; Tailor Specific Advocacy and IEC interventions that target the Community

Gate Keepers

The study established that at community level there were some resistance from elders, political leaders, kraal heads and religious leaders. There were also barriers like negative community norms and low literacy levels especially among women. Therefore tailored IEC and advocacy interventions should be designed and implemented targeting the key barriers to modern contraceptive use especially in addressing the established cultural norms. Target audiences will be the custodians of culture like kraal heads, politicians and religious leaders and others like champions of family planning where they exist. Deliberate effort should be made to use the channels most appropriate to the target audiences like radio and interpersonal communication which were the major source of information. In these IEC/BCC initiatives, entertainment education like community film shows and videos should be encouraged preferably in local languages. Regular regional specific campaigns also need to be conducted.

5.2.2.2: Scale up capacity building for health workers and village health teams.

It was observed that some family planning facilities did not have enough trained health workers especially for insertion of implants and IUD. Training needs to be conducted for key

family planning providers who should as well be provided with the tools to provide family planning services at community level. These should include the VHTs covering a manageable catchment area. Before the training, a training needs assessment is proposed for the different cadres.

5.2.2.3: Male involvement, Peer education and Peer Group Formation

Male support for family planning was inadequate and peer pressure contributed to continued use of family planning services. Therefore initiatives should be designed to target the men/husbands and cultural leaders in order to bring about change in the perceptions about family planning. This could be done through a peer education programme. In addition, male peer groups need to be formed and facilitated to be agents of behavioural change.

5.2.2.4: Promotion of Community Dialogue

In Communities where there is a strong culture opposed to modern contraception, community dialogue and discussions are critical in enhancing the positive values related to family planning. To address this, community dialogues facilitated by local volunteers who have been trained should be initiated. This needs to be promoted among the key stakeholders and also teams need to appreciate how the traditional approaches could be improved to increase the utilization of modern contraceptive methods .

5.2.2.5: Advocate for improved, health human resource, health and road infrastructure.

The study found that there is limited number of family planning outlets especially in Karamoja and that there is very poor road network in the entire Karamoja region, and more so in Kaabong district. As a means of improving access, human resource should be strengthened through recruitment of additional staff. Family planning service outlets also need to be increased to serve especially the underserved communities. This can be done through static service points, as well as regular outreach services in an integrated manner to avoid related stigma.

5.2.2.6: Scale up effective Family Planning Service Delivery

It was observed that effective management of contraceptive method side effects enhances service usage. The static facilities were also crowded and clients spent long waiting hours. To address these challenges the services need to be expanded especially through holding more frequent outreaches in partnership with functional local NGOs like Marie Stopes Uganda and AIDS Information Centre.

5.2.2.7: Design and Implement Programmes that Empower Women

Gender inequities were observed which affected service uptake and it was observed that the women who were more educated, single and independent were more likely to use contraceptive services compared to those who weren't. The initiation of empowerment programmes for females would therefore enhance contraceptive use in the population. RHU

therefore needs to network with institutions that empower women through skills, income generation projects and education of the girl children.

5.2.2.8: Regular supply of family planning methods and services to community health centres.

Stock outs of contraceptives and medical equipment should be minimized; if addressed, this will ensure consistency in the supplies and maintenance of affordable services. A range of alternative contraceptive methods especially long term methods should be made available at all health facilities near to the people hence the need to expand the FP services in terms of access, availability of service and outreach. More attention/time and counseling during clinic visits should be given to users experiencing serious side effects.

5.2.2.9: Develop Partnership with Religious Groups

It was observed that some religious leaders were opposed to the use of contraceptive services. The nature of opposition leaders varied from area. In Yumbe, it was predominantly the Muslim communities while in Karamoja it was the Catholics. Therefore, partnerships need to be developed with those leaders so that they advocate for and promote the contraceptive use.

5.2.2.10: Need to establish Private–Public Partnerships in Delivery of FP services

The cost of provision of FP services is high for private facilities yet the clients are poor. There is therefore need to subsidize private clinics to increase service accessibility. Need for training and equipping of health workers in private facilities especially on services like implants and IUD.

5.2.3: Ensure that the survey findings are disseminated widely;

In order to facilitate the utilization of the research findings; and translate results into programmes and policies, as well as implement programmatic implications, efforts should be made to disseminate the survey results widely. The study findings should be disseminated through a national stakeholder's workshop facilitated by the survey team. Participants of the workshop should be drawn from the national and district levels. All the 8 districts where the survey was conducted will be represented in the stakeholder's workshop.

5.3: Conclusion

This study on determinants of use and nonuse of modern contraceptives is timely. It revealed that the use of modern contraceptive services varied with the different demographic and socioeconomic variables. It confirmed that some of the demographic variables have a strong relationship with use of modern contraceptive methods whereas others show insignificant relationship as measured by statistical significance. The variables which show significant association with contraceptive use included: education for the women; religion; tribe ,current residence; distance to former place of residence, knowledge of source of FP methods ;exposure to the FP media messages; need and demand for family planning services; spousal support and agreement.

However, the other variables like, employment, marital status, number of children ever born, ever been pregnant and status of sexual relationship were found to have insignificant statistical associations.

The other factors influencing use and nonuse emerging from the qualitative arm show some uniqueness .This arm reveals factors influencing use at individual and community levels. At individual level: peer pressure, spousal support, fear of side effects and holding misconceptions , the nature of the relationship affected the use while at community level the opposition by cultural leaders, support by significant others like in-laws, easy service access, service cost and availability of friendly services were the influencing factors .

This study in agreement UDHS 2011 that between 2006 and 2011, there was an increase in the use of contraceptives in some areas like Karamoja where contraceptives use increased from less than 1% to 8% in UDHS and 9.9% in this particular study. Likewise current contraceptive use among women in Kanungu district is 57.1% compared to the regional estimate of 26.8%.

Comparison has been made between UDHS 2011 and the current survey in terms of the age distribution of curent users of a family planning method. The results show that although contraception use is lowest between the age of 15 and 29 years, users of contraception are generally younger in the present survey than in UDHS 2011. While the age of contraceptive users peaks at the age of 30-34 in the current survey, it does so at the age of 35-39 in UDHS 2011.

The majority(69%) of the users of family planning methods never changed their methods while 31% reported to have changed a method.The main reasons for maintaining the same methods were convenience and the partcular method having less side effects while distance of the former place of residence was the key determinant for changing methods.The other reasons for method change were fear of side effects and inconvenience.

Thirty six percent of respondents among the women who had ever used a method discontinued using it and the key detrminant was holding discussions with the spouse.The other factors were desire for children,side-effects,partner objection and absence of prefered method.

Method specific factors that encourage and discourage use of modern FP are specific to individuals for any given method. There was no evidence of a single method having a particular side effect to whoever used it across all districts. Method related side effects were reported to be the major reason that discouraged new enrolment for FP, and promoted discontinuation. There was evidence during the survey to show that across all districts, users that experienced limited side effects sustained use for longer periods and it was also discovered that most users who changed methods or discontinued all together experienced a form of side effects or had issues related to method convenience. This implies that research on how side effects may be minimized among users would boost the number of new users and those sustaining by threefold.

Social and Cultural factors varied from district to districts, but one single commonality in all districts was that cultures and traditions promote giving birth to as many children as possible. With exception of Karamoja region where there is some form of child spacing most other

cultures discouraged long periods of child spacing. These factors are related to women's need to limit or space their children and acquire adequate understanding of the importance of contraceptive use. Similar to previous studies, women's long periods of schooling is thought about as a solution to limiting number of children because women will start producing children at later age.

The results also show that younger women tend to use contraceptives less. Younger women of whatever marital status need to be reached more effectively by the family planning program through their cultures.

Finally, it is observed that contraceptive use is low and the determinants of use and nonuse appear to vary by region and some demographic characteristics. Discontinuation was at 36% among users while 31% had ever switched methods. Therefore, programme and policy design should take consideration of this invaluable information.

REFERENCES

1. Blanchfield L and Lawson ML.: The Millennium Development Goals: The September 2010 U.N. High-level Meeting. December 9, 2010. Congressional Research Service 7-5700. www.crs.gov R41410.
2. Boyce C and Neale P.: Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input. May 2006. Pathfinder International Tool Services. Monitoring and Evaluation 2.
3. Cleland J, Bernstein S, Ezeh A, Faunndes A, Glasier A, Innis J:Family Planning: the unfinished agenda. The Lancet 2006, 368 (9549):1810-1827
4. Health Sector Strategic and Investment Plan. 2010. Ministry of Health 2010.
5. Igwegbe AO, Ugbooja JO and Monago EN.: Prevalence and determinants of unmet need for family planning in Nnewi, South East Nigeria. 2009. Int. J. Med. Sci. Vol. 1(8); 325-329.
6. Indongo N and Naido K.: Family planning dialogue: Identifying the key determinants of young women's use and selection of contraceptives in Namibia. 2008. African Sociological Review Vol. 12(2); 98-116.
7. Katende C, Gupta N, Bessinger R: Facility level Reproductive health interventions and contraceptive use in Uganda. International planning perspectives 2003 29(3): 130-137.
8. Kelly GF.: Contraception (birth control). What are the various methods of contraception and their effectiveness rates? 1990-1992. Family Sexuality Today.
9. Kish and Leslie.: Survey Sampling. 1965. Wiley, New York.
10. Lutalo T, Kidugavu M, Wawer M, Serwadda et al.: Trends and determinants of contraceptive use in Rakai district, Uganda, 1995-98. 15 December 2003. DOI: 10.1111/j.1728-4465.2000.00217.x
11. Nalwadda G, Nabukeera S, Salihu HM: The abortion paradox in Uganda: Fertility regulator or cause of maternal mortality. Journal of Obstetrics and gynaecology 2005, 25(8):776-780
12. Ojaka D.: Trends and determinants of unmet need for family planning in Kenya. 2008.: Demographic Health Survey Working Paper No. 56.
13. Peter Buyingo (2005) Understanding Behavioural Determinants of modern contraceptive use Examining monitoring trends and evaluation PSI-Uganda Communication campaign.
14. Timothy Okech,N.Wawire,K.Mburu(2011) Contraceptive use among Women of reproductive age in Kenya City Slums.
15. Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. Uganda Demographic and Health Survey 2006. Calverton, Maryland, USA: UBOS and Macro International Inc.

16. Uganda Bureau of Statistics: Uganda Demographic and Health Survey 2011. Preliminary Report.

17. United Nations Global Strategy for Women's and Children's Health was developed with the aim of preventing 33 million unwanted pregnancies between 2011 and 2015

18. WHO Reproductive Health Strategy. World Health Organization

19. Williams T, Schutt–Aine' J and Cuca E.: Measuring family planning service through client satisfaction exit interviews. June 2000. International Family Planning Perspectives. Vol. 26(2):63-71.

20. World Bank: Development and the next generation. World development report Washington DC: International Bank for development for Reconstruction and development 2007.

Appendix 1: Study areas - the 26 selected enumeration areas in the 8 study districts								
District_ Code	**District_ Name**	**County_ Name**	**Subcounty_ Name**	**Parish_Name**	**LCNAME**	**NO_ LCS**	**HOUSEHOLDS**	**Rural_ Urban**
107	**MUBENDE**	BUWEKULA	BUTOLOOGO	KALAMA	KANYOGOGA	1	239	3
107	**MUBENDE**	BUWEKULA	KITENGA	KALONGA	BUDIBAGA 'A' & 'B'	1	200	3
107	**MUBENDE**	KASSANDA	BUKUYA	KYATO	MAVUVUMIRA/ BUKOBA B	2	159	3
107	**MUBENDE**	KASSANDA	KIGANDA	KIGALAMA	KIMBEJJA/GAYAZA	2	160	3
414	**KANUNGU**	KINKIIZI	KAMBUGA	RUHANDAGAZI	KIBALE I/KANYAMOMO	2	179	3
414	**KANUNGU**	KINKIIZI	KIHIIHI	KIHIHI TOWN	RWEMISISI/RUTWE	2	215	2
414	**KANUNGU**	KINKIIZI	RUGYEYO	MISHENYI	BUTAGASI/ NYAKAZINGA	2	148	3
313	**YUMBE**	ARINGA	DRAJANI	OLIVU	MONGOYO/ABOA	2	149	3
313	**YUMBE**	ARINGA	MIDIGO	MIGO	OLEBA/DERA/ADIBA	2	223	3
313	**YUMBE**	ARINGA	ROMOGI	BARINGA	ONOKO	1	150	3
321	**OYAM**	OYAM	ACABA	ATEKOBER	ADAGAYELA/ ABALO IWO	2	137	3
321	**OYAM**	OYAM	LORO	ADYEDA	OGUGU/BAR -	4	477	3

Appendix 1: Study areas - the 26 selected enumeration areas in the 8 study districts								
District_ Code	**District_ Name**	**County_ Name**	**Subcounty_ Name**	**Parish_Name**	**LCNAME**	**NO_ LCS**	**HOUSEHOLDS**	**Rural_ Urban**
					MWONY/BARLYEC/ ADYEDA FARM			
321	**OYAM**	OYAM	NGAI	AKUCA	BAR-IWALU/BAR-ALIRO/APAPIMOM	3	310	3
321	**OYAM**	OYAM	OTWAL	ALIBI	OGARO/BARLONYO/AMO-YAI/AMATO ROMA/ALENGO	5	347	3
207	**KATAKWI**	USUK	KATAKWI	KATAKWI	OCORIMONGIN	1	247	3
207	**KATAKWI**	USUK	TOROMA	OMINYA	SUDAN/ONGOKIA/ONGATUNYO-OMINYA/OMINYA	4	311	3
207	**KATAKWI**	USUK	OMODOI	ANGODINGOD	ANGODINGODI/ KALELE/AKISIM	3	247	3
308	**MOROTO**	BOKORA	IRIIRI	LORENGECORA	KOOMO	1	220	3
308	**MOROTO**	BOKORA	LOTOME	MORUONGOR	NAITAKOSOWAN/LOTOME TR.C/LOLIM	2	366	3
308	**MOROTO**	MATHENIKO	NADUNGET	LOPUTUK	LOOLI/NANGORIKIPIL	2	268	3

Appendix 1: Study areas - the 26 selected enumeration areas in the 8 study districts								
District_ Code	**District_ Name**	**County_ Name**	**Subcounty_ Name**	**Parish_Name**	**LCNAME**	**NO_ LCS**	**HOUSEHOLDS**	**Rural_ Urban**
306	**KOTIDO**	JIE	KOTIDO	KANAWAT	MERIWALA	1	384	3
306	**KOTIDO**	JIE	NAKAPELIMORU	WATAKAO	POET	1	128	3
306	**KOTIDO**	JIE	RENGEN	KOTYANG	KADUKAN	1	47	3
318	**KAABONG**	DODOTH	KALAPATA	MOROTO	KACHEMICHEM	1	149	3
318	**KAABONG**	DODOTH	KATHILE	KATHILE	LOBATOU	1	161	3
318	**KAABONG**	DODOTH	KAABONG	LOBONGIA	LOMUSIAN	1	209	3
Note: Three (3) EAs have been selected in every district, except for Mubende and Oyam which had four (4) EAs selected in each of them								

Appendix 2

LIST OF RESEARCH TEAM MEMBERS

1. Survey coordination team

Dr. Alex Opio – Lead Consultant

Michael Muyonga – Behavioural Scientist

Noordin Mulumba Biostatistician

Dr. Herbert Kadama – Reproductive Health Specialist

Patrick Nsamba Oshabe - Fieldwork Coordinator

2. Team supervisors

Awio Florence

Sam Wangalwa

David Okimait

Andrew Aninebyona

3. Interviewers

Brenda Ajidiru

Christine Ayaka Dezu

Jalobo John

Lorna Akello

Susan Ayumo

Stella Akurut

Xavia Okia

Amunyo Ezekiel

Charles Tugume

Kirabira Muzafaru

Jessica Nabulo

Resty Komucunguzi