FACTORS AFFECTING THE USE OF CONTRACEPTIVE METHODS AMONG CHILDBEARING WOMEN ATTENDING OBSTETRIC AND GYNECOLOGY CLINICS IN KIRYANDONGO DISTRICT HOSPITAL, KIRYANDONGO, UGANDA.

BY

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A RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF CLINICAL MEDICINE AND DENTISTRY IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF DEGREE OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY AT KAMPALA INTERNATIONAL UNIVERSITY

JULY, 2019

DECLARATION

I declare that this dissertation has not been produced or submitted to any Institution for any purpose whatsoever. The whole work is original; all references have been acknowledged.

Signature…… **Date**…….

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APPROVAL

This to confirm that this dissertation titled, “Factors affecting contraceptive use among childbearing women attending obstetrics and gynecology clinics in kiryandongo hospital” was conducted by MASEMBE KENNETH BMS/0059/123/DU, and supervised by;

SUPERVISOR **DATE**

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DEDICATION

I dedicate this work to my mother, family and great friend and Brother George Sekamanje.

ACKNOWLEDGENT

Firstly I want to acknowledge my supervisor DR. MOAZZAM MOHIUDDIN LODHI who has guided me in this research to make sure I produce excellent work. I also want to acknowledge my colleagues SSEKAMETE NOAH KIWANUKA and TWEKWATSE OWEN who gave me a hand where necessary in the compilation of this work.

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LIST OF ABBREVIATIONS

AIDS- Acquired Immuno Deficiency Syndrome

CIC- Combined Injectable Contraceptives

COC- Combined oral contraceptives

CVR- Combined Vaginal Ring

FP- Family Planning

GLOWM- Global Library of Women's Medicine

IUD- Intrauterine Device

HIV- Human Immunodeficiency Virus

POP- Progesterone only pills

UBOS- Uganda Bureau of Statistics

WHO- World Health Organization

OPERATIONAL DEFINITIONS

FAMILY PLANNING: Family planning (FP) is defined by the World Health Organization (WHO) as a voluntary and informed decision by an individual or couple on the number of children to have and when to have them.

CONTRACEPTION: The use of natural or artificial methods to prevent pregnancy as a consequence of sexual intercourse.

CONTRACEPTIVE: A device or drug serving to prevent pregnancy.

OBSTETRICS: A branch of medical science that deals with pregnancy, child birth, and postpartum period.

GYNECOLOGY: A branch of medical science that deals with the functions and diseases specific to women and girls especially those affecting the reproductive system.

CHILDBEARING: Relates to the process of conceiving, being pregnant with and giving birth to children.

SIDE EFFECTS: Unintended or unwanted consequences resulting from use of a drug.

ABSTRACT

BACKGROUND: Of the16.7 million undesired pregnancies occurring annually in 35 countries, 15 million could have been prevented with the optimal use of modern methods of contraception. (Bellizzi et al., 2015). In Uganda; 28 percent of currently married women and 32% sexually active unmarried women have an unmet need for family planning services (Uganda Demographic and Health Survey 2016). This study aimed at assessing the factors affecting contraceptive use among women attending obstetrics and gynecology clinics in kiryandongo hospital.

METHODOLOGY: This was a descriptive cross sectional study, the study population was women attending obstetrics and gynecology clinics in Kiryandongo hospital, and a total sample size of 100 women was used. A convenience sampling technique was used.

RESULTS: Out of the women that participated in the research, 84% of women had knowledge about family planning, 68% of these women were using contraceptives and the commonest family planning method was injectable (54%). The major reason for not using contraception was partner's disapproval (28%), others included; religious (11%) and cultural disapproval (10%), fear of side effects (13%), wrong perception that it led to some disease conditions (25%), some wanted to have more children (13%) and others their partners do not support it (28%). The distance of the family planning clinic was far for majority of the women (70%) as they incurred a lot of costs to reach the facility. The women had good psychosocial beliefs as 42% strongly disagreed with having children as a sign of respect and 48% disagreed with having many children as guarantee for generational continuity. Some weaknesses were observed with family planning services as majority of the women (42%) mentioned poor client handling, (25%) mentioned shortage of skilled man power, poor outreach and awareness to the community (18%).

CONCLUSION: The level of awareness and knowledge of contraception use is relatively high among women attending obstetrics and gynecology clinics in Kiryandongo (68%) and the most common contraceptive method used is injectable. The major reason as to why majority of the women were not using family planning was partner's disapproval (28%). The distance of the family planning clinic was far for majority of the women (70%) as they incurred costs to reach the facility. The women had good psychosocial beliefs as 42% strongly disagreed with having children as a sign of respect in the community and 48% disagreed with having many children as guarantee for generational continuity.

RECOMMENDATION: There is need to encourage men to be involved and support their partners through outreaches or motivational programs/ family planning campaigns involving them. There is need for increased access and availability of family planning services in the community. More personnel should be trained in family planning for better client handling. More out reaches should be done to remove the negative perception about family planning. There should be proper management of side effects. Religious leaders should be talked to about family planning and its benefits so that they support contraceptive use.

CHAPTER ONE

INTRODUCTION

1.1 Background

Family planning (FP) is defined by the World Health Organization (WHO) as a voluntary and informed decision by an individual or couple on the number of children to have and when to have them. Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. There are two types of family planning methods; the modern methods and traditional methods. Some of the modern methods include; Combined oral contraceptives (COC's) or "the pill", Progesterone only pills (POP's) or "the pill", implants, Progestogen only injectable, or combined injectable contraceptives (CIC), combined contraceptive patch and combined contraceptive vaginal ring(CVR), Intrauterine device (copper containing or Levonorgestrel), male and female sterilization and emergency contraceptive pill. Some of the traditional methods include calendar method and coitus interruptus (withdrawal). (WHO, 2017).

The factors controlling human fertility and the development of rational therapies to limit births have come a long way. According to the Global library of women's medicine (GLOWM); contraceptive use is traced back to the 13th century in Medieval Europe, where methods like coitus interruptus, induced abortion using Savin as an abortifacient, abstinence, heterosexual anal coitus among others where used. The methods to which the ancient scholars refer to fell into three general categories: (1) those that seemed reasonable at the time but are now known to be ineffective (e.g., wiping out the vagina after intercourse; (2) the reasonable and perhaps effective (e.g., using honey, pepper, alum, or lactic acid as pessaries and barriers; and (3) the unreasonable, manifestly ineffective, such as the woman holding her breath at the time of ejaculation or jumping backward seven times after coitus, the manufacture of vaginal pessaries from the dung of animals, such as crocodiles, elephants, or mice. (The Global Library of Women's Medicine 2009).

As the years went by, more effective methods of family planning began to be discovered. In the United Kingdom; in 1934, voluntary male sterilization was allowed. By the late 19th and 20th century, female sterilization was also carried out. In the 1950's, the oral contraception was

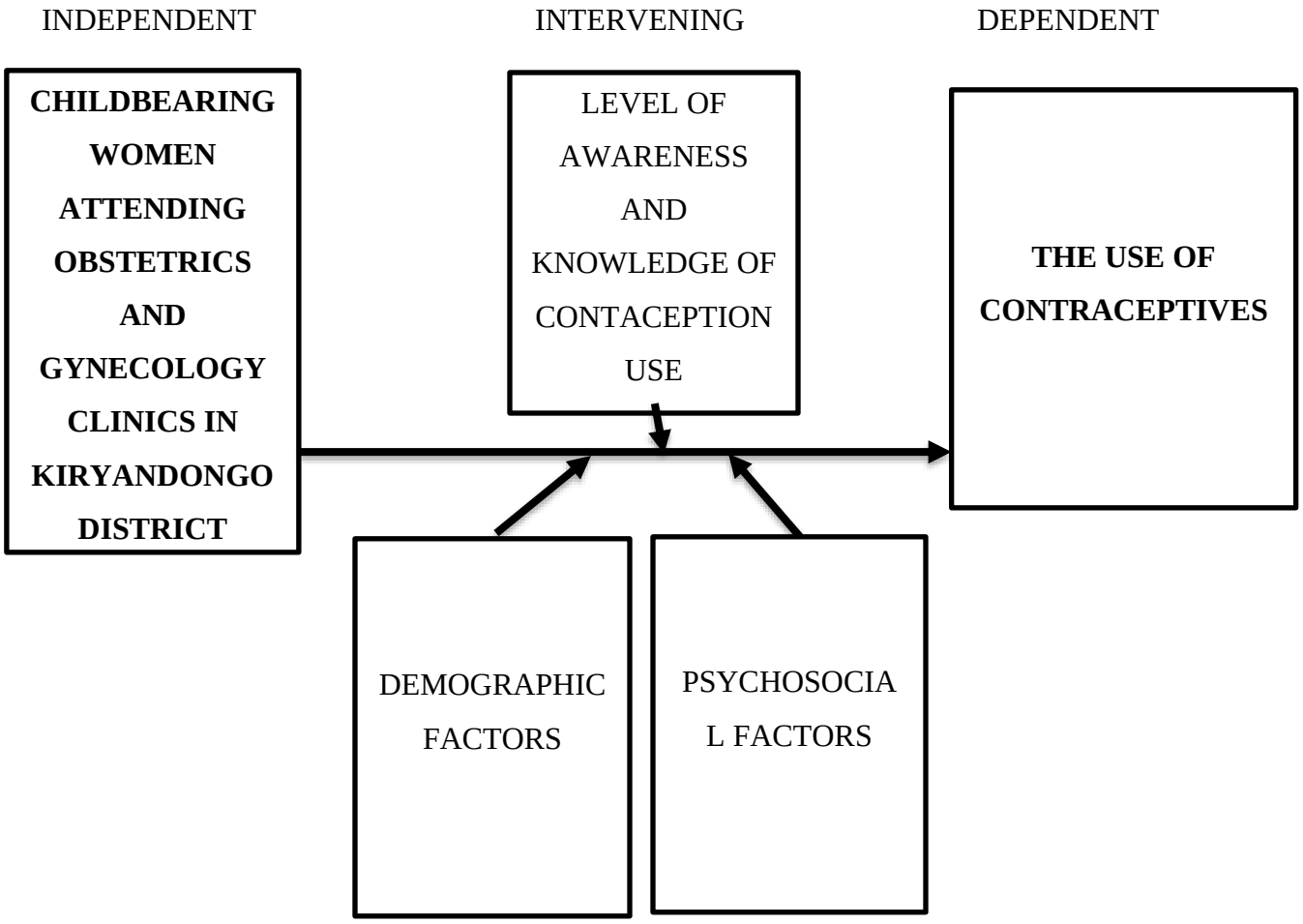
developed and by 2002 the first combined pill (Yasmin) to contain new progestogen (drospirenone) became available. In 1950's as well, the emergency contraception using high doses of estrogen alone taken over five days was developed and by 2009 an oral emergency contraceptive containing ulipristal acetate was launched. The first systemic contraceptives using short acting progestogens was also discovered in the 1950's. In 1967, implants where discovered and by 1999, single rod implant (implanon) was introduced. In 1969, the copper IUD was developed. In 1984 Depo Provera was licensed. In 1992 the first polyurethane female condom was available. In 1997, the first polyurethane male condom was launched. (Family planning association London 2010).

Some of the benefits of contraceptive use include; preventing pregnancy-related health risks in women, reducing infant mortality, helping to prevent HIV/AIDS, reducing adolescent pregnancies, slowing population growth. Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts. (WHO 2017). Oral contraceptives for example are relative safe and have a high degree of efficacy, decreased need for abortion or surgical sterilization; reduced risks of bacterial (but not viral) pelvic inflammatory disease and of endometrial and ovarian cancer; improved menstrual regularity, with less dysmenorrhea and blood flow; and, when low-dose combination (not progestogen-only) oral contraceptives are used, reduced acne and hirsutism. (Sherif at el., 1999).

Contraceptive use is not also without its risks. The risks are specific to the type of method used for contraception. For example; in oral contraceptive use; Preliminary data from nonrandomized studies suggest that oral contraceptives containing third-generation progestogens are associated with increased risk of venous thromboembolism, particularly in carriers of the coagulation factor V Leiden mutation. The risk of arterial thrombosis, such as myocardial infarction or stroke, may be directly related to estrogen dose, particularly in women who have hypertension, smoke, or are >35 years old. Considering that only users aged >/=30 years who smoke >/=25 cigarettes have a higher estimated mortality rate than that of pregnant women. (Sherif at el., 1999). Prolonged use of oral contraceptive use for more than five years acts as a risk of cervical cancer. Progestogen containing contraceptive pills are associated with menstrual irregularities such as increased menstrual bleeding, altered menstrual cycles and no menstrual cycle. In some cases, the contraceptive method may fail and a woman conceives.

1.1.1 Conceptual Framework

***Figure 1*: Conceptual Framework**



Description:

In this study, I assessed how the level of awareness and knowledge of contraception use, demographic factors and psychosocial factors affect the use of contraceptives among childbearing women attending obstetrics and gynecology clinics in kiryandongo district.

1.2 STATEMENT OF THE PROBLEM

The global fertility rate in the world is 2.5 children per woman, in Africa; the fertility rate is 4.7 children per woman (World Fertility Patterns 2015). In Uganda; the fertility rate per woman is 5.4 children (UBOS 2016).

In developing countries, one in three women give birth before the age of 20 and pregnancy-related death during child birth is two times higher compared to women older than 20 years (World Health Organisation, 2014). A quarter of the estimated 20 million unsafe abortions and 70,000 related deaths each year occur among women aged 15–19 years. In sub-Saharan Africa alone, it is estimated that 14 million unintended pregnancies occur every year, with almost half occurring among women aged 15–24 years. (Ortiz-Ortega at el., 2003). 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method. (WHO, 2017).

Every year, worldwide, about 42 million women with unintended pregnancies choose abortion, and in nearly half of these procedures, 20 million, are unsafe (WHO, 2012). Some 68,000 women die of unsafe abortion annually, of the women who survive unsafe abortion, 5 million will suffer long-term health complications. (Haddad et al. 2009). According to WHO; 21.6 million Women experience an unsafe abortion worldwide each year; 18.5 million of these occur in developing countries and 47 000 women die from complications of unsafe abortion each year. Deaths due to unsafe abortion remain close to 13% of all maternal deaths. (WHO 2014).

Women who don't use family planning are at a risk of having reduced pregnancy interval time. (Less than two years between pregnancies). This leads to a reduction in child spacing which has effects on both the mother and the child. The mother's body does not get the amount of time it needs to fully recuperate from the previous pregnancy and pregnancy complications may arise during delivery. The mother is at a risk of under nutrition which can also lead to poor pregnancy outcomes. Reduced pregnancy interval time can also lead to child malnutrition which can eventually cause stunted growth, wasting, increased risk to infectious diseases and eventually death (Naik at el., 2015).

1.3 RESEARCH OBJECTIVES

1.3.1 General objective

To assess the factors affecting the use of contraceptive methods among child bearing women attending obstetrics and gynecology clinics in Kiryandongo District Hospital, Kiryandongo, Uganda.

1.3.2 Specific objectives

i. To determine the level of awareness and knowledge about contraception of childbearing women attending obstetrics and gynecology clinics at Kiryandongo District Hospital.
ii. To identify the demographic factors affecting contraception use among childbearing women attending obstetrics and gynecology clinics at Kiryandongo District Hospital.
iii. To identify the psychosocial factors affecting contraception use among childbearing women attending obstetrics and gynecology clinics at Kiryandongo District Hospital.

1.4 RESEARCH QUESTIONS

i. What is the level of awareness and knowledge about contraception of childbearing women attending obstetrics and gynecology clinics at Kiryandongo District Hospital?
ii. What are demographic factors affecting contraception use among childbearing women attending obstetrics and gynecology clinics at Kiryandongo District Hospital?
iii. What are the psychosocial factors affecting contraception use among childbearing women attending obstetrics and gynecology clinics at Kiryandongo District Hospital?

1.5 SIGNIFICANCE OF THE STUDY

Contraception use can significantly reduce the occurrence of unintended pregnancies amongst childbearing women and consequently reducing cases of abortions which if unsafe can even lead to the death of the mother. This study serves to identify factors affecting contraception use among childbearing women which in the end will help develop measures and policies that will guide health personnels and encourage childbearing women in the use of contraceptives.

Therefore the use of contraceptives will reduce the occurrence of unintended pregnancies and cases of abortion which can lead to death. Hence saving lives and improving health in childbearing women.

CHAPTER TWO

LITERATURE REVIEW

2.1 THE LEVEL OF AWARENESS AND KNOWLEDGE ABOUT CONTRACEPTION USE AMONG CHILDBEARING WOMEN.

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57.4% in 2015. In Asia it has risen slightly from 60.9% to 61.8%, and in Latin America and the Caribbean it has remained stable at 66.7%, in Africa it went from 23.6% to 28.5%. (WHO 2017). This goes to show that Africa has the lowest percentage of contraceptive use globally. In Uganda; 39 percent of currently married women are using a method of family planning; 35 percent of these women are using a modern method while 4 percent are using a traditional method. Among sexually active unmarried women, 51 percent are currently using a contraceptive method; 47 percent these women are using a modern method and 4 percent are using a traditional method. (Uganda Demographic and Health Survey 2016).

The unmet need for contraception remains too high globally. This is caused by both a growing population, and a shortage of family planning services. According to a study in Bangladesh; the prevalence of unmet need for contraception was 13.5%, and about 30% of the women described their last pregnancy as unintended. In the adjusted model, the odds of unintended pregnancy were about 16 fold among women who reported facing unmet need for contraception compared to those who did not. (Bishwajit et al., 2017). In Asia, and Latin America and the Caribbean – regions have relatively high contraceptive prevalence, the levels of unmet need are 10.2 % and 10.7%, respectively. In Africa, 24.2% of women of reproductive age have an unmet need for modern contraception (Trends in Contraception Worldwide 2015). In Uganda; 28 percent of currently married women have an unmet need for family planning services. Among sexually active unmarried women, 32 percent have an unmet need for family planning. (Uganda Demographic and Health Survey 2016). The level of unmet need for contraception in Uganda is higher compared to Africa in general and most parts of the world as well.

Knowledge about contraception plays an important role in its usage. According to research from Tanzania and other sub-Saharan African countries indicates that knowledge of contraception is

associated with its use. The more a woman knows about contraception, the more likely she is to use it. (Naik et al., 2015).

A study showed that higher contraceptive use was associated with higher educational level. (Agyei et al., 1995). In a study in Tanzania and other sub-Saharan African countries; women with higher levels of education were found to be more likely to use contraception than women with lower education levels. (Naik et al., 2015). A study in Ghana showed that married women with higher education were three times more likely than uneducated women to use contraception. (Tawiah et al., 1997). In Uganda, a study showed that adolescent females with at least a secondary education were more likely to use contraceptives than those with primary education. (Kabagenyi at el., 2016).

2.2 DEMOGRAPHIC FACTORS INFLUENCING CONTRACEPTIVE USE AMONG CHILDBEARING WOMEN.

In a study in Uganda, results showed significant variability in contraceptive use among the young (25-24) and the older (25-35) women. (Asiimwe at el., 2014). The place of residence of a woman; in a study held in Uganda, the odds of contraceptive use were least among adolescents from Northern region compared to those from central region of Uganda. The wealth index of the woman (Osmani at el., 2015), among others.

Religious belief about family planning affects the use of contraception greatly. According to the WHO; 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method, one of the reasons for this was religious opposition. (WHO 2017). A study in Parkistan also showed that men did not want their wives going for family planning for religious reasons. (Mustafa at el., 2015). Studies in Ghana (Tawiah et al., 1997) and in Nigeria revealed part of the reasons for the poor use of contraception included religious teachings which discourage the use of contraception. (Omo-Aghoja at el., 2009). Studies in Uganda also showed similar results; Muslim adolescent females were more likely to use contraceptives compared to Catholics. (Kabagenyi at el., 2016).

Cultural beliefs affect the use of contraception greatly; a study in Parkistan showed that there was also a lot of social pressure to have more children as the more children you had the more respect you earned. (Mustafa at el., 2015). In Nigeria, a study showed that one of the factors affecting contraceptive use was the persisting pronatalist culture of the people. (Omo-Aghoja at el., 2009). A study in Uganda also showed that persistence of socio-cultural beliefs and practices promoting births (such as polygamy, extending family lineage, and replacement of the dead, gender-based violence, power relations and twin myths) greatly reduced the use of contraception. (Kabagenyi at el., 2016).

Access to contraceptive service. According, to WHO, one of the hindrances to contraceptive use particularly among young people is limited access to contraceptive services. (WHO 2017). In Nigeria, a study showed that poor availability and distribution of contraceptives affected the use of contraceptive methods. (Omo-Aghoja at el., 2009).A study in Parkistan revealed that low use of contraception was associated with lack of access to contraceptive information and services. (Mustafa at el., 2015).

2.3 PYSCHOSOCIAL FACTORS INFLUENCING CONTRACEPTIVE USE AMONG CHILDBEARING WOMEN.

Fear of experience of side effects also has tremendous effects on the use of contraception. A study in Nigeria showed that the perception that contraception could lead to infertility in later life was one of the reasons that Nigerian women had always not accepting effective contraception. (Omo-Aghoja at el., 2009). In another study; misconceptions about contraceptive use persisted, some women associate birth control use with infertility and physical deformities in children conceived after using contraception. Some women also shared that they switched methods or discontinued their contraception because of side effects such as heavy bleeding or headaches. (Naik et al., 2015). A study in Uganda revealed that misconceptions and fears about modern contraception where major hindrances to the use of modern family planning methods. (Kabagenyi at el., 2016).

Partner's attitude towards family planning methods. In Ghana, a study showed that among the three most important variables affecting contraceptive use was discussion of family planning

with the partner and his approval. The study showed that married women who discussed family planning with their partners were three times more likely to be current contraceptive users (Tawiah et al., 1997). In another study, significant determinants of approval of contraceptive use included husband-wife discussion of family planning. (Agyei et al., 1995).

Attitude towards family planning. A study in Ghana showed that one of three most important variables affecting contraceptive use was woman's approval of family planning. This showed that married women who approved of family planning were four times more likely to use contraception than those who did not approve (Tawiah et al., 1997). One of the reasons the majority of men and women across all regions in Parkistan were not using any family planning method was mainly because had negative perceptions about family planning. (Mustafa at el., 2015).

Desire to have children. According to a study in Parkistan; wives did not want to start family planning until they had the number of children they desired and majority wanted more children than they currently had. (Mustafa at el., 2015). In another study; contraceptive use was associated with the need to stop child bearing. 26.2% among women with three or more surviving children and 19.0% of women with no surviving children used contraceptives. (Agyei et al., 1995).). Respondents in a study in Uganda who had a birth in the 5 years prior to the survey had five times the odds of contraceptive use compared to those who had never had a birth. (Kabagenyi at el., 2016). A study in Afghanistan revealed that parity, number of living sons, and child mortality experience among others had an effect on contraceptive use. (Osmani at el., 2015).

CHAPTER THREE

METHODOLOGY

3.1 STUDY DESIGN

The researcher employed a cross sectional study design for this study. According to Amin (2005), a cross sectional study involves measuring different variables in the population of interest at a single point in time. This design was used because it is cheap, quicker and avoids manipulation of variables.

3.2 STUDY AREA

The study was conducted in Kiryandongo district hospital. It is a 109 bed hospital serving a population of over 400,000 people from areas of Kiryandongo, Masindi, Nakasongola, Oyam, Apac, Amuru and Nwoya districts. The hospital offers a number of services including; OPD, inpatient, Opthalmology, X-ray, ultra sound, Orthopedics, health promotion and education, occupational therapy, HIV immunization, environmental health, special clinics among others. The maternity ward is composed of 28 beds. (Ministry of health).

3.3 STUDY POPULATION

The study targets childbearing women attending gynecology and obstetrics clinics in kiryandongo hospital, Kiryandongo, Uganda.

3.4 SAMPLE SIZE ESTIMATION

The researcher used the Morgan's table (Krejcie et al., 2017), to estimate the sample size. Kiryandongo hospital receives on average 140 women per day attending the obstetrics and gynecology clinics and according to Morgan's table (included in APPENDIX I); 103 women were recruited for the study.

3.5 SAMPLING METHOD

For this study, the researcher used the convenience sampling technique. The researcher employed this method because it is inexpensive and easy to conduct. By this method, all women attending obstetrics and gynecology clinics that were consented were selected for the study.

3.6 INCLUSION AND EXCLUSION CRITERIA

3.6.1 INCLUSION CRITERIA.

Childbearing women attending obstetrics and gynecology clinics were eligible for the study.

3.6.2 EXCLUSION CRITERIA.

Childbearing women who are pregnant or terminally ill, non-sexually active and menopausal women were ineligible for the study.

3.7 TOOLS FOR DATA COLLECTION

The researcher used a self-administered questionnaire. It comprised of mainly two sections, A and B. The components of section A included the demographic data. The items of section B included both closed and open questions on assessment of the level of awareness and knowledge concerning contraception use, attitude and psychosocial factors affecting contraceptive use.

3.8 DATA QUALITY CONTROL

To ensure validity of the data collected, the approach, tools and instruments used in data collection was to ensure that the respondents are not biased and should also give sincere information thereby eliminating the responsibility of collecting worthless data..

3.9 DATA ANALYSIS AND PRESENTATION

Data was edited, coded and entered in SPSS for analysis. Presentations were done by use of tables, graphs and pie-charts.

3.10 ETHICAL CONSIDERATION

3.10.1 INSTITUTIONAL CONSENT

The study first was approved by the Faculty of Clinical Medicine and Dentistry of KIU-TH. Followed by obtaining permission from the Medical superintendent to conduct the research within the hospital.

3.10.2 INFORMED CONSENT

The researcher explained the purpose and benefits of the study to the potential respondents and those willing to participate had to provide an informed consent.

Participation in the study was voluntary and no participant was forced to take part in the study. The respondents, who consented at first but later wished not to continue in the study, were free to withdraw.

3.10.3 CONFIDENTIALITY AND ANONYMITY

Confidentiality of information and anonymity of the participants was also essential in this study. This was ensured through keeping all the information provided by respondents confidential, unless when ordered by the respondent was this reversed and through the identification of all the questionnaires to be used in the study.

3.11 STUDY LIMITATIONS AND DELIMITATIONS

The researcher anticipated the following limitations during the course of the study:

The university program of Kampala International University being tight, the researcher anticipated a hectic period when carrying out the research. This was so because the tight school schedule may have interfered with the time the researcher was collecting data. The researcher made adjustments in his personal life and showed resilience to see to it that the research was accomplished.

The researcher experienced language barrier as he was conducting the research as most locals spoke Swahili, Alur which the researcher is not conversant with. The researcher however got some assistance where needed for language interpretation.

CHAPTER FOUR

RESULTS

4.1 Demographic Parameters.

A total of 100 women responded to the questionnaire. The age range of the respondents was 15–35 years with most of the respondents falling within the age of 25-30. 22% of women that responded were between the age of 15-20, 10% between the age of 20-25, 53% between the age of 25-30, and 15% between the ages of 30-35.

Figure 2: A graph showing the percentage of ages of women in respect to how they responded to questionnaires.

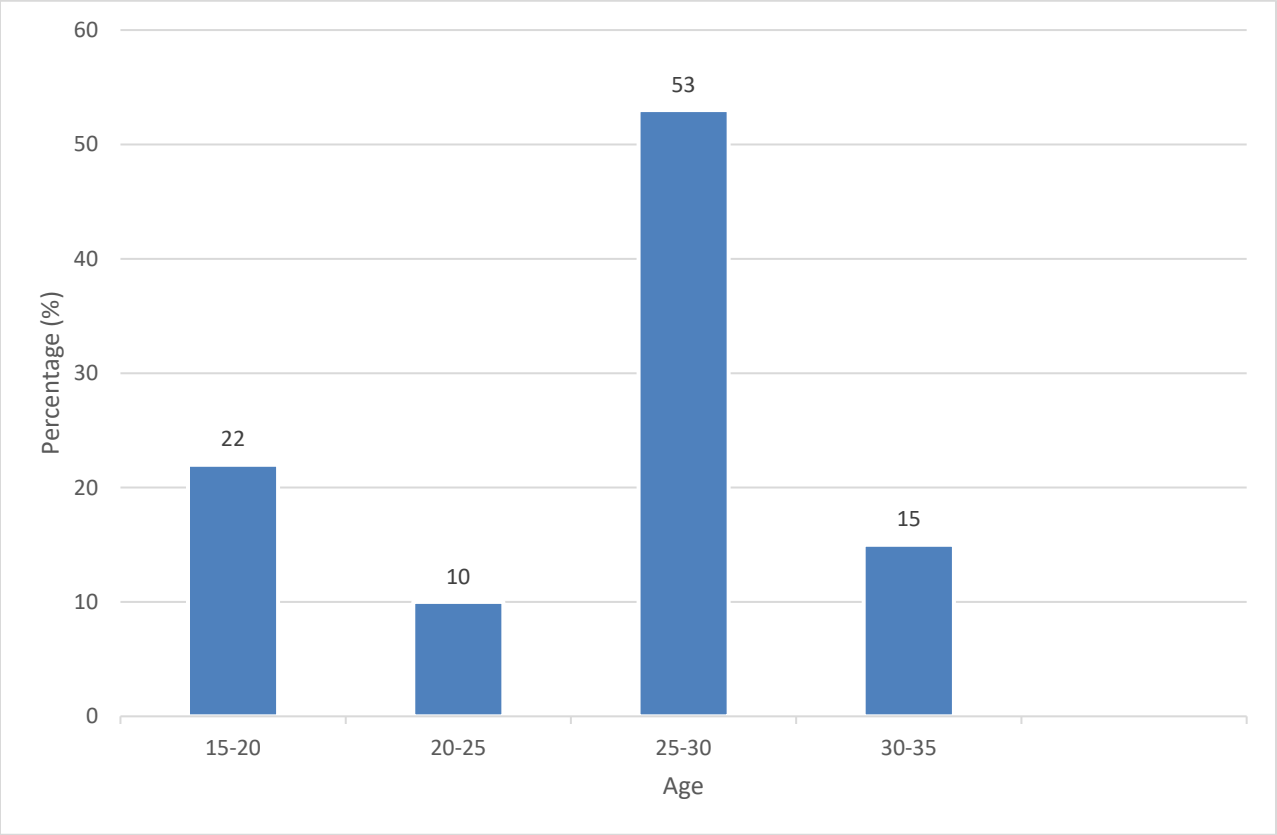


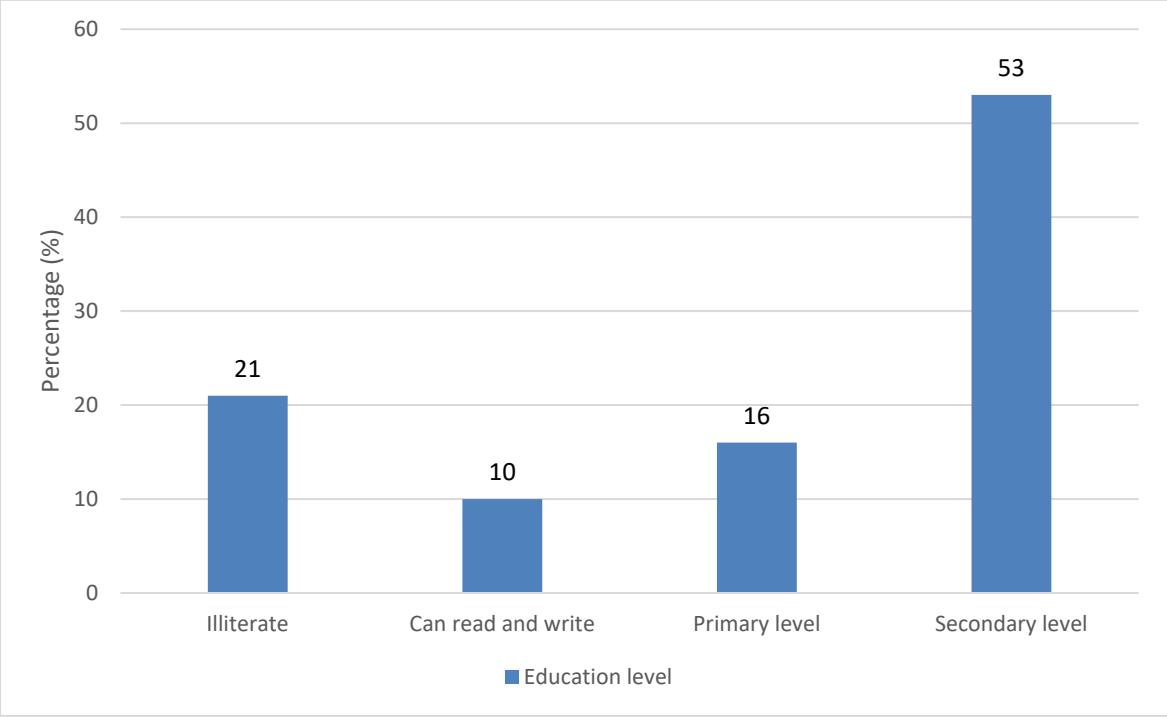
Table 1: Demographic parameters of the respondents

Parameter	***Number of Respondents N=100***	**Percentage (%)**
Age		
15-20	22	22
20-25	10	10
25-30	53	53
30-35	15	15
Occupation		
House wife	16	16
Peasant Farmer	74	74
Business woman	10	10
Religion		
Muslim	11	11
Catholic	42	42
Protestant	37	37
Seventh day Adventist	10	10
Education level		
Illiterate	21	21
Can read and write	10	10
Primary level	16	16
Secondary level	53	53

Marital status		
Unmarried	11	11
Married	89	89
Divorced	0	0
Widowed	0	0
Marriage type		
Monogamous	74	74
Polygamous	26	26

Of the women that participated in this research, 21% are illiterate, 10% can read and write, 16% reached at primary level and 53% reached secondary level.

Figure 3: A graph showing the different education levels of the respondents and their percentages.



4.2 LEVEL OF AWARENESS AND KNOWLEDGE ASSESSMENT

From the respondents; 84 women (84%) had heard about family planning while 16 women (16%) had not heard of family planning. Among the 84% of women who had heard about family planning, these where the methods they could identify, however, some would identify more than one method:

Table 2: Methods known by the respondents

Method	Pills	Implant	Injectable	Condom	IUDs
Percentage (%)	21	21	30	23	5

Table 3: Reasons why a woman should use family planning

Reason	Percentage (%)
Preventing unwanted pregnancy	26
Child spacing	58
Preventing of STI/HIV	4
To limit family size	12

95% of the women knew where to get contraceptives, while 5% did not know. Of the women who knew where to get contraceptive services;

Table 4: where to get family planning

Place	Percentage (%)
Health Centre	79
Pharmacy	16

Traditional Healer	0
Community based distributors	0
Private physician	5

4.3 ATTITUDE, PRACTICE AND OTHER QUESTIONS ON THE USE OF CONTRACEPTION.

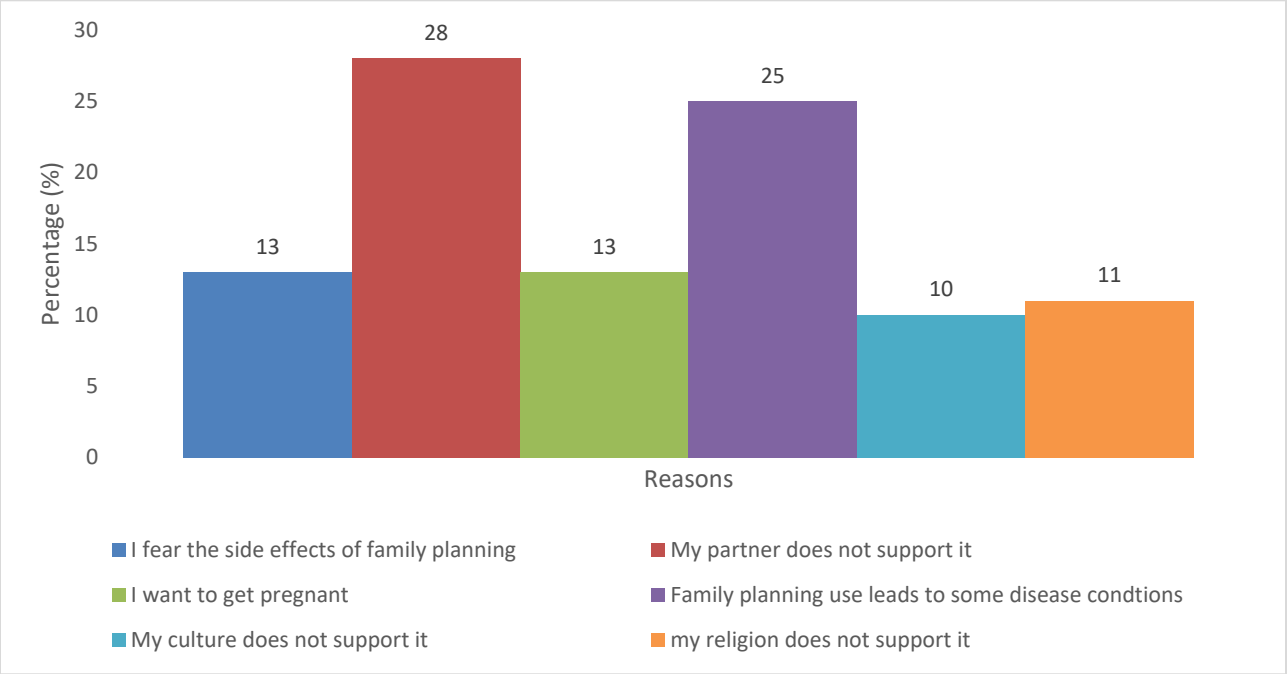
68 women (68%) were using a family planning method while 32 women (32%) were not using a family planning method. The reasons why those who were not using a family planning method are shown in table 5.

Table 5: Reasons for not using contraception

Reason	Number of respondents (N= 32)	Percentage (%)
I fear family the side effects of family planning	4	13
My partner does not support it	9	28
I want to get pregnant	4	13
Family planning use leads to some disease conditions	8	25
My culture does not support it	3	10
My religion does not support it	4	11

Of the women that participated in the study, 13% fear the side effects of family planning, 28% their partners do not support it, 13% want to get pregnant, 25% family planning use leads to some disease conditions, 10% their culture does not support it, 11% their religion does not support it

Figure 4: A graph showing the reasons why some women were not using contraception.

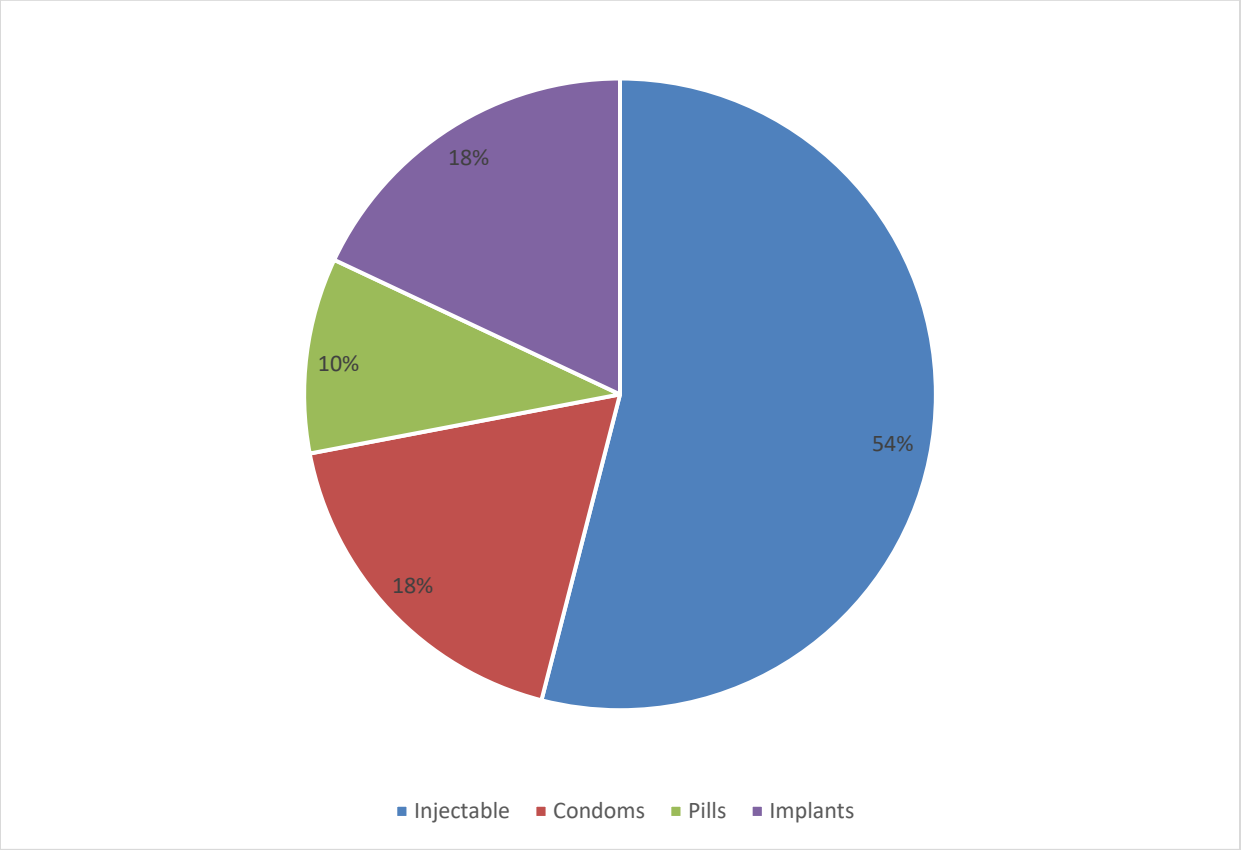


Among the 68% of women who were using family planning, the methods they were using are shown in the table below:

Table 6: Family planning methods used

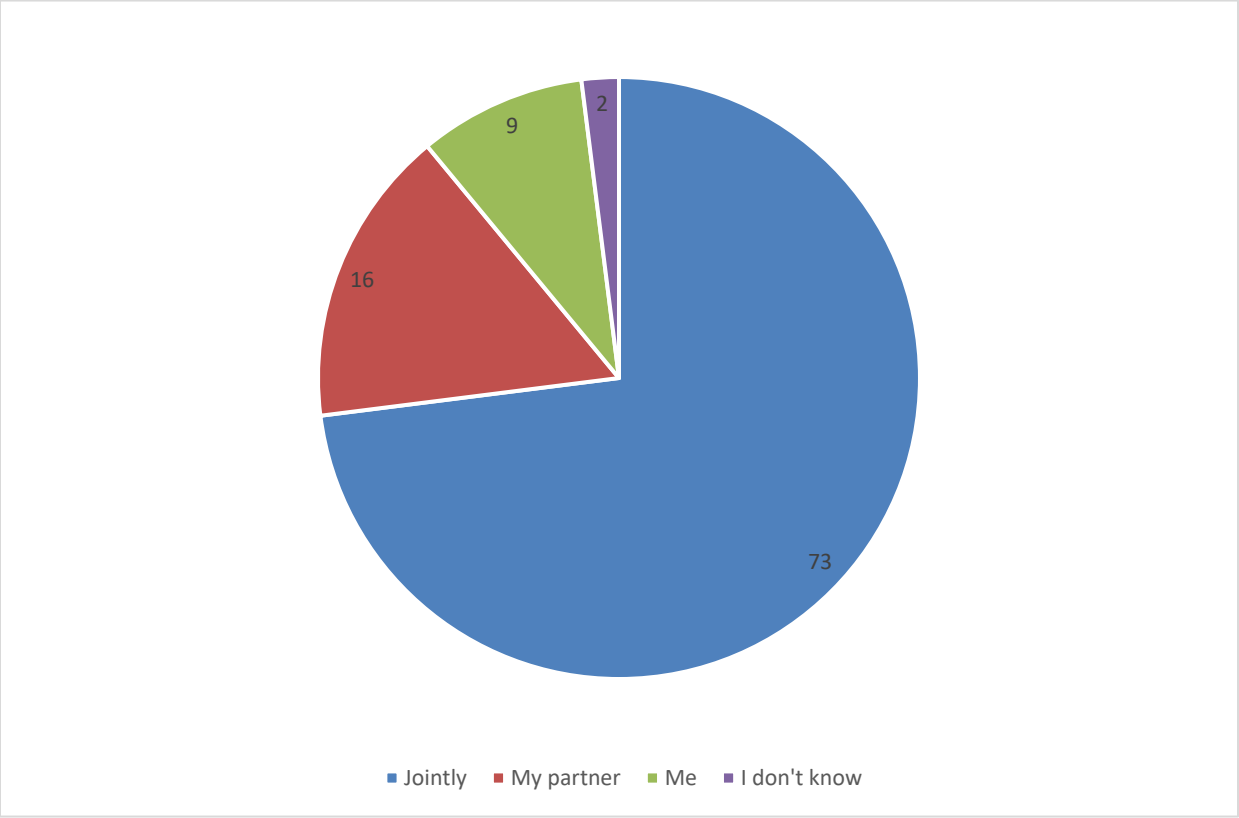
Method	Number of respondents (N= 68)	Percentage (%)
Injectable	37	54
Condoms	12	18
Pills	7	10
Implants	12	18

Figure 5: A Pie chart showing percentages of family planning methods used.



The decision to use family planning affects the number of women who use family planning methods. The results showed that 73 women (73%) thought the decision should be made jointly with their partners, 16 women (16%) thought the decision should only be made by their partners, 9 women (9%) thought the decision should only be made by themselves and 2 women (2%) did not know who should make the decision.

Figure 6: A pie chart showing who should make the decision to use family planning.



68% of women mentioned that they would stop using family planning methods if their partners did not agree with them using family planning, while 32% would still keep using family planning methods even though their partners were not in agreement with them.

70% of women were affected by the distance of the family planning health facility from their place of residence as it was expensive in terms of transport to reach the hospital.

Major weaknesses observed by the respondents about family planning where as follows in the table below:

4.5 PSYCHOSOCIAL FACTORS

Table 7: some of the socio-psychological factors that affect the decision to use family planning

No. 1 meaning strongly disagree, No. 2 meaning Disagree, No. 3 meaning Neutral, No. 4 meaning Agree, No. 5 meaning strongly agree.

Table 7: Psychosocial factors affecting the use of family planning

Question	Percentage of respondents. (%)				
	N0.1	No.2	No.3	No.4	No.5
Will having too many children guarantee generational continuity?	26	48	0	26	0
Should high infant/child mortality be compensated by too much birth?	21	48	5	10	16
Will having too many children help improve the income of the family?	37	26	0	21	16
Does child spacing help protect the health of mothers and children?	5	21	11	26	37
Does contraceptive use cause infertility in women?	29	11	28	16	16
Should men share the responsibility of family planning use?	5	0	16	21	58
Does FP help a mother to regain her strength before her next baby?	16	5	21	21	37
Does having many children give you respect in your community?	42	32	5	16	5

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 DISCUSION

Knowledge on contraceptive use

Out of 100 women who participated in this research, 84% knew and had heard of family planning, only 16% did not know about family planning. According to research from Tanzania and other sub-Saharan African countries indicates that knowledge of contraception is associated with its use, the more a woman knows about contraception, the more likely she is to use it. (Naik et al., 2015). This was evident in this research as out of 100 women, 68 were using family planning while 32 were not. Therefore more women used family planning because they had knowledge about it.

The importance of using family planning where known by the women as the majority (58%) of those using family planning mentioned that child spacing was the reason they used contraceptives, 26% mentioned that they used it to prevent unwanted pregnancy, 12% used it to limit family size and 4% used it to prevent STI/HIV.

95% of the women who participated in this research knew where to get contraceptives, while 5% did not know. Of the ones that knew, 79% mentioned that they got their contraceptives from the health centers. Therefore since these women could get access to family planning methods, there is utilization of these methods. If there wasn't good access to family planning methods then the use may have been low just like in Nigeria where poor availability and distribution of contraceptives affected the use of contraceptive methods. (Omo-Aghoja at el., 2009). Where as in Pakistan low use of contraception was associated with lack of access to contraceptive information and services. (Mustafa at el., 2015).

Demographic data

A similar study in Uganda carried out among adolescent females showed that those with at least a secondary education were more likely to use contraceptives than those with primary education (Kabagenyi at el., 2016) which could be attributed to the increased exposure to reproductive talks and lessons taught at the secondary level as part of a higher level of learning similar to the study by Agyei et al.,(1995) whose study also showed that higher contraceptive use was associated with higher educational level. This finding was also popular in other countries such as Tanzania and other sub-Saharan African countries (Naik et al., 2015).

Aside from attaining a higher level of education, the marital status of the female also had a positive impact on their willingness to use a contraceptive method. A study in Ghana showed that married women with higher education were three times more likely than uneducated women to use contraception. (Tawiah et al., 1997) as a method for child spacing. This was seen in this research as majority of women had attained a secondary level and were married.

In Uganda, 39 percent of currently married women are using a method of family planning. Among sexually active unmarried women, 51 percent are currently using a contraceptive method (Uganda Demographic and Health Survey 2016). Therefore according to Uganda Demographic and Health Survey, more unmarried women in Uganda are using family planning than the married. In this study; the majority of women using family planning were married.

74% of these marriages where monogamous while 26% were polygamous. A study in Uganda showed that persistence of socio-cultural beliefs and practices promoting births such as polygamy greatly reduced the use of contraception (Kabagenyi at el., 2016). In this study however, most marriages were monogamous.

Partner's approval greatly affected the use of contraception as the majority (28%) of the women never used family planning because their partners did not support it. This is shown in similar studies such as; In Ghana one study showed that among the three most important variables affecting contraceptive use was discussion of family planning with the partner and his approval. Tawiah et al., showed that married women who discussed family planning with their partners were three times more likely to be current contraceptive users (Tawiah et al., 1997), and finally Agyei(1995) significant determinants of approval of contraceptive use included husband-wife discussion of family planning. (Agyei et al., 1995).

Religious disapproval (10%) also decreased the use of contraceptives. This was in agreement with similar studies that revealed; in Ghana (Tawiah et al., 1997) and in Nigeria part of the reasons for the poor use of contraception included religious teachings which discourage the use of contraception. (Omo-Aghoja at el., 2009), another study in Parkistan showed that men did not want their wives going for family planning for religious reasons. (Mustafa at el., 2015).

Psychosocial factors

Women's attitude toward family planning also affected their use of family planning. 25% of women not using family planning believed that family planning was associated with some disease conditions for example some of the women thought use of Contraceptive methods could predispose one to cancer. 13% of these women feared side effects such as infertility. A similar study in Ghana showed that one of three most important variables affecting contraceptive use was woman's approval of family planning. This showed that married women who approved of family planning were four times more likely to use contraception than those who did not approve (Tawiah et al., 1997). One of the reasons the majority of men and women across all regions in Parkistan were not using any family planning method was mainly because had negative perceptions about family planning. (Mustafa at el., 2015). Another study in Nigeria showed that the perception that contraception could lead to infertility in later life was one of the reasons that Nigerian women had always not accepting effective contraception. (Omo-Aghoja at el., 2009).

42% of women in this research mentioned that they strongly disagreed that having many children gave one respect in the community. Such an attitude encourages women to use family planning, and the majority (68%) in this research were using family planning methods. The attitude of the women in Kiryandongo differed from those in both Pakistan and Nigeria i.e. in Pakistan, the study showed that there was also a lot of social pressure to have more children as the more children you had the more respect you earned. (Mustafa at el., 2015) and the persisting pro-natalist culture that encourages the bearing of children in Nigeria was one of the factors affecting contraceptive use. (Omo-Aghoja at el., 2009). However in this study, the community of Kiryandongo does not agree that having many children gives one respect and thus increased use of family planning.

In every service rendered, clients always expect a certain level of courtesy and treatment that may affect the individual's perception of the service provider and also future use of that service.

The ladies in this study were given an opportunity to mention some of the weaknesses observed by the family planning service providers. Some of the weakness in providing family planning services mentioned by women who participated were as follows; 42% mentioned that there is poor client handling by the service providers at the family planning clinics, 25% of the women mentioned that there was shortage of skilled personnel in relation to the number of women they provide services to, 18% mentioned that there is poor outreach or awareness of family planning to the community and 8% mentioned that sometimes there is shortage of family planning supplies.

Despite the above weaknesses mentioned, 7% of the women who participated in this research were completely satisfied with the family planning services available, and these greatly reduce the use of contraceptives among the women.

5.2 CONCLUSION

Based on the findings in this study, the following conclusions can be made;

- The level of awareness and knowledge on contraceptive use is relatively high among women attending Obstetrics and Gynecology clinics in Kiryandongo (68%).
- The commonest contraceptive method used was injectable.
- The major reason as to why the majority of women were not using family planning was partner's disapproval (28%).
- Other factors that reduced the use of contraception included; fear of side effects(13%) , religious beliefs(11%) , negative beliefs that family planning led to disease conditions(25%), cultural beliefs (10%).
- The distance of the family planning clinic was far for majority of the women (70%) as they incurred costs to reach the facility.
- The women had good psychosocial beliefs as 42% strongly disagreed with having children as a sign of respect in the community and 48% disagreed with having many children as guarantee for generational continuity.
- Some weaknesses were observed with family planning services as majority of the women (42%) mentioned poor client handling, (25%) mentioned shortage of skilled man power, poor outreach and awareness to the community (18%).

5.3 RECOMMENDATION

Based on the data analysis and conclusion in this study, I therefore make the following recommendations:

- There is need to encourage men to be involved and support their partners in the use of family planning. This can be down through outreaches or motivational programs/ family planning campaigns involving men which in the end increases the level of awareness and knowledge on contraception use.
- There is need for increased access and availability of family planning services in the community, this can be through opening more family planning centers to cater for women who have to travel long distances and incur costs for transport.
- More personnel should be trained in family planning for better client handling and to cater for the big number of women that require family planning.
- More out reaches should be done to remove the negative perception about family planning.
- There should be proper management of side effects and also more family planning options should be given to those with side effects.
- Religious leaders should be talked to about family planning and its benefits so that they support and encourage their congregations to use family planning.

REFERENCES

1. Agyei, W. K., & Migadde, M. (1995). Demographic and sociocultural factors influencing contraceptive use in Uganda. Journal of Biosocial Science, 27(1), 47–60.
2. Asiimwe, J. B., Ndugga, P., Mushomi, J., & Manyenye Ntozi, J. P. (2014). Factors associated with modern contraceptive use among young and older women in Uganda; a comparative analysis. BMC Public Health, 14(1), 926.
3. Bellizzi, S., Sobel, H. L., Obara, H., & Temmerman, M. (2015). Underuse of modern methods of contraception: underlying causes and consequent undesired pregnancies in 35 low- and middle-income countries. Human Reproduction, 30(4), 973–986.
4. Bishwajit, G., Tang, S., Yaya, S., & Feng, Z. (2017). Unmet need for contraception and its association with unintended pregnancy in Bangladesh. BMC Pregnancy and Childbirth, 17(1), 186.
5. Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: unnecessary maternal mortality. Reviews in Obstetrics & Gynecology, 2(2), 122–6.
6. Kabagenyi, A., Habaasa, G., & Rutaremwa, G. (2016). Low Contraceptive Use among Young Females in Uganda: Does Birth History and Age at Birth have an Influence? Analysis of 2011 Demographic and Health Survey. Journal of Contraceptive Studies, 1(1).
7. Mustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., … Munroe, E. (2015). Family Planning Knowledge, Attitudes, and Practices among Married Men and Women in Rural Areas of Mustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., … Munroe, E. (2015). Family Planning Knowledge, Attitudes, and Practices among Marr. International Journal of Reproductive Medicine, 2015Mustaf, 1–8.
8. Naik, R. (2015). IMPAOmo-Aghoja, L. O., Omo-Aghoja, V. W., Aghoja, C. O., Okonofua, F. E., Aghedo, O., Umueri, C., … Inikori, K. A. (2009). Factors associated with the knowledge, practice and perceptions of contraception in rural southern NigeriaOmo-Aghoja, L. O., Omo-Agh.
9. Omo-Aghoja, L. O., Omo-Aghoja, V. W., Aghoja, C. O., Okonofua, F. E., Aghedo, O., Umueri, C., … Inikori, K. A. (2009). Factors associated with the knowledge, practice and perceptions of contraception in rural southern Nigeria. Ghana Medical Journal, 43(3), 115–21.

10. Ortiz-Ortega, A., García de la Torre, G., Galván, F., Cravioto, P., Paz, F., Díaz-Olavarrieta, C., Cravioto, A. (2003). Abortion, contraceptive use, and adolescent pregnancy among first-year medicMustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., Mustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., Munroe, E. (2015). Family Pla. Revista Panamericana de Salud Pública, 14(2), 125–130.
11. Osmani, A. K., Reyer, J. A., Osmani, A. R., & Hamajima, N. (2015). Factors influencing contraceptive use among women in Afghanistan: secondary analysis of Afghanistan Health Survey 2012. Nagoya Journal of Medical Science, 77(4), 551–61.
12. Sherif, K. (1999). Benefits and risks of oral contraceptives. American Journal of Obstetrics and Gynecology, 180(6 Pt 2), S343-8. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10368519
13. Tawiah, E. O. (1997). Factors affecting contraceptive use in Ghana. Journal of Biosocial Science, 29(2), 141–9.
14. WHO | Preventing unsafe abortion. (2014). WHO. Retrieved from http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/
15. WHO | Family planning/Contraception. (2017). WHO. Retrieved from http://www.who.int/mediacentre/factsheets/fs351/en/
16. Sample Size Determination Using Krejcie and Morgan Table - KENPRO. (n.d.). Retrieved September 4, 2017,from http://www.kenpro.org/sample-size-determination-using-krejcie-and-morgan-table/
17. Kiryandongo Hospital | Ministry of Health. (n.d.). Retrieved August 30, 2017, from http://www.health.go.ug/content/kiryandongo-hospital
18. Trends in Contraceptive Use Worldwide 2015. (n.d.). Retrieved from http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf
19. World Fertility Patterns 2015. (n.d.). Retrieved from http://www.un.org/en/development/desa/population/publications/pdf/fertility/world-fertility-patterns-2015.pdf
20. Uganda Demographic and Health Survey 2016 Key Indicators. (n.d.). Retrieved from https://dhsprogram.com/pubs/pdf/PR80/PR80.pdf

APPENDIX I: MORGAN'S TABLE

Table 3.1

Table for Determining Sample Size of a Known Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	1000000	384

Note: N is Population Size; S is Sample Size *Source: Krejcie & Morgan, 1970*

APPENDIX II: PARTICIPANT CONSENT FORM

Date: ……

(Day/Month/Year)

Dear Participant,

I am Masembe Kenneth a student at Kampala International University pursing a Bachelors of Medicine and Surgery.

I am conducting a study to assess the factors affecting contraceptive use among women attending obstetrics and gynecology clinic in Kiryandongo hospital. The researcher hopes that the findings of this study will help determining the factors that affect the use of contraceptive methods and therefore figure out a solution to encourage more women to use contraception in the future. The data from this study will be published in the form of thesis. It is likely that portions will be used in subsequent academic publications. However, no individual answers will be exposed; all the information provided will be kept confidential. To try to achieve confidentiality and anonymity, do not write your names on the questionnaires. Your participation is voluntary and if you do not want to take part in the study, you are free not to. No one will penalize you if you refuse to participate. Please feel free to respond genuinely and if you decide to withdraw from the study any time after its commencement, you won't be stopped. As a volunteer to the study, you are requested to sign the attached consent section below.

Thank you.

CONSENT FORM

I have read and understood the description provided above. I consent to participate in the study described above; I understand that I may withdraw this consent at any time.

Participant's signature/ Thumbprint of the participant ----------Date ----------

Investigators name ----------Signature ----------Date --------

APPENDIX III: QUESTIONNAIRE

***PART ONE*: <u>DEMOGRAPHIC DATA</u>**

Age……. Tribe…… Occupation…….

Please circle round option of choice.

Religion

A) Muslim

B) Catholic

C) Protestant

D) Others……

Education level

A) Illiterate
B) Can read and write
C) Primary level
D) Secondary level
E) Others…….

Marital status

A) Unmarried
B) Married
C) Divorced
D) Widowed

Marriage type;

A) Monogamous
B) Polygamous

PART TWO: KNOWLEDGE ASSESSMENT

Please circle round option of choice and answer where appropriate.

1. Have you ever heard of contraception?

    a. Yes
    b. No

2 .Which methods of FP do you know?

    a. Pills
    b. Implant
    c. Injectable
    d. Condom
    e. IUDs
    f. Other, specify…….

3. What are the important reasons that a woman should use FP?

    a. Prevention of unwanted pregnancy
    b. Child spacing
    c. Prevention of STI/HIV
    d. To limit family size
    e. Others (specify)……

4. Do you know where to get the contraceptives?

    a. yes
    b. No

4a. if yes, where is that?

a. Health Centre.
b. Pharmacy
c. Traditional healer
d. Community based distributors
e. Private physician
f. Others (specify)…….

PART THREE: ATTITUDE, PRACTICE AND OTHER QUESTIONS ON THE USE OF CONTRACEPTION.

Please circle round option of choice. You may circle more than one if many options apply

5a. Are you using contraception (Family planning)?

a) YES b)NO

5b. if no; why are you not using family planning?

a. Am not sexually active
b. My religion does not accept family planning
c. I do not have access to family planning services
d. My culture does not support family planning
e. I fear the side effects of family planning
f. My partner does not support it
g. I was advised by my peers not to use family planning
h. I was advised by my family not to use family planning
i. Family planning use leads to some disease conditions

Others……

6. If yes; which method are you using?

a. Pills
b. Implant
c. Injectable
d. Condom
e. IUDs

Other, specify……..

7a.Whom do you think should make a decision to use family planning?

a. Jointly
b. My partner
c. me
d. I do not know

7b. If your partner refused you from using family planning, would you stop?

a) YES b)NO

8a.Does the distance from the nearby family planning health service facility affect your use of contraception?

i. YES b) NO

. 9. What are the major weaknesses you have observed so far with the family planning services offered?

a. Lack of contraceptive supplies
b. Shortage of skilled man power
c. Poor client handling
d. Poor outreach/ awareness of family planning to the community
e. Other reasons…….

10. For the following questions tick 10a-10h. No. 1 meaning strongly disagree, No. 2 meaning Disagree, No. 3 meaning Neutral, No. 4 meaning Agree, No. 5 meaning strongly agree.

No.	Question	1	2	3	4	5
10a.	Will having too many children guarantee generational continuity?					
10b.	Should high infant/child mortality be compensated by too much birth?					
10c.	Will having too many children help improve the income of the family?					
10d.	Does child spacing help protect the health of mothers and children?					
10e.	Does contraceptive use cause infertility in women?					
10f.	Should men share the responsibility of family planning use?					
10g.	Does FP help a mother to regain her strength before her next baby?					
10h.	Does having many children give you respect in your community?					

THANK YOU VERY MUCH FOR YOUR PARTICIPATION

APPENDIX IV: MAP OF UGANDA

APPENDIX V: MAP OF KIRYANDONGO.