KNOWLEDGE, ATTITUDES AND PRACTICES STUDY OF FEMALES IN CHILD BEARING AGE TOWARDS FAMILY PLANNING IN MAYUGE TOWN COUNCIL

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DEGREE OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY (MBChB) OF KAMPALA INTERNATIONAL UNIVERSITY.

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DECLARATION

I, BASEMBEZA ASUMAN REG NO BMS/0071/82/DU

A student of MBChB, faculty of health science do here by solemnly declare that this research has not been presented to any institution either in part or wholly for the award of an academic qualification .

The study was entirely result of my own independent investigations. However, various sources of in formations were used as indicated in the texts and references with permission from relevant authorities.

Name Basembeza Asuman

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Sign : ……

Date:……...

ACKNOWLEDGEMENT.

I wish to acknowledge the contribution of the following institutions and persons toward the success of this research work;

The government of Uganda particularly the Ministry of Education and sports, the Ministry of health and the Kampala International university in their various capacities for the different forms of support and contributions, they offered to me in order to make this research study a success.

My supervisor who worked tirelessly to offered his time to guide me in compiling this research .

To all the teaching and non teaching staffs of the Kampala international university.

Special regards goes to all my friends at all levels of academic training institution colleges and schools where I have been.

I finally give my high thanks to the almighty God who provided me with the wisdom to carry out this study.

ATTESTETION.

This was to confirm that this Research title Kap study of Females in Child bearing age toward Family Planning in Mayuge Town Council was conducted by Mr. Basembeza Asuman registration number BMS /0071/82/DU was supervised by:

Professor……..…….

Sign:…….

Date; ……

DEDICATION

The booklet is dedicated to the following persons:

My father Mr.Mukama Nathan Balyanango oF Iganga Namungalwe

My wife Shaidha Nakimuli

My brother in law sheikhe Asharif Kigozi ,Awoli Awali

My sister in-laws Nanteza Aisha,Nabagala Saluuwa

My sister Nankwangaadia,Nankwanga Sadia,Tibiwa .

My brother Nkulebye Bumali,Mukama Robert,Kwaso,Juma kyaku

My Dear friends Mutete Julliet of BTC kampala,

My Sons Umar Nakwagala and Usthman Ukasha

To all those who are under my authority and Guadian.

Table of Contents

Chapter two

Chapter three: Study methodology

Chapter four

LISTS OF ABBREVIATIONS USED.

AIDS- Acquired Immune Deficiently Syndrome.

CBCD- Community Based Contraceptive Delivery.

CDC- Centre for Disease Control.

FP- Family Planning.

FPAU- Family Planning Association of Uganda.

HIV- Human Immune Virus.

IUD- Intra Uterine Device.

IUDS-Intra Uterine Device System.

MOH- Ministry of Health.

PHC- Primary Health Care.

STIs- Sexual Transmitted Infections.

UDHS- Uganda Demographic Health Survey.

WHO- World Health Organization.

UPR- Contraceptive Rate.

ICPD- International Conference on Population and Development.

UN- United Nations.

RH- Reproductive Health.

RHCS- Reproductive Health Community Security.

MDGs- Millennium Development Goals.

HSSPII- Health Sector Strategic Plan two.

NMS- National Medical Stores.

JMS- Joint Medical Stores.

LCV- Local Council five.

H/C- Health Care.

HDI Human development index.

KAP- Knowledge, attitude and practice.

DISH- Delivery of Improved Services of Health (2000).

LIST OF TABLES

LIST OF FIGURES

DEFINITION OF TERMS

Attitude- Way of thinking about something.

Good Attitude-positive way of thinking/ feeling or behavior towards something.

Bad attitudes- Negative way of thinking/ feeling or behaviour towards something.

Intrauterine Device System- The small coiled material inserted inside the uterus to prevent conception by releasing contraceptive hormones into the blood stream.

Contraception- Practice/methods of preventing pregnancy.

Contraceptive- Device or Drugs used to prevent unwanted pregnancy.

Conception- Pregnancy.

Vasectomy- Surgical resection of male (Vas deferens) to stop release of sperm outside through the penis.

Tubal ligation- Surgical resection of the female fallopian tubes to stop the movement of egg to meet sperms.

Condom- A thin rubber tube closed at one end which is worn on male penis or put inside the vagina during intercourse.

Abortion-Is the expulsion of product of conception before the age of viability which varies from country to country.

Castration-Removal of male testacles.

Lactational amenorrhea-Regular breastfeeding at least 8times in 24hours to prevent fertility resumption and method of contraception in lactating mother.

Unmet need-The gaps to be filled to meet the expectation.

ABSTRACT

Uganda has a population of approximately 29.6 million people, of which almost 6 million are women of reproductive age (15-49 years) (Uganda Bureau of Statistics [UBOS], 2007). The annual growth rate is approximately 3.2 percent (UBOS, 2006), and the total fertility rate (TFR) (measured in the 2006 Uganda Demographic and Health Survey [UDHS]) remains high at 6.7 children per woman. As a result, Uganda is the third fastest growing country in the world (United Nations Population Division [UNPD], 2005).

Researchers have identified several reasons why women who do not want to become pregnant do not use contraceptives. These include little perceived risk of pregnancy, health concerns about contraceptives and side effects, opposition to use (from husbands, families, and communities), poor access to and quality of family planning supplies and services, and lack of information (Ropey et al., 1996; Govindasamy and Boadi, 2000; Westoff, 2001; Drennan, 1998).However, these reasons had not been studied localy in Mayuge town council.

The results from this study have revealed that the majority of the populations do not accept family planning practice even if they have wide Knowledge. Their attitudes are guided by cultural and the religious values.

The main aim of this study was to find out the knowledge, attitides and practices of females in reproductive age towards family planning services in Mayuge Town Council –Mayuge district.

This was a descriptive cross sectional study to determine the knowledge, attitude and practices of the females in child bearing age groups towards family planning in Mayuge town Council. In the study (250) two hundred and fifty respondents were randomly selected and interviewed using designed pre-tested questionnaires.

It is anticipated that the results from this study will be used by different partners in health sector like ministry of health , Reproductive health Uganda, Mariestops Uganda among others in designing better programs that address knowledge,attitudes and practices gaps that were identified.

CHAPTER ONE

INTRODUCTION

1:1 **Definition**

Family planning is a term used to indicate deliberate spacing of children to allow long term birth interval (CH Hood, DH, DC Glenville and JP. Vaughan community health).

Family planning refers to the practices that help the individual or couples to achieve their objectives and to avoid un wanted birth, regulate birth interval between pregnancies determine the time at which birth should occur in relation to the age of the parent and to determine the number of the children in the family of which the parents are capable of supporting.

1.2 (a)Back Ground

Historically, Family planning was declared as an element of primary Health Care (PHC) in the former USSR during the 1978 Alma-Ata conference. Here the word community committed herself to address the problems that come as a result of poor family planning. In Uganda it remainedun implemented until 1986 when the NRM government committed itself for the implementation of programme. In 1988, family planning was clearly observed in existence and in 1993 a report obtained from the family planning association of Uganda (FPAU) had shown its development.(Uganda Demographic and Health survey 1995 quoted by Mr. Ogwal Richard in his pamphlet of2010).

During the 20^{th} to the beginning of 21^{st} century, medical advances such as the use of vaccines antibiotics and better nutrition, couple with other socio-economic developments have greatly improved the health conditions of many people.In fact mortality rate has gone down and life expectancy has increased.

In Africa the average life expectancy at birth is 49 years and infact mortality rate average is 149 per 1000 live births.The maternal mortality rate is estimated to between 110 to 647 deaths per 100,000 live births.

The estimated population of the world in 1995 was 5,702 billion and the population growth rate was 1.5% per year, this increase in population was substantially adding 234,000 more people every day and about 10,000 more people every hour .should this growth rate of 1.5% continues, the population of the world will be 12 billion in 50 years. And it will be 25.3 billion in 100 years. (Source family planning method and practice in Africa CDC 1999).

According to Helen Clarke (UNDP) Administrator and Denishprime minister Helen ThorningSchnidt in Copenhagen on population reports ;(Title a Better future for all 3/11/ 2011) Uganda population growth rate was said to be 3.2% the highest in the world with about six children per every fertile female and there were already observed effects directly on environmental resources with forest coverage reduction of 6% in the last twenty five years. The Uganda population was projected to be 50M in ten years. Uganda was placed under low human development cater gory number 161 out of 187 world poorest countries in ranking on Human development index (HDI) and number 3 in East Africa after Tanzania .Source (UNDP Website). On the other hand the Uganda demographic health survey (UDHS) of 2006.

Contraceptive rate (UPR) which refers to the percentage of married women who were using any method of family planning was a dismal 24%.At 41% Uganda's unmet need for family planning is the third highest rate in the world. (Family Planning Association of Uganda website 2010). In mayuge District the total number of women age in 2010 was 71351 and the number of women using contraceptive in child bearing age was 5541 in 2011 giving the percentage of 7.7% (mayugeDistrict annual health report 2009).

(b) Types of family planning method

Family planning methods are divided into two broad group namely, natural and artificial method, both of which aim at delaying and stopping pregnancy respectively.

The artificial methods include barrier, surgical, and hormonal. While the natural methods include lactation amenorrhea, coitus interrupters, safe days and abstinence during fertile (danger) periods. The barrier methods include use of intra uterus devices, condoms, and diaphragm. Hormonal method includes; inject able, Depo-Provera, IUDS, oral pill, and Norplant.

And finally the surgical method or the permanent method includes vasectomy for male and tubal ligation for female.

1.3 Statement of the Problem

The family planning as an element of primary health care is still poorly practiced worldwide. Looking at the problem of unwanted pregnancies high rate of abortion and its complications as well as uncontrolled population increase; the estimated population of the world in 1995 was 5,702 billion and the population growth rate was 1.5% per year. This increase in population was substantially adding 2,340,000 more people every day and about 10,000 more people every hour.

Should this growth rate of 1.5% continue the population of the world will be 12.3 billion in 100 years to come. (Source family planning method and practice in Africa CDC 1999). Also the UNDP report 2011 by Administrator Helen Clarke put Uganda population growth rate at 3.2% the highest in the world.(UNPD website).

On other hand the Uganda demographic health survey (UDHS) of 200 Contraceptive rate (CPR),Which refers to the percentage of married women who were using any method of family planning was a dismal 24%

At 41% Uganda's unmet need for family planning was the third highest rate in the world. (Family Planning Association of Uganda 2010 website.).

In Mayuge district the total number of women in child bearing age in 2012was 71351 and the number of women using the contraceptive in child bearing age was 5541 in 2012 giving percentage of 7.7% (mayuge District annual health report 2012).

The adequacies of family planning services become more apparent as the world population is expected to double in a half century. The majority of the populations do not accept family planning practice even if they have Knowledge, their attitude are guided by cultural and the religious values.

1.4 Hypothesis

Inadequate of family planning services doesn't affect the social economic activities of any place.

1.5 The Purpose of the Study

To assess the knowledge attitude and practices of women in child bearing age in mayuge town council towards family planning.

1.6 Objective of the Research

A. To assess the knowledge and attitude of females in child bearing age groups in mayuge town council about family planning.
B. . To describe family planning practices of females in child bearing age groups in mayuge town council.
C. To determine the factors influencing the knowledge attitude and practice of females in child bearing age groups in town council towards family planning

1.7 Research Questions

A. To what extent do the females in child bearing age groups in mayuge town council have knowledge and attitude about family planning method and services?
B. what are the attitudes that women in the child bearing age in mayuge town council towards family planning ?
C. What are the practices of the females in child bearing age in mayuge town council towards family planning?

1.8 **Research Justification**

Family planning in many part of the world has been looked at as problem facing women; the male involvement was lacking and must be emphasized.

To plan a good family planning services needs a through understanding of what people know about family planning services their feeling perception and what they are doing about family planning for their families.

On the other hand reports by Helen Clarke UNDP Administrator in Copenhagen 3/11/2011 put Uganda population growth rate at 3.2% the highest in the world source (UNDP) website. Also according to the Uganda demographic health survey (UDHS) of 2012, contraceptive rate (CPR) which refers to the percentage of married women who were using the contraceptive is a dismal 24 %.

At 41% Uganda unmet need for family planning is the third highest rate in the world.

The mayuge district annual health report 2012 shows that the percentage of women on child bearing age group stands at 7.7%.

Therefore there was need to define the knowledge, attitude and practices in this town so that the health authorities, government must translate the national and International commitment into concrete action by increasing, guaranteeing, financing and improving the logistics system, procurement and effective service delivery to enable mayuge town council, district to realize their reproductive right.

Ensuring access to high quality reproductive health information, products and services, requires commitment not only in policy but also in action.

CHAPTER TWO

LITERATURE REVIEW

This chapter review related literature about knowledge, attitudes and practices about family planning. It has been discussed in different sections as below;

2.1 ATTUTUDE AND KNOWLEDGE IN FAMILY PLANNING.

Attitudes to family planning and to contraceptive methods have changed tremendously since the beginning of the 20th Century and it is now an accepted medical discipline. In most part of the world individuals have the privilege of making their decisions about their family size and the method they wish to use.

But cultural, religious and personal social constraints are still great. Attitudes are driven by these values.

The FP providers, whose role is to ensure the acceptability, efficiency and Medical safety of the chosen method, should respect the choice of the users.

(Contraception and sexuality in health, and disease by K.EstherSapire).

It has been found out that 65% of the population in developing world or approximately 2.9 billion people live in rural areas where total fertility rates and infant mortality rates are often double that of urban areas.. Even though rural to urban migration is increasing the size of the urban population, people living in rural areas will out number urban inhabitants until some years between 2010 and 2025 , and most of the unmet demand for family planning services are in the rural areas and is likely to remain there in to the foreseeable future. This is partly because they lack knowledge about family planning and have limited access to services. Positive attitudinal change is fundamental.

Earlier skepticism about whether family planning programme would be acceptable in rural areas where children are valued for the contribution they make to family income has slowly been dispelled as the average family size has declined in some countries with predominantly rural populations. (Manual by Janice Mike and James Wolf 1994. Page 9).

2.2 PRACTICES OF FAMILY PLANNING.

Some recorded literature in the bible includes a story of Onan the son of Judah describing the practice of Coitus-inter raptor on his brother's wife to avoid pregnancy.

During the 19th Century, condoms made of sheep cesium were being used as a birth control measure. Lawanga (1965) mentioned a few of the contraceptive practices in the Africans, lying facing downwards after intercourse to help flow of semen out of the vagina and pumping up and down immediately after intercourse to facilitate the flow of semen out of the vagina.

He further observed that on the African continent, plants, dried parts of dead animals, and behaviors that directly or indirectly affect fertility have been used. (Family planning method and practices in Africa, CDC, 1999).

Traditional family planning method/ practices used to space children have been rich and varied. The creative and occasionally life threatening techniques used to limit child bearing shows how desperately women and men tried to control certain societal values to increase the like hood of male and female infertility. For example, male genital mutilation (castration) was an ancient practice that made them incapable of impregnating women.(Family planning method and practices in Africa, CDC, 1999).

Despite the availability of modern contraceptives, the traditional practices have been used throughout history and still in use today. There is need to assess the effectiveness and safely of these practices and to compare and contrast with the modern methods of contraceptives available.

Historically, people have many methods of control their fertility. The use of these methods makes it evident that people believe in their ability to regulate their fertility and have seen a benefit in doing so for quite some time. (Source: Family planning methods and practices in Africa, 1983.

Reprinted, 1984, Page-20).For example, postpartum abstinence together with lactation amenorrhea was the most important of these practices in Africa. Surveys done indicated that lactation amenorrhea and postpartum abstinence are still important due to their effects on fertility in some parts of Africa.(family planning methods and practices in Africa, CDC, 1999).

Other example included the value on virginity in many areas, which prohibit the beginning for sexual activity until a girl is married. Another practice that affects fertility and is commonly encountered in heavily Islamic areas of Africa is the female circumcision. While another method is the withdrawal of the penis prior to ejaculation, but this has a high failure rate.(Family planning method and practices in Africa , 1983, reprinted 1984).

Giving birth is something in which mankind and animal are equal but rearing the young and especially educating them for many years is a feature unique , a gift and responsibilities of man. It is for this reason that makes it important for human beings to put emphasis on caring for children and the ability to look after them properly rather than thinking only about the number of children and the ability to give birth.

It often happens that a man’s ability to give birth is always greater than his ability to bring up the children in a proper way, said the former Tanzanian president, Mzee Julius Nyerere. (source: Community health , By CH. Hood De Glanville, and JP. Vanghan, 1997).

In the 19th Century and early 20th Century, sterilization was a major operation that involved the hazards of anesthesia and abdominal surgery and required lengthy hospitalization.

But as people have become accustomed to making decisions about contraceptive practice in Family planning, it has therefore become a permanent method of Family planning increasingly accepted by many couples who don't wish to have any more children. Vasectomy and tubule legation has become popular methods of contraceptive practiced around the world today. For instance, it has been found that 1/3 of the contraceptive users practiced it and 1/8 of the couples in reproductive age have been sterilized (Stephan 1981). Acceptance rose from 3 million in 1951 to 90 million in 1979 (MUM LORD 1980). Ward (1981) predicted that 400 millions sterilization would be performed by the year 2020 around world.

(Contraception and sexuality in health and disease by K. Ether Sapire 1983).

2.3 IMPORTANCES OF FAMILY PLANNING

The links between reproductive health and social- economic development were first clarified at the landmark international Conference on Population and Development (ICPD) held in Cairo in 1994 and have since been cited by the UN and World Bank.

The ICPD programme of action made reproductive and sexual rights a priority and explicitly stated that it is the right of all men and women to be " informed and to have access to safe, effective , affordable, and acceptable methods of family planning of their choices, as well as other methods of choice for regulation of fertility, which are not against the law", and that they have " the right of access to health care services that will enable women to go safely through pregnancy and child birth"

In addition, national legal instruments and policies oblige the state of Uganda to ensure all Ugandans realize their fundamental rights, including the right to health .The constitution gives government the responsibility to fulfill the fundamental rights of all Ugandans to social justice and economic development. This requires government to do every thing in Policy,law and action to ensure people can access a health services .(Source: Uganda national family planning association website 2012).

For instance, the National Population Policy (2008) recognizes that all couples and individuals have the basic right to decide freely and responsibly the spacing of their children, and to have access to information and education in order to make an informed choice, and the means to do so.

It recognizes that health, in particular reproductive health, is a basic human right, and specifically points out the importance of commodity security and increased budgetary allocation for reproductive health.

Uganda has policies and guidelines that guarantee access to reproductive health services and commodities to enable all Ugandans realize their sexual and reproductive health rights, but disinterest among political leaders and policy markers has undermined implementation.

Basing on the findings of the Ministry of health's reproductive health commodity analysis of December 2008 and a June 2009 case study report of reproductive health supplies by population Action international, this paper outlines the current challenges in accessing Reproductive health commodities and the need for stronger commitment to change the situation.(Uganda national family planning association website 2012.

Secure and sustained access to quality and affordable reproductive health (RH) commodity supplies is a critical driver of reproductive and sexual health. The concept of reproductive health commodity security (RHCS) requires that every person should be able to choose, obtain and use quality contraceptives, medicines and other medical products for prevention and treatment of STIs, and to ensure healthy pregnancy and delivery whenever they need them.

The potential health impact of availability and access to essential reproductive health commodities is the foundation for the wellbeing of individuals and families. Simple iron folate preparations can reduce maternal and child mortality from pregnancy- related anemia and family planning can reduce the rate unintended pregnancies and risky abortions.

Guaranteed access to these commodities is therefore necessary if Uganda is to make visible progress on the Millennium Development Goals (MDGs) and the goals set in the programme of Action of the 1994 UN internationalConference on Population and Development (ICPD). (Uganda national family planning association website 2012)

It is important to emphasize that it is impossible to have commitment to reproductive health without commitment to RHCS. Such commitment is empty and deceptive.

The Ministry of Health underscores the critical role of RHCS in attaining better reproductive health status and sustaining services,as stated in the strategy to improve Reproductive Health in Uganda (2005-2010), and the National Family Planning advocacy Strategy.

The second health sector Strategic Plan (HSSPII) targets an increase in contraceptive prevalence rate (CPR) to 40% from the current 23%, full availability of condoms (100%), eliminate drug stock- outs, including RH commodities in 80% of health units, and provide emergency contraceptives in 60% of health units – all by end of June 2012

In spite of these and other policy commitment and promises, stock-outs of all drugs, including RH commodities, occurs regularly. According to the Annual Health Sector performance report 2005/06, 73% of health units had a monthly stock- out of one more tracer RH commodities and availability had actually deteriorated over last two years, as the unmet need for reproductive

health commodities continues to rise.(Uganda national family planning association website 2012).

The annual tracking of essential drugs found that the availability of Depo-Provera, an inject able contraceptive, has varied widely in recent years, with 16% of facilities having a monthly stock-out in 2006/07. Even though the stock level of RH supplies at central level is officially described as adequate, National Medical Stores (NMS) experiences stock-out. For instance, February 2012 NMS was stocked out of one brand of implants and had an inventory of less than two weeks supply of Microgynon, an oral contraceptive, with the next shipment not expected until two months later. The stock levels of four other methods (Condoms, a second brand of implants, IUDs and a second brand of oral contraceptives) were lower than the recommended six months of supply.

What is more, Joint Medical Stores (JMS) is not alternative when RH commodities stock-out at NMS, as it is for other essential medicines, because it is Catholic founded and the Catholic Church is opposed to “artificial” family planning methods. These supply problems translate into access problems.(Source : Uganda national family planning association website 2012).

CHAPTER THREE

3.0 STUDY METHODOLOGY

3.1 STUDY DESIGN

This was across –sectional descriptive study, because this way the prevailing events would be arrived at within a point in time by administering short questions in form of questionnaire.

3.2 STUDY AREA

This study was carried out in mayuge HCIII of mayuge town council mayuge District.

3.3 STUDY POPULATION

3.3.1 Target population

The study populations consisted of females in reproductive age group in mayuge town council (15-49) years old.

3.3.2 Accessible population

All females educated and non-educated shall be considered.

All ladies from any religious denomination shall be considered

All females residents in town council in child bearing age group irrespective of tribe, occupation,socio economic status will be considered

3.4 SAMPLING METHOD

The choice of mayuge town council was by purposive non random sampling, (250) tow hundred fifty respondents was selected by systematic random sampling method of which (N /250)is be used.

3.5 Sample size

According to population office of mayuge District, it was estimated that mayuge town council has a population of 2500 women in child bearing age. There 250 women were randomly selected to participate in this research

3.6 .**TOOLS FOR DATA COLLECTION**

The researcher developed a questionnaire which was pretested and re adjustmentmade appropriately.

The question was written in English and interpreted in local language (Lusoga) to those who don't know English and medical term. And the data was cleared for coding; a total of two hundred fifty respondents were used.

3.7 .DATA ANALYSIS

The data was processed by Epic data and exported (SPP) and then to excel.

It was then be analyzed and the finding presented in form of percentage table pie chart bar chart and statement as appropriate with the aid of a computer.

3.8 ETHICAL CONSIDERATION

A letter was written from the University to the district authorities.

(The mayuge district LCV, town Mayor, and District health officer).

The informed consent was sought from respondents before the administrations of the questionnaire confidentiality, privacy and respect was observed for the respondents.

3.9 STUDY INCLUSSION

- The study included females' of reproduction age groups only (15-49) years old
- Females' respondents of all walks of life respective of religion, academic back ground, culture and political dimension were considered.

3.10. STUDY EXCLUSION

- The Women above 49 and girls below 15 years old were not considered.
- The Men were not considered

CHAPTER FOUR

BACK GROUND (PROFILE) OF THE DISTRICT

4.1: LOCATION.

The study was carried out in mayuge town Council mayugeDistrict Which is found in the republic of Uganda, located in the Eastern region. It lies between longitudes 29^0 - 42^0 East and latitudes 4^0-5^0 North.

The district is boarded by Iganga district from the North, Bugiri from the East, Jinja from the West and south Lake Victoria which shared by Mukono District,Bugiri,Mayuge itself and Jinja.

Mayuge district has a total land area of approximately 4672.22 sqkm. (District planning and population Office 2012)

4.2: DEMOGRAPHY.

The population of Mayuge district according to district annual report 2010was estimated to be 494118 people and Mayuge town council was estimated to have 5452 people of which 7407 were males and 8045 were females.The district population density was 317 persons,51.2% of the population is female while 48.8% are male.

4.3 :THE HEALTH INDICATOR.

The District has latrine coverage of 30% and a safe water coverage of 44% . The life expectancy at birth was 45 years with female having 46 and male 44 years.

The maternal mortality rate of district was 536per 100,000 life birth while the infant mortality rate was 136 children per 1000 life birth and population growth rate was at 2.8 %.(District of district health services Office 2013

4.4 :CLIMATE AND RELIEF.

Climatically, the district has a savannah grassland type of climate with two seasons and a mono modal rainfall pattern.The wet (rainy) season begins from April to November with the highest peaks of rainfall in the months of May, August and October.

The dry season range from December to March. However there may be slight variation in these patterns of the season throughout the year.

The average rainfall for the district is 130 mm per year. Average temperature is about 22^0c the relative humidity is high especially during the wet season.

Mayuge district has a gently rolling land space with a number of residual hills in the Eastern part of the district boarding Bugiri(District planning and population office 2009).

4.5:SOCIAL-ECONOMIC BACKGROUND.

Ethnically the Busoga tribe predominately occupy Mayuge but all the other tribes of the republic of Uganda were also living in mayuge district especially in the mayuge town including foreigners.

The major economic activities of the people in the district include a arable farming and live stock rearing. Arable farming was practiced at subsistence level basically for house hold consumption with a small proportion being sold to get money for purchasing essential commodities.

The common crops grown were , maize, rice, bean, potatoes, cassava and vegetables, just to mention but a few. The major livestock include cattle, goats, sheep's and pigs for milk and meat with a small proportion sold in the market. Poultry farming was also practiced both for domestic and commercial purposes.

A small proportion of the populations were engaged in small scale business activities in the sales of essential commodities. Meanwhile other people work as civil servants with the government and non-government organizations. This kind of situation put the entire population of the district in a low level of socio economic status, with an average house hold income of approximately 300,000/= Uganda shillings per year (District planning and population office 2013).

4.6 : HEALTH SERVICES.

The district has got two HC1v health centers one non government hospital many privately owned clinics especially with in the town and major trading centers. However some of these health units provide facilities for family planning services.

It was also important to note that the family planning services provided by these health units were limited to only a few methods.

The district has two H/C IV two H/C II and seven H/C III.Of the two H/C IV found in the district, one is catholic founded hospital which actually is the one handling more medical cases but does not provide the family planning services.(District Heath officer office,2013).

4:7: THE POLITICAL SITUATION.

The district has enjoyed relative peace since its birth though this peace has not been translated into development in general terms.

CHAPTER FIVE:

STUDY FINDINGS.

This chapter presents study findings which have been summarized in form of tables and figures.

Table one: Distribution of respondent according to age (N=250).

Age group	Frequency	Percentage
15-24	120	48%
25-34	90	36%
35-44	33	13.2%
45-54	7	2.8%
Total	250	100

The study reveals that the majority (48%) of the respondent were in the age group of (15-24) years old.

Table two: Distribution of respondents according to marital status (N=250)

Marital status	Frequency	Percentage (%)
Married	170	68
Single	80	32
Total	250	100

The study revealed that there were more married (68%) of respondents than single respondents.

Table three: Distribution of respondents according to religious denomination (N=250).

Denominations	Frequency	Percentages%
	120	48
Protestants	75	30
Muslims	25	10
Catholics	15	6
Born Again Christians	15	6
Total	250	100

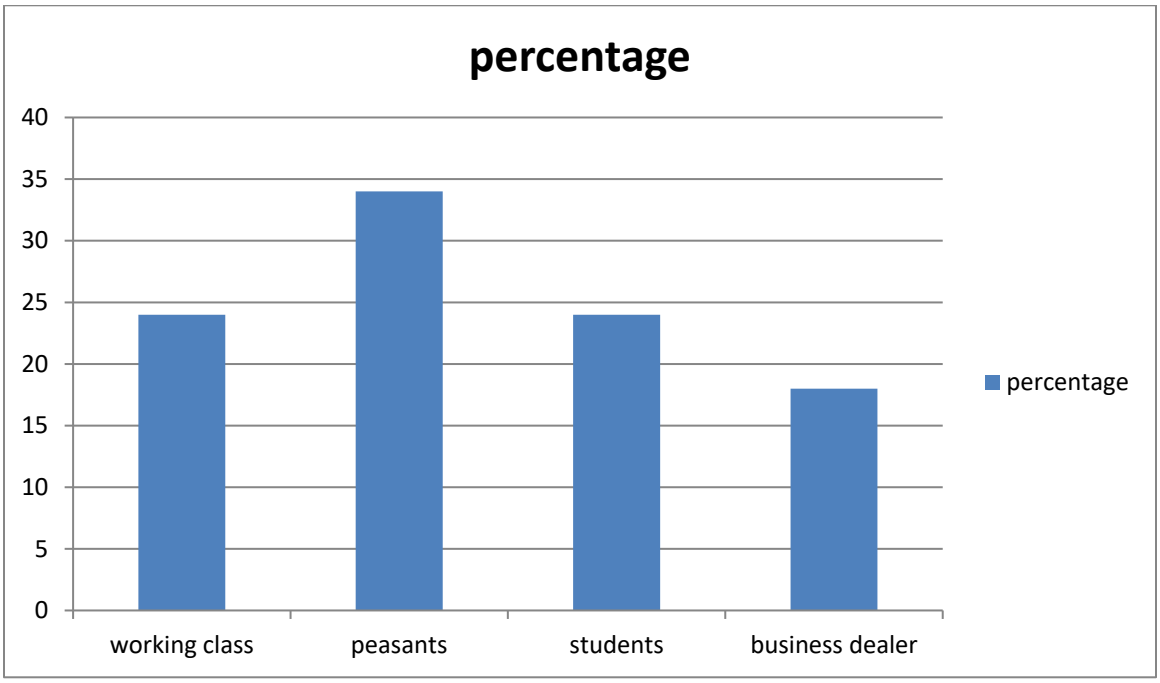
The study revealed that majority of the respondents were Catholic (48%), with minority the traditionalists and Born Again Christians each with (6%).

Table Four: Distribution of respondents according to level of education (N=250).

Educational level	Frequency	Percentage%
Not At all	55	22
Primary	75	30
Secondary	65	26
Tertiary	55	22
Total	250	100

The study revealed that majorities (75%) of respondents have been to school and only 22% of the respondents have never been to school.

Bar chart 1: Distribution of respondents according to occupation according to occupation (N=250).

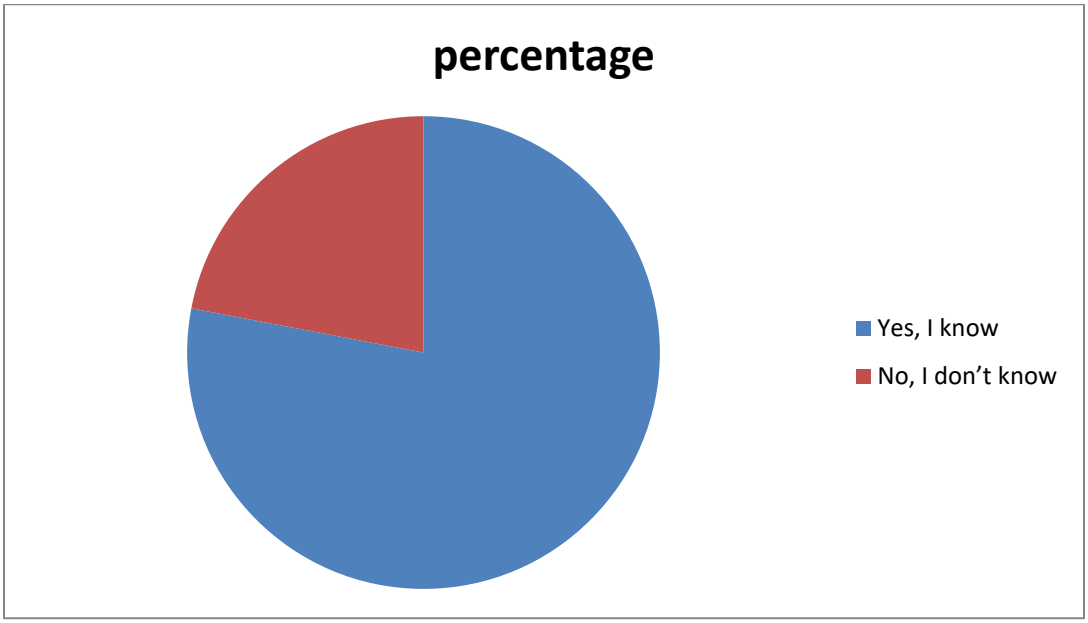


KEY:

Working class 24%, peasants 34%, students 24%, and business dealers 18%.

This study showed that majorities (34%) of the respondents were peasants and the minorities (18%) were engaged in business activities.

Pie chart 1; Distribution of the respondents according to their knowledge on family planning (N=250).

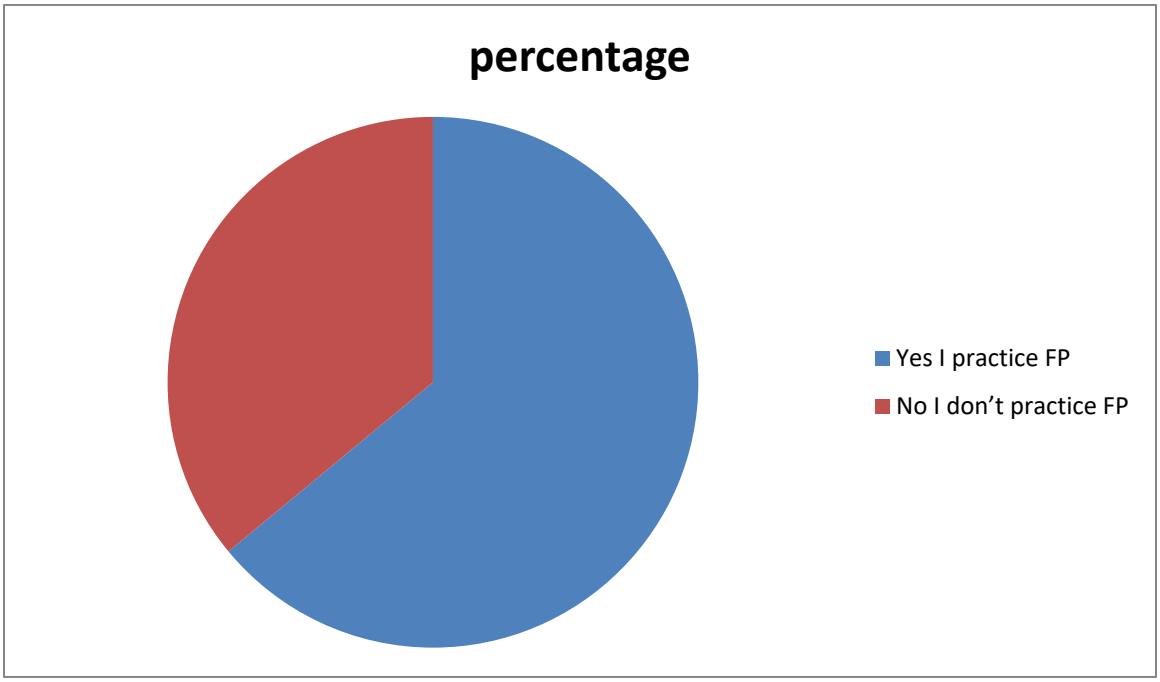


KEY;

Yes, I do know 78%, No; I do not know 22%.

The study has demonstrated that the majority 78% of the respondents had knowledge about family planning and minority (22%) had no knowledge about family planning.

Pie chart 2: Distribution of respondents according to practices of family planning (N=250).

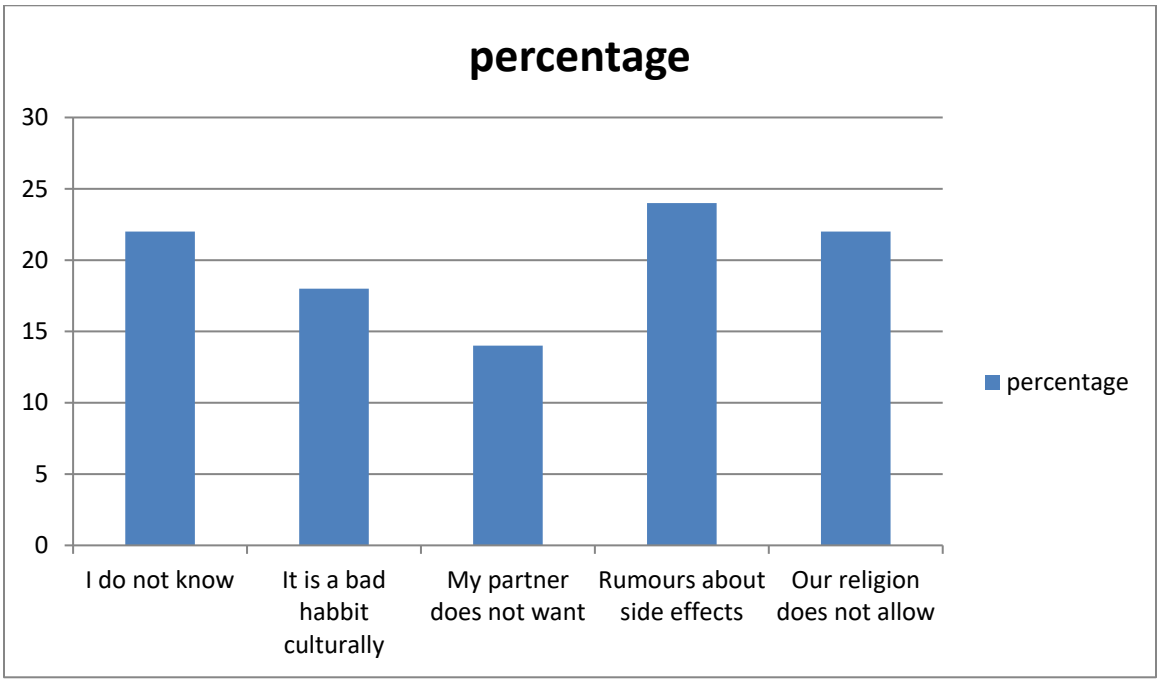


KEY;

Yes I practice FP 36%; no I don't practice FP 64%.

The study revealed that the majority (64%) of respondents were not practicing family planning while minorities (36%) were practicing family.

Bar chart 2: Distribution of the respondents according to reason why they are not practicing family planning.



KEY:

I do not know 22%, it is a bad habit culturally 18%, my partner does not want 14%, rumors about side effects 24%, and our religion does not allow 22%.

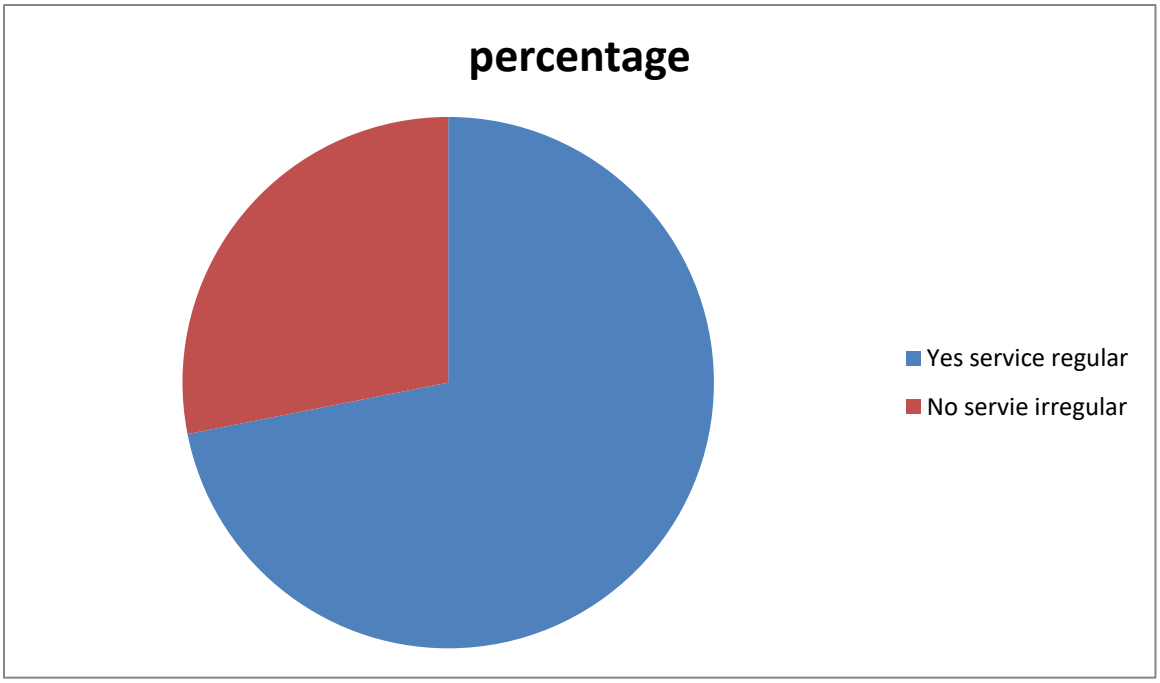
The study revealed that the majorities (24%) of respondents saw the side effects as the main reason for not practicing family planning and the minorities (14%) said it was their male partner who does not want

Table Five: Distribution of respondents according to accessibility to family planning services (N=160).

Places of services	Frequency	Percentage %
Private clinics	25	15.6
Health centers	40	25
Government hospital	75	46.9
Friends	10	6.25
NGOs	10	6.25
Total	160	100

The study showed that 46.9% of the respondents were getting the services from the government hospitals within the town while few of the respondents were getting from friends and NGOs each with 6.25%.

Pie chart 3: Distribution of the respondents according to service regularities (N=160).

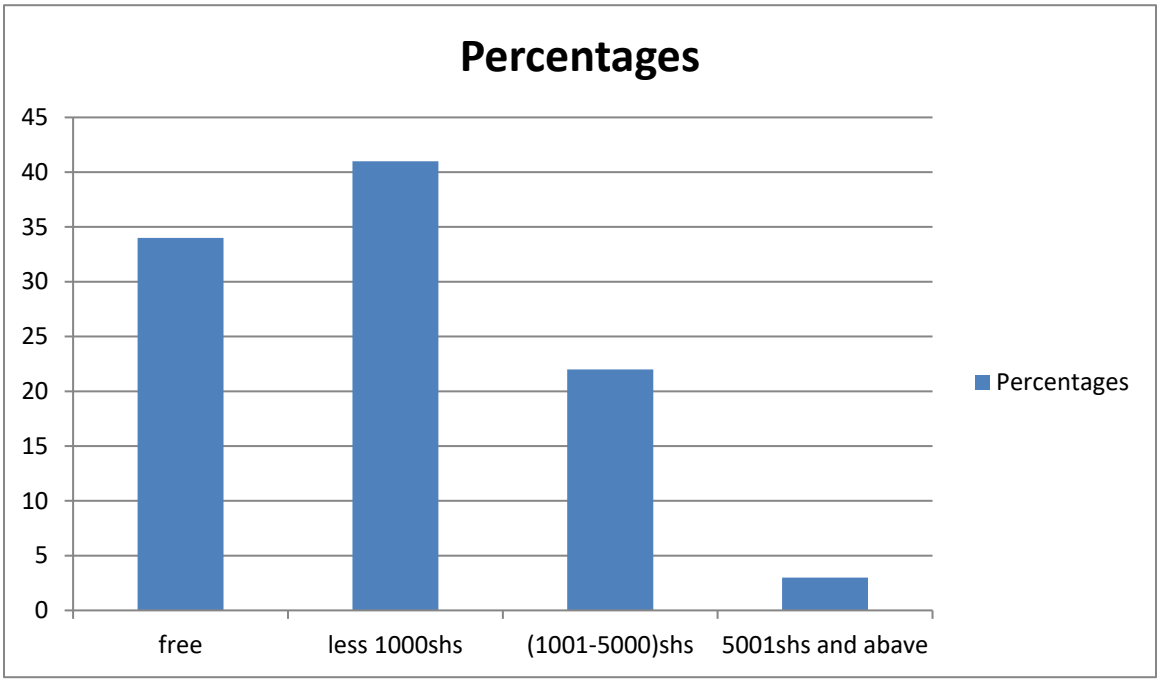


KEY:

Yes services regular 71.9% and no service irregular 28.1%.

The study revealed that a out of 160 respondents that were practicing family planning 71.9%S accepted that the services were regular while 28.1% said the services were irregular.

Bar chart Three: Distribution of respondents according to cost of family planning services (N=160).



Key; free 34%, less 1000Ushs 41 %,(1001-5000) Ushs 22%and (5001 and above) Ushs.

The study revealed that the majorities (75%) 0f the respondents were getting their services at the cost of 1000Ushs and below.

Table Six: distribution of the respondents according of distance from the service places (N=250).

Distances Kms	Frequency	Percentages%
O-5	210	84
6-10	40	16
Total	250	100

The study showed that majorities 84% of respondents were with 5Kms and below from the service places while 16% were within (6-10) Kms.

CHAPTER SIX

6.1 DISCUSSION OF THE STUDY FINDINGS.

This was a cross sectional descriptive study carried out in mayuge town Council to assess the knowledge, attitude and practices of the female in child bearing age group towards family planning.

In the survey, most of the respondents about 68% were married and 48% were below 25 years of age

These are the age group whom should be empowered with the knowledge of family planning if the town would to register improvement in the practices of family planning or reduction in population growth. Uganda as a country has 3.2% population growth rate according (UNDP 2011 Reports on population) source Website.

About 75% of the respondents have been to school and 48% of them have gone post primary. The high level of literacy in this female population was expected because of the urban setting. This could explain why the majorities of the respondents (78%) were knowledgeable about family planning and 36% of them practiced family planning.

This finding is in disagreement with the UDHS (Uganda Demographic Health Survey of 2006, which talks about contraceptive rate in married women in Uganda using any method of family planning standing at 24% (htp/www.fpau)

However, this finding is in agreement with the survey carried out in DISH districts of Uganda (2000)which stated that most respondents who were in reproductive age and have been to school were found to have better knowledge and practice of modern methods of family planning compared to other group who have not gone to school.

On the other hand the survey also revealed that the majorities of the respondents (48%) were Catholics, (30%) were Protestants, (6%) were born again Christians, (10%) were Muslims and (6%) were traditionalists.

The catholic faith does not accept the use of family planning. The town also has a very big missionary set up and a catholic founded hospital which does not provide family planning services to the people.

This hospital, although is not a district referral hospital, the entire town, District and part of that region rely on it for health services delivery. This could have attributed to the 22% and 36% of the respondents who have no knowledge and not practicing family planning respectively.

Despite all the above factors, the perception of female towards family planning is quite different, majorities of Christians (64%) were actually practicing the modern methods of family planning

irrespective of their religious affiliation, only 22% accepted religion as an influence, most female complained of cultural influence (18%), rumor about side effects (24%) and male partner influence (14%) as some of the reasons if any for not practicing family planning.

This study was in agreement with Hatcher et al (1997) which said that a number of factors may be found to influence the decision to use family planning method giving examples such as socio-economic, culture, religion, occupation and psychological factors among others.

The study also revealed that 32% of the respondents were single and 24% were students, of which some said that they were not practicing because they were still single and still in school respectively, this could explain partly the 36% of respondents who were not practicing family planning.

On the other hand the majorities of the single group value modern family planning methods as a way of controlling pregnancy as well as safeguarding against sexually transmitted infections (barrier method condoms), this could be one of the reasons explaining the 64% of the respondents practicing family planning.

The study also revealed that of the respondents who were using family planning none of them uses surgical method of family planning (vasectomy and tubule legation), note that the survival rate of children in this part the world was low, with infant mortality rate of about 136/1000 live birth and average life expectancy 46 years these poor health indicators could explain why no one was found using surgical methods.

This was in agreement with Led Cankester M. A which stated that permanent methods are used when no more children are needed and where survival rate of children is high (Manual for practice of FP in developing countries by 1999)

Also in this study, 46.9% were getting their services from Government hospital, 25% from the health centre 15.6% from private clinic and 12.5% from friends/ NGO. The later factors could explain the reason about 28.1% who expressed irregularity in service delivery as a factor of not practicing family planning. This was in agreement with the 2010 report of family planning association of Uganda (FPAU), which talks about the irregularity of the service delivery as factor for poor implementation of family planning program me in Uganda.

6.2: Conclusion

In conclusion, this study revealed that the majority of the respondents were found to be knowledgeable about family planning (78 %) but few of them (36 %) were actually using contraceptives due to poor attitudes towards family planning.

The factors that have been identified as an obstacle to decision making into the practice of family planning methods includes; lack of knowledge 22%, cultural influence18%, male partner influence14%, rumor about side effects24% and religious influence22% .

6.3: **Recommendations**.

1. The government need to facilitate health workers to intensify on health education on family planning. This should aim at improving awareness to both females and males.

2. The government should by all means try to make the supplies chain of the family planning contraceptive regular to avoid stock out problem.

3. The intersectional collaboration approaches should be adopted involving the traditionalists, opinion leaders, cultural leaders, religious leaders, political leaders and health workers if reductions in poor health indicators are to be reversed.

4. The government should collaborate with N.G.O, Donor nations to help bridge the gap in funding program me and purchasing of the contraceptives required.

5. The District health authorities should strengthen the outreach activities within the community; they should also establish a strong Community Based Contraceptive Delivery (CBCD) system to help bridge the gap of service delivery.

6. The Ministry of Health (M.O.H) should encourage more research in all aspects of Primary Health Care (P.H.C) especially family planning service, there is a clear link between family planning and socio economic development the high fertility rate directly dictates on environmental resources.

QUESTIONNAIRE

TOPIC. The knowledge Attitude and practices of females in reproduction age group towards family planning in Mayuge town council.

INSTRUCTION.

1. Answer all questions
2. Tick the answer of your choice
3. Use the blank spaces provided to write where need be.

DEMOGRAPHIC DATA.

1. What is your respondent's number ……
2. How old are you…….
3. What is your occupation?

   Working class ☐ Farmer ☐ student ☐ Business dealer ☐
4. Are you married?

   Single ☐ Married ☐
5. What is your religion?

   Protestant ☐ Catholic ☐ Muslim ☐ Traditionalists ☐

   Born Again Christians ☐
6. What is your level of education?

   Not at all ☐ Primary ☐ Secondary ☐ Higher institution ☐

KNOWLEDGE OF FAMILY PLANNING

7. Do you know family planning?

   Yes ☐ No ☐

   if yes, explain …….
8. What methods of family planning do you know?
   a. Barrier method

      Condom ☐ Intra uterine ☐ device Copper T ☐ Diaphragm ☐

b. Natural method

Lactation amenorrhea ☐ Abstaining ☐ Coitus interrupter(Safedays) ☐

Basal body temperature ☐ cervical mucus test ☐

c. Surgical method

Tubule ligation ☐ Vasectomy ☐

d. Hormonal method

Oral pill ☐ Inject able ☐ Norplant ☐

Emergency contraceptive ☐

e. Are the services of family planning available?

Yes ☐ No ☐

f. Are the services of family planning accessible?

Yes ☐ No ☐

ATTITUDE TOWARD FAMILY PLANNING / PRACTICES OF FAMILY PLANNING.

9. Are you using family planning?

   No ☐ Yes ☐

10. Why are you not using family planning?

    It's a bad habit culturally ☐ my partner doesn't want ☐

    Rumour about side effect ☐ Lack of money ☐ our religion doesn't allow ☐

    I don't know ☐

11. Which method have you used or you are using?

    Barrier ☐ Natural ☐ surgical ☐ Hormonal ☐

12. Why have you used the method above? ……

13. From where do you get the service?

    Drug shops / private clinic ☐ Health centers / units ☐ Hospital ☐

    None of the above ☐

14. Are the services regular in the place above

    Yes ☐ No ☐

15. If you are charged how much do you pay?

    Less than 1000ush OR Free ☐ Between (1000-5000)Ushs ☐

    More than 5000Ushs ☐

16. How far in term of kilometer is the place?

    0-5kms ☐ 6-10kms ☐

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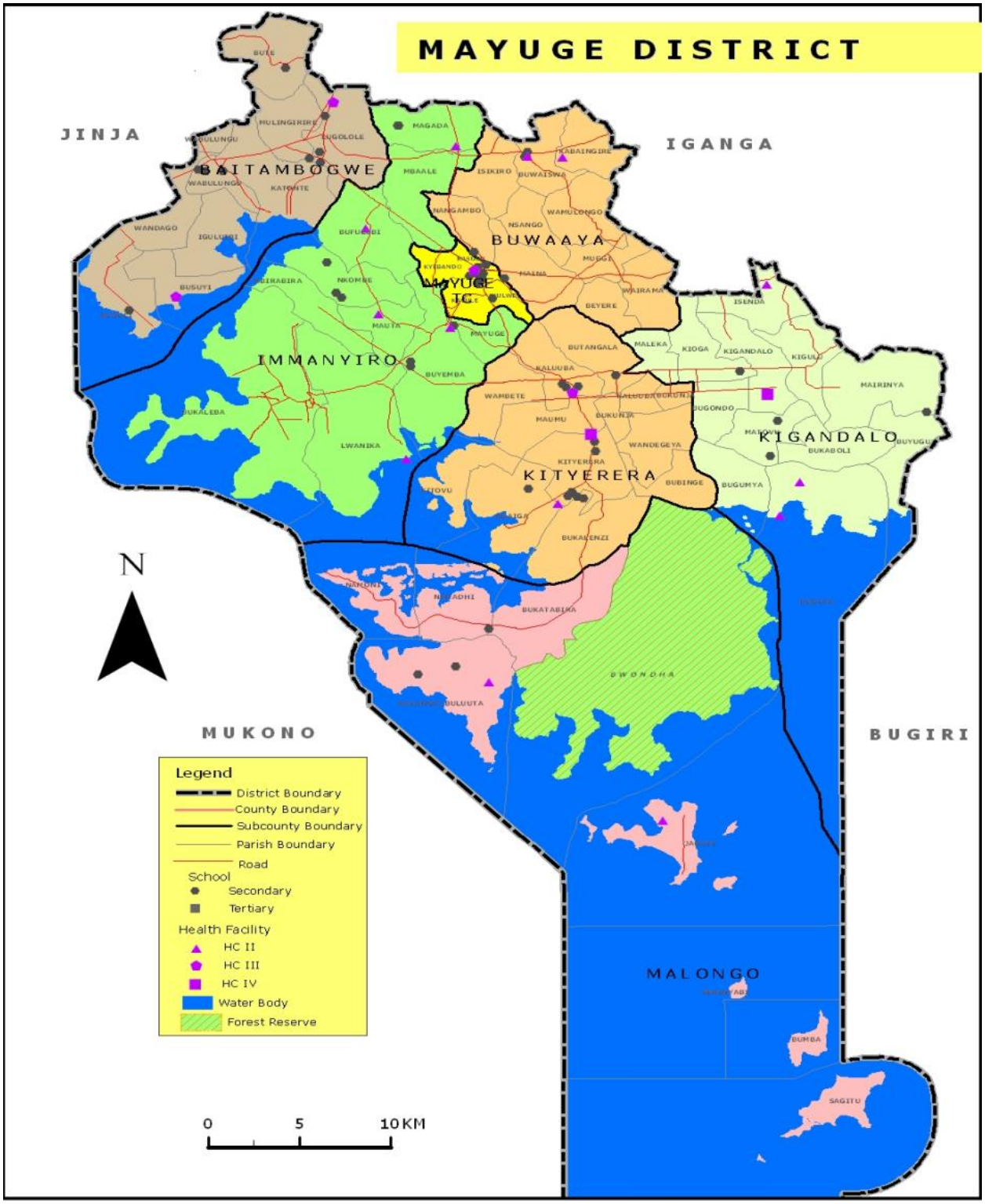
MAYUGE DISTRICT
JINJA
IGANGA
MUKONO
BUGIRI
BAITAMBOGWE
BUWAAYA
IMMANYIRO
KITYERERA
KIGANDALO
MAYUGE TC
MALONGO
N
Legend
District Boundary
County Boundary
Subcounty Boundary
Parish Boundary
Road
School
Secondary
Tertiary
Health Facility
HC II
HC III
HC IV
Water Body
Forest Reserve
0
5
10KM