KAMPALA INTERNATIONAL UNIVERSITY,

WESTERN CAMPUS

FACULTY OF CLINICAL MEDICINE AND DENTISTRY

P.O.BOX 71

BUSHENYI

UGANDA

FACTORS THAT ARE HINDRING THE USE OF MODERN CONTRACEPTIVE METHODS AMONG WOMEN OF CHILD BEARING AGE (14-49 YEARS) IN BUSHENYI-ISHAKA TOWN COUNCIL; WESTERN UGANDA

BY

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BMS/0024/81/DU

A RESEARCH PROJECT SUBMITTED IN FOR PARTIAL FULFILLMENT FOR THE AWARD OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY FROM KAMPALA INTERNATIONAL UNIVERSITY –WESTERN CAMPUS

DECLARATION

I Nabukeera Mary Prossy declare that this research report is my original work and has not been submitted to any institution of higher learning for any academic award.

Signature Date

……. ……

APPROVAL

This is to certify that this research report has been prepared under my supervision and has never been presented anywhere for the purpose and is now ready for submission to the Faculty of clinical Medicine and Dentistry

Signature Date

……. ……

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ACKNOWLEDGEMENT

I wish to appreciate the various people whose hand was so crucial in the successful completion of this project. Sincere gratitude to my Supervisor, parents, husband and all classmates for the moral support offered.

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LIST OF ACRONYMS

FP……...family planning

FPAU…… Family Planning Association of Uganda

MCH ……...Maternal and child health

MOH …….Ministry of Health

UCMS……Uganda catholic medical secretariat

NGO……...Non-Governmental Organisation

W/C……Western Campus

KIU…….Kampala International University

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CHAPTER ONE

1.1 INTRODUCTION

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

This concept has been in existence worldwide throughout ages in widely differing cultures and societies. Dating back to 1850 BC, ancient Egyptians were responsible for using the infamous dung In addition to the female irrigating her vagina with a mixture of honey and sodium bicarbonate. The ancient Egyptians also developed a tampon-like object that contained lactic acid anhydride, a chief ingredient in modern contraceptive jellies.

In East Africa, among the kikuyu of Kenya, a method called ''Thingira'' was used where a woman after delivering would be barred from visiting here husband until after there years. In Uganda, a similar method was practiced by the Iteso where a wife after delivering would stay in her mother in law's house for at least 1 and a half years. It was an offence for a husband to have sex his wife and a heavy fine would be paid on such a husband. Among the Banyankole in Uganda a young girl was always severely punished if she became pregnant, she would be beaten and severely harassed and often chased from Home. This method could scare off young girls from boy-girl relationships hence preventing early pregnancy.

The origin of the condom is still unknown but it is said that a ''Dr condom'' supplied king Charles ii of England with animal tissue sheathes to prevent him for fathering illegitimate children.

However, all these maneuvers had little impact on controlling unwanted pregnancies and the population explosion warranting a need for modern contraceptives. After world war ii the increasing rise in world population was alarming, the birth control pill was developed in order to curve this increase.

In 1950 and American biologist Grgory Pincus developed the ''ideal'' oral contraception, was tested on women in Haiti and Puerto Rico. In 1960 the first oral contraception; Enovid-10, was launched in the United State market known as the ''Pill''. Within two years oral contraception was said to be over 1.2 million women and the number continued to increase.

In Uganda, family planning services were introduced by the FPAU in 1957 and two years later, the alma alta declaration was made at Kasangati Health Centre in Mpigi district. In 1963, comprehensive maternal child health (MCH) and family planning services were started in Mpigi district and later spread to the entire nation.

Today, family planning services are an integral part of PHC in most countries and Uganda, these services are provided by the government and non-government owned health institutions and facilitated by the MOH and NGOs , these family planning services are almost free of charge. Government continues to train personnel the purpose of improvement and sustainability of the family planning pregame.

The available data indicates that the most frequently used family planning method has also gained some support in Uganda thought organized programs like the Uganda catholic medical secretariat.

The success of the family planning program in many countries in Africa is affected by many factors that most important of which is client's compliance. Women who form majority of clients race special circumstances that make it difficult for them to obtain the health care they need even when it is seemingly available thought as specific program. Some off the circumstances related to their statures in many parts of the world. For example in most cultures especially in Africa, a woman may be unable to obtain reproductive health care without consent from her husband. In some instances the threat of domestic violence which may increase further deter them from seeking care.

Also of particular concern to most clients is the safety of various contraceptives. Health workers therefore have the duty of calming the client's anxieties.

Family planning services in Uganda are almost exclusively for women with men's participation still minimal yet men in the African setting are the key determiners of family size and child spacing. In this generally illiterate and poverty stricken population, the chances of off spring's survival tend to be less compliant with utilization of family planning services.

The availability, accessibility and cost-effectiveness of the family planning program also affects the outcome following it's implementation if any. The researcher therefore focuses on the perception, fears and concerns of the potential users about health associated risks of contraceptive methods. It will also establish the level of knowledge about the effect of family size on health. The researcher also examines the role of men in reproductive health and hopes to discover the short-comings in the family planning program implementation which may limit the choices of use of the available contraceptive methods.

1.2 PROBLEM STATEMENT

Worldwide, poor family health remains a fundamental problem. This explains why the general health status of most of these counties is abnormally low bearing in mind that the family is the basic unit to the community.

In Ugandan like most sub-Saharan African countries the reliable data shows very miserable health indicates including maternal mortality rate of 506 per 1000 live births, infant mortality rate of 88 per 1000 total births and under five mortality rate of 155 per 1000 total births. Total

mortality rate of still remains high at 6.9 per women while CPR is 23% (UDHS 2001). All these poor health indicators are directly or indirectly related to risky pregnancies (too early, too close, too many, too late or unintended). These common undesirable pregnancies have serious consequences.

Early pregnancies as a result of not using contraceptives are not only associated with dropping out of school of the girl child but also with higher social and medical risks including illegal abortions, increased rates of prematurity, low birth weight, anemia, pre-eclampsia and later on increased infant and maternal morbidity and mortality, adolescent pregnancies also increase the incidence of child abuse, neglect and infanticide. Worse still the frequency of kwashiorkor and the nutritional deficiencies is higher in families where births are many and closely related. Maternal depression syndrome is also a common problem in such families. Apart from rampant claiming many Ugandan lives due to failure to use modern contraceptives.

It's tragic but in the WHO 1994 report, it was revealed that some 120 million women are not practicing family planning despite their wish to avoid pregnancies. This applied mainly to Africa where the needs of less than 1/3 of potential users are being met. And the most revealing reality of the world's inability to provide safe, accessible , acceptable and affordable family planning services is the fact that world wide between 50 and 60 million pregnancies are terminated annually. Some 20 million of these abortions are included under usage conditions and at least 7000 women die every year as a result (WHO report 1994)

Another sad fact revealed by the UNDFA (19997) reported that the rate of unwanted pregnancies is still alarming of the average 175million pregnancies annualy, 75 million are unintended indicating that there is a lot of work to do in the family planning department to improve this situation. The same report revealed that 50 million unintended pregnancies are terminated annually. Most of these are unsafe very expensive and illegal. About 95%of these unsafe abortions occur in developing countries, causing deaths of ore than 200 women daily.

The world fertility survey (sathar and childambarana 1984) showed that use of family planning methods varied widely from 69% in south East Asia to 11%in Africa. The same survey further revealed that approximately 300 million couples in reproductive age did not want more children but were not using any methods of contraception. These figures indicate a significant unmet need for family planning.

The world population has also become an acute emergency; this population expands by 30 individuals every second and is expected to double by 2050. Paradoxically, the rate of growth of social services doesn't correspond with this high population explosion especially in the developing world. This has resulted into population related problems including environmental degradation, increased prevalence of communicable diseases and sanitation related diseases (UNFPA 1997). Uganda is not an exception on these crises, unregulated population growth is of great concern and fertility and birth rates are still very high. This is an acute imbalance between

resources and beneficiaries (AVSPICE) and NGO in Uganda recently noticed that 45% of Ugandan population is below the poverty line and Ishaka town council is not an exception. Small scale peasant is the basic economic activity and life fundamentals like education, medication and food are difficult to afford. According to Mohammed and Rold (1990) over the last four decades, there has been concern about rapid population growth and it's negative impact on the quality of life. The result of this has been establishment of institutions, policies and programs to enable people regulate their fertility. In spite of such developments, population explosion and improving family health, in fact according to (Sai 1986) if family planning methods are more widely available up to 42% of maternal death would avert in the developing countries . However, family planning methods are more widely available up to 42%of maternal death could avert in the developing counties. However, family planning is not widely accepted in Uganda of which the area of study is not and exception. The higher fertility rate of women in this area that is already densely populated has serious implications which impede the improvement of family welfare cause of the poor health situation in this area.

Not withstanding all efforts over the years, health indicators still remain miserable. There are still too many unwanted pregnancies and in particular the number of teenage pregnancies is alarming. This therefore poses a fundamental question. What factors hinder utilization of modern contraceptives in Ishaka town council Bushenyi district.

1.3 JUSTIFICATION

Despite the availability of a variety of modern contraceptive methods in most health facilities in Bushenyi-Ishaka town council, the contraceptive prevalence rate is still vey low. As well as serving as a learning experience to the researcher the findings of this study will help to complete a report that will be submitted to Kampala International University western campus in partial fulfillment for the award of bachelors' of medicine and surgery.

1.4 OBJECTIVES

1.4.1 MAJOR OBJECTIVE.

To assess the factors that have led to under utilization of modern contraceptive methods in women of child bearing age (14-49) years in the area of study.

1.4.2 SPECIFIC OBJECTIVES

To determine the knowledge of mothers in child bearing age on contraceptive use

To determine the attitude of mothers towards modern family planning methods

To access accessibly and affordability of these mothers to modern family planning facilities

To identify any social, cultural factors linked with use of modern contraceptive methods, in the area of study. To determine the family planning methods that are commonly used by women in the area of study.

CHAPTER TWO: LITERATURE REVIEW

2.1 KNOWLEDGE AND ATTITUDE TOWARDS MODERN CONTRACEPTIVE METHODS

When asked how a specific modern method of contraception works in the body to prevent pregnancy, many women offered somehow expected constant responses. The pills or injections (hormonal method) appears to generate heat in the body and alters the balance of bodily elements resulting in dying of the womb, other bodily parts and the skin as well as thickening of menstrual blood (R. Sadan.R.Snow/social sciences and medicine)

The pill is viewed to generate heat to either melt the man's sperm and /or melt the blood that support the baby when growing (R. Sadan.R.Snow/social sciences and medicine)

If contraceptive methods and their practice are recognized and understood, both adults and adolescents are forced to choose among the methods fit for them. However, known methods may or may not meet their individual needs. The known methods are expensive in convenient or uncomfortable to use. They therefore suggested that contraceptive methods will continue to be underutilized if people are not educated about a variety of contraceptive methods and allowed to customize those methods to their individual needs (lethbrigde 1991, podlack 1993 and szarewsin 1993)

Knowledge about contraceptives especially use of condoms should be taught to all primary pupils and secondary students of reproductive age in Uganda (straight talk magazine march 2010)

2.2 SOCIAL ECONOMIC FACTORS/TRADITIONAL BELIEFS

When the encyclical, ''Human Vitae'' was published in 1968 was surrounded with controversy. In it pope Paul said wide spread use of contraception would lead to ''conjugal infidelity and general lowering of morality .'' the pope said men would no longer respect women but would treat them as mere instruments of selfish enjoyment, and no longer as his respected and beloved companion. (professor W Bradford Eilcox university of Virginia, Tuchstone Magazine 2001)

Research by six scholars shows contraception to be responsible for significant rise in divorces and illegitimacy both of which lead to social ills like heightened rates of criminal behavior and increased high school drop out rate (professor W Bradford Wilcox university of Virginia, Touchstone Magazine 2001)

Traditionally, women who wanted to either abstain from sex or at least receive a promise from their boyfriends that he would marry her in case of pregnancy could no longer compete with ''modern'' women who embrace contraception. This created an environment in which premarital sex became the norm and women ''felt free for obligated to have sex'' this way traditional women ended up having sex and children out of wedlock, while many of the

permissive women ended up having sex and contraception or aborting so as to avoid child bearing (Akerlof 2010)

2.3 METHODS OF CONTRACEPTION

The male contraceptive choices are so limited, the clinician generally caundals the female partner. Data from the natural survey of family planning growth reveals that about 39 million women are at a risk of unintended pregnancy of these 90% use some form of contraceptives unfortunately 10% of the women who do not account for 53% of intended pregnancies, half of which end in abortions. (Primary care for women Phyllis.C. Leppert and Fred.M. Howard 1997

CHAPTER THREE: GEOGRAPHIC LOCATION

Uganda is an East African country among the sub-Saharan countries. It's land locked and contains a varied landscape of savanna. Dense forests and tall mountains as well as almost half of lake Victoria gold, beryllium, iron ore, limestone, tungsten, phosphates and oil that has recently been discovered. The country also has spectacular wild life including leopards, gorillas, chimpanzees, rhinos, antelopes, zebras, elephants, lions, crocodile and giraffes. Uganda is an ethnically diverse nation with a deeply ingrained intellectual and artistic culture poor but developing, Uganda's economy is predominantly agricultural. Uganda became a British protectorate in 1894 and it's present borders were established in 1926. Uganda is bordered by Kenya in the East, Democratic republic of Congo in the West, Tanzania in the south , Sudan in the North and Rwanda in the South West. Uganda's current population is about 34 million people with a population growth rate of 4.38%, projected population in 2025 is 56, 560, 727 and projected population in 2050 is 132, 699,173, the density of Uganda is 150 persons per square Kilometer.

3.1 CLIMATE

Uganda usually receives sufficient rains thought out the country to permit corps to grow once or even twice a year. Most areas have distinct dry and we seasons, thought the year. Thought the lake Victoria areas receives rains throughout the year.

The rainy seasons occur form March through may form October through November. The driest areas is the North, usually receives 900mm (40in) annually while the wettest in the south get more than 1500mm (160in). Rainfall varies greatly however, local drought are not uncommon. Uganda's temperatures are moderately throughout the year. In Kampala near lake victoria it's daily temperature range between 18 degrees to 28 degrees Celsius in January and from 17- 25 degrees in July.

3.2 ETHNICITY AND LANGUAGE

Uganda has 34 ethnic groups, although people customarily are identified with just a single group. Many of the languages presently used are not mutually intelligible. About 2/3 speak Bantu languages and live in the south, including the largest ethnic groups. The Baganda, Banyankole, Bakinga and Basonga. About one sixth of Uganda's people are west Nilotic speakers living in North, such as the Langi and Acholi. Another one sixth speak Eastern Nilotic Language and is the Northeast, including the Iteso and Karimajong.

3.2 STUDY AREA: BUSHENYI

This study was carried out in Bushenyi-Ishaka town council, Igara county Bushenyi district which is in western Uganda. It's bordered by Mbarara district in the East Ntungamo district in the south west, Kasese and Kamwenge district in the North.

3.2.1 STUDY AREA BUSHENYI ISHAKA TOWN COUNCIL

It's carried out from Bumbaire Kyeizoba sub-counties on the North, Kyeizoba/ kyabugimbi sub counties in the south and Nyabubare in the East. It's found in Igara county of Bushenyi district. its headquarters are in the district administration and has area of 44 square kilometers.

3.2.2 ECONOMIC ACTIVITIES

The major economic activities include but not limited to crops and animal farming, trade in retail, wholesale, carpentry workshops for furniture, hoteling and food kiosks, Bodaboda and taxi services, clinics, educational, institutions and church.

3.2.3 ADMINISTRATION

Bushenyi-Ishaka town council has four Wards which are I,ii,iii and iv. This is further divided into 16cells and each cell is headed by local council I chairman.

3.2.4 POPULATION

Bushenyi-Ishaka town council has an estimated population of 23, 799 people according to the Bushenyi district population and housing census primary results. This was reached at after a house to house census released by the district census officer.

CHAPTER FOUR: METHODOLOGY

4.1 STUDY AREA

Bushenyi Ishaka town council has four wards which are I,ii,iii and iv. This is further divided into 16 cells and each cell is headed by LC I chairman. In this research, I used a descriptive cross sectional study which involved getting a letter of acceptance from the town clerk and local leaders in the community.

4.2 STUDY POPULATION

In this research the researcher and her team targeted women of child bearing age i.e. 15-49 years of age.

4.3 SAMPLE SIZE DEFINATION

In this research, 100 respondents were used because of time limitation and financial hardships while carrying out the research.

4.4 SELECTION CRITERIA

4.4.1 INCLUSION CRITERIA AND EXCLUSION CRITERIA

All women of child bearing age 14-49 years participated only those women who granted consent participated and no force or payment were given for anyone to participate. Children below the age of 13 and women above 49 who were most likely not of child bearing age were not allowed to participate. Those who had not consented were not allowed to participate.

4.5 DATA COLLECTION

Two research assistants helped the researcher to conduct the research using questionnaires for the respondents who were only women of child bearing age 14-49 years. The questions were interpreted in Runyankole for those who did not understand or read English.

4.6 DATA ANALYSIS

The data collected from the study was analyzed by using the manual commutation and Microsoft excel version 2007 and the results form analysis was represented in form of pie charts and bar graphs.

4.7 ETHNICAL CONSIDERATIONS

The study was carried out after this proposal had been approved by my supervisor. A letter of introduction from the department of medicine was obtained before the study. Permission was first obtained from the town clerk and LC chairperson in the area of study. Informed consent was obtained from women of child bearing age 14-49years. Privacy was ensured by not writing down names of respondents on the questionnaires.

4.8 DISEMINATION OF FINDINGS

A copy of the research project was given to the supervisor, another to the research department for the partial fulfillment of the award of the bachelor in medicine and bachelor of surgery.

4.9 STUDY LIMITAION

Time allocated to the study was very short therefore a smaller population sample was dealt with. Financial constraint; high cost of typing, feeding the assistants and the researcher during data collection. The researcher got financial aid from. her husband and other well wishers. Some women of child bearing age refused to consent. I minimized this by explaining to them about the purpose of the study and privacy of their information.

CHAPTER FIVE: DATA PRESENTATION AND ANALYSIS

5.1 INTRODUCTION

The study was carried out in the period between August and September 20013 to establish the factors that hinder the use of modern contraceptives in women of child bearing age i.e (14years to 49 years) in Ishaka- Bushenyi town council. The study involved 100 respondents and the data was processed and analysed using basic statistical methods like pie charts, bar graphs, percentage frequency distributions and simple statements.

5.1.1 DEMOGRAPHIC CHARACTERISTICS

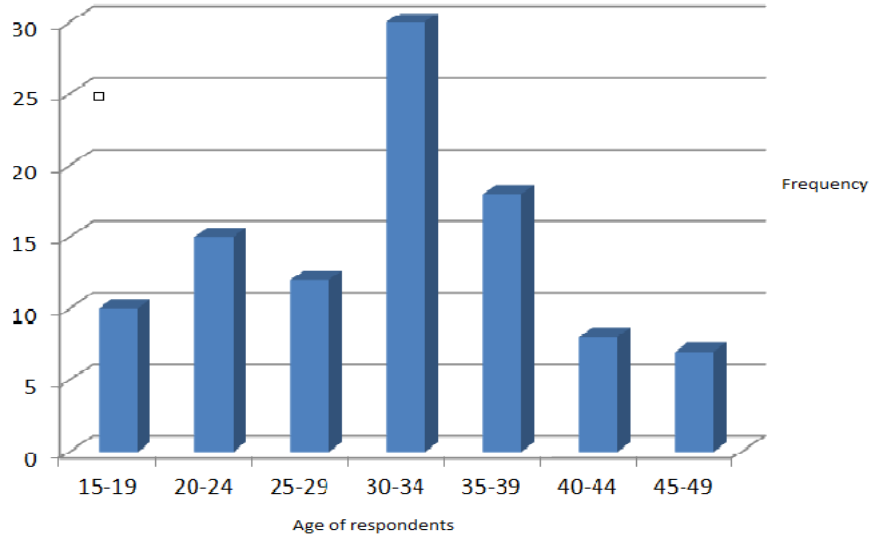

Figure 1: Bar Graph demonstrating demographic characteristics

The age range was 34 years with the youngest woman interviewed aged 15 years and the oldest 46 years. The range of the median age was 30-34 years and the mean was 32 years. The modal age group was 30-34 years.

5.1.2 MARRITAL STATUS

Figure 2: Pie Chart showing marital status

39% of the respondents were married, 30% separated, 17% single and 12% widowed.

5.1.3 RELIGION OF RESPONDENTS

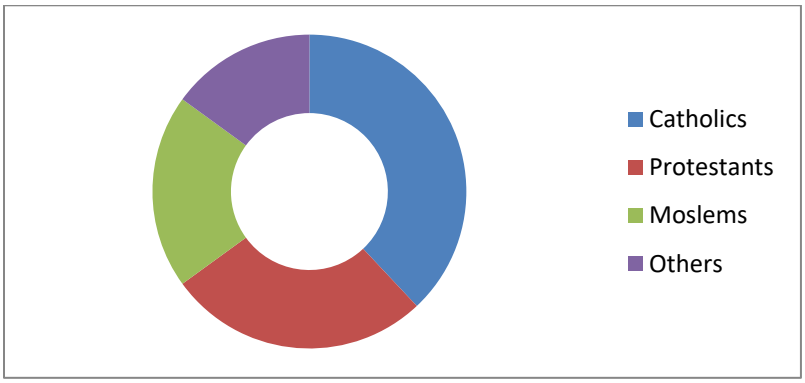

Figure 3: Pie Chart showing religion of the respondents

38% of the respondents were Catholics, 27% were Protestants, 20% Muslims and 14% were other denominations.

5.1.4 EDUCATION LEVEL OF THE RESPONDENTS

Table 1: Education level of respondents

Education level	**percentage**
Primary	47
Secondary	25
Tertiary	16
No formal education	12
Total	**100**

As indicated above the majority of the respondents attended primary level education

5.1.5 OCCUPATION

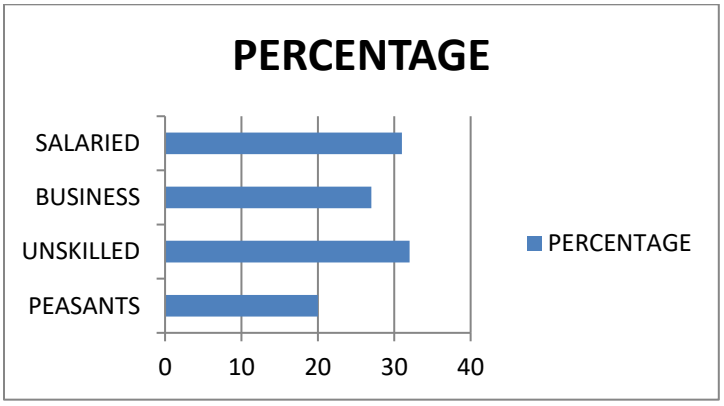

Figure 4: Graph demonstrating occupation of respondents

32% of the respondents were unskilled in any form of occupation, 27% were running business, 21% were earning monthly salaries while 20% were peasants.

5.2 HISTORY OF KNOWLEDGE OF CONTRACEPTIVES

The majority of the respondents i.e 93% had brief knowledge on contraceptives while on 7% were ignorant about contraceptives.

Chart showing source of information about contraceptives

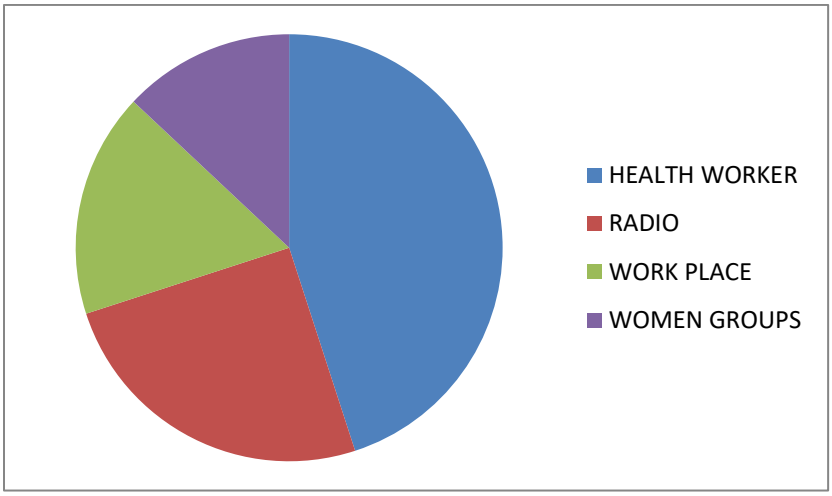

Figure 5: Source of information about contraceptives

The majority of the respondents i.e 45% obtained information about modern contraceptives from health workers, 25% from local radio stations, 17% obtained information about modern contraceptives from their work places while 13% heard from other fellow women groups.

Table 2: Table showing level of contraceptive knowledge by method

Method	**Percentage**
Oral pills	26
Condoms	38
Abstinence	15
Withdrawal	10
Norplant	7
IUCD	4
TOTAL	**100**

As observed above, the majority of the respondents i.e 38% were conversant with condoms as a contraceptive method, 26% were knowledgeable about oral pills, 15% knew of abstinence, 10% were informed about the withdrawal method, 7% Norplant while the least i.e 4% knew about the IUCD.

Reasons why family planning methods are still not applied

- Most people never use family planning methods because they are interested conceiving to give birth
- Male counterparts are never comfortable with the contraceptives, so they always discourage their female partners from using modern birth control methods
- Many are scared of the side effects resulting from the use of contraceptives
- In other areas, modern contraceptives are not available for people to utilize
- To some people the modern methods of birth control are very costly for them to afford
- There are incidents where the contraceptives have been used and they fail to work

Respondents' knowledge on problems associated with unwanted pregnancies

- Poor health
- Unsafe abortions
- Malnutrition
- Low birth weight
- Early ageing
- Mistreatment and lack of care for the born child

Child spacing of the respondents

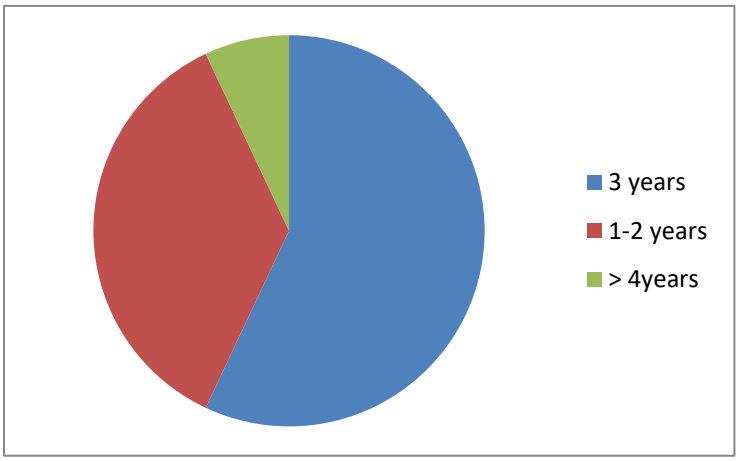

Figure 6: Pie chart showing child spacing of the respondents

Among the respondents, 57% had an average child spacing of three years, 36% had an average child spacing of 1-2 years while only 7% had an average child spacing of four and more years.

Table 3: Source of family planning method by percentage

Source	**No. of respondents**	**Percentage**
Health Centre	58	47
Pharmacy	26	22
Private Doctor	21	18
Community Distributor	2	1.7
Traditional Herbalist	1	0.9
Others	10	9
Total	118	100

CHAPTER SIX: DISCUSSIONS, CONCLUSIONS AND DEDUCTIONS

6.1 DEMOGRAPHIC CHARACERISTICS

The respondents in this survey were women of reproductive age (15 – 49 years) with a model age group of 30 – 34 years which is of a very high reproductive potential hence the need of family planning services.

About the marital status of the respondents, most of the women i.e 39% were married, 30% were separated and 19% were single while 12% were widowed. The occurrence of so many women without partners, (61% of the total respondents) and yet in reproductive age, represents a population which is at risk of getting multiple partners hence standing a high risk of obtaining unwanted pregnancies and worse still acquiring HIV/AIDS or STDs. Therefore this population requires family planning services.

Regarding the religious affiliation of the respondents, 65% were Christians while 20% were Muslims. This partly explains the low prevalence rate of use of modern contraceptive methods in Ishaka – Bushenyi town council. This is because the Christian faith is strongly objective to the use of birth control methods.

Most of the respondents had low levels of education with only a 16% having completed tertiary institution while 47% had only obtained primary education and 12% with no formal education at all. Due to the low level of education, this explains the reason for under utilization of modern contraceptives. The high levels of illiteracy reduced exposure to modern methods of birth control and health education on the use of family planning methods

6.2 KNOWLEDGE ABOUT PRACTICE OF CONTRACEPTIVES

The major source of knowledge about contraceptives in Ishaka – Bushenyi town council is through the health worker i.e. 45% followed by the local radio stations, 25% then 17% from their work places and 13% in women groups.

The most known method is the use of condom. The use of modern methods of contraceptives is limited in Ishaka – Bushenyi town council because of limited knowledge about alternative methods.

Many of the respondents had reasons for failure to use modern contraceptives for example, wanting 41%, side effects 23%, failure of previous method 15%, disapproval from their partners 10%, costly 7% and unavailability 4%. All of these reasons partly explain the under utilization of

modern contraceptives. The majority of the respondents had a birth interval of three or less years showing that the use of modern contraceptives is low in Ishaka – Bushenyi town council.

6.3 AFFORDABILITY AND ACCESSIBILITY OF CONTRACEPIVES

Most of the respondents reported that modern contraceptives were supplied freely in government owned health centers while in private pharmacies modern contraceptives were sold at an affordable price. This demonstrates that the cost is not one of the factors hindering the use of modern contraceptives in Ishaka - Bushenyi town council. Therefore modern contraceptives are easily accessible and affordable in Ishaka – Bushenyi town council

6.4 CONCLUSION

- Most respondents do not have awareness and also have a low level of actual use of modern contraceptives.
- Contraceptive prevalence rate is lower in Christians especially Catholics.
- Majority of the respondents are scared of using modern contraceptives I fear o the side effects.
- Due to the low levels of education, most respondents were not using contraceptives.

RECOMMENDATIONS

After analyzing the research the following recommendations were made;

Efforts should be made to ensure availability of several contraceptive types in health centers so that there are a variety of modern contraceptive methods such as IUCD,Norplants,Tubal ligation and vasectomy

QUESTIONNAIRE

FACTORS THAT ARE HINDERING THE USE OF MODERN CONTRACEPTIVE METHODS AMONG WOMEN OF CHILD BEARING AGE (14-49 YEARS) IN BUSHENYI-ISHAKA TOWN COUNCIL

a. DEMOGRAPHIC DATA

1. Age ……
2. Marital status
   i. Single ( )
   ii. Married ( )
   iii. Separated ( )
   iv. Windowed ( )
3. Level of education

i. Primary ( )
ii. Secondary ( )
iii. Tertiary ( )
iv. Never studied ( )

4. Religion

i. Catholic ( )
ii. Protestant ( )
iii. Muslim ( )
iv. Others ( )

5. Occupation

i. Salary earner ( )
ii. Business ( )
iii. Peasant ( )
iv. Unemployed ( )

b. KNOWLEDGE AND ATTITUDE TO CONTRACEPTION AND USE OF CONTRACEPTIVE.

1. Have you ever heard of family planning ?

i. Yes ( )
ii. No ( )

2. If yes, where did you get that information from?

i. Radio ( )
ii. Women groups ( )
iii. Health workers ( )
iv. Work place ( )

v. Specific
……
…….

3. Which method do you know about?

……
……..

4. Are you using any lately?

i. Yes ( )
ii. No ( )

5. If yes specify it?

……
……

6. If no, state the reason why

i. To conceive ( )
ii. Partner disapproved ( )
iii. Side effects ( )
iv. Not available ( )
v. Costly ( )
vi. Method failed ( )

7. Do you intend to use any family planning methods to prevent pregnancy any time in the future

i. Yes ( )
ii. No ( )

8. If yes which one do you prefer?

……
…….

9. What are the most likely problems associated with contraception
    i. Unwanted pregnancies ( )
    ii. Ill health ( )
    iii. Malnutrition of offsprings ( )
    iv. Unsafe abortions ( )
    v. Age early ( )
    vi. Others,
    specify……
    ……

10. What is your average child spacing?

i. 1-2 years ( )
ii. 3years ( )
iii. 4years ( )

C. ACCESSIBILITY AND AFFORDABILITY OF CONTRACEPTIVES

1. Do you know where to get contraceptives?

i. Yes ( )
ii. No ( )

2. if yes, where is that?

i. Health center ( )
ii. Pharmacy ( )
iii. Traditional healers ( )
iv. Private doctor ( )
v. Community based distributors ( )
vi. Others, specify

……
……

3. if you wanted to get a contraceptive, which of these places would you prefer

……
……..

4. are there any charges for family planning services?

i. Yes ( )
ii. No ( )

5. If yes, is it affordable?

i. Yes ( )
ii. No ( )

6. How far is it from your place of residence to the health center where family planning services can be found?

i. Near ( )
ii. Far ( )
iii. Very far ( )

Thank you so much for your cooperation God bless you abundantly

APPENDIX II

ESITMATED BUDGET FOR THE PROPOSAL

Table 4: Estimated budget for the project

ACTIVITY	QUANTITY	AMOUNT PER ITEM	TOTAL
Reams of plain paper	2	14.000	28.000
Writing material	4	500	2000
Research assistants	2	20.000	40.000
Collection of materials		10.000	10.000
Typing and printing	3	100.000	100.000
Transport	3	1.000	3.000
Miscellaneous		25.000	25.000
Total			208.000/=

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