THE RIGHT TO REPRODUCTIVE HEALTH- WOMEN'S ACCESS AND USE OF FAMILY PLANNING SERVICES IN MITYANA DISTRICT

A CASE STUDY OF MALANGALA SUB-COUNTY

BY

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DECLARATION

I **Kiddu Ronald** declare that this research report is my original work, and has never been presented anywhere for any award.

Signature..... Date....11th/10/19.....

Kiddu Ronald.

APPROVAL

This is to certify that this research report has been submitted with my approval as a University Supervisor.

Signature; ..... Date 11/10/19.

Mr. Ochen Paul Ernest.

DEDICATION

I dedicate this research work to my lovely parents Mr. Matale Nathan and Mrs. Ndagano Agnes and also my relatives that empowered me and support me during the my study at Kampala international university .

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ACRONYMNS

CBO's	Community Based Organizations
F.P	Family planning
FGM	Female Genital Mutilation
HIV/AIDS	Human Immune-deficiency Virus
H/C	Health Center
H/h	House hold
ICESCR	International convention on Economic, Social And Cultural Rights
NGO	Non-Governmental Organization
R.H Rights	Reproductive Health Rights
STD/STI	Sexually Transmitted Disease/Infection
TBA	Traditional Birth Attendant
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHMG	Uganda Health Marketing Group
UNFPA	United Nations Population Fund
WHO	World Health Organization

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ABSTRACT

The research was carried out to find the Right to reproductive health-women's access and use of family planning services in malangala sub-county, Mityana district. The objectives of the study was; to assess the challenges women face in accessing family planning services, to assess women knowledge of existing family planning services in Malangala sub-county and to establish the level of family planning service usage by women in Malangala.

The study adopted a case study design on both qualitative and quantitative aspects. This method was preferred because it was an ideal method that could ease the collection of information from the respondents at both individual and group levels. The research design was descriptive in nature. The research findings were displayed in table form which has figures in percentage form.

The researcher concluded that the ICESCR to which Uganda is a state party states that everyone has rights with regard to health Article 12.2a with a focus on maternal and reproductive health and article 2 of the UDHR that states that rights should apply to all human beings without any discrimination based on gender or race.

The study recommended the MOH and NGOs that deal in reproductive health and family planning, funds should and must be injected in this area of Malangala in Mitiyana so the above problem can be solved. In my opinion, not a lot of money is need though the first step to be taken is sensitization of the masses both the women and men about the Right to family planning use and access.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction to the study

The world over there is the realization of the need for family planning services and reproductive and sexual rights in less developed countries. The control and enjoyment of family planning services as a right by rural women has the potential to provide for population control, poverty reduction, decline in maternal mortality rates and the prevention of the spread of Sexually Transmitted Diseases and Infections like HIV.

The Right to family planning by an individual and couples too was first recognized in 1968 in Teheran while the United Nations held a conference on Population control and later on in 1995 at the Beijing plat form, it is here that the need for family planning and reproductive health as a right was discussed and since then many conferences have been held about this particular area of concern.

However the comprehension of this is a great challenge especially by the many rural women in Uganda and in this case those in Malangala sub-county. This challenge may exist because the limited information about their entitlement to safe and effectiveness access and use of family planning and reproductive health services.

The Ugandan Government provides substantial support for family planning, and most users of contraception in developing countries rely on their governments for contraceptive supplies and services, although the private sector, including pharmacies and private organizations that is Non Governmental Organizations like UNFPA, Pathfinder and Marie Stopes are also an important source of such services.

Many of the family planning programs in developing countries have been carried out with considerable support from international donors (Kohler 2001). But millions of people particularly the poor still lack access to quality services, including modern family planning methods, emergency obstetric services, and prevention and management of STIs, all this

because of various reasons including fear of side effects, lack of knowledge and lack of access to family planning supplies.(W.K. Kiwanuka 2011)

1.1 Background of the Study

Despite the increase in contraceptive prevalence, some 137 million women still have an unmet need for contraception and another 64 million are using traditional family planning methods that are less reliable than modern methods.

Fertility levels have remained high over the past 3 decades, with the Total Fertility Rate (TFR) of 6.2 children per woman. The 2011 Uganda Demographic and Health Survey (UDHS), preliminary findings indicate that the TFR has reduced to 6.2 children per woman. The TFR is higher in the rural areas (6.8 children per woman) compared to urban areas (3.8 children per woman).

In Uganda the current unmet need for family planning by rural women is 42.6% compared to 41% in the 2003/4 and 35% in 2000/01. In central Uganda where my area of research lies the unmet need is at 35.5% (UBOS 2006). Overall 79.2% of women in developing countries specifically Uganda have an unmet need for modern contraception with a prevalence rate for modern methods at only 18%. The highest proportion, several times the level of current use, is in sub-Saharan Africa where 46 per cent of women at risk of unintended pregnancy are using no method (UNFPA Uganda 2009). The fertility rates have remained high over the past three decades with a total fertility Rate of 6.7 children per women according to the 2006 Demographic and Health survey.

Women's Sexual and Reproductive Health (including HIV/ AIDS) The Right of women to control their fertility; According to the World Population data sheet (November 2007) Uganda has the world's third fastest growing population (3.2% per annum) and will as a result have the biggest population increase in the next four years. According to the UDHS, many women have more children than they would prefer. Married women consider 5.3 children to be the ideal number of children. However, the high unmet need for family planning (41%) has led to an increase in unplanned births from 38% in 2000 to 41% in

2006.43 Indeed at 6.7 children per woman, Uganda has a much higher fertility rate than her neighbors Kenya (5.3) and Tanzania (4.9) and this poses not only a strain on the women's health but also places a high demand on the economy for various social services including health and education. *(Interview with Richard Ndikuryayo, Department of Statistical Co-ordination, Uganda Bureau of Statistics .UBOS- Uganda National Household Service Delivery Survey 2006).*

Until the mid-1990s, family planning services in Uganda were restricted to married women accompanied by their husbands or to married women who had their husband's written permission to use contraception (Blacker et al., 2005). In 1995, after many other East African countries had already done so, the Government of Uganda (GOU) created its first national population policy. The Ugandan Ministry of Finance (MOF) has noted the limited progress of family planning in Uganda and that Uganda's traditionally large family sizes are now becoming an impediment to the speed of economic growth and social and structural transformation (MOF, 2004).

In addition, misconceptions about family planning abound due to lack of information, limited access to services, and high costs. This coupled with limited decision-making power on reproductive choices and opposition from male partners has led to a high rate of unplanned pregnancies estimated at 775,000 each year (approximately 25% of these being adolescents) *Study by the Family Planning Association of Uganda, 2006/7. (The Uganda's baseline survey on the Africans Women's Rights Protocol. The Maputo Protocol)*

In developing countries like Uganda one third (11/3) of illnesses of women in the age group of 15-44 is related to reproductive health through pregnancy, child birth, reproductive tract infections and Sexually transmitted diseases like HIV, abortion among others. And yet all this would be avoided if women and men had access to safe, affordable and effective means of contraception. Because of the observed number of deaths caused by pregnancy and childbirth, it is proposed that there should be a specified services and practices that will protect the women and at the same time emphasize the family planning.

1.2 Statement of Problem

Despite the significant efforts of the Ugandan government and the international community through the different Non Governmental Organizations and community based Organizations like Reproductive Health Uganda, Pathfinder and Marie Stopes Uganda among others have committed funds in the area of family planning, reproductive and sex education, access and use, a large number of rural women may not know that it is their right/entitlement to have the choice/decision to use family planning services.

1.3 Scope of Study

The study focused on rural women and their right o reproductive health by focusing on their access to Family planning services. This was mainly entail looking at the women's knowledge to access family planning services, use and challenges faced by looking at different aspects in the community hospitals and other aspects such as culture, poverty among others.

The study covered three rural villages of estimated population of 1000people per square miles in Malangala sub-county in Mityana District the geography of the area was hilly and the time scope of three weeks which was in the central region of Uganda.

1.4 GENERAL OBJECTIVES

To assess the level of access of safe and effective family planning services for women in Malangala.

1.4.1 SPECIFIC OBJECTIVES

- To establish the level of family planning service usage by women in Malangala.
- To assess women knowledge of existing family planning services in Malangala sub-county.
- To assess the challenges women face in accessing family planning services.

1.4.2 Significance of the Study

The study provided information to policy makers and other stake holders of the fact that these rural women were clueless about their Right to reproductive health and use of family planning and therefore help in the government rethinking of the introduction of essential development in the field of reproductive health, especially family planning.

The study contributed to the existing literature on the Right to Reproductive health with a focus of access and use of family planning services.

1.5 Justification

This area was chosen because many of the women in this village don't know that it is their right to use and choose family planning services simply by virtue of being females. And therefore, it seeks to give an audience to this fact and as a result I hope to uplift the health of the women in Kasalaga.

Another reason was that a large number of women in this area was that they have many children that are above 6 within a short time apart which indicated that the knowledge and use of family planning was at a minimal or barely there at all. And this was risk to the whole community from the populations view, a risk to the women's health who keep giving birth year in year out and also failure to control the spread of STD like HIV by use of methods like condoms both male and female ones. Hence bringing light of the ongoing situation helped to the people in these villages.

1.6 Conceptual Framework

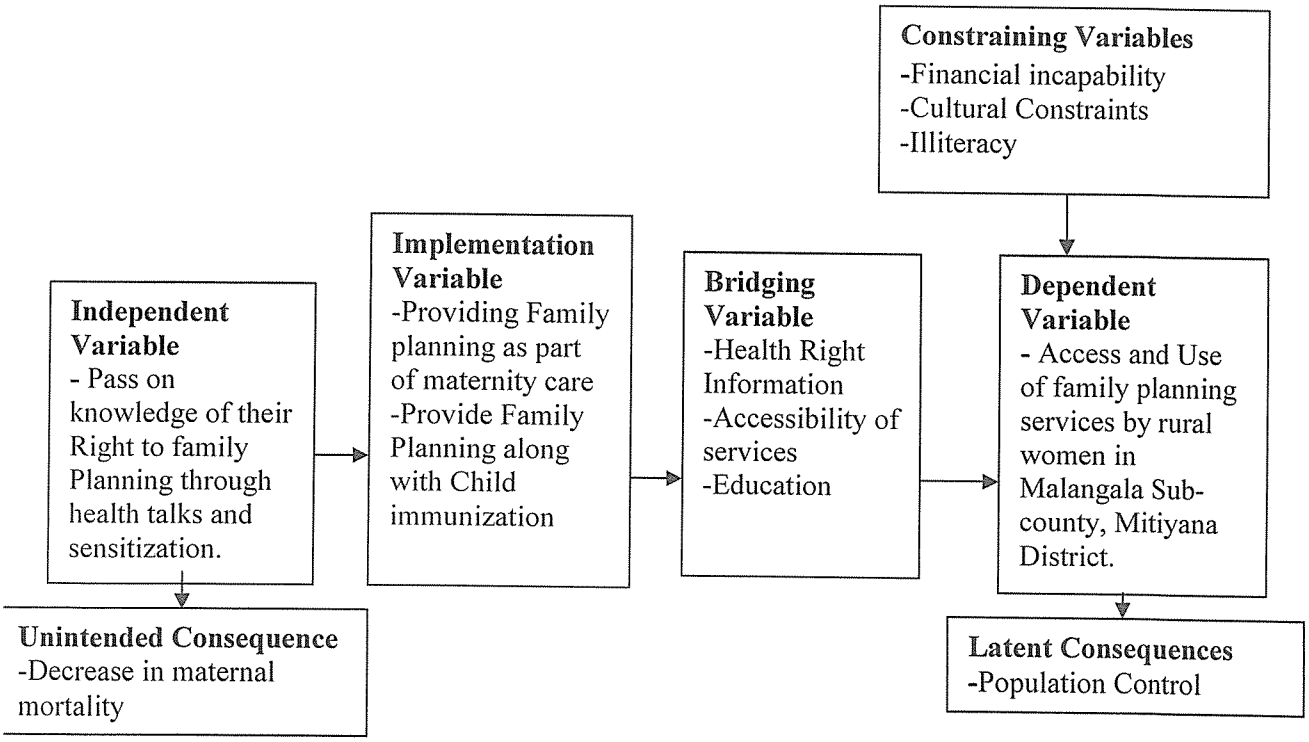
The Conceptual framework based on the understanding of the dynamics of policies as well as socio-economic and cultural interactions between these issues which hinder the rural women of Kasalaga A and B, kasozo, Bulenge, Zigotti (Malangala sub-county) in exercising their Reproductive and sexual right through safe and effective family planning methods. As illustrated in ***figure 1***, rural women and the right to reproductive health with a focus on family planning is understood differently by many, and the women in this area need to know how they can be affected as a result of implementing and using these services that they are

fully entitled to. A number of Human rights instruments on the right to health and to reproductive health have been put in place, setting standards on the basis of how state parties should treat their people and in this case the women.

However there are strong socio-economic and cultural practices in the rural areas of Uganda like patriarchy, illiteracy, culture, long distance to the health centre, poverty among others that may be a challenge to the achievement and use of these services and as a result some attempts to uplift this area may fail because of the mentioned reasons. However there is a high chance of many realizing the importance of Family Planning and access to reproductive health services and hopefully this will lead to other problems being tackled hence leading to situations like the decrease in maternal and infant mortality, increase in use of Family planning services to mention but a few.

All the above can be explained in the figure below

Figure 1: A Conceptual framework showing social, economic and cultural processes regarding the right to reproductive health with a focus on access and use of Family Planning.



Source: Primary data 2019

1.7 Definition of key terms

Abortion: the deliberate termination of a pregnancy

Contraceptives: a device or pill used to prevent pregnancy

Antenatal care: Medical visits made by an expectant mother before delivery or during pregnancy

Family Planning: this is the practice of controlling the number of children you have, usually by using contraception.

Human rights: Entitlement to everyone simply by virtue of being Human, regardless of one's sex, age, race, tribe among others.

Maternal mortality: This is the death of a woman during or shortly after a pregnancy

Pregnancy: the developing of a baby in a woman's womb

Reproductive tract infections: Refer to three different types of infections that affect the reproductive tract: Endogenous infections, Intragenic Infections and Sexually transmitted Infections

Reproductive Health Rights: these are legal Rights and freedoms relating to reproduction and reproductive health.

Women (Rural women): Females who live in the Rural Areas of a country.

Women Empowerment: the ability of women to have the authority to make their own decisions and have power over it.

CHAPTER TWO:

LITERATURE REVIEW

2.0. Introduction

This chapter reviewed all relevant literature of authors who had researched on the topic. The secondary data was got from text books, journal, newspapers and other relevant sources.

2.1. Human Right and Family Planning.

UNFPA (1990).The publication in 1990 of a quality of care framework established the components of good reproductive health care. Clients need a choice of contraceptive methods, accurate and complete information, technically competent care, and good interaction with providers, continuity of care, and a constellation of related services. Another framework detailed the support, tools and resources that providers need to offer quality care. The Right to Family planning has been defined as the right for individuals to control the spacing and timing of births, and to attain their desired number of children, hence it's not a privilege but a right.

2.1.1. The international conference of population development Cairo 1994

The United Nations coordinated the International Conference on Population and Development in Cairo, Egypt from 5–13 September 1994. Its resulting Program of Action is the steering document for the United Nations Population Fund (UNFPA).

Some 20,000 delegates from various governments, UN agencies, NGOs, and the media gathered for a discussion of a variety of population issues, including immigration, infant mortality, birth control, family planning, the education of women, and protection for women from unsafe abortion services. The conference received considerable media attention due to disputes regarding the assertion of reproductive rights.

This conference focused on the access to reproductive and sexual health services including family planning: Family-planning counseling, pre-natal care, safe delivery and post-natal care, prevention and appropriate treatment of infertility, prevention of abortion and the management of the consequences of abortion, treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions; and education, counseling, as appropriate, on human sexuality, reproductive health and responsible

parenthood. Services regarding HIV/AIDS, breast cancer, infertility, and delivery should be made available. The gap here is that it aimed at achieving all the goals it set by 2015 and its 2013 and there is no sign of this happening in the coming two years.

2.1.2. Beijing Plat form of Action (1995) defines Reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.
Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.
Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

International Human Rights Instruments like the 1948 Universal Declaration of Human Rights, Article 25. (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2.1.3. The Convention on the Elimination of all forms of Discrimination against Women CEDAW (1979). *Article 12* (1). States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2.1.4. The International Convention on Social Economic and Cultural Rights;

Article 12.2 (a). The right to maternal, child and reproductive health, 14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.

2. Maputo Protocol African Charter on Human and Peoples Rights Article 14

Health and Reproductive Rights

Article 1, States that States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.

This includes:

a) The right to control their fertility;

b) The right to decide whether to have children, the number of children and the spacing of children;

c) The right to choose any method of contraception;

d) The right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;

e) The right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognized standards and best practices;

g) The right to have family planning education.

2. States Parties shall take all appropriate measures to:

a) Provide adequate, affordable and accessible health services, including information, education and communication programs to women especially those in rural areas

b) Establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;

c) Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.

General comment No. 14 Rights to the highest attainable standards of health focuses on Article 12 of the ICESCR which goes on to break down the different groups regarding health below is women and their right to health. ***Special topics of broad application: .....***

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotional and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

2.3. NATIONAL HRTS INSTRUMENTS

2.3.1. Uganda Constitution.

National Human Rights Instruments like Article 33 of the Ugandan Constitution which focuses on the Rights of women. (2) The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realize their full potential and advancement.

(3) The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society.

2.3.2. National health Policy

In this document **section 4.5.1** *'the right to highest attainable level of health'* mentions the following:

- The Constitution guarantees rights of access for all people in Uganda to high quality health care services.
- Patients have the right to information about diagnosis, treatment, cost of treatment and consent after obtaining information and protection of privacy.
- Patients are entitled to safety in the public and private health sector. This has implications for treatment protocols, standards of medicines, medical supplies, medical equipment and infrastructure.

However this doesn't in particular mention the right to family planning by the women in Uganda and yet it is a vital part of women's health.

2.4. Family planning methods

The following are F.P methods, some temporary and others permanent and are explained in detail (Voluntary efforts for rural development, 2010 - VERDE Uganda)

1. Family Planning Injection Method. This has proved very easy, positive and acceptable amongst the rural women because it is confidential to other of their spouses who may be opposed to family planning. Once an Injection is taken, it has no other instructions to follow or remember to adhere to.
2. Use of Condoms to Prevent Pregnancies and Protection against Sexually Transmitted Infections. Acceptable but with a lot of resistance from men or both spouses because of the psychological attitudes of using condoms as they are always associated with prostitution.
3. Using Family Pills. Not readily acceptable by many because women believe that if error occurs while in use, the resultant pregnancy will be with a lot of problems as the child may have deformities/may not be normal.
4. Norplant Family Method. Fixed into a woman's arm for five years. This method would be good but it is only acceptable by few women who have gone to school or

know a little bit of reading. Women also believe that five years in family planning method of this kind is too long a period.

5. Foam Tablet Method. Where a tablet is inserted into the vagina before sexual intercourse. Very few women respond to this method.
6. Prolonged Breast Feeding Method. This is acceptable by many women but not reliable to most of the illiterate women whose sexual timetables are dictated by their equally illiterate or drunkard husbands who will demand to have sexual intercourse as early as three/four weeks from the time of child birth.
7. Withdrawal Method. The man withdraws his erected penis at the time of ejaculations. This method is extremely unreliable because most often men will not allow such a thing to occur at the climax of his sexual excitements.
8. The Safe Period Method for Women. For rural women to adhere to this method is difficult because women have no sexual rights in the rural African Communities except in the cases where women are totally independent or widows, otherwise all the time they are subjected to forced sexual intercourse by their often drunkard or non-listening husbands.
9. Abstinence or Rhythm Method. The couple will agree when they should have sexual intercourse. This usually works in well to do or civilized families.
10. Vasectomy Operation / Tubal Ligation Method. Last resort methods when pregnancies and child births have become life threatening to either the Mother or the Father or both of them, the operations will be advocated for in order to save threatened life.

2.5. Knowledge of family planning among women Ugandan women

Improving access to family planning resources requires filling critical gaps in knowledge to inform policy and program e implementation. There is need to support research to test ways to integrate family planning services with other health services like HIV prevention and care, maternal and child health care including immunization and post-pattern care, and post abortion services. There is also the urge to seek better data on the potential interaction between HIV acquisition ns the use of hormonal contraceptives.

The use of contraception increases with increasing level of education. Forty-four percent of currently married women with secondary or more education are using a contraceptive method compared with 18 percent of those with no education. (UDHS 2011)

2.6. Access to Family Planning services

Uganda Bureau of Statistics (2011) shows that the use of family planning is lower in rural areas than urban areas, an overall four in ten currently married women age 15-49 have unmet need for family planning services, 24 percent have met need and 64 percent have demand for family planning. Unmet need for spacing is higher than unmet need for limiting; this however doesn't show the many reasons why the women in the rural areas do not know of their right to access family planning services. (UBOS 2006)

W.H.O hand book (2011). The job of family planning remains unfinished. Despite great progress over the last several decades, more than 120 million women worldwide want to prevent pregnancy, but they and their partners are not using contraception. Reasons for unmet need are many: Services and supplies are not yet available everywhere or choices are limited. Fear of social disapproval or partner's opposition pose formidable barriers. Worries of side effects and health concerns hold some people back; others lack knowledge about contraceptive options and their use. These people need help now.

W.K. Kiwanuka (2011), every year Uganda loses about 6,000 women as a result of pregnancy related complications. A significant proportion of these deaths occur because women are not able to have healthy planned pregnancies. In Uganda, according to the Uganda Demographic and Health Survey, 41% of married women wish to space their pregnancies or want to stop child bearing altogether but are not using family planning methods. Women may have unmet need for family planning because of various reasons including fear of side effects, lack of knowledge and lack of access to family planning supplies.

Guide to Family Planning **(ISBN 978-029-492-9):** by Grace Ebun Delano, published by Spectrum Books Ltd. This new edition of Guide to Family Planning and Reproductive Health sets out to fill gaps in the knowledge of the general populace and health professionals about the benefits and the need for a healthy reproductive and sexual life; 219 pages (English). However it doesn't look at the women in less developed countries like Uganda

and the need for them to realize that this knowledge and use is their Right as human beings and hence should used it if they want without any restrictions

2.7. The use of family planning services by women.

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through the use of contraceptive methods and treatment of infertility.

Although contraceptive use has increased in many parts of the world like Asia and South America, it continues to be low in sub-Saharan Africa. Globally the use of modern contraceptives has risen slightly from 54% in 1990 to 57% in 2012. Regionally the proportion of women aged 15-49 reporting the use of modern contraceptives has risen minimally between 2008 and 2012. In Africa it went form 23% to 24%. (WHO May-2013)

It should be noted that the use of family planning would be of great advantage in many areas like the prevention of spread of STIs and HIV, it reduces the need for unsafe abortions, and it reinforces people's right to determine the number and spacing of their children. Helps prevent pregnancy related health risks in women due to spacing and delay between births, slows population grown and also empowering people and enhancing education by enabling them to make informed choices about their sexual and reproductive health.

For rural-urban differentials there is a wide gap in the use of any methods between urban and rural areas (39 percent versus 23 percent). Distribution by sub region shows that the percentage of women currently in union using a contraceptive method is highest in Kampala (48 percent) while West Nile (15 percent) and Karamoja (8 percent) sub regions had the lowest percentages. (UDHS 2011)

In general, women do not begin to use contraception until they have had at least one child. Only about one-third of currently married women with three or more children are currently using a method of contraception. (UDHS 2011)

2.8. Unmet need for family planning by Ugandan women

An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include:

- Limited choice of method
- Limited access to contraception, particularly among young people, poorer segments of population or the unmarried people especially women.
- Fear or experience of side effects
- Culture or religious opposition
- Poor quality of available services.
- Gender based barriers

The unmet need for contraception remains high. This inequity is fueled by both a growing population and a shortage of family planning services. In Africa 53% of women of reproductive age have a un met need for modern contraception. (WHO 2013)

Table 1 below shows the components of unmet need by year and place of residence. Compared to urban areas, rural areas have much higher levels of total unmet need, unmet need for spacing, and unmet need for limiting (Table 1). From 1995 to 2006, the urban-rural differences in total unmet need and in unmet need for spacing and limiting increased. For example, in 1995, the urban-rural difference in total unmet need was 2 percentage points, and by 2006, the difference was 16 percentage points. (UDHS 2006)

Table 1 also shows that current use of a method in urban areas, despite an initial increase from 1995 to 2000-01, stalled during 2000-01 to 2006. The stall occurred in both spacing and limiting in urban areas. Increases in current use in rural areas continue. Increases occurred in use of a method for both spacing and for limiting, but the magnitude of the increases was small. The percentage of total demand satisfied remained steady in urban areas from 2000-01 to 2006, whereas it increased marginally in rural areas. (*Khan, Shane, Sarah E.K. Bradley. 2008*). Family planning programs need to reach women in rural areas where high levels of unmet need persist. Programs need to target the rural areas of the country where levels of unmet need remain high and have continued to increase throughout the past decade

2.7. Challenges faced by women worldwide regarding access and use of family planning services.

There are many challenges recorded faced by women worldwide regarding family planning, some of which include, the influence of physical access on the utilization of family planning services is well founded, with many studies demonstrating the greater use of services among women who live in relative proximity to a service (see for example, Tsui & Ochoa 1992). Research into the barriers faced in accessing reproductive health services, however, now recognizes that problems of access extend beyond physical access to services, and include issues of economic, administrative, cognitive and psychosocial access (Bertrand et al. 1995: Foreit et al.1978).

The barriers to family planning service use are seen as extending beyond factors operating at the individual and household levels, to include characteristics of the social and cultural environment and the health service infrastructure.

This view of access recognizes the importance of attributes of the health system in shaping an individual's ability to seek health care, highlighting the importance of the supply environment on health care utilization. This conceptualization of access incorporates factors operating at the individual, household and community level to influence an individual's ability to utilize a health service, thus framing an individual's access to services in terms of the socioeconomic, cultural and service supply context in which they live.(Rob Stephenson, PhD and Monique Hennink, PhD)

According to Biddlecom et al. (1996), most research on contraception has focused on the supply and demand factors determining contraceptive behavior.

Demand, defined as the motivation to limit, postpone, and space births, is itself determined by an array of economic, social, and cultural factors, whereas supply refers to the accessibility and quality of family planning services. In rhetoric and in practice, this implies that supply-side factors should also entail promoting family planning and service delivery (Biddlecom et al., 1996; Easterlin & Crimmins, 1985). Casterline et al. (2001) suggested that fertility regulation is a function of the motivation to avoid pregnancy and the cost of fertility regulation. Bulato & Lee (1983) reported that the cost of contraception includes financial, time, health, psychic, social, and cultural aspects. Biddlecom et al. (1996) also suggested that

the cost of contraception encompasses much more than accessibility to family planning services and that it includes all factors (social, psychological, and cultural) that may act as barriers to contraceptive practice among men and women. Casterline et al. (2001) noted that socio-cultural and religious disapprovals of contraception repeatedly emerge as important obstacles to the use of a contraceptive method.

Wall (1998) identified a combination of these factors that obstruct contraceptive knowledge, adoption, and use among Hausa women in northern Nigeria 234 (S.M. NANGENDO). He asserted that few Hausa women have any knowledge of birth control and they consider family planning as the moral agnate of murder. This is because birth is an antidote for bereavement in the cultural idioms of this Islamic society and children are considered a divine benefaction. Children are the desired outcome of any Hausa marriage, and giving birth is traditionally viewed as the greatest fulfillment of being a woman (Wall, 1998). Such cultural beliefs and sentiments may render the adoption and use of contraceptive methods difficult in many sub-Saharan African communities.

Lack of knowledge about contraceptive methods and concerns about health side effects and effectiveness are also major barriers to adoption of family planning services. These factors may also argue against increased continuity of contraceptive use. For example, Bangladeshi women wishing to delay or prevent pregnancy chose not to practice contraception because of some of the above factors (Bongaarts & Bruce, 1995; Casterline et al., 2001; Feyistan & Casterline, 1999).

However, Luck et al. (2000), in a study of family planning services in Bangladesh, found that culturally appropriate counseling can mobilize the presumably latent demand for contraception by reassuring potential clients of the social acceptability and by allaying their fears about side effects of contraceptive methods (cf. Amin et al., 2000; Phillips et al., 1997). Various cross-national studies have also found that health and social concerns are the principal causes of the unmet need for contraception in many countries (Bongaarts & Bruce, 1995; Casterline & Sinding, 2000). Luck et al. (2000) concluded that individual face-to-face counseling by family planning service providers is an effective means of providing potential users with necessary information, particularly regarding their health concerns. For example, demand mobilization interventions resulted in increased knowledge and use of injectable

contraceptives in rural Gambia (Luck et al., 2000). However, such interventions had little effect on women's knowledge and use of other methods. It appears that many women in rural Gambia perceive injectable contraceptives to be the most effective, private, and convenient contraceptive method. Similar results were reported from the Matlab region in Bangladesh (cf. Biddlecom & Fapohunda, 1998a; 1998b; Phillips et al. 1988; Simmons et al., 1988). In both of these countries, many women often practice clandestine family planning (cf. Biddlecom & Fapohunda, 1998a; 1998b). For example, Luck et al. (2000: 333) reported that Bangladeshi and Gambian women:

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter highlighted the research design that was used in the study, targeted population of the study, population size and sampling technique, data collection methods and procedures, as well as encountered limitations to the study.

3.1 Research Design

The study adopted a case study design on both qualitative and quantitative aspects. This method was preferred because it was an ideal method that could ease the collection of information from the respondents at both individual and group levels. The research design was descriptive in nature. The research findings were displayed in table form which has figures in percentage form

3.2 Study Area

The study was carried out in Malangala sub-county in Mitiyana District which was one of the districts in Central region, west of the capital Kampala. Under this sub-county are villages like Kasalaga A, Kasalaga B, Bulenge, Kasozo and Zigotti.

3.3 Study population

The study population consisted of rural women of reproductive age between 15 and 49 years; that means only women who were able to conceive children. Malangala has been chosen as the area of study because there wasn't literature showing women's knowledge of use and access of F.P.

3.4 Sample size

The respondents were about 35 women and were randomly selected as the main aim was to discover if these women know about family planning and their right to access and use it. These women were the ones to make up the primary data.

3.5 Sample procedure

Random sampling was the procedure, whereby I randomly selected the women that were interviewed.

3.6 Methods of data collection

The following were the methods I used to collect data and carry out the research.
Interviews were of crucial importance.

Interviews

A series of carefully targeted interviews with participants. The interviews were semi-structured and mainly involved open-ended questions (Use of questionnaires) in order to get as much access as possible to the participants' minds and meanings they attach to security.

Use of Focused Group Discussions

Use of secondary information; Using secondary data like from clinics and health centers, to find out why rate of maternal mortality is on the increase in Uganda despite family planning services by women in the age group of 15-49 years old by visiting the health centers and the materials that were used were the academic contexts, books that focused in family planning services, journals, case studies, previous researches and survey information that done in Uganda and in other countries.

Observation: the researcher through observation method took note of how the women in this area have many children, respond to family planning questions, spacing in between children, space for the patients to talk to the service providers with confidentiality and distance of clinic that offer F.P services.

3.8. Data Analysis

Data analysis was largely qualitative, themes and sub themes were developed for the purpose of data analysis. Answers of the different respondents were compared to establish the most occurring responses which were then used in the analysis and interpretation of the

data. The data was then summarized in a narrative form and the most important quotations from the field have been used to illustrate the major findings of the study.

However to a small extent the data was analyzed qualitatively to enable the researcher to summarize the data using percentages and tables.

3.9. Limitations of the study

The study had a number of limitations which included:

Language barrier because many preferred local languages to English.

Cost of moving from one village to another.eg inadequate transport means.

Lack of cooperation by some women in the various sub-counties, some said they had no family problems

Falsifying of ages by the women i.e. they tended to say they were younger than they are and yet when you ask for the year they were born; the ages don't coincide.

The area of study is a little bit personal so it felt like some women were holding back on some of the questions asked

3.10. Ethical consideration

The researcher obtained a letter of approval from the department of psychology, college of humanities and social sciences. Kampala international University which was presented to the respondents to show authenticity and legitimacy of the study/research being carried out, the respondents were not forced into giving replies to the queries asked.

The researcher guaranteed the respondents of at most discretion and confidentiality, Protection of information that was collected and that nothing happened if they talk to the researcher, their information was safe and sheltered from others.

CHAPTER FOUR

DATA PRESENTATION

4.0 Introduction

In this chapter findings of the study are presented, analyzed and discussed. The chapter begins with an account of social demographic characteristics of the respondents that is the women of Malangala sub-county. All this information has been laid down according to the major research questions.

4.1 Demographic and social characteristics of respondents

Under this we show brief demographic background information of the study; that is then women and their ages, occupation and level of education.

4.1.1 Age

Table 1: Demographic characteristics of respondents

Characteristics	Number of respondents	Percentage
Age		
15-20	8	18.6
21-30	16	37.2
31-40	14	32.5
41-50	5	11.6
Total	**43**	**100**

Source: Primary Data 2019

All the respondents were women and girls aged from 15 to 49 years. The research focused on the access of rural women to reproductive health rights and family planning services and the respondents were categorized in the following age groups. There were 8 girls below the age of 20 which constitutes a percentage of 18%, 16 of them aged between 21 and 30 with a percentage of 37.2%, 32.5% of the respondents were aged between 31 and 40 years and 11.6% of these women were 41 years and above.

4.1.2 Occupation of the respondents.

Out of the 43 respondents 38 of them were farmers, 2 were students, 1 is a former nursery school teacher who came back to the village to look after her ill mother and 2 are small scale business owners.

Table 2: Showing the occupation of women respondents of Malangala Sub-county

Occupation	No of respondents	Percentage
Peasant farmers	38	88.3
Students	2	4.65
Teacher(Nursery)	1	2.3
Business women (small scale)	2	4.65
TOTAL	**43**	**100**

Source: Primary Data 2019

The above information is determined by the level of literacy by the women and since most of them dropped out in primary or didn't get an education at all, it poses a high problem of not knowing about their right to access and use family planning services, lack of money to use these services since most are peasant farmers and ignorance.

In the second cluster held for a focus group discussion, An example is the mention of "them having no choice but to wake up in the morning and dig and hence don't get enough money to help sustain their use and access of these family planning services and as a result go ahead to get pregnant due to failure to afford the services"

4.2 The meaning of the right to family planning.

According to table 2 and the data collected in the interview questionnaires, 65.08% knew about family planning and that it was their right to use it, 34.88% knew that it entailed child spacing, 11.6% knew it was about choice in the number of children a women would like to have and 18.6% thought that it's about a woman deciding to prevent pregnancy and none of the women respondents knew that choosing to use a particular method of F.P is their Reproductive health right. On the other hand 34.88% were oblivious of what the right to family planning was and claim not to have ever heard of it.

Therefore the above data leads one to ask the question; if a higher percentage of the women in this area know about family planning why is it then that the fertility is high and most of them have more than 6 children.

Table 3: Showing the women knowledge on the rights to FP.

Category of rights	No. of respondents	Percentage
Child Spacing	15	34.88
Choice of number of children	5	11.6
Choice of method of F.P	-	0
Ignorant to F.P	15	34.88
Prevent getting pregnant	8	18.6
Total	**43**	**100**

Source: Primary Data 2019

While having a discussion in the focused group, one woman said that all they know about family planning is that "it's about planning for a family" which was further elaborated by another by saying "you plan for the family by deciding on the number of children you want to have"

Table 4. The source of knowledge of the right to family planning by these women

Source	No. of respondents	Percentage
Radio	10	23.2
Friend	17	39.5
Health center	25	58.1
Others(work)	1	2.3
School	2	4.6
Never heard of it	15	34.88
TOTAL	**43**	**100**

Source: Primary Data 2019

Building on the above table out of the 43 women respondents, 58.1% of the total number of women revealed that they first heard of the right to reproductive health from the different health centers and hospitals like kasozo health center, Zigotti medical center among others that they have accessed, 39.5% indicate their knowledge to use of family planning to their friends. 23.2% got to acquire this information from the radio stations that advertise about

family planning use and its benefits. A very small percentage got to learn and hear about their reproductive health rights from their work place and school. However, 34.88% have not and do not know what it entails.

In all the three clusters most women revealed that they attained the knowledge of F.P from the health centers. "One said she first heard of it when she went to give birth to her fifth (5^{th}) child in the health center and that's when the nurse 'musaawo' talked to her about using contraceptives to avoid getting pregnant."

The women were also asked of the knowledge of the types of family planning methods that exist and the table below shows which methods are known by them and which aren't.

Table 5: Types of family planning methods that exist

Method	No. of respondents who know	Percentage %
Pills	16	37.2
Injectable	18	41.8
Condoms	1	2.3
IUD	1	2.3
Implants	10	23.2
Diaghphram	-	0
Coils	9	20.9
Rhythm method	2	4.6
Total	**57**	**100**

Source: Primary Data 2019

The table above shows that the majority of respondents know of different existing methods of F.P with the most common method mentioned and that seems to known most by the respondents at 41.8% being the Injection (Injecta-plan) that is given to women after a period of 3 months. The other commonly known methods were the pills and implants at 37.2% and 23.2% respectively. Only one of the women knew of condoms as a method of family planning but instead many knew it for its use in the prevention of HIV/AIDS and STD's. A small percentage of the women in this area mentioned the knowledge of the rhythm method in prevention of pregnancy and methods like the IUD at 2.3% was barely known and Diaghphram was not known at all by any of the women respondents.

In the F.G.D's held some of the women as seen above didn't know of condoms as an F.P method, "condoms are only used to prevent us from getting AIDS other than that I don't see how it is helpful in F.P as my husband can even beat me if I suggest its use because he will think I am being unfaithful or that I don't trust him".

4.2 Usage of the F.P services

The women in this area mainly use injectable according to the data collected as it's the method most of them know about. The other methods these women mentioned are pills, implants and the coil. Very few know about the existing family planning methods and others do not even know that condoms can be used as a contraceptive as they claim it's for prevention of HIV/AIDS.

In all the F.G.D's held there was a clear agreement by most of the women who said that they all prefer the use of" injecta plan" as the husbands don't have to know about it and it has the benefit of being taken once in every three months which makes it efficient for them."

4.3 Challenges faced by the women in accessing and using family planning services.

The findings made of the challenges the women face are shown in the table below.

Table 6: Showing **Challenges faced by the women in accessing and using family planning services.**

Challenge in accessing and use of F.P services	**No. of**	**Percentage**
Distance	32	74.4
Culture	24	55.8
Poverty	43	100
Illiteracy/Ignorance	33	76.7
Patriarchy	14	32.5
Inadequate Government support	43	100
Lack of proper well equipped hospitals	27	62.7
Negative Attitudes towards F.P	31	72
Lack of male involvement	0	0
Limited time to access the H/C	19	44.1
Lack of other supportive organizations and incentives (NGO's and CBO's)	6	13.9
Totals	**43**	**100**

A number of challenges were recorded as faced by the women in Malangala sub-county as seen in the table above. The most common and highly faced challenge is that of poverty, all the women I talked to that is 100% mentioned the lack of finances to keep accessing and using these services, this is mainly because they have no proper employment that is a source for them to earn some income and therefore they end up being reliant on their spouse who controls and decides how the money should be used and in this case family planning and contraceptive use is not high on their priority list.

The women also claimed that another challenge faced is the lack of government support provided to them by building health centers nearer to the villages and equipping them with quality products for them to use, 74.4% also said that distance to the health center's from where they stay is too far which makes it had for them as it means them having to cancel the days' work to go and access and use these services.

76.7% face the problem of ignorance and illiteracy which means they don't know that it is their right as women to use F.P, they have never heard of some of these methods and some go ahead to attach wrong beliefs to the use of these methods. Other challenges mentioned by the respondents include culture, patriarchy/gender, lack of support from NGO's and CBO's in the area, the negative attitude attached to the use of F.P and the lack of male involvement.

In the F.G.D'S, all the women agreed on poverty as the main obstacle to their use and access of F.P services. One stated that "If I had money I would definitely use the services, but the problem is you go to the health center and they ask for 500/= to get some pills or 1,500/= for an injection which I can't afford and as a result I decide not to use these services." Another woman mentioned that "the negative effects of contraceptive use like over bleeding and its cause of infertility makes it hard for them to use as it builds fear in them hence becoming discouraged".

CHAPTER FIVE

DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.0. Introduction

This chapter is a discussion of the findings which were presented in chapter four. It gives interpretations and opinions of the researcher on what was presented against the degree to which the findings endorsed or violated the rights to access and use family planning services by the rural women in Malangala sub-county as specified in the Human rights instruments relating to Health.

5.1 Discussion of findings

5.1.1 The Right to access and use family planning services by the women in Malangala sub-county.

Family planning access and use are among the most important issues affecting women's right to health today. This is so as it goes hand in hand with reproductive health, transmission of STD's and HIV/AIDS and the economic standing of the entire population. The social-cultural construction of society like patriarchy especially in the rural areas like Malangala which restrict women from using F.P, this is because aspects like decision making contact and regulation of resources is done by the male spouses leaving the women out. Situations like this lead to these rural women being excluded from making choices about their needs and requirements and among this is the right to access and use family planning. Case in point is the UNFPA give statistics on their view on family planning by rural women. The ICESCR Article 12 and under General comment 14 urges for state parties to ensure the attainment of the highest standards of physical and mental health without discrimination which the Ugandan government has adopted and put in law in The Uganda Constitution Article 33 of the Ugandan Constitution which focuses on the Rights of women. (2) The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realize their full potential and advancement. (3) The State shall protect women and their rights, taking into account their unique status and natural maternal

functions in society. The restrictive aspects to this result therefore disrupts women's right to health in particular the ones in the research area.

5.1.2 Services that make up reproductive health and family planning.

In order for the women of Malangala to know more and be able to access and use family planning services and therefore meet their right to reproductive health and family planning as was stated in the Cairo convention in 1994 and Article 14 of the UDHR which sets standards on the basis of which women should be able to access and use these services a lot needs to be done to educate and sensitize them on the right to access and use F.P and what it entails at large as part of the women's reproductive health rights.

The UNFPA and WHO have put in place a number of programs to tackle the issue of reproductive health maternal mortality and family planning. However in this area its only visible that Uganda health Marketing Group (UHMG) is the one that is largely involved in this sub-county as seen that they are the ones who offer support to the health centers by giving them brochures and leaflets that contain information about family planning and reproductive health rights for them to hand over to the women who come to the health centers. These flyers given out help pass on knowledge on what family planning rights and services are its uses, benefits and the different methods of family planning.

The health centers also provide outreaches and counseling on the use of contraceptives, coupled with voluntary counseling and testing for those who wish to know their HIV status. Other services provided include treatment of STDs and STIs, safe deliveries, immunization and talks given to women for them to not only use family planning but also come back to give birth in the Health centers and avoid the use of the Traditional birth Attendants (TBA's).

5.1.3 Knowledge of Family planning and reproductive health (brochures, radio)

For the knowledge of family planning services and reproductive health rights to be achieved a lot has to be done in this area. There are practically no NGOs that deal in reproductive health rights that have set up shop in Malangala sub-county, the only visible one is UHMG and this organization has given out contraceptives to the health centers, branding and helped

in advertising by putting up sign posts about contraceptive, information leaflets and brochures have also been handed out to the health centers to be used to pass on knowledge an use of contraceptives and women's rights to use and access these services.

Different radio stations have also passed on information and knowledge on contraceptive use like condoms, pills, implants among others. This on its own has been quite helpful in educating the rural women, especially those with radios.

However with all these efforts, many women still don't know about their right to family planning and contraceptive use which hence continues to pose a problem.

5.1.4 Privacy and confidentiality

The health centers workers be it nurses or doctors are very discreet regarding the passing on of family planning and reproductive health rights information to the women who decide to access and use the services, in all of the H/C and drug shops visited; there were rooms for consultation and areas in the back where the medical practitioners take the women and ensure their privacy and confidentiality. By doing so, it encourages women to come in especially since those whose spouses don't allow them to use family planning.

5.1.5 Accessibility of services

Although it's said in Article 12.2 (a) of the ICESCR that the right to maternal, child and reproductive health. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care.

However the accessibility of these services by the women of Malangala becomes hard as most of the H/centers are miles away and require a lot of time to reach. In the surrounding areas there were 5 health centers that were visited of which one isn't functional, 2 were drug shops that offer family planning services and the other two(2) were health center III's.

5.1.6 Availability of skilled labor and personnel at health centers

In all the health centers and drug shops there were professional health workers however they were all attended to by nurses and no doctor was on sight (The all claimed that the head

doctor works at Mitiyana Hospital and is only available in the evening) which raises the question of what would happen in case of a woman going to the health center and seeking help for a serious reproductive health issue? Will the nurse attend to her or will they have to wait for the doctor to come from the main hospital which is about 30-45 minutes away?

5.1.7 Women's participation in decision making

The women's participation in deciding whether to use and access family planning services can be said to be on the lower end as many of those currently using say that they have to ask their spouses for permission and also financial help in order to go ahead and access these services. There is therefore the need to carry out sensitization on women's rights to family planning and reproductive health by using conventions like CEDAW, ICESCR, UDHR, the Beijing Plat form and the 1994 Cairo convention; so that the women in Malangala can know that by virtue of them being women they can go and both access and use these services. "Family planning is one way of enabling women to contribute to their families and national development agenda. The smallest investments will save lives and improve maternal and child health," *(Observer 6th-June 2013 Matiya Kasaija").*

5.2 Recognized output/ achievements

The health centers have largely recognized an increase in the number of women who come for family planning services as registered per month. some of those that exist don't have a variety of family planning services and are only limited to a few as was recorded that most of the health centers have Oral contraceptives (Pills), Injectable, condoms, IUD and implants and yet there are other methods like coils, rhythm method, tubal ligation that can also be as effective but are not being offered and used.

5.2.1: By the women of Malangala

According to the data collected it can be stated that at least some of the women of Malangala have heard about and few use family planning and hence have some knowledge of what it entails as seen that a percentage of them get this information from the health centers. Although the percentage is low and a lot has to be done for the numbers to go up by carrying

out of sensitization and outreaches. It shows that the women are hoping to change habits and take charge of their reproductive health rights.

"I have heard of family planning over the radio and fro the health centers where I go to get treatment, I have also told some of my friends about it and that it will give us a break and let our bodies rest a bit before getting another child" said one of the women in the 3rd cluster of focused group discussions held.

Imperative to note is that under the International Convention on the Economic, Social and Cultural Rights (Article 12), the African Charter on Human and Peoples Rights (Article 24) that provide for the right to health and in specific reproductive health, which Uganda is a state party to and has ratified and domesticated and yet regardless of the above efforts, several challenges were reported by respondents that showed that the women's Reproductive health rights and the right to family planning were still unmet. The major trials that were reported were illiteracy, poverty, culture and biological and physical problems as explained further below.

5.2.2 Socio-cultural factors

It is important to recognize that the old fashioned notion that having many children is prestigious still exists among the people in this village, the cultural values that look at a sizable number of children in the homestead may block women from accessing and using family planning services and contraceptives that serve to limit and space the number of children born per a woman. The face that women also believe that giving their spouse many children will hold them down and make them not leave is also a problem.

For instance in the focus group discussions held one of the female respondents stated that: *"once they remarry even though they have a handful of children from a previous relationship, they have to give the current spouse children who are biologically his*". This therefore leads to the increase in the number of children that a women would have. Another woman stated that "*the men are the ones to decide whether or nor not to use family planning especially when it comes to methods like condom use"* this therefore poses a challenge in the use and access of F.P services by the women of Malangala sub-county, Mitiyana District.

5.2.3 Illiteracy

This also posed a huge problem to the positive application of FP services in Malangala. Since women especially those in the rural areas aren't prioritized in the receiving of education due to culture and norms, the girl child right to attain education is therefore abused and as a result this has a great negative impact on her as a woman in terms of her knowledge of women's rights to reproductive health and family planning. As seen from the data collected most of the women in this area are school drop outs with a high percentage of them stopping in Primary schools are not going to school at all. This therefore hinders them in the aspect of them not knowing about contraceptive use or the fact that they don't get to learn of their right to use and access theses services simply by virtue of them being women.

5.2.4 Economic difficulties

The financial situation of the women in this sub-county is also a challenge that was specified by the respondents as most of the women are peasant farmers, have no source of employment at all and are completely dependent on their spouses who may or may not give them money and hence have no stable income to be able to access and use the contraceptives offered in the health centers. This not only poses an issue in accessing the F.P services but also the attainment of other reproductive health services like Antenatal care, delivery in which case here they end up going to the traditional birth attendants (TBA) who may not be able to help in case of a serious/complicated reproductive health issue that can only be solved by a medical practitioner and also Post natal care. As a result the number of maternal mortality is on the rise due to pregnancy related issues which can easily be avoided.

5.2.5 Ignorance

The women of Malangala are extremely ignorant when it comes to Family planning access and use of contraceptives they have not received proper information on what family planning and reproductive health are exactly about and as a result they tend to shy away from it due to the negative belief. For example one of the women interviewed stated *"She was discouraged from using them by other women who claimed that one can get fibroids so she doesn't use F.P and contraceptives due to the fear of developing fibroids"* another woman in a FGD said that *"it causes cancer and miscarriages and infertility"*. This therefore is a big barrier that

prevents the access and use of F.P especially if they go spreading the word around to others. This however can be controlled by sensitizing of the public through frequent community health talks and outreaches by the health workers.

5.2.6 Biological/ side effects

Some of the women face the problem of horrible side effects and reaction to the different contraceptives and as a result they are biased and develop a negative attitude towards the use of F.P. some of the side effects noted are over bleeding, irregular menstrual periods, low libido as one of the female respondents stated that *"the use of family planning leads her to lose her sexual appetite, which in turn discourages her"*. Factors like these tend to dishearten the women from using contraceptives and accessing family planning services in general and as a result they don't get to exercise their rights as women.

Additional restrictions for the inability for the women in Malangala's access and use of family planning services were conveyed to be the distance to the health centers being too long, inadequate medical personnel, lack of drugs, amount of time spent waiting to see a medical doctor and receive services is also unbearable, fear of their spouses finding out that they are using contraceptives is also a huge hindrance and also the fear of accessing these services due to "*being too young* "as was stated by a 15 year old pregnant girl in Kasalaga village, Malangala sub-county. Since the nearest major hospital is about 30 minutes away in Mitiyana town, the government should therefore think about building a hospital closer to the women in Malangala to help tackle these issues and the international community too through NGOs and CBOs should come in and help deal with this issue.

5.3 Strategies for further improvement of the services.

Addressing the obstacles; that is distance, economic difficulties, culture, illiteracy, ignorance and physical problems that affect the women Malangala is crucial to ensuring that these women have access to family planning services and reproductive health information.

First and foremost there is need to sensitize about the need to use contraceptives and family planning methods to help reduce on the high fertility, educate the women on the health risks

attached with spacing and planning for smaller families, create strategies that involve the men in participating in the family planning process, teach the women other income generating activities to help uplift them from the peasants that they are to women who can earn some income, building or putting up of better and well equipped health centers in the area to avoid the time they spend walking and to at least make it a little bit easier for them. The government should also prioritize family planning and contraceptive use in all regions of the country as seen that it connects to the economic sphere and all in all population increase affects us as a country and not only the women of Malangala. International NGOs should also continue to advocate for the education of the girl child as it's said; *"educate a girl and you educate the nation*". It is clear that by doing so the acquisition of the knowledge of women's Right to reproductive health and family planning broadens and hence the eradication of its ignorance. All these strategies can be further elaborated below:

Sensitize the population on their right to access and use family planning services and contraceptives. Sensitizing and training of women and men on better family planning practices, such as safer birth control methods, spacing births, reducing HIV/AIDS through the use of condoms. The program involves training local healthcare workers and laypersons to outreach the community. Recipients receive family planning birth control options and training.

Educate them on the risks of having too many children both health wise like Anemia & Nutritional Deficiencies. Uterine prolapse rapture, preeclampsia, blood clots, Postpartum Hemorrhage and dysfunctional labor and economically

Create strategies to involve the men in participating in the process of family planning. A more couple-oriented approach to family planning is needed. Measures could include, for example, recruiting males as family planning providers, offering more family planning counseling for couples, and promoting female-oriented methods with men and vice versa. Therefore in order to increase men participation in family planning, it is imperative that we increase better understanding towards gender equality and equivalence, as well as reproductive rights, which is an integral part of universal human rights.

Teach the women of the different income generating activities to make them more independent both socially in decision making and also economically. The government

should aim at building of better and closer health centers in the area and making sure that they are well equipped with the required drugs and contraceptives to make reproductive health and family planning use easier for these women.

"At a global family planning summit in July, Uganda's President Yoweri Museveni announced that his government would increase its annual expenditure on family planning supplies from US$3.3million to $5million for the next five years. He also pledged to mobilize an additional $5 million from the country's donors." This shows that change is being thought about although a lot has to be done to achieve the maximum goals of full access and use by all women.(IRIN, humanitarian news and analysis)

Focus on the area of promoting the education of the girl child to help equip them with knowledge about their rights and make them better decision makers and not prone to culture and norms that are imposed by society

5.4 Conclusion.

The ICESCR to which Uganda is a state party states that everyone has rights with regard to health Article 12.2a with a focus on maternal and reproductive health and article 2 of the UDHR that states that rights should apply to all human beings without any discrimination based on gender or race.

As was mentioned in the 1994 Cairo convention on Population and the 1993 Beijing Platform, the 2 conventions create a podium for the right to family planning , maternal, infant and reproductive health which includes sexual and reproductive health rights made available to all women Rural and urban.

5.6 Recommendation

Interventional recommendation for the MOH and RHR NGO's

To the MOH and NGOs that deal in reproductive health and family planning, funds should and must be injected in this area of Malangala in Mityana so the above problem can be solved. In my opinion, not a lot of money is need though the first step to be taken is sensitization of the masses both the women and men about the Right to family planning use and access. This can be done by carrying out of outreaches, building of a Nearby

Government hospital in the area so that access of services is made easier especially for the women who have to first do the household chores like digging which is done till noon 12pm, then preparation of meals and looking after the children so by the time she is done doing all these activities there isn't any time left for her to go to the health centers and use the family planning services.

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APPENDICES

APPENDIX 1

QUESTIONNAIRES

For the women in Malangala Sub County on their right to Reproductive health and access to family Planning Services.

My name is Kiddu Ronald a student from Kampala international University Kampala Department of Psychology, college of humanities and social sciences, pursuing a bachelor's of Degree in social work and social administration. I am carrying out a study titled; The Right to Reproductive Health, a Case Study of Women's Access to Family Planning Services in Malangala Sub-County, Mityana District

I am requesting you to answer the following questions as honestly as possible. Strict discretion will be upheld throughout the entire data collection and analysis process. The information provided will be used strictly for academic purposes and treated with privacy.

Your assistance in this regard is most valued

Date of Interview: .....

CODE: .....

SECTION A: BIODATA

1. How old are you? .....
2. What is your marital status?

   ☐ Married ☐ Single ☐ Divorced/ Separated ☐ Widow ☐ Cohabiting
3. Who is the head of your House hold?

   ☐ Husband ☐ Self ☐ Others (Specify) .....
4. Do you have children?

   ☐ YES ☐ NO

If YES, How many children?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Above 6

5. What is the highest level of education

☐ None ☐ Primary ☐ Secondary ☐ Tertiary

6. What is your occupation?

.....

7. Where do you live?

.....

8. What is your Religious Affiliation

☐ Catholic ☐ Anglican ☐ Moslem ☐ Pentecostal

SECTION B: OBJECTIVES.

Now I am going to speak to you about Human rights, and by this (Human rights) I mean things freely entitled to you simply by virtue of being a human being so as to enable you to meet your sexual and reproductive health rights and access to family planning services. That is the knowledge of reproductive health rights, the use, freedom to choose and access quality services, make one's own decisions to mention but a few.

1. Do you realise that safe and effective family planning is your right as women?
2. What rights in regard to reproductive health and family planning do you know?
   a) .....
   b) .....
   c) .....
   d) .....
3. Where did you learn or hear about Rights?

   ☐ Friend ☐ Radio ☐ Health centre ☐ Other (Specify).....
4. Do you know that maternal health, Family planning, fertility and sexually transmitted diseases/Infections like HIV are all under reproductive health?

   ☐ YES ☐ NO
5. Have you ever accessed reproductive health or Family planning services?

   ☐ YES ☐ NO

If YES, where did you access them? .....

6. Do you know any type of family planning methods?

☐ YES ☐ NO

6.1 If YES, please tick the methods you know.

- Pills..... ☐
- Condoms..... ☐
- Injectable..... ☐
- IUD (Intra Uterine Device)..... ☐
- Diaghphram ..... ☐
- Implants..... ☐
- Coils ..... ☐
- Other.....

6.2. Which of the above method have you ever used?

.....

.....

6.3. Why did you choose that particular method?

.....

.....

.....

.....

6.4. Have you ever had any problem with the use of the above mentioned method?

YES ☐ NO ☐

6.5. If yes please elaborate on the problem.

.....

.....

.....

SECTION C

7. Do you face any challenges in accessing family planning services?

☐ YES ☐ NO

If YES, Please mention the challenges.

a) .....

b) .....

c) .....

d) .....

7.1. How do you deal with the challenges?

a) .....

b) .....

c) .....

7.2. What do you wish the government/MOH would do to in the area of family planning?

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.....

.....

.....

8. For those who have used Family planning services before;

What advantages did you get out of it?

a) .....

b) .....

c) .....

What disadvantages did you get out of it?

a) .....

b) .....

c) .....

APPENDIX 2

For the service provider/ heath centre attendants/ Doctors in the various health centres in Malangala sub-county Mityana District

My name is Kiddu Ronald a student from Kampala international University Kampala Department of Psychology, college of humanities and social sciences, pursuing a bachelor's of Degree in social work and social administration. I am carrying out a study titled; The Right To Reproductive Health, A Case Study Of Women's Access To Family Planning Services In Malangala Sub-County, Mityana District

I am requesting you to answer the following questions as honestly as possible. Strict discretion will be upheld throughout the entire data collection and analysis process. The information provided will be used strictly for academic purposes and treated with privacy.

Your assistance in this regard is most valued

Date of Interview: .....

SECTION A: BIODATA

Position held.....

Department .....

Period worked in the Health Centre/Hospital .....

SECTION B: FAMILY PLANNING SERVICES PROVIDED

1. Do you offer F.P services in this Health centre?
2. How do the women in this area learn about the services you offer?
3. Do you teach the women about their right to reproductive health?
4. Do you provide information access of Family Planning services?
5. What age does a girl/woman have to be to use these services?
6. What are the requirements for accessing these services?

7. What F.P services do you offer exactly?

   a) .....

   b) .....

   c) .....

8. What is the most commonly used method by the women of Malangala sub-county?

   .....

9. Do you offer any other methods?

   8.1. What are the other methods offered?

   a) .....

   b) .....

   c) .....

   d) .....

10. How do you handle confidentiality of personal Information concerning the women who come to the centre for services?

    .....
    .....
    .....
    .....

11. What challenges do you face in accessing family planning services as a woman?

    .....
    .....
    .....
    .....
    .....
    .....

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Is your husband/spouse in support of the use of family planning?

YES ☐ NO ☐

SECTION C: ACHIEVEMENTS OF THE HEALTH CENTRES IN MALANGALA SUB-COUNTY.

12. What achievements has the health centre registered statistically in regard to access and use of Family Planning services since 2005 (statistics)?

.....

.....

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.....

SECTION D: CHALLENGES FACED BY SERVICE PROVIDERS OF F.PLANNING

13. Do you face any challenges in administering and providing these services to these women?

9.1. What are the challenges you face?

a) .....

b) .....

c) .....

d) .....

14. Have you tried to address/tackle these challenges?

a) .....

b) .....

15. What in your opinion can be done to provide and maintain the attainment of knowledge and the access and use of Family planning services?

.....

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.....

What in your opinion can be done to maintain full use of family planning services to achieve proper child spacing, and that the women come back to the clinics for safe delivery and not traditional birth attendants (TBA's)?

.....

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.....

.....

APPENDIX 3

FOCUSED GROUP DISCUSSION QUESTIONS

My name is Kiddu Ronald a student from Kampala International University Kampala Department of psychology, college of humanities and social sciences, pursuing a bachelor's of degree in social work and social administration. I am carrying out a study titled; the right to reproductive health, a case study of women's access to family planning services in Malangala sub-county, Mityana district

1. Is Family Planning information available in this community?
2. Do women know their rights to reproductive health? Do the women in their community know that it's their Right to space between the births of the children? What about to decide on the number of children they want?, how do they access this information?
3. Do the women in Malangala use family planning services?
4. Where did the women in this community go to get these services? What about availability of services – a general question on the services in the community
5. Do you normally use clinics and health centres OR Traditional Birth attendants (TBA's) in regard to family planning?
6. Do the women of Malangala register any advantages of using TBA's?
7. What methods of Family planning do the women in this community use?
8. Have the women in the community faced any challenges in accessing these services?
9. How do women in Malangala deal with these challenges?

Questions should be asked and answers should be like a story