PATTERN OF CONTRACEPTIVE USE AMONG WOMEN OF CHILD BEARING AGE IN OVUJO HEALTH CENTRE III, MARACHA DISTRICT

BY

MUNDUA LAWRENCE

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UGANDA

SUPERVISOR: Dr ANYAMA PHILLIP

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Abstract

The study of the pattern of contraceptive use among women of child bearing age at Ovujo Health Centre III, Maracha district.

A cross sectional descriptive study approach was used which involved both quantitative and qualitative method. A simple random method was used to select 30 respondents for the study. The results indicated knowledge about family planning services at 57% while those women who had ever used any contraceptive methods were 67%.

The findings exposed myths and misconceptions in relation to pattern of use as well as long distance travelled, few methods offered at H/Cs, rejection by men, poor services and poor attitude by the health providers, drug stock out and influence of church teachings as main factors contributing to low utilization of contraceptives in Ovujo Health Centre.

Therefore, a number of socio cultural factors limited utilization of oral contraceptives notably lack of support from men, inadequate knowledge, myths and misconceptions about contraception, over bleeding, weight loss and restriction by the Catholic Church remained key barriers. While facility related factors such as long distance that requires transport money, negative attitude of some of the health workers, long waiting hours, drug stock out, few clinic days, limited choices of methods offered contributed to low utilization of contraception use.

There is need for advocacy and health education by district health workers through the local radio talk shows and social gatherings eg. market places on importance of family planning services and the available services with emphasis on addressing the myths and misconceptions plus information education communication materials .

Besides, the district health office and other stake holder service providers like Mariestopes International plus the use religious leaders.

Uganda should organize outreach programs to overcome the challenges of long distance and limited methods.

Declaration

I **Mundua Lawrence** hereby declare that to the best of my knowledge this is my original work and it has never been submitted to any institution of learning for the award of Bachelor of Medicine and Bachelor of Surgery.

Sign:…….. Date:……..

Mundua Lawrence

APPROVAL

This research dissertation has been produced under my close supervision and guidance and I therefore

Recommend the student goes ahead and submit it.

Supervisor

Dr Anyama Phillip

Consultant Surgeon

Jinja Regional Referral Hospital

Signed……

Date……

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Dedication

To researchers, past, present, and the future who utilize the Knowledge, to Health care workers Who apply the knowledge, and to public officials who do their best to promote the health of their Citizens with the knowledge of Science and improve on factors that facilitate utilization Of contraceptives at Ovujo Health Centre III in Maracha District.

Acknowledgement

Special thanks goes to my Supervisor Dr Anyama Phillip for his tireless efforts in guiding me to successfully complete this research project.

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As well as many whose names I have not mentioned here.

Definition of Terms

Contraceptive: Contraceptive widely known in most rural setting as family planning is the planning of when to have children and the use of birth control and other techniques to implement such plans of child birth.

Family planning: Refers to a decision made by an individual or couple on the number of children to have and when to have them.

Infant: A human child from birth (newborn infant) to the end of the first year of life.

Maternal mortality: Refers to death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Modern contraceptive: Modern contraceptive methods are technological advances designed to overcome biology. In this regard, modern methods must enable couples to have sexual intercourse at any mutually-desired time.

Morbidity: Is a term used to describe how often a disease with ill health of mothers occurs in a specific area or is a term used to describe a focus on death.

Neonate: Refers to a new born baby of up to 4 weeks (28 days).

Oral contraceptive: Refers to those short term birth controls tablets administered by swallowing through the mouth.

Women of reproductive age: the period in a woman's life between puberty and menopause (13-49 years).

List of Acronyms/Abbreviations

AIDS: Acquired Immune Deficiency Syndrome

ART: Antiretroviral Therapy

CDC: Centers for Disease Control and Prevention

CPR: Contraceptive Prevalence Rate

FHI: Family Health International

FP: Family Planning

FPAU: Family Planning Association of Uganda

HIV: Human Immunodeficiency Virus

IUCD: Intra-Uterine Contraceptive Device

MCU: Modern contraceptive use

MOH: Ministry of Health

OCP: Oral contraceptive Pill

PMTCT: Prevention of Mother to Child Transmission

RHU: Reproductive Health Uganda

STI: Sexually Transmitted Infections ix

UBOS: Uganda bureau of statistics

UDHS: Uganda Demographic and Health Survey

UNFPA: United Nations Fund for population Activities.

UNICEF: United Nations International Children's Emergency Fund

WHO: World Health Organization.

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Chapter One

1.0 Introduction

This chapter highlights about the background of the study, statement of the problem, purpose of the study, specific objectives, research question and justification of the study.

1.1 Background of the Study

Global health has improved considerably over the last four decades (Andreea, et. al, 2011). However, everywhere the health status of the poor compares unfavorably with that of the more affluent sectors of society. In Africa, one in 26 women of reproductive age die of child birth related complications, as opposed to one in 9400 in Europe. Parallel disparities in fertility and in contraceptive use are found between poor and wealthy countries (Andreea, et. al, 2011).

Out of the 7.4 billion world's population, half (3.7 billion) are entering their child bearing age. Consequently there is tremendous need for contraceptive use, especially in areas with high fertility rate like Uganda. Uganda has a persistent high fertility of (6.7 children per woman) that contributed to the high maternal morbidity and mortality Rate (435/100,000 live births), as well as the rapidly growing population at 3.2% (Nalwadda et. al., 2010). This fertility is high compared to neighboring countries like Kenya and Zimbabwe with an average of 4.5 and 2.8 children respectively. Maternal mortality is further increased by unplanned pregnancies resulting in unsafe abortions, drug abuse or costs incurred during labour as well as the upkeep of a child. High fertility rate and high maternal morbidity and mortality not only strain individuals, families, and public resources, but also hinder opportunities for economic growth and development of a poor country like Uganda with low per capita income. Use of modern contraception has the potential to avert unplanned births, decrease maternal morbidity and mortality, and increases

welfare of families and protect future generations against over population growth (Nalwadda et. al., 2010).

Contraceptive services widely known in most rural setting as “family planning” is the method of choice when and how to have children as birth control measures.

Uganda young population of 15 (52% who are below the age as 15 years, and 17% are between age 15–24 years) and a high total fertility rate (TFR), at 6.7 children per woman (Asiimwe, 2014). As this large cohort of young people enter the childbearing years, their reproductive behavior will determine the growth and size of Uganda’s population for decades to come. Uganda still struggles with as low as (30%) contraceptive prevalence rate (CPR), which is lower than that of her neighbors, Kenya, Rwanda, and Tanzania, which had a CPR of 46%, 52%, and 34% (Asiimwe, 2014).

Additionally, young women face barriers like fear of side effects, costs, and lack of knowledge on contraception services. In the Ugandan context, only 24% of all Ugandan sexually active are married women. Early marriage exposes these young women to frequent and unprotected sexual intercourse, that leads to early and risky child birth. In Uganda, the median age at first marriage is at risk of unwanted pregnancies. This study focused on women of reproductive age (age 15–45) because, in Uganda, the majority of the population is in reproductive age. Given the context of high fertility in Uganda, this study will establish factors contributing to low utilization of contraceptives among women of reproductive age.

1.2 Statement of the problem

Globally, utilization of modern contraceptive like condom and IUD have increased in the recent past years – from 54% in 1990 to 57% in 2012 (WHO, 2012). However, the estimates in Africa remain persistently low at 23% and 24%, respectively. Of the 210 million pregnancies that occur each year, almost 80 million are unplanned. Each year, approximately 42 million pregnant women seek termination of their unplanned pregnancy whereby 20 million undergo unsafe abortions 67,000 die annually. Almost all of these deaths (99%) occur in under developed countries e.g DR Congo (Kangale, et. al., 2014).

A study carried out in Uganda (Okech, et al, 2011) found out that only 51% of the respondents were using family planning services. Besides, Uganda has one of the highest total fertility rates (6.7) worldwide (Hladik, et al., 2009). The same study revealed that, the most commonly used contraceptives methods were condoms (35%), pills (33%), injection (19%), and IUD (4%). Ugandas' contraceptive prevalence rate is lower than that of Kenya (46%), Tanzania (34%) and Rwanda (52%) (ICF International, 2012). It is for this reason that the researcher is prompted to assess the factors contributing to low utilization of oral contraceptives among women of reproductive age, as the recommendations of the findings can be documented to increase utilization of family planning services among women especially of reproductive age.

1.3 Purpose of the study

The purpose of the study is to establish factors influencing utilization of contraceptives among women of child bearing age in Ovujo Health Centre III, so that the findings will be documented to improve provision of family planning services by the health centre.

1.4 Specific Objectives

1. To identify socio-economic factors contributing to low utilization of contraceptives among women of child bearing age in Ovujo health centre III Maracha district.
2. To assess socio-cultural factors contributing to low utilisation of contraceptives among women of child bearing age in Ovujo health centre III Maracha district.
3. To identify health facility related factors contributing to low utilisation of contraceptives among women of child bearing age in Ovujo Health Centre III Maracha district.

1.5 Research questions

1. What are the socio-economic factors contributing to low utilization of oral contraceptives among women of child bearing age in Maracha district?
2. What are the socio cultural factors contributing to low utilization of oral contraception among women of child bearing age in Maracha district?
3. What health facility related factors contribute to low utilization of oral contraceptives among women of child bearing age in Ovujo Health Centre III?

1.6 Significance of the study

The findings contribute to formulation of guidelines and policies to improve on utilization of contraception services among women of reproductive age in the district and the country at large.

The findings of the study will be documented into a report and submitted to Kampala International University Institutional research review committee as well as guide future researchers.

The report on factors contributing to low utilization of family planning services in Ovujo health centre III will give the general picture of the utilization of contraceptives in Maracha district.

Chapter Two: Literature Review

2.0 Introduction

This chapter presents related literature about the study on factors affecting utilization of contraceptives. The presentation is in form of themes in relation to the specific objectives of the study.

2.1 Socio economics factors influencing the pattern of contraceptive use among women of child bearing age.

Several other studies demonstrated that the lower the education the woman has, the less likely she uses contraceptives services. The incidence of unwanted pregnancies is also high amongst the less educated women (Kei et. al, 2011). It is also clear that the uneducated women were unlikely to find husbands who will support her sexually. She only performs her household duties, whilst the man decides on the family and size whether she can use contraceptives or not (Ehlers, 2009). This has left many women with no control over their reproduction.

Creanga et. al., (2011), stated that poorer women use contraception much less than wealthier women probably because some methods or services have associated costs like transport money. The poor do not have the same access to life-saving and health-maintaining interventions as the rich, yet they aspire to the same healthy lives as those who are economically better off. However, a difference in fertility between the rich and poor is not an inequity provided the poor have higher fertility because they want to have more children as source of wealth and security in their community. An inequity exists when people are unfairly deprived of something they want or require to protect them from an unwanted or undesirable condition.

Socio-cultural factors several socio-economic factors are shown to be associated with high fertility rates, low levels of female education and income per capita, rural residence and high infant and child mortality. Other barriers to sustained contraceptive use include medically inaccurate notions about how conception occurs and fears about the effects of contraception on fertility and menstruation, which were not taken seriously by care provider (Andrea et. al.., 2011). Many contraceptives are encumbered with potentially unnecessary restrictions on their use. Indeed, fear of side effects, fostered by alarmist labeling, is a leading reason that women do not use contraceptives (Nyongesa, et. at., 2015).

Christian teaching vary depending upon the denomination, Roman Catholics are therefore forbidden to use medical or physical contraception methods. Natural contraceptive methods such as abstinence and the rhythm method remain permissible. Among Protestants, no specific forms of contraception are forbidden. Hindu doctrine prefers sons and no prohibition against contraception. Buddhist religious dogma allows contraceptive methods with promiscuous behavior, a lack of information about the safety of contraceptive methods, and lack of access to health facilities because of the expenses or availability of contraceptives may limit their effective utilization (ibid) (Nyongesa et. al., 2015).

It has also been hypothesized that there is a positive correlation between contraceptives use and level of education. Other things being equal the higher the level of education the higher contraceptive use is expected to be. Although both the wife's and husband's education is important that appears to be consensus that the former is more important than the latter (Nyongesa, et. al., 2015)

Use of family planning is higher in urban than rural areas. Urban-rural difference in the adoption of contraception is the highest in Sub Saharan Africa, where the rate is more than twice as high as among urban than among rural in all surveyed Countries. The observed variation in contraceptive use by place of residence may be attributed to differences in the availability of such social service as education, information about family planning, access to family planning and health care services (Nyongsa, et. al., 2015).

In Malawi, religious affiliation also affects contraceptive use. Religions differ in their stand on fertility regulation and among the major world regions, Catholicism and Islam are widely regarded as pronatalist in their ideology. However, the relationship between religion and contraceptive use is much more complex than expected. In one study conducted in India, it was discovered that even though the average number of children born to a Muslim or Christian couple is higher than that born to a Hindu couple, the acceptance of sterilization to limit family size was greater among Muslims and Christians than Hindus. A study of contraceptive use in Bangladesh found out that Muslim women were less likely to use contraception than Hindu women. The strength of one's religiosity or degree of one's adherence to the norms of a given religion may exert an influence on one's mode of life including reproductive behavior. Furthermore, studies in developing Countries revealed that social, cultural and religious unacceptability of contraception frequently emerged as an obstacle to use contraception (Palamuleni, 2013).

The work status of women in Malawi has been linked to knowledge and use of contraceptives. Consequently, they have more control over reproductive decisions. Some studies also add that paid work also provides alternative satisfactions for women, which may complete with bearing and rearing children and may promote contraceptive use (Palamuleni, 2013).

2.2 Socio cultural factors influencing the pattern of contraceptive use among women of child bearing age.

In the U.S.A, oral contraceptives are currently available by prescription, with the exception of some emergency contraceptives, thus the growing debate over whether or not to provide oral contraceptives over the counter. The Oral Contraceptive over-the-Counter, and women's health clinical and research institutions, argued that prescriptions to access oral contraceptives is "patronizing to women that limits contraceptive freedom, and is ineffective against intractably high teen-pregnancy rates," (Naidoo, et. al., 2013).

In South Africa, where contraceptives are provided free due to better economic of charge, 30% to 50% of women present with unwanted and unplanned pregnancies and then seek termination of pregnancy. In 2009 report on Nigerian women, 31.5% believed that having sex once with a man would not result in pregnancy, although 90.0% knew about the benefits of family planning services. Consideration of personal health and husband's approval were major determinants regarding the respondents' use of contraceptives services. The authors concluded that there was a need for continuous education about contraception (Kangale et. al., 2014).

Men's attitude towards contraception strongly influences the willingness and ability of women to use contraception. Ten percent (10%) of married women were with unmet need for contraception in Latin America, and the Caribbean, 22 to 25% in Sub-Saharan Africa and Asia. This poses an enormous challenge to women in Sub-Saharan Africa, where spousal consent on females to receive contraceptives is often required by health care providers. For instance, in Democratic

Republic of Congo, many clinics and hospitals provide women with contraceptive services only if their husbands are present, (Kei, et. al, 2015).

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Religious belief has played a leading role in discouraging dissemination of information on other family planning methods except natural methods like withdrawal. Particularly, Catholics have a restriction in matters concerning contraception use e.g condoms (Lanre, et. al., 2011). Their teaching discourages the use of modern contraceptives on grounds that unnatural methods encourage promiscuity.

Countries that predominantly belief in Catholic teachings , (for example Brazil), the church is at the forefront of influencing government policies particularly in the area of limiting FP services available and discouraging fertility limiting behaviors as written in the bible in fulfillment of the call to "produce and fill the earth" (Genesis 2:28). However, there is no consensus regarding the use of contraception among the Muslims although conservative Islamic leaders have openly campaigned against the use of condoms and other birth control methods (Dawud, 2008). Nevertheless, the influence of religion has stiffened the transmission and accessible information via media as well as in School wealth (Andi, et. at. 2014).

Misconceptions and beliefs surrounding contraception and reproduction were mentioned in a focus group discussion in a study by Nalwadda, et. al., (2010), where young people believed that contraceptives interfered with fertility, and that it could affect their ability to produce children. Most of the women belief that pills burn the woman's eggs. Both male and female participant's belief that these pills can accumulate in the body causing swellings, such as fibroids, cancer, destruction of the fallopian tubes, and when used they are abortifacient. Also they are convinced that the intra uterine device could pierce the uterus and disappear into the body.

Adeomi et al., (2009), found out that, the main reasons for non- use of contraceptives such as oral contraceptives was the fear of side effects of using family planning, husbands' disapproval and the desire for more children, religion and family setting having a significant association with the use of modern contraceptive methods. There were also knowledge gap on contraceptive methods, e.g fears, rumors and misconception about specific methods and unavailability or poor quality of services (Kamau et al, 2006).

2.3 Health facility access related factors contributing to pattern of contraceptive use among women of child bearing age.

UNFPA, (2012), reported that the estimated contraception use among Sub-Saharan countries were much lower than the developed countries. For example, the average contraceptive prevalence rate (22 percent) is less than half that of South Asia (53 percent) and less than a third that of East Asia (77 percent) (World Bank report, 2009). This has been attributed to other factors like shortfalls in health infrastructure and transport facilitation. Further, these studies

show that women tend to seek long lasting family planning methods such as intrauterine devices, Injectable and implants which are often not readily available at the health facilities.

A report by WHO, (2013), revealed 222 million women in developing countries who want to space or prevent child bearing, but they lack access to modern contraceptive methods. This situation normally results in high fertility rates which in turn are associated with high levels of maternal mortality especially among poorest women.

Women in many communities face significant barriers to contraceptive access, with at least 9 to 15% of married women in developing countries reported that they "do not have access to contraceptives service due to long distance, lack of information on where to go for FP services". Although oral contraceptives and hormonal injections are popular in many developing regions, particularly in Africa, these methods are constrained by limited supplies at family planning clinics (Naidoo, et. al., 2013).

In Mali, young women suggested that access to modern methods was not a problem, but health services were considered inaccessible in most of the studies. This was partly because of the distance to these, but mainly because young women perceived services to be catered principally for married women and they had significant fears of receiving a negative reception from clinic staff (Lisa, et. al., 2009).

Attitude of service providers /service users, coupled with lack of privacy and confidentiality, were said to inhibit young men and women from seeking contraception services. There is fear of disclosure by service providers. Lack of privacy among health workers create especially the young men or women who come to the health unit for contraception services was reported in the

focus groups. In addition to that, the clinics were habitually out of stock of oral contraceptives and had limited choices of methods, making it very difficult to use any method consistently. Access was further restricted by cost implications in terms of transport, and long distance to health facilities (Nalwadda, et. al., 2010).

Poor attitude from service providers also serve as obstacles to initiation as well as to continuation of modern contraceptive methods among young people. It was noted that health providers restrict access to modern contraceptives to the unmarried, adolescents and those with no children expecting them to abstain until they get married (Nalwadda, et. al., 2010). Strategies to strengthen health care provider's knowledge, skills and attitudes in youth friendly services. The provider's opinion influence services young people receive and their subsequent contraceptive behavior.

Uganda's health sector strategic plan for 2010–2015 addressed its policies on the procurement and distribution of contraception to all males and females specially focuses on adolescents. By contrast, another study conducted in Uganda found out that young people are restricted when they request for contraceptives from providers (Devika, 2012). Nearly one-third of the providers said that they will not supply contraceptives to individuals below 18, unmarried, still in school, and those without children, although the policy guidelines of Uganda are clear on adolescent health. Therefore, the unwillingness to provide contraceptives due to cultural or individual biases illustrate the urgency of prioritizing young people's contraceptive needs. The existing gap between reproductive health, policy, and the availability of contraception restricts actual contraceptive use in Uganda (Devika, 2012).

Long waiting time on line and lack of “youth friendly services” were other barriers in accessing facilities as mentioned. Young people also felt ashamed and reluctant to ask for contraceptive services from busy health care professionals. Furthermore, young women would sometimes buy condoms from private clinics and drug stores with unqualified staff who cannot give appropriate information to health problems and thus, in discontinued use (Nalwadda, et. al., 2010). The same study reported fears of social stigma at the health facility that propelled some women to procure contraceptives from private clinics/stores since they provided privacy at the facility.

Chapter three: Methodology

3.0 Introduction

This chapter draws attention to study design, study setting, and rationale, study population, sample size determination, sampling procedure, inclusion criteria, definition of variables, research instruments, data collection procedures, data management, data analysis, ethical considerations, limitations of the study and dissemination of results.

3.1 Study Design and Rationale

This study employed a descriptive quantitative study design to identify the pattern of contraceptive use in Ovujo health Centre III, Maracha district.

3.2 Study Setting and rational

This research was carried out in Ovujo health centre III which is located in Oluffe Sub County Maracha district. Maracha district is bordered by Koboko district in the North, Yumbe district in the North-East, Arua in the South and Democratic Republic of Congo (DRC) in the West. Maracha town, this is the Administrative and commercial headquarters of the district which is 556 kilometers away from Kampala which is Uganda's capital city.

3.4 Study Population

The eligible population was men and women of reproductive age who came for antenatal care (ANC) and postnatal clinic (PC) in the health Centre at the time of data collection.

3.4.1 Sample Size Determination

Simple random sampling was used to identify and interview mothers who come for YCC, ANC, PN services. A total of 30 respondents were interviewed.

3.4.2 Sampling Procedures

Mothers/fathers who turned up for young child clinic, antenatal care and postnatal care were selected for the interviews. Simple random sampling method was used to select respondents. The In-charge of the health Centre helped to introduce the researcher to other staff members before interacting with the respondents. A research assistant was trained to help the researcher during data collection.

3.4.3 Inclusion Criteria

Mother/ father of reproductive age who turn up for ANC and PN services in Ovujo health centre III were selected for the interviews.

3.5 Definitions of Variables

Dependent Variable:

These refer to variables that do not change and include; age, occupation, sex, level of education, marital status.

Independent variables

These refer to effects of low utilization of contraceptives unplanned pregnancy.

3.6 Research Instrument

The required data was collected using semi structured questionnaires and interviews with the help of Research Assistant. The questionnaire items were derived from the specific objectives where both open ended and closed questions were raised to capture various responses derived from the objectives. The questionnaire was pre-tested with 5 respondents from antenatal care (ANC). To ensure that all questions asked were understood by editing where things could not be clear to the respondents to avoid biases.

3.7 Data Collection Procedures

Data collection was carried out using semi structured questionnaire and then data was coded, edited and fed into computer processed, analyzed using Ms excel computer package. The justification for using quantitative design was to enable the researcher report the findings in a manner that is simple to interpret and can easily be understood and costs effective.

3.7.1 Data Management

Quantitative method was used, edited, coded, cleaned and fed into statistical data analysis package such as Ms excel and Microsoft word for further analysis. The interpretation and presentation of data was carried out using descriptive statistics such as bar charts, pie charts and tables. Averages and percentages were applied to aid interpretation of the results of the study.

3.7.2 Data analysis

The interpretation and presentation of data was carried out using descriptive statistics such as bar charts, pie charts and tables. Averages and percentages were applied to aid interpretation of the results as well as text to support the findings. Explanations to the result were given in narrative form for better understanding.

3.8 Ethical Considerations

Introductory letter was sought from Kampala International University Western Campus Faculty of Clinical Medicine and Dentistry and the District Health Office Maracha District Local Government, and presented to the Incharge Ovujo Health Centre III to carry out the study in the Health Centre, prior to obtaining consent from the respondents.

3.9 Limitations and delimitations to the Study

Financial challenges faced in relation to secretarial costs such as typesetting and printing, as well as binding. This was overcome by having drafted hand written and followed with typesetting with the help of friends personal computers to cut down costs of typesetting. The short during of time allocated for the study and other assignments which were addressed by drawing proper time table for research and other class room assignments. There was a barrier of language challenge with respondents who spoke Alur which the research assistant helped to translate.

3.10 Dissemination of Results

The results were interpreted from conclusion and recommendations drawn from the study. This was followed by documentation into a full report that will be submitted for partial fulfilment for the award of Bachelor of Medicine and Bachelor of Surgery, the District Health office Maracha District local Government, Supervisor and as well as file copy for future refernce. Dissemination provided information to various stakeholders on pattern of utilization of contraceptive use among women of reproductive age in Maracha district.

Chapter Four: Results

4.0 Introduction

This chapter presents the results of the study obtained using the research questionnaire designed. The results are based on the specific objectives of the study and illustrated using figures and tables for easier interpretation.

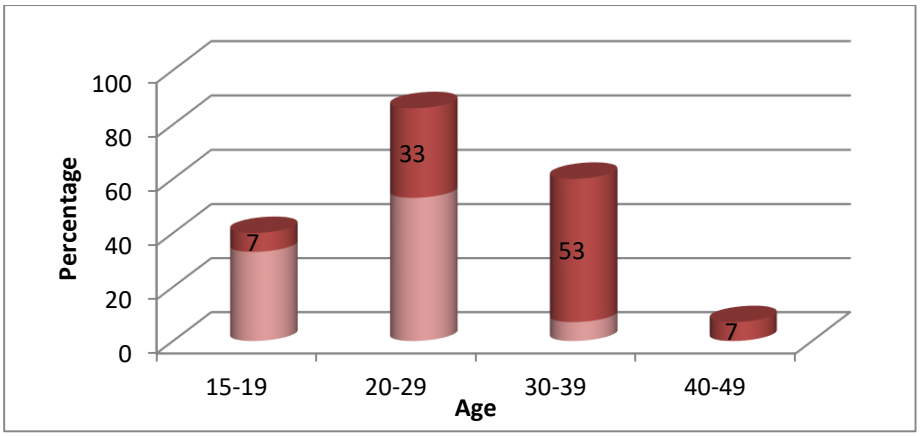
4.1 Socio Demographic Characteristics

Table 1: Distribution by genda of respondents (n=30)

Genda	**Frequency (*f*)**	**Percentage (%)**
Male	4	13
Female	26	87
Total	**30**	**100**

Majority (87%) of the respondents were females while 13% were male.

Figure 1: Distribution by age of respondents



Fifty three percent (53%) of the respondents were aged between 30-39 years, 33% between 20-29 years, 8% between 15-19 years and 6% 40-49 years of age.

Table 2: Distribution by level of education (n=30)

Level of education	**Frequency (*f*)**	**Percentage (%)**
Non formal education	1	3
Primary	14	47
Secondary	10	33
Tertiary	5	17
Total	**30**	**100**

Forty seven percent 47% (14) of the respondents attained primary education, 33% (10) secondary level, 17% (5) tertiary level of education and 3% (1) non formal education. Since the majority of the women dropped out from school in primary the level of understanding was limited. This a direct correlation with the utilization of contraceptives.

Table 3: Distribution by marital status of respondents (n=30)

Level of education	**Frequency (*f*)**	**Percentage (%)**
Married	20	67
Single	9	30
Cohabiting	1	3
Total	**30**	**100**

Majority 67% (20) of the respondents were married, 30% (9) lived single while 3% (1) cohabiting. They had some knowledge on contraception.

Table 4: Distribution by occupation of respondents (n=30)

Occupation	**Frequency (*f*)**	**Percentage (%)**
Employed	5	17
Unemployed	20	64
Self employed	5	17
Total	**30**	**100**

Sixty four percent (64%) of the respondents were unemployed, 17% employed and 17% self-employed. Thus, poverty level remains high compared to other communities who get regular income.

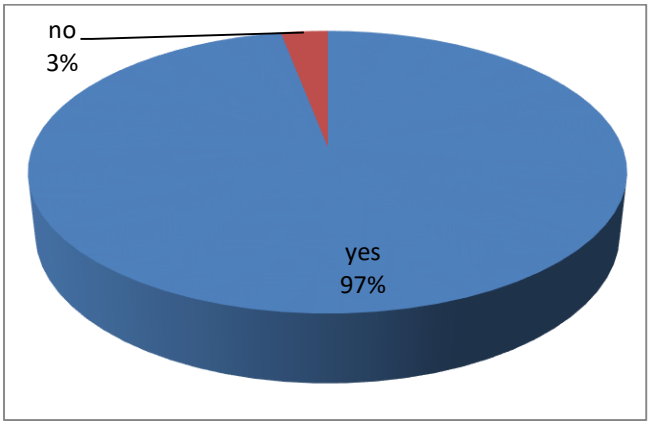
Table 5: Distribution by Religion of respondents (n=30)

Religion	**Frequency (*f*)**	**Percentage (%)**
Protestant	10	33
Catholic	16	53
Muslim	3	10
Born again Christian	1	3
Total	**30**	**100**

Fifty three percent (53%), of the respondents were Catholics, 33% Protestants, 10% Muslim and 3% Born again Christians. The Christians were more concerned about contraception services.

4.2 Socio cultural factors contributing to low utilization of oral contraceptives among women of child bearing age.

Figure 2: Knowledge about family planning



Ninety seven percent (97%), of the respondents had some knowledge about family planning while 3% did not know. Much as they had some knowledge on FP services, they could not utilize the services.

Table 6: Source of information about family planning (n=30)

Source	**Frequency (*f*)**	**Percentage (%)**
Hospital Friends school	22	73
School Friends	7	24
Friends hospital	4	13
Total	**30**	**100**

Seventy three percent (73%) of the respondents heard about family planning services from the hospital during health education, friends and school. 24% (7)reported having got their information from school and friends meanwhile 13%(4) got to know about family planning from friends and hospital

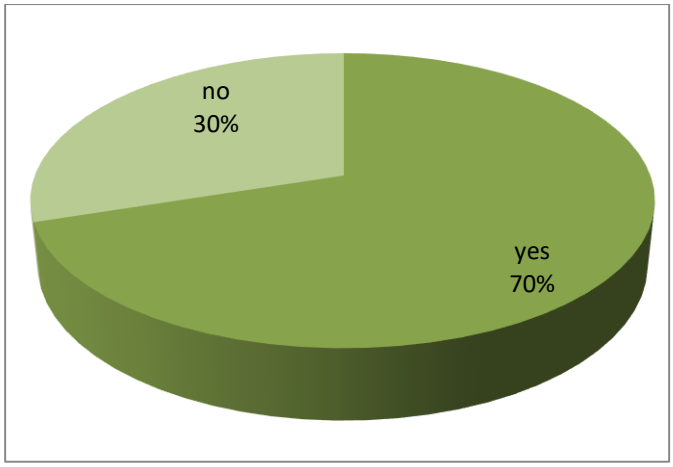
Table 7: Misconceptions and myth about family planning (n=30)

Misconceptions	**Frequency (*f*)**	**Percentage (%)**
Causes barrenness Cancer Weight loss	11	37
Causes cancer Disappear in the body	8	27
Loss of weight Caner	4	13
Weight increase (fat) Sterile	1	3
Disappears in the body hypertension	3	10
Becomes sterile Cancer	2	7
Causes hypertension Weight loss	1	3
Total	**30**	**100**

Thirty seven 37% (11) percent of the respondents complained that family planning causes barrenness, cancer and weight loss. 27% (8) reported it causes cancer, disappear in the body and hypertension. 13% (4) report loss of weight and cancer, 10% (3) disappears in the body and cause hypertension. 7% (2) becomes sterile and causes cancer 3% (1) causes hypertension and weight loss. 3% (1) causes weight loss and sterility.

There is need to address or give correct information about different methods of family planning.

Figure 3: Whether respondents ever used any contraceptives



Seventy percent (70%) of the respondents had ever used contraceptives for family planning methods while 30% never used any. This means that they had knowledge on the different family planning methods.

Table 8: Method of contraceptive used (n=30)

Method	**Frequency (*f*)**	**Percentage (%)**
Condoms	15	50
Oral contraceptive pill	9	30
IUCD	2	7
Abstinence	2	7
Depoprovera	1	3
Implanon	1	3
Total	**30**	**100**

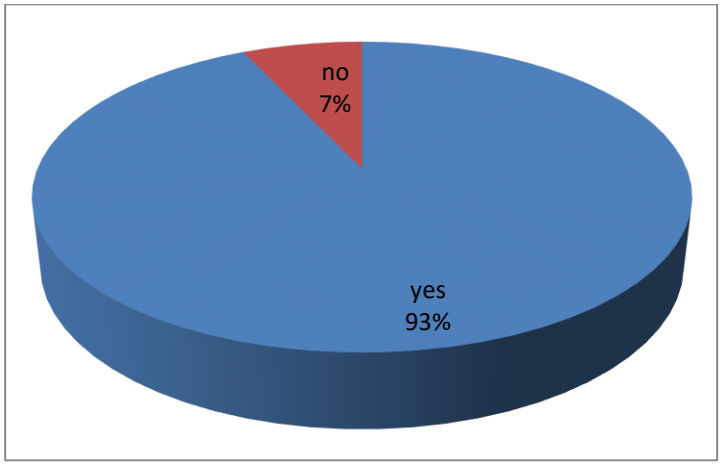
Half 50% (15) of the respondents used condoms for family planning, 30% (9) used pill plan, 7%(2) IUD, 7% (2) abstained from sex, 3%(1) depo and 3%(1) implanon. Condom is the most common method used by the couples.

Table 9: Duration for which respondent used family planning method (n=30)

Duration	Frequency (*f*)	Percentage (%)
1-12 months	16	53
1-2 years	6	20
3-4 years	5	17
5-6 years	3	10
Total	**30**	**100**

53%(16) of the respondents used family planning for a period of 1-12 moths, 20%(6) for 1-2 years, 17% (5) for 3-4 years and 10% (3) for 5-6 years. Which means they were mostly using short term acting method.

Figure 4: Whether the health facility offers family planning services



Ninety three percent (93%) of the respondents reported that the health facility offers these family planning methods while 7% said the services were not provided.

Table 10: Possible reasons for not accessing family planning services (n=30)

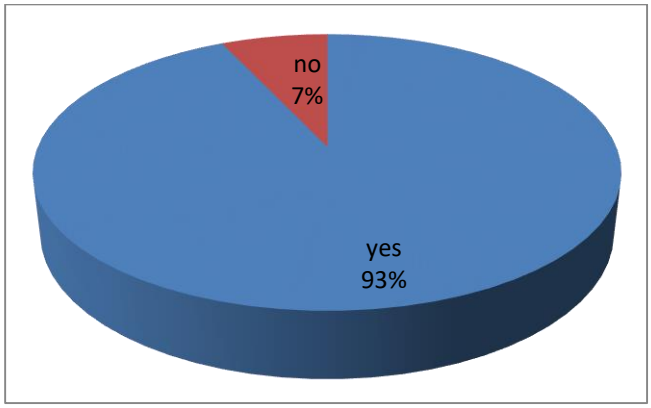
Reasons	Frequency (*f*)	Percentage (%)
Fear of permanent infertility Influence of catholic church Choice to produce more children	6	12
Fear of permanent infertility Fear of over bleeding Dislike by spouse Use of natural method	14	28
Fear of over bleeding Use of natural method	6	12
Dislike by spouse Use of natural methods	6	12
Influence of catholic church Dislike by spouse	6	12
Use of natural method Choice to produce more children	12	24
Total	**50**	**100**

Twenty eight percent 28% (14) of the respondents do not use family planning due to fear of permanent infertility, fear of over bleeding, dislike by spouse, and they prefer use of natural method, 24%(12) choice to produce more children and use of natural method 12%(6) fear of over bleeding and use of natural method, 12%(6) dislike by spouse and use of natural method 12%(6)dislike by spouse and influence of catholic church, 12%(6)Fear of permanent infertility, influence of catholic church and choice to produce more children. The findings have shown that the society does not have adequate knowledge on the different family planning services.

Whether the community is aware of family planning services

All (30) of the respondents reportedly said the community were aware of family planning services, but could not access the services.

Figure 5: Whether there are costs associated with family panning



Ninety three percent (28) of the respondents reported that there were costs associated with family planning as opposed to 7% who said no costs.

Table 11: What prevents respondents from accessing family planning services (n=30)

Barriers	**Frequency (*f*)**	**Percentage (%)**
Lack of money to buy contraceptives Lack of information Negative attitude	1	3
Long distance to the health Centre' Fear of side effects Fear of reaction from spouse	14	47
Myths/misconception about family planning Fear of side effects Preference for natural methods	4	13
Fear of side effects Lack of information fear of over bleeding Preference for natural methods	3	10
Fear of reactions from spouse Lack of information Negative attitude	2	7
Fear of over bleeding Lack of money to buy contraceptive Long distance to the health Centre	1	3

Preference for natural method Myths and misconceptions about family planning		
Preference for natural methods Fear of reaction from spouse Fear of side effects Fear of over bleeding	1	3
Lack of information (ignorance) Lack of money to buy contraceptives Negative attitude Fear of reaction from spouse	2	7
Negative attitude Fear of reaction from spouse Fear of side effects Long distance to health center Myths/ and misconception about family planning	2	7
Total	**30**	**100**

Forty seven percent (47%) of the respondents were not accessing family planning services due to long distance travelled to the health Centre, fear of side effects and fear of reaction from spouse. 13% myths and misconception about family planning services, fear of side effects and preference for natural methods.

10% fear of side effects, preference for natural methods, fear of over bleeding and lack of information.

7% fear of reactions from spouse, lack of information, and fear of side effects.

7% lack of information, negative attitude, and fear of reaction from spouse.

7% negative attitude of respondents, myths /misconceptions about family planning services, long distance to the health Centre', fear of side effects. 3% fear of over bleeding,

myths/misconceptions about family planning services. 3% lack of money to buy contraceptives, negative attitude and lack of information (ignorance).3% preference for natural methods, fear of side effects, fear of reaction from spouse, fear of over bleeding.

4.3 Health facility related factors contributing to low utilization of oral contraceptives

Whether respondent was aware of FP services in the health Centre.

All the respondents were aware of availability of family planning services in Ovujo Health Centre III.

Table 12: Knowledge of available methods (n=30)

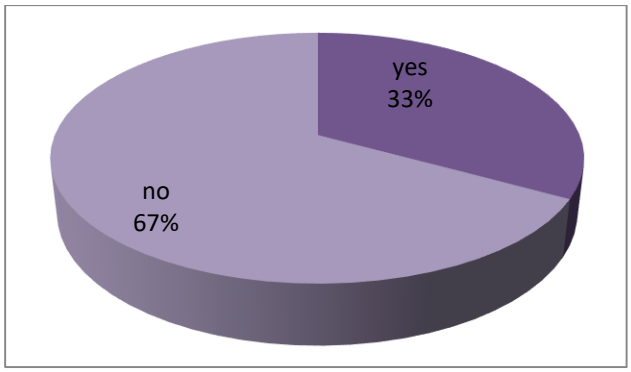
Method	**Frequency (*f*)**	**Percentage (%)**
IUCD Injectables	2	7
Pills condoms	8	26
Injectable(depo) Pills Condoms IUCD	9	30
Condoms Pills Injectable(depo)	11	37
Total	**30**	**100**

37% (11) of the respondents were aware of condoms, pills and injectable (depo).

30% (9) knew Injectable, pill condoms and IUCD.

26% (8) were aware of pills and condoms .7% (2) knew IUCD and injectable.

Figure 6: Whether respondent ever used any oral contraceptives



Sixty seven percent (67%) of the respondents never used oral contraceptives while 33% ever used. Therefore, condom is the most commonly used F.P method.

Table 13: Reasons stopping mothers from using contraception services (n=30)

Reason	**Frequency (*f*)**	**Percentage (%)**
Poor attitude of health workers Ignorance about importance of FP	7	23
Fear of men's reactions Poor attitude of health workers Long distance	9	30
Ignorance about importance of FP	2	7
Long distance Long waiting hours Fear of Men reactions	4	13
Long waiting hours Inadequate drugs Fear of infertility	3	10
Inadequate drugs Fear for infertility	2	7
Preference for calendar method	1	3
Fear for infertility	2	7
Total	**30**	**100**

30% ((9) of the respondent were not utilizing family planning due to fear of men's reactions, poor attitude of health workers and long distances 23% (7) poor attitude of health workers, and ignorance about the importance of family planning. 13% (4) reported long distance, long waiting hours and fear of men reactions. 10% (3) reported long waiting hours, inadequate drugs and fear of infertility. 7% (2) ignorance about importance of FP services and fear of infertility 7% (2) inadequate drugs. Poor attitude of men (spouse), health workers, long distance travelled were the common factors stopping mothers from using contraception services.

Health facility related factors stopping women from accessing contraceptives from Ovujo HC III

Inadequate drugs at the health facility e.g, pills where sometimes women come back without getting the service they require.

Inadequate information on family planning hence women remain ignorant.

The poor attitude of some Health Workers scares women from accessing family planning.

The limited available method to the women in the health facility was yet a barrier.

No or little knowledge about FP services due to lack of exposure especially among the illiterate women in rural communities and some of the health workers.

The fear of side effects like over bleeding, severe abdominal pain, changes in body weight were reasons for negative attitude towards utilization of contraception.

Myths like delay to regain fertility after removing or discontinuing drugs.

The influence of the Catholic Church, that preaches natural methods as opposed to modern FP methods.

Measures to improve utilization of oral contraceptives

Mass community sensitization on family planning so that both men and women have the same mind set.

Male involvement in family planning because many women fear the reaction of men who in most cases reject family planning services.

Contact health education to women on family planning for clear decision making.

Counseling on side effects so as to change the mind set of myths and misconception and write information given to the community by trained health workers.

Improve on outreach programs to serve more clients who find it difficult to reach the health facility.

There is need for adequate stocking of drugs so that women who turn up for family planning are able to get the required service once.

The district should provide capacity building trainings to the health workers to improve their knowledge on the various methods of contraception provide so as to minimize myths and misconception about F.P methods and routes of administration.

Improve information system by fully involving VHTs so that message reaches all people.

Increase number of staffing in the health centers to reduce on the long waiting hours as well as reduce workload on the few staff on duty.

Increase number of clinic days to at least two in a week so that women find a day convenient to them. Besides, integrate services to attract women to the facility. This can be achieved by creating youth friendly related services like film shows on the various family planning methods.

Start health education on adolescent sexual and reproductive behaviors early enough targeting teenagers in schools to prepare them in life.

Provide privacy at the clinic specifically for family planning so that women can freely share their experiences so as to gain confidence.

Chapter Five: Discussion of Findings, Conclusion and Recommendations

5.0 Introduction

This chapter discusses the findings of the study derived from the results obtained using the questionnaire interviews. It also draws conclusions and recommendations based on the study findings.

5.1 Discussion of findings

Results correlate relevant positive findings with other studies

Majority (87%) of the respondents were females (table 1). This was a true reflection of accessibility of family planning in facilities. Very few men get involved in family planning as such family planning has over time being women's affair despite rejection by most men. These were mainly (53%) youths of age 30-39 years (figure 1). This is age bracket that has mostly achieved the number for children needed as they approach their menopause age.

The level of education was as low as primary as reflected by 47% of the respondents (table 2). It was observed that the higher the level of education the better the knowledge on family planning. This agrees with a report by Kei et. al, (2011), who noted that the incidence of unwanted pregnancies still remain very high amongst the less educated women. In this study 33% of those who attained secondary education used contraceptives yet they were fewer in number compared to the semi illiterate who do not access health care services.

Contraceptive use was more among married couples as reported by 67% of the respondents (table 3). This helps to space children by choice not chance given that couples who live together have high chances of producing more children than required. This agrees with findings by Lisa,

et. al., (2009) “young women perceived services to be catered principally for married women and they had significant fears of receiving a negative reception from clinic staff”.

The majority (64%) of the respondents were unemployed (table 4). Since there are associated costs in provision of the services for example costs of transport money to the health facility, sometimes the drugs may be out of stock at the facility hence prescriptions given for purchase from drug shops. This agrees with findings of a study in the United States by Creanga et. al., (2011), “stated that poorer women use contraception much less than wealthier women probably because some methods or services have associated costs like transport money.”

The majority of the respondents were Catholics as reported by 53% (table 5). The stand of the Catholic Church on modern contraceptives has been negative as they preached abstinence which modern society has been grossly abused. This probably explains the low utilization of contraceptives among communities dominated by Catholics. This agrees with a report by Lanre, et. al., (2011) “Religion has played a leading role in discouraging dissemination of information on other FP methods except natural methods like withdrawal. Particularly, Catholics have a restriction in matters concerning contraceptive use e.g condoms”.

The study noted that awareness about family planning as represented by 97% of the respondents who reported to have heard about family planning (figure 2). However, this does not mean they have adequate knowledge and therefore utilize contraceptives but simply heard about the services at the facility hence the low utilization.

The study noted that most (73%) of the respondents got information about family planning services from the health facility (table 6). This is an indication that mothers who come for ANC and postnatal care got informed about family planning from the health facilities.

The majority (70%) of the respondents have ever used contraceptives for family planning (figure 3). However, different methods were used but most commonly used was the condom and pill plan while IUD, and Implanon were the least used methods alongside abstinence. Women find it easier to use pill plan because it can be stopped any time however the complication is following all the dosage required.

The study found that 53% of the respondents used family planning for a period of up to one year and stopped (table 9). These short term methods included pills and depo provera.

The study noted that 93% of the respondents were aware of the family planning services offered at the facility (figure 4). Despite availability of family planning services, there were specific days in a week this service is offered. This is contrary to findings of a study in Mali by Lisa, et. al., (2009) "young women suggested that access to modern methods was not a problem, but health services were considered inaccessible". This was partly because of the distance travelled.

Some women were not using any contraceptive method and this was mainly (20%) attributed to fear of permanent infertility, influence of the catholic church on FP methods, fear of over bleeding, dislike by spouse (men) who prefer to produce more children and use of natural methods (table 10).

All the 30 respondents reportedly said the community was aware of family planning services but utilization was very poor.

The study found out that family planning services were provided free of charge (figure 5). This being a government facility, services are meant to be provided free of charge except minor costs that may be transferred onto a client in case of stock out.

A number of factors that prevented respondents from accessing family planning services (table 11). The most common challenges were long distance to the health center, myths and misconception about family planning methods, fear for side effects, fear for reactions of men, lack of information, fear of over bleeding, preference for natural methods, negative attitude of respondents and single status. This concurs with findings of a study by Kangale et. al., (2014) who reported that consideration of personal health and husband's approval were major determinants regarding the respondents' use of contraceptives.

The study noted that all the respondents were aware of availability of family planning services in Ovujo Health Centre III but there was low utilization. Other than knowing availability of the services most of the respondents did not know the specific methods offered and duration of most methods.

Majority (57%) of the respondents ever received some services from the health Centre before (figure 6). As stated in table 12, most of the women in Ovujo HC received short term contraceptives such as condoms, pill plans and depo provera. This could mainly be due to influence of men who do not permit their wives to use contraceptives as such women end up using methods they know can be stopped any time for fear of men's reactions.

Most (67%) of the respondents had ever used oral contraceptives (figure 6). This percentage is still low given that oral contraceptives are short term methods e.g the pill plans that many women find it tedious to effectively use on daily basis. As such women tend to conceive amidst use of pills due to missed days or clinics running out of stock that are not covered timely. This concurs with findings of a study by Nalwadda, et. al., (2010) "the clinics were habitually out of

stock of oral contraceptives and had limited choices of methods, making it very difficult to use any method consistently".

The study found out various reasons for which women were not using various methods of contraception (table 13). Women fear the reaction of their partners when they use any family planning method. This implies that, couples do not hold prior discussion on the need to go for family planning services as required or when their partners refuse, women sometimes go ahead to use. This therefore becomes source of conflict in families than relief. According to Kei, et. al, (2015), "Men's attitudes towards contraception strongly influences the willingness and ability of women to use contraception". Other barriers included negative attitude of some health workers, long waiting hours at the facility, ignorance about importance of FP services and inadequate drugs at the facility.

Long distance travelled to the health Centre's that require transport money which has been hard amidst low income by the families. Naidoo, et. al., (2013) who noted that women in many communities face significant barriers to contraceptive access, with at least 9 to 15% of married women in developing countries reporting that they "do not have access to contraceptive services due to long distance, lack of information on where to go for FP services among others.

Poor attitude of men and women towards family planning services to myths and misconceptions all affect the utilization of F.P negatively.

Fear of spouse's reaction mainly the men who wish to produce many children. Ehlers, (2009), "it is also clear that the uneducated women are unlikely to find husbands who will support her after sexually act. She only performs her household duties, whilst the man decide on the family size whether she can use contraceptives or not".

Stock out at the health facility e.g pills where sometimes women come back without getting the service they require. Naidoo, et. al., (2013), "although oral contraceptives and hormonal injections are popular in many developing regions, particularly in Africa, these methods are constrained by limited supplies at family planning clinics".

Inadequate information on family planning services hence women still remain ignorant about the availability of family planning services.

Poor attitude of some Health Workers that scares women from accessing Family Planning. Nalwadda, et. al., (2010) who noted that the attitude of service providers, coupled with lack of privacy and confidentiality do inhibit young men and women from seeking contraceptive services.

Limited (few) options available to choose from. This concurs with a report finding of a study by UNFPA, (2012), that showed that women tend to seek long lasting family planning methods such as intrauterine devices, Injectable and implants which are often not readily available.

No or little knowledge about FP services due to lack of exposure especially among the illiterate women in rural communities. According to Kamau et al, (2006), who noted knowledge gap on contraceptive methods, e.g fears, rumors and misconception about specific methods and unavailability or poor quality of services.

Fear of side effects such as over bleeding, severe abdominal pain, changes in body weight.

Women complaint of delay in regaining their fertility after removing or discontinuing drugs.

Myths and misconceptions about family planning. This concurs with findings of a study by Nalwadda, et.al., (2010), where young people believed that contraceptives interfered with

fertility, and that it could affect their ability to produce children. Most of the married and unmarried women believed that pills burn the woman's eggs. Both male and female participants believed that pills accumulate in the body causing swellings, such as fibroids, cancer, destruction of the fallopian tubes, and when used they are abortifacient.

Mass community sensitization on family planning so that both men and women have the same mind set.

Partner/spouse involvement in family planning, because many women fear the reaction of the spouse /partner who in most cases reject family planning services.

Contact health education to women on family planning for clear decision making.

Counseling on side effects so as to change the mind set of myths and misconception and write information given to the community by trained health workers.

Improve on outreach programs to serve more clients who find it difficult to reach the health facility.

Adequate stocking of drugs so that women who turn up for family planning are able to get the required service once.

Government should train more health workers on contraceptives which may minimize myths and misconception about F.P methods, correct information given by correct route and right people.

Improve information system by fully involving VHTs so that message reaches all people.

Increase number of staffing in the health Centre to reduce on the long waiting hours as well as reduce workload on the few staff on duty.

Increase number of clinic days to at least two in a week so that women find a day convenient to them. Besides, integrate services to attract women to the facility. This can be achieved by creating youth friendly related services like film shows on the various family planning methods.

Encourage youth friendly services to attract the adolescents in schools to prepare them in life.

Provide privacy at the clinic specifically for family planning so that women can freely share their experiences so as to gain confidence.

5.2 Conclusion

There are various socio economic, socio cultural factors that limit utilization of contraceptives in Ovujo health Centre' III. Male involvement in utilization of contraceptives was very low coupled with inadequate knowledge about family planning mainly due to myths and misconceptions as such most women feared permanent infertility, over bleeding, causes cancer and restriction by the Catholic Church that prefers abstinence against modern contraceptives.

Utilization of family planning services in Ovujo health Centre' III has remained as low as (57%) partly due to a number of facility related factors constraining services. Cases of long distance covered by clients to the health facility, negative attitude of men and women towards family planning and that of some health workers, long waiting hours, drug stock out, few clinic days, limited choices of methods offered, inadequate knowledge about family planning among others greatly affect utilization of family planning services at the facility.

5.3 Recommendations

There is need for massive health education by district health office and the health workers through the local radio and social gatherings on importance of family planning and the available services at the facility. Emphasis should be made on addressing the myths and misconceptions

surrounding family planning methods so as to change the negative attitude of community on family planning.

There is need for service providers like the district health office and private service providers like Mariestopes International Uganda to provide outreach programs to overcome the challenges of long distance and limited methods. This can be achieved by a bigger team of specialists who come following massive mobilization to offer various services including long term methods on a given day to a bigger population. This will also reduce the maternal mortality rate in Uganda.

5.4 Implication to Medical practice/service provision

Health workers/service providers are reminded that family planning methods can be effective if the myths and misconceptions are satisfactorily addressed and they uphold their code of conduct in handling clients especially during clinic days so that more people open up for the services they offer.

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Appendices

Appendix I: Consent Form

Factors Contributing to the pattern of Contraceptive use among Women of Child Bearing Age in Ovujo Health Centre III Maracha District.

I Mundua Lawrence, a student of Kampala International University Medical School is conducting an academic research on pattern of low utilization of oral contraceptives among women of child bearing age in Ovujo Health Centre III Maracha District. Any information you give will be highly needed for the study and will be given at most confidentiality and only used for academic and policy purposes. You are therefore requested to contribute in this study by reading and signing below. You are free to choose whether to participate or not but no penalty will be given if you choose not to.

I **a respondent** have agreed to participate in the research carried out on factors contributing to low utilization of oral contraceptives among women of child bearing age in Ovujo Health Centre III because I have been explained the benefits of the study in a language I can understand fully. I am free to withdraw from the study at will without any condition. I have been assured of confidentiality of the data collected.

Signed:……. Date:…….

Appendix II: Research Questionnaire

PATTERN OF CONTRACEPTIVE USE AMONG WOMEN OF CHILD BEARING AGE AT OVUJO HEALTH CENTRE III IN MARACHA DISTRICT

My name is **Mundua Lawrence** carrying out a research on factors contributing to low utilization of contraceptives among Women of child bearing age at Ovujo Health Centre III in Maracha District. You are kindly requested to respond to the questions below for this study for academic purpose and all the information you give will be accorded at most confidentiality. Feel free to stop or ask me any question where need be.

Instructions

Please either tick or write in the blank space provided.

Section A: Social Demographic data of the Respondents.

1.1 Sex of respondents

a) Male ☐
b) Female ☐

1.2 Age (in years)

a) 15-19 ☐
b) 20-29 ☐
c) 30-39 ☐
d) 40-49 ☐

1.3 Level of education

a) None ☐
b) Primary ☐
c) Secondary ☐
d) Tertiary ☐

1.4 Marital status.

a) Single/cohabiting

b) Married ☐

c) Widow ☐

1.5 Occupation

a) Employed ☐

c) Unemployed ☐

d) Self employed ☐

e) Others (specify)…….…....……

1.6 Religion:

a) Protestant ☐

b) Catholic ☐

c) Muslim ☐

d) Seven days Adventist ☐

e) Others specify……

Section B:Socio cultural factors affecting the pattern of contraceptive use among women of child bearing age at Ovujo Health Centre III Maracha District .

2.1 Do you have knowledge about family planning?

a) Yes ☐

b) No ☐

2.2 If yes, where did you get the information from?

a) Hospital ☐

b) school ☐

c) Friends ☐

d) Others (specify) ……...

2.3 What do people say (misconceptions and myths) about family planning?

a) Becoming sterile ☐
b) Disappears from the body ☐
c) Causes cancer ☐
d) Loss of weight ☐
e) Become barren ☐
f) Others specify……

2.4 Have you ever used any contraceptive for family planning?

a) Yes ☐
b) No ☐

2.5 If yes state what you used

a) Pill plan ☐
c) IUD ☐
d) Condoms ☐
☐
d) Others (specify).....

2.6 If no, give reason

a) Fear of permanent infertility ☐
b) Fear of over bleeding ☐
c) Dislike by spouse ☐
d) Choice to produce more children ☐
e) Others (Specify)……

2.7 Is your community aware of family planning services?

a) Yes ☐
b) No ☐

2.8 Are there costs associated to family planning that prevent you from using contraceptives?

a) Yes ☐

b) No ☐

2.9 What is it that which prevents you from accessing family planning services?

a) Lack of money for buying ☐

b) Long distance to Health Centre ☐

c) Others (Specify)……

Section c: Health facility related factors affecting the pattern of contraceptive use among women of child bearing age at Ovujo Health Centre III

3.1 Are you aware about the availability of family planning services in the health Centre?

a) Yes ☐

b) NO ☐

3.2 What are the methods available?

a) IUD ☐

b) Pills ☐

c) Condom ☐

d) Injectable(depo provera) ☐

e) Others (Specify)…….

3.3 Have you ever used or received any contraceptive

a) Yes ☐

b) No ☐

3.4 In your view, what is the impact of low utilization of contraceptive in the community?

a) Maternal mortality rate ☐
b) Infant mortality rate ☐
c) Morbidity ☐
d) Others (specify) …….

3.5 If no explain

a) Poor attitude of health workers

b) Long distance ☐

c) Long waiting hours ☐

d) Lack of information ☐

e) Inadequate drugs ☐

f) Others (Specify)…….

3.6 In your view what stops women from accessing contraceptives from Ovujo Health Cenrtre' III?.

i)…….

ii)……..

iii)…….

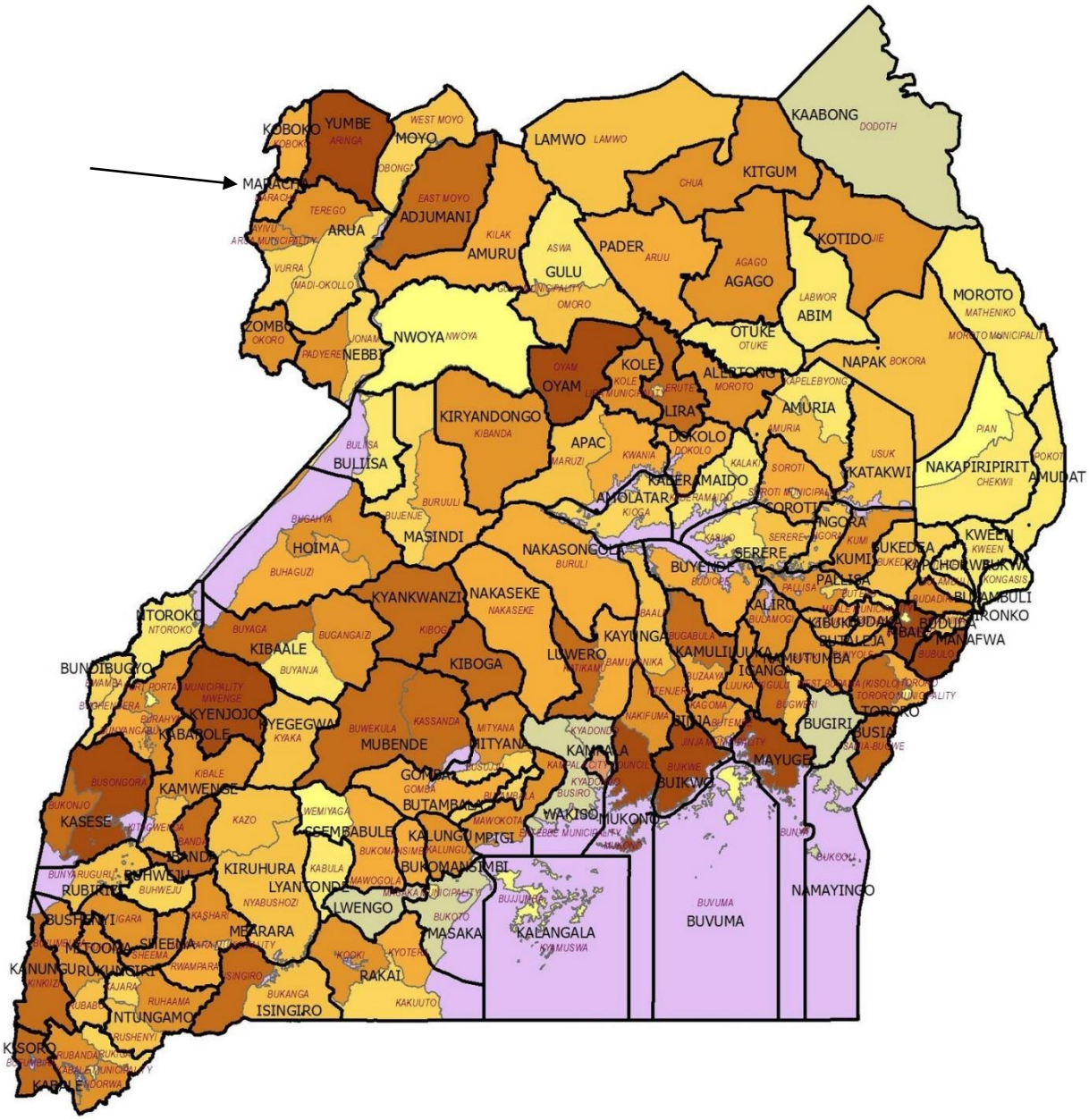
3.7In your view what can be done to improve utilization of contraceptives in Ovujo Health Centre III

i)…….

ii)…….

iii)……

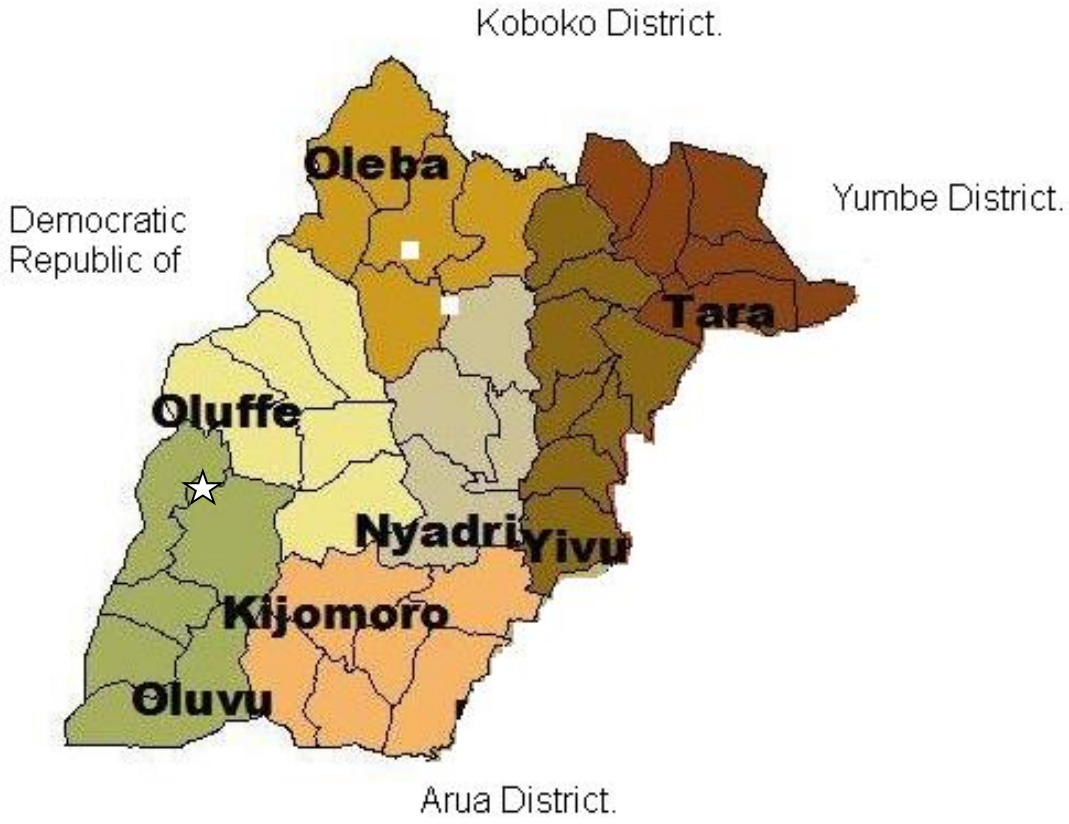
Appendix III: Map of Uganda showing Maracha District



Appendix IV: Map of Uganda Showing Maracha District

Maracha District

Appendix V: Map of Maracha District Showing Ovujo Health Centre III



Key

☆ Ovujo Health centre III