DETERMINANTS OF WOMENS' DECISIONS TO MODERN CONTRACEPTIVE USE AMONG WOMEN AGED 15-49 YEARS IN LIRA MUNICIPALITY INNORTHERN UGANDA

BY

ACAR WILLY
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UGANDA MARTYRS UNIVERSITY

OCTOBER, 2018

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A GRADUATE RESEARCH DISSERTATION PRESENTED TO THE FACULTY OF HEALTH SCIENCES IN PARTIAL FULFIILLMENT

OF THE REQUIREMENTS FOR THEAWARD OF MASTER

OF PUBLIC HEALTH- HEALTH PROMOTION OF

UGANDA MARTYRS UNIVERSITY

OCTOBER, 2018

DEDICATION

I dedicate this work to my mother Grace Eyenga and my late father Eyenga Stephen, my wife Emily Lilian Akoriand my lovely children Acar Elisa and Acar Jesse.

ACKNOWLEDGEMENT

I wish to extend my sincere thanks, gratitude to all those who contributed to the completion of this study materially, morally, spiritually and financially. God bless you.

My “BIG” thanks go to my committed supervisor Dr. Miisa Nanyingi for her tireless professional guidance and supervision from day one to the end of this study. Special thanks goes to the entire Staff of Lira district local government especially health department and community for their good will, support and most importantly, for permitting me to access information in their sub county. Many thanks you to my dear friends Okello Emmanuel, Opio Sam, Eripu Emmanuel for their continued guidance and moral support during the data collection. Above all, to God Almighty who has brought me this far and enabled me to finally complete this research report and studies.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS : Acquired Immune Deficiency Syndrome

ANC : Antenatal Care

APHRC : African Population and Health Research Center

CBS : Community Base Services

CDC : Center for Disease Control and Prevention

CPR : Contraceptive Prevalence Rate

FP : Family Planning

HBM : Health behavioral model

HIV : Human Immune Deficiency Virus

ICPD : International Conference on Population and Development

KDHS : Kenya Demographic Health Survey

LAM : Locational Amenorrhea Method

LBW : Low Birth Weight

MMR : Maternal Mortality Rate

MoH : Ministry of Health

NASCOP : National AIDS and STD Control Programme

NU-HITES : Northern Uganda Health Integration to Enhance Services

OCP : Oral Contraceptive Pill

PPH : Postpartum Hemorrhage

SPSS : Statistical Package for Social Science

SRH : Sexual and reproductive health

STD : Sexually Transmitted Diseases

STI : Sexually Transmitted Infection

TV : Television

UDHS : Uganda Demographic and Health Survey

VCT : Voluntary counseling and testing

WHO : World Health Organization

WRA : Women of Reproductive Age

ABSTRACT

Introduction: Uganda's population constitutes a large pool of women entering their reproductive age which represents rapid population growth for decades to come. Given the current low contraceptive prevalence rate more profoundly in northern Uganda among all women of reproductive age 15-49 years. The study was intended to assess and provide detail factual report on the determinants of women's decisions to modern contraceptive use among women aged 15-49 years in Lira Municipality as one the northern districts with low contraceptive prevalence rates.

ObjectiveThe main objective of this study was to assess the determinants of women's decisions to modern contraceptive use among women aged 15-49 years in Lira Municipality.
Methodology: The study used a descriptive-analytical cross-sectional quantitative study design. Simple random sampling technique was used to select 2 out of 4divisions within Lira municipality.A total of 246 women of reproductive age (15-49) years were selected from Adyel and central wards in Lira municipality. The study locations were divided into primary and secondary sampling units, wards and villages were the primary and secondary sampling units respectively.

Results:65.4% of the respondents were in the age group of 15-19 years. Four in every ten, 40.2% of the respondents were married. 54.9% were not employed. 40.2% of the respondents had attained secondary education. Six in every ten, 60.2% of the respondents had a monthly income of 50,000shs-200,000shs. About 39.8% of the respondents had ever used modern contraceptives and 35.0% were currently using modern contraceptives, the commonest methods being used at 41.9% was Deprovera injection, pills and condoms at 15.1%. However,55.6% were not using modern contraceptives because of their husbands' disapproval. The commonest reason for using modern contraceptives was to prevent unwanted pregnancy at 55.3%. Women who got information about modern contraceptive from their friends were 5.5 times more likely to use modern contraceptives.

Conclusion: Generally, the prevalence of modern contraceptives use was relatively low at 39.8% and with the proportion of women currently using or not using modern contraceptives at 35.0% and 65% respectively with the most preferred modern contraceptive method being Depo-Provera Injection at 41.9% and condoms at 15.1%.The main reason for some individual contraceptive choices are influence from friends(recommendation from satisfied users). The factors that significantly influenced modern contraceptives use were distance to the nearest family planning health facilities and provision of adequate information about contraceptive use. The other knowledge factors that significantly influenced modern contraceptives use were; sources of information, knowing if contraceptives have side effects and the knowledge on the actual side effects of modern contraceptive

Recommendations: Integration of FP services in sexual and reproductive health, most especially in child health clinics and immediately after delivery before mothers are discharged was critical in order to improve FP uptake. To strengthen modern contraceptive family planning usage, the study recommended for policy reviews, non-discriminatory public awareness creation, and increase of funding for family planning, strengthening health education syllabus and conducting research on viable Modern contraceptive method use, other than condoms use, there is need to improve method specific knowledge on a wide range of contraceptives and address related safety concerns.

CHAPPTER ONE:

INRODUCTION

1.0 Introduction

This chapter gives detailed information about the background of the study, problem statement, study objectives, research questions and justification of the study.

Contraceptive use is a human right and is identified as a priority in the National Reproductive Health Policy (Uganda MOH, 2014). All individuals have the right to access the services, including all pertinent data regarding benefits and scientific progress made in the area of contraception.

A rights-based approach on the provision of contraceptives assumes a holistic view of clients, which includes considering the client's sexual and reproductive health (RH) care needs. Appropriate eligibility criteria and practical recommendations in helping clients choose and use a contraceptive method needs to be considered (WHO, 2016). There are several methods of contraception, which include oral contraceptives pills, Deprovera injection, emergency contraceptive pills, implants and intra- uterine devices which should be made accessible to all sexually active women as to reduce the rate of unwanted pregnancy and its complication.

Family planning (FP) is an important component of sexual and reproductive health services that empowers men and women to determine the number and spacing of their children. It includes all methods of preventing and regulating conception and should be equally accessed by all. In developing countries, desire for small families and motivation for healthy spacing of births has steadily increased. To achieve their childbearing preferences, women and their partners need effective contraception methods to prevent unintended pregnancies (Darroch, 2013; West off,

2010). The numbers of women that need contraception and the proportion with unmet need are some of the moving targets of population growth. The increasing desire to control the number and timing of births lead to increase in the numbers of women needing contraception in developing countries; therefore, there is need for Rapid improvements of modern contraceptive methods that should be made in a wide coverage and of quality if women's needs are to be adequately met with quality care and if the number and proportion of women with unmet needs for contraception are to decrease over time and reduce high fertility rate (Darroch and Singh, 2013).

In Uganda, the total fertility rate has been consistently high and stands at 5.7 children per woman (Ugandan MoH, 2014). This rate is slightly higher than the average total fertility rate for African countries of 5.5and one of the determinants for this high total fertility is low Contraceptive Prevalence Rate (CPR). This is even worst in northern Uganda where CPR stands at 40% among all women of 15-49 years old and 23% among married women age 15-49 years with only 18% using modern methods (NU-HITES, 2012) and yet this would not be the case if all women had access to modern contraceptive methods.

1.1 Background of the study

Globally, contraceptive prevalence rate is estimated at 63 % and this is higher in more developed regions (72 per cent) than in the less developed regions (61 per cent). In the majority of the less developed regions contraceptive prevalence was 50 per cent or more (United Nations 2011). A study of contraceptive method of choice in developing countries revealed high prevalence rate in countries where access to a wide range of methods was uniformly high (Ross *et al*., 2012). However, Darroch and Singh (2013) reported that unmet needs for modern contraceptives in other developing countries was still low in 2012, especially in sub-Saharan Africa (53 million

[60%] of 89 million), South Asia (83 million [34%] of 246 million) and western Asia (14 million [50%] of 27 million. But from, 2014 the use of modern contraception slightly rose from 54% to 57% globally among the women aged 15-45 years. In Latin America and Caribbean, it rose slightly from 64% to 67 % and from 23% to 24 % in Africa (WHO, 2015). Despite the fact that the use of contraception in many parts of the world like Asia and Latin America increased, it remained low in Africa (WHO, 2013) with the major exceptions being sub-Saharan Africa, Melanesia, Micronesia and Polynesia, where the estimated levels of contraceptive prevalence are still below 40 per cent. By the end of 2011, sub-Saharan Africa had the lowest level of contraceptive prevalence, with only 22 per cent of married women of reproductive age or women in union using modern method of contraception. Over half of the 48 countries in sub-Saharan Africa where data were available, had a level of contraceptive prevalence below 20 per cent (United Nations, 2011).In many developing countries (also termed as low- and middle-income countries), official family planning programs began during the 1960s with the aim of reducing high fertility (Seltzer, 2012). However, in recent years, Demographic and Health Surveys (DHS) of 2015 reported that women in developing countries had lower desired fertility than actual fertility, i.e. women have more children than they want. This indicates that there is still an unmet need for family Planning making people unable to make informed choices about their sexual and reproductive health. Family planning presents an opportunity for women to enhance their education and participation in public life. Additionally, having smaller families allows parents to invest more in each child and children with fewer siblings tend to stay in school longer than those with many siblings (WHO, 2014). In the same report by WHO, (2014), it was highlighted that Sub Saharan African countries by and large, are characterized by high fertility and correspondingly high rates of population growth. Most countries in the region are expected to grow by 100-300 percent by 2050 and the total population of the region will double over the next

45 years. Fertility would decline only if women had no desire childbearing, that is, if greater access to quality family planning services responds to unmet need (Levin, 2012).Therefore, provision of a wide range of contraceptive methods increases the opportunity for individual couples to obtain a method that suits their needs (Uganda Ministry of Health 2015). Darroch and Singh (2013) confirmed a substantial and unfinished agenda towards meeting of couples' reproductive needs through contraceptive use.Studies of contraceptive method of choice in countries of sub-Saharan Africa are few probably because of the generally low contraceptive prevalence with an average of seven children born per woman with Uganda having the highest fertility rate in Africa compared to neighboring Kenya where the fertility rate stands at 4.6 births per woman (KDHS 2015).

In Kenya, adolescents are more likely to use short term contraceptive methods such as pills and injectable. Adolescents aged 15-24 years constituted only 10% of injectable users in 1989, but this proportion increased more than doubled to 22% in 1998 (APHRC, 2015). The 2015-9 KDHS reveals that 16.3% of women in Kenya have an unmet need for family planning with 8.4% and 7.8% in need for spacing and limiting respectively. The current Kenya family planning strategic goal was to make available quality and sustainable family planning services to all who need them in order to reduce the unmet need for family planning (Magadi and Curtis, 2013).In Uganda, almost 4 in 10 currently married women are using some method of contraception with majority of the users rely on modern methods. The use of modern methods had increased substantially from 8% in 2012 to18% in 2015 and from 18% in 2015 to 35% in 2016 (UDHS, 2016). Uganda isalso characterized by high fertility rates at 5.9 births per woman (UDHS, 2016) with low contraceptive prevalence (CPR), high unmet need for FP services of 28% (UDHS, 2016).

The contraceptive prevalence rate among married women was 39%, in the year 2016, meaningthat nearly seven in ten currently married women in Uganda (62 percent) have a demand

for family planning (UDHS, 2016), although only 35% used modern methods. Meanwhile MDG 5 expected the country to reach contraceptive prevalence rate of 46% by 2015 a far cry for Northern Uganda to achieve where the unmet need for FP services is increasing from 23.1% in 2014 to 31.6% in 2015(Shane Khan et al., 2015) especially inGulu, Kitgum, Lira and Lamwo districts where only 18 percent of women use family planning compared to the national average of 40 percent, (Mwesigye, 2012).Information on Contraceptive prevalence ratewas available, but what remains unclear is, whether preferences for modern contraceptive rhyme well with choices women makein using modern contraceptive methods. It is also not clear whether the discrepancy between preference and choice could be responsible for the low Contraceptive prevalence rate. This study therefore, aims at assessing the determinants of women's decisions to modern contraceptive use among women aged 15-49 years in Lira Municipality in Northern Uganda.

1.2 Statement of the problem

In the past, the need for family planning was rationalized by a significant number of women who state a desire to cease child bearing or to delay pregnancy (Konje, and Ladipo, 2014).

However, in spite of the apparent unmet need for contraceptives, very little had been achieved in aggregate fertility reduction. especially in the northern districts of Gulu, Kitgum, Lira and Lamwo where only 18 percent of women use family planning compared to the national average of 40 percent, (Mwesigye, 2012). The lack of success of the family planning revolution is attributable to socioeconomic, cultural, and religious barriers among many other factors. In a context where maternal and infant mortality rates are high, poverty is rampant, and malnutrition is common, empowering women with the knowledge and resources to plan their own families is vital. The ability of women to freely determine the timing and number of births could be limited partly due to unmet needs. Willingness to control fertility and ability to access and use

contraception must also exist for a change in fertility to occur (Kathryn, 2009).Uganda has one of the youngest and fast-growing population in the world and its total fertility rate is among the world's highest at 5.7 children per woman (Ugandan MoH, 2014).The Uganda's actual fertility exceeds women desired fertility by one or two children (UDHS 2016) which is indicative of wide spread unmet needs for contraception. Lack of government support for family planning and cultural preference for large families are some of the major cause of high number of births, short birth intervals and early age of child bearing contributing to Uganda's high maternal mortality.

Gender inequalities among Ugandan women also makes fertility reduction very difficult, women on average are less educated, participate less on paid employment, and often have little say in decision over child bearing and their own reproductive health. However, even when the birth rates are significantly reduced, Uganda's large pool of women entering their reproductive age represents rapid population growth for decade to come. With a very low contraceptive prevalence rate of 36.9%(UGHS 2016), Unchecked population increase will further strain the availability of arable land, natural resources and overwhelm the country's limited means of providing food, employment, education, health care, housing, and basic services. This is even worse in northern Uganda which is still behind the general trend of development that is observed in rest of the country. This has been attributed to high population growth rate with a fertility rate of 7.5 birth per woman which is much high than the national fertility rate. A low contraceptive prevalence of less than 40% among all women aged 15-49 years old and 23% among married women age 15-49 years with only 18% using modern methods (NU-HITES, 2012). The study therefore sought to analyze the determinants of women's decisions to modern contraceptive use among women aged 15-49 year. The result obtained from this study will be used to improve the design of reproductive health Programmes.

1.3 Objective of the study

To establish the determinants of women's decisions to modern contraceptive use among women aged 15-49 year in order to contribute in improving maternal child health in the country

1.3.2 Specific objectives

These objectives met the SMART criteria

i. To determine the proportion of women aged 15 - 49 years currently using modern contraceptives services in Lira municipality.
ii. To examine the most preferred options of modern contraceptive method used by women aged 15-49 years in lira municipality.
iii. To establish reasons for the choice of the method a couple is using.
iv. To establish the factors related to modern contraceptive use among women aged 15 -49 years in lira municipality.

1.4 Research questions

i. What proportion of women aged 15 - 49 years are currently using modern family planning services in Lira municipality?
ii. What are the most preferred options of modern contraceptive method used by women aged 15-49 years in lira municipality?
iii. What are the reasons for the choice of the method a couple is using?
iv. What are the contraceptive preferences and choice determinants among women aged 15-49 years in Lira municipality?

1.5 Scope of the study

1.5.1 Content Scope

The study was geared towards assessing the determinants of women's decisions to modern contraceptive family planning use among women aged 15-49 years in Lira Municipality. It Specifically found out the reasons for modern contraceptive family planning use by women aged 15-49years, identified the most preferred modern contraceptive family planning methods used by women aged 15-49 years, established the socio-cultural factors affecting modern contraceptive use among women aged15 -49 years and identified actors promoting use of modern contraceptive family planning methods among women aged 15-49 years in Lira Municipality

1.5.2 Geographical Scope

The study was conducted in two Divisions making Lira Municipality namely; Adyel, and Central which at the heart of Lira District. Being urban, the occupants have various health related issues including family planning; hence the justification for its selection as a study area.

1.5.3 Time Scope

This study looked at the period running from January 2017 to August 2017. The researcher chose this period because, it is sought to be good enough to enrich the study with up to date information in line with family planning concerns.

1.6 Significance of the study

During Ottawa Charter in 1986, five health promotion action areas were highlighted and these are; building healthy public policy, creating supportive environment, strengthening community action, developing personal skills, and re-orient health services addressing both the myth and the misconception that are common with regard to family planning services. Re-orienting health services by making family planning services more accessible to all in order to enable people to take their reproductive health choices may help to break the 'circle of silence' and shatter the

myths and misconceptions that fuel the family planning use, hence creating supportive environment especially for women of reproductive age (15 to 45 years) who are sexually active and at risk of getting unplanned pregnancy (WHO, 2010). In addition to this, it will also help in developing personal skills by enabling them to learn through providing them with information, education for health and enhancing life skills acquisition. This will increase the options available for them to exercise more control over their own health and creating enabling environment to make choices conducive to their reproductive health.The community based modern contraceptive family planning, counseling and sensitization improves community participation as community members are engaged in mobilizing their fellows (VHTs) in taking the services for family planning, hence creating ownership and strengthening community action as far as meeting family planning demand is concerned.This is also believed to influence several intermediate outcomes including increasing knowledge on HIV/AIDS prevention strategies, maternal mortality and neonatal mortality risk reduction strategies associated with unplanned pregnancies, beliefs, attitudes and behaviors, which in turn help clients take up safer and healthier behavior as they are able to take control over their sexual life and improve their reproductive health (UDHS.2016). Family planning services is also promoted as a cost-effective prevention strategy in most developing countries (Grabbe et al., 2010); because it provides people with the opportunity to receive information on HIV/AIDS and other STDs that may facilitate reduction of HIV risk behavior (WHO, 2013) therefore, developing personal skills. Over the last decade various approaches to increase modern contraceptive uptake have been implemented including: client-initiated counseling, provider-initiated family planning services, mobile community-based family planning outreaches and provision of home-based family planning services (Marie stopes Uganda family planning report, 2016).This study will helpto identify; determinants of women's decisions to modern contraceptive use among women aged 15-49 years. Family planning

programs that offer a variety of safe, effective, acceptable and affordable contraceptive methods helps women to prevent unwanted pregnancies and sexually transmitted diseases (STDs) and also achieve their child bearing goals. Method mix is a key determinant of the fertility impact of contraceptive practice. The use of more effective methods even by a smaller proportion of eligible couples can produce a greater decline in fertility than can the use of less effective methods by a large proportion of couples (Magadi and Curtis, 2013). In 1967, Uganda launched a national family planning program under this plan, family planning was integrated into the maternal and child health division of the Ministry of Health. In 2014, the Government of Uganda ratified a set of population policy guidelines to assist in the implementation of the program. Reflecting the 1994 international Conference on Population and Development (ICPD), these guidelines were further revised in the population policy for sustainable development, issued in 2012 (United-Nations 2014; Jain 1998; CBS *et al*. 2014).

Despite these developments in population policy and programs, there is still evidence of unmet need for contraception. This study therefore explored the factors that influence realization of this need. Uganda's demographic and contraceptive-use indicators have also varied in interesting patterns. Contraceptive prevalence rose from just 7% in 1977/78 to 39% in 1998, but then did not change in 2013 (CBS *et al*. 2014). This will lead to improvements in quality of health care, program planning and management that will enable the country to realize the desired impact of its family planning policies and programs concerning fertility reduction.

1.7 Justification of the Study

The study is meant to assess and provide detail factual report on the determinants of women's decisions to modern contraceptive use among women aged 15-49 years in Lira Municipality. This was triggered by the underlying family planning issues affecting reproductive health among young and mature women in Lira Municipality. This study is intended to provide opportunity to

the different health stake holders from the village, Parish, Sub County, District to the National level to share, understand and appreciate each other's role in selection of suitable contraceptives for usage in family planning. It is further driven by the urgency to facilitate in helping the stakeholders at the decision making and implementation portfolios identify gaps and generate workable solutions for addressing the inefficiencies to better future gains for family planning programme. The other justification of this study is to generate information to be available for use by future researchers in the same field for reference purposes. It is also a partial fulfillment of the requirements for the award a Master's Degree in Public Health Promotion of Uganda Martyrs University, Nkozi

1.8 Definition of key terms.

Contraceptive Prevalence: This is the proportions of Women of reproductive age or their partners who are using a contraceptive method at a given point in time (UDHS, 2015)

Contraceptive Method choice: This refers to all the varieties of contraceptives methods made available to women for them to take choices including the option of not using any method (Entwisle, 2015)

Family planning: A reproductive strategy that individual and/or couples employ to meet their reproductive goals and to prevent unwanted pregnancies or a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methodsor (UDHS, 2016)

Parity: Number of pregnancies a woman has ever carried(UDHS,2016)

Unmet family planning: Percentage of women who do not want to get pregnant but are not using any method of modern family planning. (WHO, 2015) They want to wait two or more years for their next birth.

Women of Reproductive Age (WRA): This is an indicator of reproductive health. It refers to women aged 15- 49 years; they are women of child bearing age (MoH, 2009).

Method mix: Percentage distribution of contraceptive users by method.

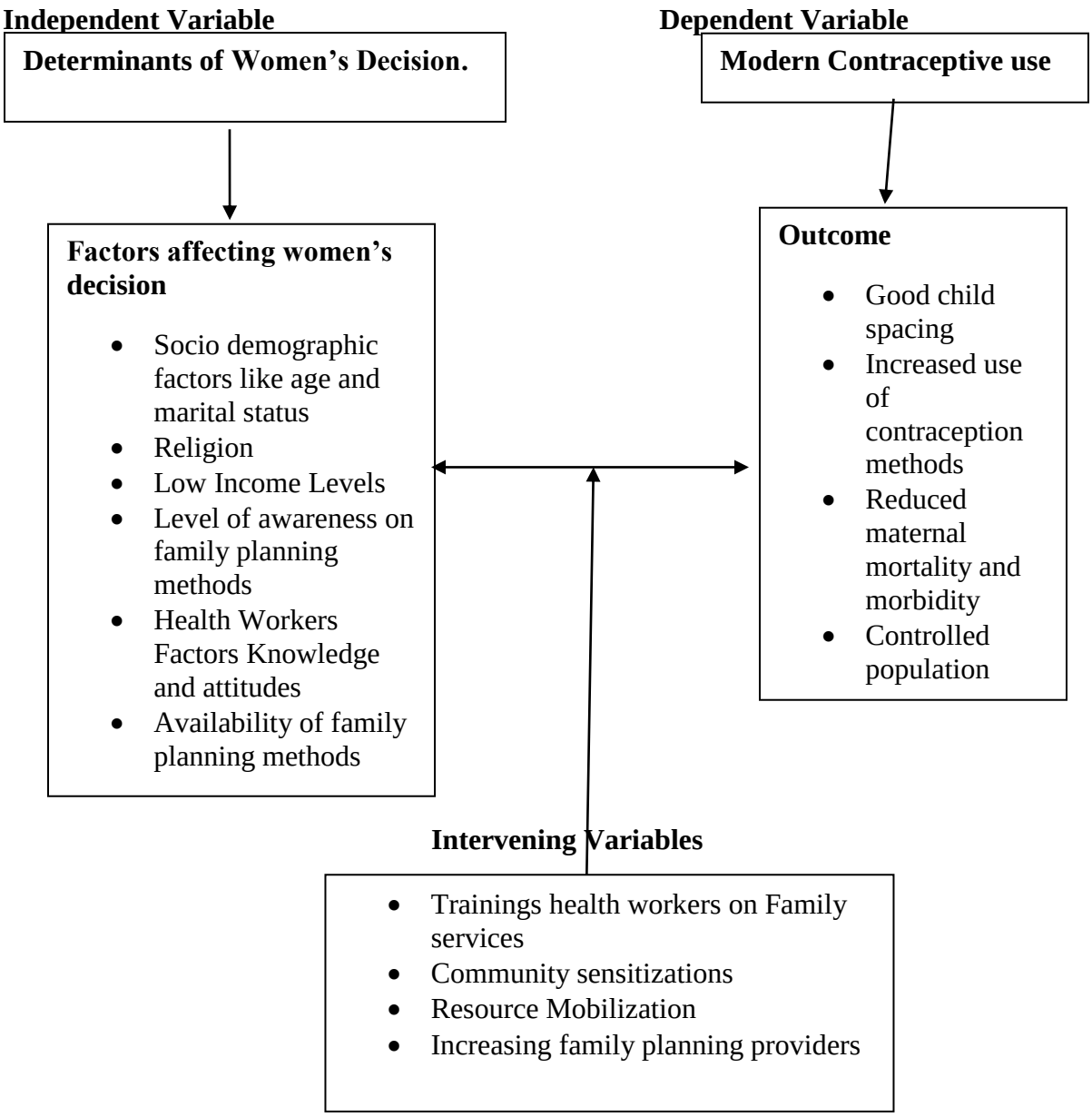
Modern contraceptives use: Thisrefers to the use of various devices, drugs, sexual practices or surgical procedures to prevent conception or pregnancies (Bradley, et al.2012)

1.9 Theoretical framework.

The study used Health belief model theory in assessing the perceived risk, consequences and the benefits of the intervention as an influencing aspect of the utilization of Family planning among the respondents. Using the HBM theory the study assessed three independent variables to

determine their influence on uptake of family planning among women of reproductive age 15 to 49 years. Socio-demographic characteristics that include age, sex, marital status, religion among others were tested to determine their influence. The level of knowledge women age 15 to 49 years on various family planning methods, Importance and risks were as well assessed to determine their influence on uptake of family planning. The others also assessed are the health care factors that included health workers level of knowledge, attitude, health facility structural design and distance from the people. The Health Belief Model (HBM) is intended to describe health behavior by better understanding attitudes and principles regarding wellbeing and health. It was first applied in vaccination programs and in screening programs of public health nature and further adopted to study other 23 behavioral areas (Becker, 1976). The model is coined on four beliefs viz; perceived susceptibility, perceived severity, perceived benefits and Perceived barriers that would prompt one take immediate action. It therefore follows that, in order to adopt behaviors that minimize women vulnerability to unwanted pregnancy, they need to: view self to be at risk of experiencing that, perceive that unwanted pregnancy has potentially grave consequences, perceive that preventive measures are available that can reduce their susceptibility. The theory is applicable to family planning in the sense that, if women know that they are vulnerable to unwanted pregnancy with its complication, if they know that preventive measures that can lessen vulnerability or minimize the aftermath of unwanted pregnancy are within their disposal, and if they believe that positive aspects are more than the costs, then they would be motivated to seek family planning (Becker, 1976).

FIGURE 1:ILLUSTRATION SHOWING INDEPENDENT AND DEPENDENT VARIABLES.



CHAPTER TWO:

LITERATURE REVIEW

2.0 Introduction

This chapter covers; related literature to the topic of the study, which was reviewed to identify gaps and lessons learnt from those studies in order to establish the need for the study. It is arranged logically following the objectives of the study.

2.1. Current Modern Contraceptives Family Planning Use.

By the end of 2011, the prevalence of contraceptive use had increased worldwide due to the development and introduction of modern contraceptives and the establishment of organized family planning programs (D'Arcanques, 2012). Family planning services offers various economic benefits to the household, country and the world at large.Contraceptive behavior in the developing world has changed remarkably over the last three decades. This revolution has beendriven by the behaviors of desired family size, social and economic changes. The proportion of women who have heard of at least one method of contraception is higher compared to that of women who have not heard any method at all (John. et al 2012).By the end of 2011, in Latin America and the Caribbean, more than one half of pregnancies was unintended, even though about 65% of married women of reproductive age used modern contraceptives (Aassve&Gereltuya, 2012). This implied that almost two-thirds of pregnancies in Caribbean (62%) and South America (63%) were unintended, as were 43% of pregnancies in Central America (including Mexico). Women in Mongolia married early and had their first child soon after marriage. Between 1963 and 1965; total fertility fluctuated between seven and eight children per woman. However, from 1975 onwards, there has been a continuous decline in total

fertility; reaching 2.3 children per woman in 1998.This was attributed to various population policies implemented in Mongolia over the period 1960 to 1998 (Altankhuyagiin*et al*.,2013). With the lifting of restriction on supply and distribution of contraceptives by Mongolian government, the uptake was rapid. Following the implementation of the UNFPA Maternal and Child Health project, among Mongolian women, the contraceptive prevalence rate of women of reproductive age increased from 25% in 1998 to 33.4% in 2014. In contrast, the proportion of traditional method users declined from 35.7% in 1994 to 10% in 1998.The use of some methods increased more than others, with significant increase in the used of the pill, injection and female sterilization, although from a low base. Despite their absolute growth, in 1998 just 4% of women were using oral contraceptive, whilst injection and female sterilization accounted for 3% and 2.4 % respectively. The IUD and periodic abstinence in the overall contraceptive was 13% and more (Mongolian MoH& UNFPA, 2012; United Nations, 2012). Substantial evidence is found in existing literature that broadening the choice of family planning methods increases overall family planning prevalence. The provision of a wide range of contraceptive methods increases the opportunity for individual couples to obtain a method that suits their needs. Contraceptive choice is also a central element of quality of care in the provision of family planning services and an important dimension of women's reproductive rights.

To increase prevalence, family planning programs offer a variety of safe, effective, acceptable and affordable contraceptive methods to help women prevent unwanted pregnancies and sexually transmitted diseases (STDs) and to help them achieve their childbearing goals (Magadi and Curtis, 2013). Young people have a real need for reproductive health and family planning information and services. The age at which young people have their first sexual experience is falling, while the number of unmarried sexually active young people isgrowing significantly (National Research Council, 2016). Although many adolescentsclaim to know about

contraception and safe sex, their actual knowledge was often quite poor (Bankole*et al*., 2013).Many young people believe that you can't get pregnant the first time you have sex, for example, or that you can't get pregnant if you havesex while standing up (Boonstra, 2013). As a result of incomplete knowledge about family planning, adolescents are vulnerable to sexually transmitted infections and unwanted pregnancy. A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2.2 to 4 million annually. Research shows that unmet need for contraceptive among sexually active adolescents, those who express a desire to prevent pregnancy but aren't using any contraception, was high in many regions (Djamba, 2014).

Many societies disapprove of premarital sex and consider reproductive health care for young people inappropriate. As a result, parents, educators and health care providers often areunwilling to give young people the information and services they need. Laws and policies restrict adolescent's access to services, for example by limiting family planning services to married adolescents (PATH & UNFPA, 2016) or by including conditions such as parental or spousal approval. In addition to ignorance about sexual and reproductive health and harmful sexual behaviors that carry on into adulthood, negative attitudes to young people's sexuality lead to stigma against young people who use or ask for contraceptive, reinforcement of local cultural and faith based restriction on access to services, service provider's reluctance to provide contraceptives to young people, difficulties for young people in insisting on condom use with their partners and in accessing contraceptives, unwanted pregnancies among adolescents and young people and increased rates of sexually transmitted infections, including HIV.

WHO (2012) reviewed Trends in the use of short term and long-term methods of contraception in 13 developing countries in sub Saharan Africa and there was substantial increase in the use of contraception, short term methods primarily. These findings were related to the cause that most

of women are using contraception to space rather than stop childbearing. The result shows that contraceptives mix is dominated by short term methods, pills and injectable, implants also contributed highly to method mix. The contribution of the IUDs and condom was very minimal while permanent family planning methods were non-existence (John et al, 2012) There is abundant information that contraceptive knowledge and awareness was high among the population, but this awareness has not translated into increased contraceptive use, with the end result being very low contraceptive prevalence.

In Nigeria, this low contraceptive prevalence correlated with high levels of unplanned pregnancies and abortions, leading to increases in the maternal mortality ratios especially in the rural areas. In East Africa the trend of family planning use among married women in the reproductive age between 15-24 years has gradually been increasing for example Kenya from 7% in 1978 to 46% in 2015.This has resulted to decline in fertility rate over the years from 8.1 births per woman in 1977/8 to 4.7 in 1998, 4.9 in 2013 and 4.6 in 2015 (KDHS, 2015). However, the fertility rate (approximately five children per woman) is still high in a developing country. The contraceptive methods available in Kenya include male or female sterilization, oral pills, intrauterine device, injections, and implant, male and female condom. The traditional methods include withdrawal and rhythm/natural method NASCOP (National AIDS and STD control program**,** 2013**).** The IUD has virtually disappeared from the national mix of modern family planning methods in Kenya over the past 15 years, despite its proven safety, effectiveness, acceptability and low cost. While the percentage of women using any modern contraceptive has more than tripled since 1984, the proportion of contraceptive users choosing the IUD decreased from 31% to 15% between 1984 and 2015-9. Despite the increased use of contraceptive methods, as more Kenyans enter reproductive age, unmet need continues to grow. Limited donor resources and a skewed method mix toward short-term (morecostly) methods compound this unmet need

(FHI, 2014). Modern contraceptive use increases dramatically with woman's education. More than half of married women with at least some secondary education use modern methods, compared with only 8% of women with no education (KDHS, 2013). Contraceptive use has increased only slightly since 1998 from 39% to 41% of married women (excluding the northern districts for comparability). This was a dramatic slowing of an upward trend that began in the 1980s.Barriers to the use of contraception are many and diverse but include shortcomings intrinsic to contraceptive methods such as cost, inconvenience, and unacceptable side effects. Several new methods that are in development or that have recently become available may help improve user acceptability and lower barriers to contraceptive use.

2.2. Preferred options of modern contraceptive method used by women aged 15-49 years.

The prevalence of contraceptive use increased worldwide due to the development and introduction of modern contraceptives and the establishment of organized family planning programs (D'Arcanques, 2012). Family planning services offer various economic benefits to the household, country and the world at large. In 13 developing countries in sub Saharan Africa records show substantial increase in the use of contraception, short term methods primarily, these findings were related to the cause that most of women were using contraception to space rather than stop childbearing. The result shows that contraceptives mix was dominated by short term methods, pills and injectable, implants also contribute highly to method mix. The contribution of the IUDs and condom was very minimal while permanent family planning methods are non-existence (John et al, 2012). There was abundant information that contraceptive knowledge and awareness was high among the population, but this awareness has not translated into increased contraceptive use, with the end result being very low contraceptive prevalence.

2.3. Reasons for the choice of family planning method.

Individual contraceptive use is influenced by factors at the individual, household, and community levels, but the geographic distribution of contraceptive use was often associated with contextual variables, particularly at the community level. Distances from health facility, cost of services (Stephenson *et al*., 2013). These contextual variables typically include social, economic, and cultural influences at the community level (Burgard, 2014). Increased use of contraception is linked to rapid population growth rates, high levels of unemployment, religious affiliation, higher socioeconomic status and greater availability of contraceptive services (Grady, 2013).

In another study done in the Philippines found that provision of family planning outreach services and the average community wage for women were significant community-level predictors of the use of contraceptive services (DeGraff, 2007). Research in South Africa has also shown significant relationships between the wealth status, level of female autonomy, level of female education of communities, and the choice of contraceptive method (Stephenson *et al*., 2015). Other studies have examined the relationship between spatial patterns of use of contraceptive methods and the influence of community-level factors. In Bangladesh and India, districts located on the border and which share a common language were positive outliers for contraceptive use (Amin *et al.,* 2012).

2.4. Factors related to Modern Contraceptive use among women age 15 -49 years.

Unmet family planning need refers to women who are not practicing contraception, but do not want any more births (limiting) or want to postpone the next birth at least two years (spacing) (Bayer, 2012). In East Africa young women had an unmet need for family planning and, without access to modern contraception; they faced the risk of an unintended pregnancy. In Tanzania, 22 % of young married women ages 15-24 had an unmet need, as do 40 % of sexually active,

unmarried women in this age group. In Rwanda 35% of young married and 55% of sexually active, unmarried women report an unmet need. Data are not available on young women in Uganda (Khan and Mishra, 2015).

According to APHRC, (2012) the proportion of married and sexually active non-users aged 15-24 is increasing and their reproductive health needs are different from those of older married women who have been the traditional focus of family planning activities in Kenya. Understanding the factors that contribute to unmet family planning need was critical to the efforts of Programs to meet the demand for contraception. Much unmet need for family planning persists, even in settings where knowledge of family planning methods was high.

2.4.1 Household Wealth

In Tanzania, household wealth was related to unmet need; 23% of young poor women report had an unmet need, while 16% of young wealthy women did. However, household wealth had little effect in Rwanda; 33% of both poor and wealthy young women indicated that they had an unmet need for family planning. Women with unmet need also had low status and weak bargaining power within the household (Tanzania demographic health survey 2014).In terms of income, out of the total number of women using contraceptives, 31 percent had an average monthly income of KS 20,000 and 28 percent had an average monthly income of between Ksh.15, 000 to 20,000. On the other hand, 7 percent of users had an average monthly income of less than 5,000. Those with no income were notably, the least users of family planning services. The results thus revealed that in the absence of an income source, usage of family planning would decline. The lower the economic status of the households, the higher the non-usage (Sharma et al. 2015). This is also indicated by the low contraceptive prevalence of less than 39% in Uganda due to high poverty rate among the community and high cost attached on family planning (UDHS.2016)

2.4.2 Misconceptions, myth and concern about health-related risks

Studies suggested that many potential users choose not to use more reliable methods due to misperceptions and concern about health-related risks. For example, a study in Maldives found that knowledge of family planning was universal, but only 30% of couples were using a contraceptive. Several studies, including one from Malaysia, found that non-use of contraceptive was linked to fears about side effects (Oyedokun, 2014). In some communities, pills were believed to cause weight gain and infertility which is not true. Although it may be true that progesterone in the pill can increase appetite which may result in weight gain (Rajaseker&Bigriggs, 2012), pills do not cause infertility. There is a myth that indicates that intra-uterine contraceptive devices prevent pregnancy by causing an abortion. The devices might cause a miscarriage if accidentally inserted in a pregnant woman, or in the highly unlikely event of a woman getting pregnant with an IUCD in place.

Given the fact that IUCD is highly effective in preventing fertilization, risk of abortion was almost non-existent if pregnancy is ruled out in all clients prior to insertion. IUCDs are very safe; they do not cause pelvic inflammatory disease (PID) in low-risk couples. Risk of infection is very low when the IUCD is inserted using the no-touch" technique in women who have no cervical infection. Client who already has gonorrhea or Chlamydia at the time of insertion, or if the service provider inserts the IUCD without maintaining sterility, there is a small risk of pelvic infection in the first four weeks after insertion. Prophylactic antibiotics are generally not recommended for IUCD insertion unless the risk for cervical, gonococci and chlamydia infections are high and facilities for STI screening were inadequate. In these cases, such prophylaxis might be considered. In any case, clients in these circumstances should be counseled on symptoms of PID, especially during the first month of insertion, and to return immediately if symptoms develop (MOH, 2013).

2.4.3 Female Education

Female education has been seen as a key determinant of contraceptive use (NPC and ORC Macro 2014). Better educated women have more knowledge of contraceptive methods or of how to acquire them than less educated women because of their literacy, greater familiarity with modern institutions and greater likelihood of rejecting a fatalistic attitude towards life (Koc.2012).

Studies have showed a positive association between the educational level of both spouses and the use of contraceptive methods. In a Study done by Hagen et al., (2014) showed that even after controlling the effects of other factors, education was a key factor influencing contraceptive use. Majority of those using contraceptives had post primary education, while the least users of family planning had no formal education. Only 49 percent of the users of family planning services had secondary education, 28 percent had university education while only 15 percent had primary education with 6 percent reporting no formal education. Women could not convince their spouses to regularly adopt any contraception either because of illiteracy or low education levels.

Damdouane (2012) in his study also realized that, women who were educated had higher chances of using contraception. Ojakaa (2015) in Uganda found that numbers of women not using contraception were higher among women with no educations than among women with primary education, but the numbers decreased among women with secondary educations or higher educations. There was a strong trend towards declining fertility and increasing utilization of contraceptives among relatively well-educated, middle-class population in Karachi-Pakistan (Hagen et al., 2014). Secondary or higher educational attainment was more likely to be associated with use of modern contraceptives in African countries; for example, in Burkina Faso,

higher educational attainment was more likely to be associated with use of modern contraceptives compared lower educational attainment (Rob et al. (2013).

Current users of contraceptives were more educated or had spouses who were more educated than their counterparts who were not current users. (Utomo et al., 1983). Pills, condoms and traditional methods were more common among the educated women while injectable and permanent methods were more common among uneducated women

2.4.4 Gender of couple's living Children

The study by Koc, (2012), also showed that, to a greater extent, contraceptive use and choice of modern method depend on the sex of couple's living children, implying some preference for sons although generally women prefer to have children of both sexes. In another study by Chacko (2012), among married women, in four villages in rural West Bengal, India, it was found that the number of living sons a woman had influence her contraceptive use.

2.4.5 Spousal Communication on Modern Contraceptive use.

Female autonomy and seclusion, equality between spouses linked with spousal communication influence contraceptive use (Narzary, 2012). Shrestha (2012) found in a study done in Nepal that spousal communication on family planning was a significant predictor of contraceptive use in the study area. Sometimes women think that their husbands oppose contraceptive use when in fact they approved it. Thus, this lack of communication about family planning between partners also contributes to unmet needs. Spousal communication was an important factor in contraception use**.**

The most important determinant of the likelihood of the respondents in slums using family planning services was partners' approval. A study carried out in Nepal found out that about 56 percent of the women sought approval before using contraceptives, while 23 percent did not bother (Raiford et al., 2013), the remaining 21 percent of the respondents were however

uncertain an indication that they were either not having a regular sexual partner whom they could seek approval from, or that they were not sexually active. The high percentage of those who sought approval from a partner clearly indicated the importance of a partner's consent in making a final decision on use of family planning services. The wife and husband's approval of FP use positively influenced the adoption of all methods. However, the wife's approval was more important for the temporally methods than for the permanent methods (usually tub ligation and vasectomy). Partner opposition was found to cause statistically significant increase in unmet need accounting for as much as 20 percent of unmet need reported by women and a shift in contraceptive use favoring traditional methods over modern methods (Wolff et al., 2012).

2.4.6 Religious Affiliation

A study carried out by (Stephenson et al 2012) in United states showed that Individual factors that determined a person's use of services such as family planning are mediated by the characteristics of the community in which the individual lives. This study indicated that elevated levels of religious affiliation, was associated with increased uptake of contraceptives (Stephenson *et al*., 2012**).**It was important to look beyond individual factors when examining family planning use or nonuse. Disapproval by friends, neighbors and relatives, stories from social networks proved to be more salient than medical opinions in shaping safety and perceptions for example, Women with strong social networks such as friends are likely to use short term methods due to their influence.

Similarly, Family structures, religious, political affiliations and education were found to play significant role to contraceptive use and choice among women and sexually active youth (Srikanthan and Reid 2015)

According to Neeti et al, (2012) in their study explored the perceptions and attitudes of women towards currently available contraceptives and facilitating factors and the result showed that 52 percent were Protestants, 35 percent Muslims while only 13 percent were Catholics. This is an indication that use of contraceptives vary across religion with Catholics using the least as they are instead encouraged to rely more on observation of menstruation cycles and natural safe days of a woman. This clearly indicates a significant difference in the use of family planning services between Catholics and other religions (USRH report 2014).

2.4.7 Man's Attitude

A study in South Western Nigeria reveals about 63% of men compared to just 35% of women would approve the use of family planning (Oyedokun, 2013). This study also found that men's or Husband's opposition as a prominent reason for high family planning unmet need although women themselves do not cite it as their principal reason for not intending to use contraceptives for example a study on correlation of consistent condom use among HIV-positive African American women living in the United States showed that women were more likely to use condoms if they had high partner communication and reported low partner-related barriers to condom use (Raiford et al., 2013) an indication that partner attitudes plays a big role in determining women's decision to contraceptive use.

2.4.8 Source of Contraceptives methods/information

In a comparison of 15 African countries, Blanc *et al*. (2012) showed that within a year of starting a contraceptive method among 50 women, 7-27ceased to practice contraception for reasons related to quality of the service environment and the provision of a range of contraceptive methods at family planning service site and this had also shown to influence contraceptive options. In United states, a study by (Stephenson et al 2012) Showed that rapid population

growth, high rates of unemployment, elevated levels of religious affiliation, higher socio-economic status and ready access to family planning services were all associated with increased uptake of contraceptives. Similarly, a study in Philippines found that the presence of family planning services and community labor-market conditions and infrastructure development were strong influences on contraceptive use. Other studies have examined other community characteristics including the influence of levels of community economic development, levels of school participation, economic roles of children and community fertility norms on contraceptive (Chacko, 2012; Stephenson *et al*., 2012) and the result showed high influence on contraceptive use. The study by Chacko, (2012) also showed that the availability and quality of permanent village-based government health care affects the use of modern contraception. In his study he found that contraceptive prevalence rate was more among women nearer to the facility than those who were far away from the health Centre. This therefore means providing access to quality family planning services has greater influence of women decision on using family planning.

2.4.9Age

In a study done by Rob et al, (2013) Use of family planning was found to be high in women aged between 20-39 years compared to those below 20 years and above 39 years.An earlier study done by Utomo et al,(1983) showed that younger age especially age group (20-29) years was more likely to be associated with use of modern contraceptive.

In a recent study done by Leyland, (2016) showed that24 percent and 16 percent of the women who were using family planning services were less than 20 years and between 40 – 49 years of age respectively. This therefore, shows that age has greater influence in determining the women's choice to contraceptive use.

2.4.10 Marital status

Use of contraceptives was found to vary across marital status with married women using the services most compared to single women due to high incidences of sexual activities compared tosingle women. In this case, it was revealed that use of contraceptives was aimed at helping to space children and prevent unwanted pregnancy (Meharab et al., 2016).Unmarried youth have distinct contraceptive method preferences due to unsteady partnership dynamics; increased awareness of the risk of HIV has altered the context of contraceptive choice. Condom was the leading method among unmarried youth and this was a desirable option since it minimizes the dual risks of unintended pregnancies and STIs. Data also revealed a growing shift from condom to the pill, with increasing age and partnership stability.

The positive influence of marital status on the likelihood of using family planning services could be attributed to the fact that couples might decide to postpone raising children by resorting to use of family planning services. Therefore, the value of the marginal effect simply means that a married woman was 2 percent more likely to use family planning services than a single woman (Ristya .I. 2013). George andLungwena (2013) also noted that across ages, unmet need for family planning indicated higher levels among adult women compared to adolescent. In time perspective, unmet need for modern family planning was relatively high at time the women become pregnant with the first child and the level went down by the time the women conceived the last-bornchild but went up again by the time the women conceived current pregnancy. Sex combinations of surviving children and women's' education were the most important significant determinants of family planning method use and method choice (Oyedokun ,2013). The positive influence of the number of living children on the likelihood of using family planning services could be attributed to the woman's desire for children having been satisfied. (Mahidu et al. 1998)

2.4.11 Number of children

Various Studies revealed that the higher the number of living children, the more the desire to use family planning services. This was because those with more children might not be having desire for children as the desire had already been satisfied. The desire for more children was attributed to many factors, including a cultural perception that more children signified a source of wealth (Teresa. 2015). Contraceptive use was 26.2% among women with three or more surviving children compared with 19.0% of women with no surviving children (Agyei and Migadde 2015). Injectable and IUCDs were preferred by the young or low parity women, while permanent methods were preferred by the older or high parity women. Relatively older women preferred condoms and traditional methods (Kibuuka et.al, 2012) suggesting that age has got a lot of influence in a women's contraceptive choices.

2.4.12 Service Provider' Factors

Health services providers played a big role in sexual and reproductive health behaviors and determining women's decision to family planning use. In one study, results showed that increased availability and uptake of family planning methods was positively associated with the presence of a number of trained family Planning service providers (Katende et al., 2013). For example, discussion of family planning between clients and service providers during ANC of the first child was key to subsequent use of family planning methods and reduction of unmet need for family planning. Use of pills, condoms, traditional methods, injectable and IUCDs was higher in women who had home visitations by welfare assistants. Studies further indicated that FP counseling and regular follow-up was accompanied by a high rate of contraceptive use and a low pregnancy incidence after delivery (Brou et al., 2012).Kidane. (2015) looked at providers and client attitude/knowledge towards long acting and permanent methods and assessed the

content of information exchange between the provider and the client. Clients learn little about long acting and permanent methods at the facility, due to the providers' approach to the counseling and sharing information.

The providers tended to focus the family planning information they gave to a client on the method asked about, without carrying discussions first on the reproductive needs of the clients. The providers have good attitudes towards long term method and permanent but they are concerned more on temporary family planning methods. In Rakai Uganda, a community randomized trial of enhanced FP efforts program showed a statistically significant higher use of hormonal contraceptives and lower pregnancy rates in the intervention arm as compared to the control arm. Investigators found that using trained volunteers and social marketing of contraceptives can improve contraceptive uptake among women of reproductive age (Lutalo et al., 2012). Therefore, the quality of providers' interaction and client should be improved by retraining the providers, provider knowledge and understanding of the methods and procedures should be improved, printed materials should be made available to interested clients. Friendliness of family planning staff had a marginal effect implying that the likelihood of respondents using family planning services was 19 percent higher if family planning staff was friendly than when they were not.

The significance of this determinant could be explained by the fact that provision of certain types of family planning services requires performance of some procedures by the person administering the services. With regard to quality and cost of family planning services, the probability of a woman using family planning services was 17 percent higher for respondents who perceived the services to be of high quality and costly than for those who perceived otherwise. The positive impact of quality could be attributed to the fact that in the process of making a decision on using family planning services, perceived quality of the service was given

a high consideration as supported by theory whereby taste and preference is an important factor in making demand de

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research methodology used in the study and it is presented under subheadings such as: study design, study population, sample size, study setting, sampling procedure, determination, definition of variables, inclusion and exclusion criteria, data collection procedures, data management, research instruments, ethical consideration, analysis, expected limitations and dissemination of the results.

3.1 Area of Study

The study was carried out in Lira Municipality in Lira District. Lira District is located in Lango sub-region in Northern Uganda and is bordered by the districts of Pader and Otuke in the North, Alebtong in the East, Dokolo in the South and Apac in the West. The district is composed of three counties that, is, Erute South, Erute North and Lira Municipality (Ministry of Local Government, 2013). The current population of Lira District is at 410,516 people with 196,891men and 213,625 women (National Population and Housing Census, 2014). The study was conducted in two divisions of Lira Municipality namely; Adyel and Central which lie at the heart of Lira District located at 233 Kilometers North of the Ugandan capital; Kampala.

As an urban constituency, the municipality houses all categories of people including schooled, semi-schooled and unschooled originating from different parts of the country. The occupants have various health related issues including family planning; according to a study conducted by (NU-HITES, 2012), it revealed that there is low contraceptive prevalence in Northern Uganda, Lira inclusive of less than 40% among all women aged 15-49 years old and 23% among married

women aged 15-49 years with only 18%using modern methods and high fertility rate at 7.5 more than the national average birth rate of 5.7 per woman(UDHS 2017)hence the justification for its selection as a study area.

3.2Research Design

The study was descriptive cross- sectional quantitative study design. The design was chosen because it was simple and aimed at studying a group or population at a particular point in time. In this case it was intended to understand the determinants of women decision to contraceptive use.

3.3 Study Population

The study population comprised of all women of reproductive age (15 to 49 years) living in Lira Municipality. The study considered women of 15-49 years of age within Lira municipality from homesteads, market areas, offices (private, public and Non-Government organization), and all institutions within the perimeter of the Municipality.

3.4 Sampling procedure

3.4.1 Sample Size Determination

The sample size of respondents who participated in this study was determined using Kish and Leslie formula (1965).

$n = z^2pq/d^2$

Where N is the sample size

z = The Z score corresponding to 95% confidence level = 1.96

p = the proportion of women attending FP services, 20%=0.2

q = I-P

d = sampling error that will be allowed for 0.05

p= 0.2

q= 0.8

$N = ((1.962)^2 \times 0.2 \times 0.8)/0.05 \times 0.05$

= 245.86≅ 246 Women.

3.4.2 Sampling Techniques

Cluster sampling technique was adopted by selecting women in different cluster in the different divisions of lira municipality which included Adyel, Ojwina, Railway and Central Divisions.

A simple random sampling technique was used to select 2 out of 4divisions within Lira municipality. Names of all the 4divisions were written on pieces of paper, put in a bucket, shaken and someone who was not a member of the team was allowed to pick names of the divisions without replacement.

Systematic sampling procedure was used to obtain the households from the selected villages, this was possible with the help of research assistants who had more knowledge of the study area, the house holds that participated in the study were picked by making numbers of homestead from 1 to 6, then every third homestead on the list that had an a woman of reproductive age was selected through the systematic random sampling approach, and in each of the selected homestead, those women of reproductive age who fulfilled the inclusion criteria were selected and interviewed.

The purpose of this heterogeneous sample was used to enable the researcher to collect data from respondents of varying characteristics, thus increased the validity, reliability and presentation of the findings.

3.5 Study Variables

3.5.1 Dependent Variable

Modern contraceptive use among women aged 15-49 years in Uganda was the dependent variable measured in terms of using any modern family planning method.

3.5.2 Independent Variables

The independent variables are factors such as;

demographic factors, marital status, age, level of knowledge, sex, types of family planning, importance of family planning, risks of family planning, preference of modern contraceptive method, choice of a method, health provider related factors, access to family planning services (in term of cost and distance), health provider related characteristics and health facility structural design.

3.6. Data Collection Methods and instruments

3.6.1 Data Source:

Primary Data: Primary data was information gathered directly from the respondents in the field through the direct efforts of the researcher through; interview. Primary data was collected directly and physically from the 246 respondents.

This was meant to facilitate the collection of first hand, correct or new information, because of direct involvement of the researcher in interaction with respondents.

3.7.0 Data collection Methods

Interview administered questionnaires were used to collect responses from the respondents where by the researcher asked the respondents basing on the semi structured questionnaire. The

respondents' responses were recorded immediately by researcher the exact way it was said, each participant was asked in the same order.

3.7.1 Data collection tool

Semi structured questionnaires of both closed and open-ended questions were used to collect data. The questionnaires were translated into Luo at the time of data collection by the researcher since the study participants were not all educated and learned enough to understand and back to English.

3.7 .2 Data collection procedure

Data was collected using semi structured questionnaires. The researcher made self-introduction to each respondent who qualified to participate in the study. After introduction the researcher sought for respondent's consent to participate in the study. The procedure for the data collection was interview administered questionnaire to the respondents. Where the researcher asked the respondents basing on the structured questionnaires and the respondents answered and he recorded the exact answer, each participant was asked in the same order.

3.8 Data Analysis and Presentation Methods

The raw data gathered from the study area were cleaned, edited to suit the general study purpose. Data cleaning is the process of removing errors from data during collection or data entry. cross-tabulations were used as form of presentation and analysis for the study. Quantitative data from the survey was analyzed using SPSS version 18 statistical package.

3.9Quality Control Method.

Approval

Following the approval of the research proposal from the supervisor, Uganda Martyrs University Research Ethics Review Committee and permission was granted by Lira District Health Office to conduct the study. Upon securing the permission, the researcher sought consent from the respondents and the essence of the study was thoroughly clarified and explained to them.

Pre-testing: Interview guides were well pre-tested with the purpose of forming appropriate questions that the selected respondents can easily understand. It was also meant to allow the researcher to familiarize with the terminologies used by the policy makers, implementers and beneficiaries. Pre-testing exercise was done in Ojwinadivision, with similar characteristics of the study areas. This enabled the researcher to identify question ambiguity and response categories, interview instructions and also provided the insight into the level of understanding of both the respondents and the researcher.

Training of research assistants

Twelve Research assistants were recruited and trained for two days to ensure that they are fully aware of the study and what information to be collected to ensure that the respondents understood what they were answering.

Validity and Reliability

Validity and reliability of the tool was ensured by pre-testing the tool in among 20 women of reproductive age between 15 to 49years in Lira central division in lira Municipality. The participants were selected based on the fact that it possessed similar characteristics of the other study areas.

The questionnaire was pretested and refined according to feedback generated from the pre-testing exercise before data was collected. This exercise was intended to validate the appropriateness of the tools, whether too long or not, difficult or easy to understand, check for clarity of the questionnaire items and eliminate ambiguity, difficult wordings or unacceptable questions. Participants also had the opportunity to comment on the clarity of the questions and

were requested to make suggestions for any improvement were necessary.

Translation:

Questionnaire was translated in to Luo and back to English to ensure accuracy of the data collection.

3.10. Ethical consideration.

The researcher was cleared by University Research Ethic Committee and was given an introductory letter from the University, sought permission from the relevant departments at Lira Municipality and Local council's one to three (LC1 to 3). He explained the study purpose to the respondents, sought informed consent from respondents, ensured confidentiality and anonymity and ensured neutrality throughout the interviews.

3.10. Limitation of the study.

There were anticipated constraints encountered during the study. There was limitation in resource availability. The researcher planned and used the available resources sparingly.

Secondly, since the data was collected during the rainy season, many respondents were not got at home since most of the populations in this area are peasant farmers and had gardens far away from town. They went away to their garden at the time of data collection. To avoid this limitation, data was collected in the afternoon hours when the respondents have returned from the garden. Thirdly, the geographical area covered only the urban households in the four Divisions therefore; this may not represent all communities. The sample of 246 respondents may not possibly be representatives of the views of all women of reproductive age between 15 to 49years residing in the four Division of Lira Municipality at large. The research recommends for another study to be done in other division.

3.11. Inclusion criteria

Women of reproductive aged between 15-49 years who consented to participate in the study after explaining to them the content of the consent form that was attached to the questionnaire.

3.11.2 Exclusion Criteria

The study excluded women of reproductive age (15-49 years) with the following features;

Those with a known history of primary and secondary infertility; Women who have/had undergone gynecological operations leading to permanent sterility like Total abdominal hysterectomy not done in view of family planning as an indication; Women who have chosen to live a life of celibacy like nuns; Those with mental disorders that they couldn't give valid information; and women below or above the age mentioned. Those who refused to consent to take part

CHAPTER FOUR:

RESULTS

4.0 Introduction

This chapter presents the findings of the study based on the specific objectives

4.1.0Women aged 15 - 49 years currently using modern contraceptives.

4.1.1 Demographic information

A total of 246 women of reproductive age where interviewed. The background information is shown in table 1

Table 1: Demographic characteristic of the respondents

Variables	Frequency, N	Percentage, %
Age		
15 – 19 years old	161	65.4
20– 24 years old	60	24.4
25– 35 years old and above	25	10.2
Marital status		
Single	87	35.4
Married/cohabiting	99	40.2
Widowed	48	19.5
Divorced/separated	12	4.9
Employed		
Yes	111	45.1
No	135	54.9
Highest level of education		
None	25	10.2
Primary level	86	35.0
Secondary level	99	40.2
Tertiary level/University	36	14.6
Monthly income		
50,000shs-200,000shs	148	60.2
200,000sh-350,000sh	62	25.2
350,000shs-500,000shs	24	9.8
Above 500,000shs	12	4.9
Religion		

Catholics	74	30.1
Protestants	136	55.3
Pentecostal	24	9.8
Muslim	12	4.9
Others		
Number of children		
<4	111	45.1
>4	114	46.3
Not applicable	21	8.5
Final decision makers		
Yes	96	39.0
No	150	61.0

Most of the respondents (65.4%) were in the age group of 15-19 years. Four in every ten, 40.2% of the respondents were married. Majority of the respondents 54.9% were not employed.

On the analysis of level of education, 40.2% of the respondents had attained secondary education compared to the 35% had attained primary education. Six in every ten, 60.2% of the respondents had a monthly income of 50,000shs-200,000shs. Slightly above half, 55.3% of the respondents were Protestants by religion, regarding number of children, 46.3% of the respondents had at least four children compared to 45.1% who had at most four children and finally, 61% of the respondents said that they were the final decision makers regarding modern contraceptives.

4.1.2 Current Modern contraceptive use

Table 2: Bi-variate analysis demographic characteristic and modern contraceptives

Variables	Modern contraceptives		OR	CI, 95%		P-value
	Yes (%)	No (%)		Lower	Upper	
Age						.007
15 – 19 years old	49(57.0%)	112(70.0%)	2.476	1.06	5.81	
20– 24 years old	24(27.9%)	36(22.5%)	1.625	0.64	4.16	
25– 35and above	13(15.1%)	12(7.5%)	1.0			
Marital status						.000
Single	25(29.1%)	62(38.8%)	1.21	0.33	2.47	
Married/cohabiting	37(43.0%)	62(38.8%)	1.79	0.53	2.95	
Widowed	18(20.9%)	30(18.8%)	0.60	0.21	1.57	
Divorced/separated	6(7.0%)	6(3.8%)	1.0			
Employed						.000
Yes	12(14.0%)	99(61.9%)	10.01	5.03	19.92	
No	74(86.0%)	61(38.1%)	1.0			
Highest level of education						.000
None	13(15.1%)	12(7.5%)	0.542	0.48	1.26	
Primary level	40(57.0%)	46(28.8%)	0.43	0.36	1.41	
Secondary level	9(10.4%)	90(56.3%)	0.05	0.00	0.46	
Tertiary level/University	24(27.9%)	12(7.5%)	1.0			
Monthly income						.000
50,000shs-200,000shs	62(72.1%)	110(68.8%)	2.77	1.23	3.46	
200,000sh-350,000sh	12(14.0%)	38(23.8%)	0.48	0.14	0.97	
350,000shs-500,000shs	8(9.3%)	8(5.0%)	1.0	0.00	2.83	
Above 500,000shs	4(4.7%)	4(2.5%)	1.0			
Religion						.000
Catholics	54(62.8%)	20(12.5%)	1.35	0.45	1.39	
Protestants	16(18.6%)	120(75.0%)	0.06	0.00	0.28	
Pentecostal	8(9.3%)	18(11.3%)	0.22	0.03	0.65	
Muslim	8(9.3%)	4(2.5%)	1.0			
Number of children						
<4	35(40.7%)	76(47.5%)	0.92	0.64	2.73	.532
>4	44(51.2%)	70(43.8%)	1.26	0.53	2.73	
Not applicable	7(8.1%)	14(8.8%)	1.0			
Final decision makers				0.462	1.573	027
Yes	27(31.4%)	69(43.1%)	0.60			
No	59(68.6%)	91(56.9%)	1.0			

Women who were in age group of 15-19 years were 2.5 times more likely to use modern contraceptives than those in the age group of 35years and above. Most of the respondents were

either married or cohabiting, Respondents in this group were twice more likely to use modern contraceptives, Women who were employed were 10 times more likely to use modern contraceptives that those who were not employed, Women who were educated were 5 times less likely to use modern contraceptives. On monthly income, Women earning between50,000 and 200,000 were more likely to use modern contraceptives compared to those earning above 500,000/=, Religion and final decision makers were the demographic factors that were significantly associated with use of modern contraceptives among women of reproductive age.

4.2 Most preferred option of modern contraceptive method

Table 3: Preferred modern contraceptives

Variables	Frequency, N	Percentage, %
Ever use of Modern contraceptive		
Yes	98	39.8
No	148	60.2
Currently using modern contraceptive		
Yes	86	35.0
No	160	65.0
Methods used		
Contraceptive Pills	13	15.1
Deprovera injection	36	41.9
Condoms	13	15.1
Intrauterine Copper Device (IUD)	12	14.0
Implant	12	14.0
Reasons for not using modern contraceptive		
Religious prohibition	12	7.5
Husband disapproval	89	55.6
Influence of others	63	39.4
Rumors	79	49.4
Fear of side effects	55	34.4
Fear of infertility	22	13.8
The need for more child	20	12.5
preferred to use another method		
Yes	74	30.1
No	172	69.9

On the analysis of the contraceptives use, 39.8% of the respondents had ever used modern contraceptives while 60.2% never used. 35.0% of the respondents were currently using modern contraceptives and 65 were not on any method.

The commonest methods used was Deprovera injection at 41.9% followed by pills and condom at 15.1%. Majority of the respondents who were not using the modern contraceptive 55.6% was because of their husbands' disapproval.

Finally, 69.9% of the respondents would not prefer to use modern contraceptives methods.

4.3 Reasons for the choice of method

Table 4: Knowledge information

Variables	Frequency, N	Percentage, %
Ever heard of modern contraceptives		
Yes	246	100.0
No		
Source of information		
Health workers		30.1
Radio	74	19.9
TV	49	19.9
Friend	49	24.8
Other	61	5.3
	13	
Types of modern contraceptives methods		
Pills	124	50.4
Depo-Provera Injection	102	41.5
Condoms	220	89.4
IUD	49	19.9
Implant	83	33.7
Female sterilization	3	1.2
Vasectomy	25	10.2
Reasons for using modern contraceptives		
Prevent unwanted pregnancy	136	55.3
Allows child spacing	61	24.8
Prevent STI	49	19.9
Contraceptives have side effect/disadvantage		
Yes	137	55.7
No	109	44.3
Side effects of modern contraceptives		
Weight gain	48	35.0
Amenorrhea	71	51.8
Secondary infertility	25	18.2
Heavy menses	43	31.4
Irregular menses	88	64.2
Encourage promiscuity	25	18.2

All the respondents 100% had ever heard about modern contraceptives. On the sources of information, 30.1% of the respondents got to know about modern contraceptives from health workers. Almost nine in every ten of the respondents, 89.4% mentioned condoms as one of the modern contraceptives. Most of the respondents, 55.3% mentioned prevention of unwanted pregnancy was the reason for using modern contraceptives. Majority of the respondents 55.7%

said modern contraceptives had side effect/disadvantage with 64.2% of the respondents mentioned irregular menses as the main side effect of modern contraceptives.

4.3 .1 Reasons for the choice of method of contraceptive

Table 5: Bivariate analysison Reason for the choice of method contraceptives

Variables	Modern contraceptive		OR		CI, 95%	P-value
	Yes (%)	No (%)				
Source of information						.000
Health workers	25(29.1%)	49(30.6%)	0.81	0.21	1.84	
Radio	11(12.8%)	38(23.8%)	0.46	0.11	1.77	
Friend	38(44.2%)	11(6.9%)	5.53	2.93	3.48	
TV	7(8.1%)	54(33.8%)	0.21	0.04	0.74	
Print media	5(5.8%)	8(5.0%)	1.0			
Types of modern Contraceptives methods						.094
Contraceptive Pills	12(11.3%)	8(6.7%)	7.88	4.36	9.66	
Deprovera Injection	7(6.6%)	17(14.2%)	2.16	1.78	3.28	
Condoms	36(34.0%)	12(10.0%)	15.75	10.63	18.83	
IUD	13(12.3%)	27(22.5%)	2.53	1.47	4.02	
Implant	9(8.5%)	22(18.3%)	2.15	1.43	4.00	
Female sterilization	25(23.6%)	13(10.8%)	10.10	7.62	12.58	
Other	4(3.8%)	21(17.5%)	1.0			
Reasons for using modern contraceptives						.215
Prevent unwanted pregnancy	50(58.1%)	86(53.8%)	1.79	0.68	2.95	
Allows child spacing						
Prevent STI	24(27.9%)	37(23.1%)	2.0	0.94	3.74	
	12(14.0%)	37(23.1%)	1.0			
Contraceptives have side effect/disadvantage						.048
Yes	38(44.2%)	99(61.9%)	0.49			
No	48(55.8%)	61(38.1%)	1.0	0.13	1.04	
Side effects of modern contraceptives						.000
Weight gain	7(10.9%)	17(26.2%)	1.30	0.18	2.20	
Amenorrhea	9(14.1%)	5(7.7%)	5.70	3.91	5.92	
Secondary infertility	13(%)	6(9.2%)	6.86	4.01	7.07	
Heavy menses	4(20.3%)	9(13.8%)	1.41	0.33	2.00	
Irregular menses	25(39.1%)	9(13.8%)	8.89	4.55	10.56	
Encourage promiscuity	6(9.4%)	19(29.2%)	1.0			

On the bivariate analysis of knowledge factors and use of modern contraceptives, Sources of information (P-value=0.000), knowing if contraceptive have side effects (P-value=0.048) and the knowledge on the actual side effects of modern contraceptives (P-value=0.000) were significantly associated with modern contraceptive use.

Women who got information about modern contraceptives from friends (satisfied users) were 5.5 times more likely to use modern contraceptives, those who got the information from health workers; radio and TV were less likely to use modern contraceptives than those who got it from print media. Women who mentioned that modern contraceptives have got side effects were less likely to use modern contraceptives that is those who mentioned that modern contraceptives lead to amenorrhea were 5.7 times, those who mention secondary infertility were 6.86 times and those who mentioned irregular menses were 8.89 times more likely not to use modern contraceptives than those who mentioned that modern contraceptive encourages promiscuity.

4.4: Factors related to modern contraceptive use

Table 6: Univariate analysis of health facility factors

Variables	Frequency, N	Percentage, %
Distance from nearest health facility		
Within 5km	147	59.8
Above 5 km	99	40.2
Costs of modern contraceptives		
Affordable	73	29.7
Relatively affordable	124	50.4
Not affordable	49	19.9
Provision of alternatives of modern contraceptives	98	39.8
Yes	148	60.2
No		
Provision of adequate information		
Yes	98	39.8
No	148	60.2
Available modern contraceptive		
Contraceptive Pills	32	13.0
Deprovera injection	74	30.1

Condoms	140	56.9
Comfortable with the methods Yes No	 147 99	 59.8 40.2
Health workers available Yes No	 86 160	 35.0 65.0
Health worker's attitude Good Fair Poor	 74 111 61	 30.1 45.1 24.8

Majority of the respondents, 59.8% of the respondents had their nearest facility within 5 km. Half of the respondents, 50.4% mentioned that modern contraceptives was relatively affordable. Six in every ten, 60.2% of the respondents have the facility that provide them with modern contraceptives alternatives. Most of the respondents 60.2% said that the health workers do not provide them with adequate information regarding modern contraceptives. Most of the respondents 56.9% said the always available methods was condom, majority of the respondents 59.8% were comfortable with the methods. Almost, two third 65% of the respondents said the health workers are not always available and 45.1% of the respondents rated the health workers' attitude as fair.

4.4.1 Factors related to modern contraceptive use

Table 7: Bivariate analysis of the health facility factors and modern contraceptive use

Variables	Modern contraceptives		OR	CI, 95%		P-value
	Yes (%)	No (%)		Lower	Upper	
Distance from nearest health facility						.004
Within 5km	62(72.1%)	85(53.1%)	2.28	1.53	2.95	
Above 5 km	24(27.9%)	75(46.9%)	1.0			
Costs of modern contraceptives						.000
Affordable	36(41.9%)	37(23.1%)	0.93	0.62	1.99	
Relatively affordable	25(29.1%)	99(61.9%)	0.24	0.12	0.87	
Not affordable	25(29.1%)	24(15.0%)	1.0			
Provision of alternatives of modern contraceptives						.454
Yes	37(43.0%)	61(38.1%)	1.23	0.83	2.11	
No	49(57.0%)	99(61.9%)	1.0			
Provision of adequate information						.000
Yes	74(86.0%)	24(15.0%)	34.94	30.01	98	
No	12(14.0%)	136(85%)	1.0			
Available modern contraceptive						.586
Pills	12(14.0%)	20(12.5%)	0.98	0.38	1.54	
Injectable	24(27.9%)	50(31.3%)	0.79	0.13	1.69	
Condoms	55(64.0%)	90(56.3%)	1.0			
Comfortable with the methods						.009
Yes	61(70.9%)	86(53.8%)	0.85	0.33	1.87	
No	25(29.1%)	74(46.2%)	1.0			
Health workers available						.089
Yes	24(27.9%)	62(38.8%)	0.61	0.22	1.37	
No	62(72.1%)	98(61.2%)	1.0			
Health worker's attitude						.000
Good	13(15.1%)	61(38.1%)	0.14	0.04	0.61	
Fair	36(41.9%)	75(46.9%)	0.31	0.10	0.83	
Poor	37(43.0%)	24(15.0%)	1.0			

On bivariate analysis of the health facility and modern contraceptives use, the results showed that the respondents within 5km distance to the health facility were 2 times more likely to use

modern contraceptives than those who live more than 5km from the health facility. The cost of modern contraceptives (P-value=0.000) respondents who said it was costly were more less likely to use modern contraceptives. Respondents with adequate information (P-value=0.000) were 34 times likely to use modern contraceptives where as those comfortable with the methods (P-value=0.009) and health workers attitude (P-value=0.000) were significantly associated with modern contraceptives use

CHAPTER FIVE:

DISCUSSION, CONCLUSIONAND RECOMMENDATIONS.

5.0 Introduction

This chapter gives a comprehensive assessment of the study results according to the study objectives, how the current findings relate to other scholar's findings and impact of the current results on policy evaluation about modern contraceptives

5.1Proportion of women using modern contraceptives:

The study found that 39.8% of the women have ever used use modern contraceptive and 35% of the women were on modern contraceptives compared to national statistics which shows that 28 percent of currently married women have an unmet need for family planning services, while 39 percent of married women are currently using a contraceptive method.

Therefore, nearly seven in ten currently married women in Uganda (67 percent) had a demand for family planning. At present, 58 percent of the total demand for family planning was met, almost entirely by modern methods (52 percent of total demand). Thus, if all married women who said they want to space or limit their children were to use family planning methods, the CPR would increase from the current level of 39Percent to 67 percent. Among sexually active unmarried women, 32 percent have an unmet need for family planning, and 51 percent are currently using a contraceptive method. The total demand for family planning among unmarried sexually active women was 83 percent, and at present 61 percent of the potential demand for family planning was met. If all of the unmarried sexually active women who said they want to space or limit their births were to use family planning methods, the CPR would increase from 51 percent to 83Percent. This could probably be because of more awareness programs put in place

to sensitize the community. This was in line with Mongolian MoH& UNFPA, (2012); United Nations, (2012), which indicated that contraceptive prevalence rate among women of reproductive age, was at 33.4%.

5.2. Socio-demographic and contraceptive use.

5.2.1 Age

In this study age range was significantly associated with modern contraceptive use (P-value=0.007), women who were in age group of 15-19 years were 2.5 times more likely to use modern contraceptives than those in the age group of 35years-and above years. This could be because a lot of young women were involved in sexual practice and they want to prevent unwanted pregnancy. This was inconsistent with Rob et al (2013) which found that use of family planning was found to be high in women aged between 20-39 years compared to those below 20 years and above 39 years, younger age especially age group (20-29) years was more likely to be associated with use of modern contraceptive. However, Leyland, (2016) showed that 4 percent and 6 percent of the women who were using family planning services were less than 20 years and between 40 – 49 years of age.

5.2.2Marital Status

The study found that marital status was significantly associated with modern contraceptive use (P-value=0.000). This could be probably because women sometimes have to seek approval form their spouses. This was in line with Ristya, (2013) whoreported a positive association between marital status and use of modern contraceptives. The positive influence of marital status on the likelihood of using family planning services could be attributed to the fact that couples might decide to postpone raising children by resorting to use of family planning services. The value of

the marginal effect simply means that a married woman was 2 percent more likely to use family planning services than a single woman.

5.2.3 Employment.

The study found that employment status was significantly associated with modern contraceptive use (P-value=0.000), women who were employed were 10 times more likely to use modern contraceptives than those who were not employed. This could be probably because of easy access to money for any contraceptive needs and also fear of interference from work as a result of pregnancy related effects.

5.2.4 Level of education

The study also revealed that level of education was significantly associated with modern contraceptive use (P-value=0.000); women who had no formal education, primary education and secondary education were less likely to use modern contraceptives than those who had tertiary education. This could be probably because educated women were more likely to have more knowledge to make informed decision on their own regarding contraceptives. This was in agreement with Oyedokun, (2013) who revealed that better educated women are also argued to have more knowledge of contraceptive methods or of how to acquire them than the less educated women because of their literacy, greater familiarity with modern institutions and greater likelihood of rejecting a fatalistic attitude towards life. In addition, Koc (2012) finds a positive association between the educational level of both spouses and the use of contraceptive methods in Turkey.

Studies showed that even after controlling the effects of other factors, education was a key factor influencing contraceptive use. Majority of those using contraceptives had post primary education, while the least users of family planning had no formal education. Whereas 49 percent

of the users of family planning services had secondary education, 28 percent had university education while only 15 percent had primary education with 6 percent reporting no formal education. Women could not convince their spouses to regularly adopt any contraception either because of illiteracy or low education levels (Hagen et al., 2014). This implies that educating women enlightens them which would increase their chances of using modern contraceptives.

5.2.5 Income level

The study found that monthly income was significantly associated with modern contraceptive use (P-value=0.000); women who earned 50,000shs-200,000shs were 2.27 times more likely use modern contraceptives than those who earned above 500,000shs. This could probably be because most of the women in the town areas especially those with little income have embraced contraception as a way of reducing the number of children against their husbands' will. This was inconsistent with Sharma et al. (2015) who found that Women with unmet need also have low status and weak bargaining power within the household, 31 percent had an average monthly income of KS 20,000 and above while 28 percent had an average monthly income of between Ksh.15, 000 to 20,000. On the other hand, 7 percent of users had an average monthly income of less than 5,000. Those with no income were, notably the least users of family planning services. This could be because of the difference in the study settings as it was done in urban areas while the other study was done in rural areas. This implies that more income was required to support women in search of the services in terms of transport cost hence improving women economic status will lead to improve used of modern contraceptives.

5.2.6 Religion:

In this study religion was significantly associated with modern contraceptive use (P-value=0.000).). This could be probably because some religion preached against contraceptives

though in addition, religion teaches morals that fight against promiscuity. This was in line with Stephenson et al., (2012) who noted that elevated levels of religious affiliation, was associated with uptake of contraceptives. Similarly, Srikanthan and Reid 2015) who reported that religious background of the woman, out of the 51 percent that were using contraceptives, 52 percent were Protestants, 35 percent Muslims while only 13 percent were Catholics. This was an indication that use of contraceptives vary across religion with Catholics using the least, probability of a woman using family planning services if she was a Catholic was 28 percent lower compared to others with different religious background such as Protestant and Muslims. This was because catholic faith discourages its faithful from using contraceptives as birth control measures. They are instead encouraged to rely more on observation of menstruation cycles and natural safe days of a woman. This finding clearly indicates a significant difference in the use of family planning services between Catholics and other religions.

5.2.7 Partners approval

The study found that final decision makers was significantly associated with modern contraceptive use (P-value=0.027). This could be probably because in some cultures a man or mother in laws are the final persons to make decision as further as reproductive issues was concern. This was in line with study by Shrestha (2012) which found that spousal communication on family planning was a significant predictor of contraceptive use in the study area. Sometimes women think that their husbands oppose contraceptive use when in fact they approve. Thus, lack of communication about family planning between partners also contributed to unmet needs. This was further supported by Raiford et al., (2013) who also indicated that 56 percent of the women sought approval before using contraceptives, while 23 percent did not bother. In addition, wife and husband's approval of FP use positively influenced the adoption of

all methods. However, the wife's approval was more important for the temporally methods than for the permanent methods. Partner opposition was found to cause a statistically significant increase in unmet needs accounting for as much as 20 percent of unmet need reported by women and a shift in contraceptive use favoring traditional methods over modern methods (Wolff et al., 2012). The high percentage of those who sought approval from a partner clearly indicates the importance of a partner's consent in making a final decision on use of family planning services.

5.2.8 Gender and number of children:

The study found no association between number of children and use of modern contraceptives. This was contrary to Koc, (2012) who showed that contraceptive use and choice of modern method depend on the sex of couple's living children, implying some preference for sons although generally women prefer to have children of both sexes. In disagreement, Chacko (2012) also found that the number of living sons a woman had influenced her contraceptive use. This implies that because of the different values put on certain child gender, influences the use of modern contraceptives, where male gender is valued than their female counterpart which in most cases makes a woman to continue reproducing until she gets a male child if she does not have one.

5.3 Most preferred options of modern contraceptive

On the analysis of the contraceptives use, 39.8% of the respondents had ever used modern contraceptives and 35.0% of the respondents were currently using modern contraceptives, the commonest methods being Deprovera injection used at 41.9%. Majority of the respondent who were not using the modern contraceptive at 55.6% was because of their husbands' disapproval. Finally, 69.9% of the respondents would not prefer to use modern contraceptives methods.

The study found that cost of modern contraceptives was significantly associated with modern contraceptive use (P-value=0.000). Considering that condoms are readily available in the local market. This is inconsistent with Kibuuka et.al, (2012) who indicated that the probability of a woman using family planning services was 17 percent higher for respondents who perceived the services to be of high quality and cost than for those who perceived otherwise. The positive impact of quality could be attributed to the fact that in the process of deciding on using family planning services, perceived quality of the service is given a high consideration as supported by the theory of taste and preference as an important factor in making demand decision.

5.4 Reason for the choice of method

5.4.1 Level of knowledge of women aged 15-49 years regarding the modern contraceptive methods

The study found that information was significantly associated with modern contraceptive use (P-value=0.000); Women who got information about modern contraceptive were 5.5 times more likely to use modern contraceptives than those who got it from print media and those who got the information from health workers, radio and TV were less likely to use modern contraceptives than those who got it from print media. This could be probably because the way the information was passed influenced the uptake of the service. This was in line with Amin *et al., (*2012) who noted that women tend to follow information and advice from their relatives or friends compared to those got from other sources. The study also revealed that knowing if contraceptive have side effects was significantly associated with modern contraceptive use (P-value=0.048).

The study found that knowledge on the actual side effects of modern contraceptives was significantly associated with modern contraceptive use (P-value=0.000), Women who mentioned that modern contraceptives had side effects were less likely to use modern contraceptives

(OR=0.13); Women who mentioned that modern contraceptives leads to amenorrhea were 5.7 times, those who mentioned secondary infertility were 6.86 times and the who mentioned irregular menses were 8.89 times more likely to use modern contraceptives than those who mentioned that modern contraceptive encourages promiscuity. This could be probably because of the misconception the community has against modern contraceptives. This was consistent with Oyedokun, (2014) who indicated that non-use of contraceptive was linked to fears about side effects. Similarly, pills are believed to cause weight gain and infertility which was not true. The progesterone in the pill can increase appetite which may result in weight gain. Pills do not cause infertility. A woman (or her partner) may have always had a fertility problem but it was never realized before because they were not trying to get pregnant. It may take a few months for cycles to return to normal for women who were on the pill (Rajaseker &Bigriggs, 2012).

5.5 Factors related to modern contraceptive use among women aged 15-49years

5. 5.1 Health facility factors and modern contraceptive use:

5.5.2Distance to health Centre.

The study found that distance to the nearest hospital was significantly associated with modern contraceptive use(P-value=0.004); women who live within 5 km were 2.28 times more likely to use modern contraceptives than those who live more than 5 km. This could be probably because of the time constraint that it takes from their home steads to reach the health care facility. This is in line with Stephenson et al., (2013) who reported that distance to the health facility was one of the main determinants of uptake of contraceptives. This was also supported by DeGraff, 2007) who reported that health facility distance to the residence was found to influenced uptake of modern contraceptives.

5.5.2 Cost of contraceptive methods

The study found that the cost of modern contraceptives was significantly associated with modern contraceptive use (P-value=0.000). Taking into account that condoms are readily available in the local market. This is inconsistent with Kibuuka et.al, (2012) who indicated that the probability of a woman using family planning services was 17 percent higher for respondents who perceived the services to be of high quality and cost than for those who perceived otherwise. The positive impact of quality could be attributed to the fact that in the process of making a decision on using family planning services, perceived quality of the service is given a high consideration as supported by the theory of taste and preference as an important factor in making demand decision

5.5.3 Availability of alternative modern contraceptive methods:

The study found that 39.8% of the respondents said they were provided with alternative modern contraceptives of the choice. This was in line with Blanc *et al*. (2012) study which showed that provision of a range of contraceptive methods at family planning services has also been shown to influence contraceptive option hence determinants of woman decision to contraceptive use.

5.5.4 Provision of adequate information:

In the study provision of adequate information was significantly associated with modern contraceptive use(P-value=0.000). This could be probably because this would allow the women or couple to make informed choices. This was in line with Brou et al., (2012) who noted that FP counseling and regular follow-up was accompanied by a high rate of contraceptive use and a low pregnancy incidence after delivery. Similarly, Kidane, (2015) stated that Clients learn little about Long Acting and Permanent Methods at the facility, due to the providers' approach to the counseling and sharing information. The providers tended to focus the family planning

information they gave to a client on the method asked about, without carrying discussions first on the reproductive needs of the clients**.**

5.5.5 Health worker's attitude:

The study revealed that health workers' attitude was significantly associated with modern contraceptive use (P-value=0.000). This could be probably because attitude of the health workers would enhance the way the information is assimilated during counseling. This was line with Kidane, (2015) study which revealed that the good attitude the provider leads to increased used of modern contraceptives. Similarly, Lutalo et al., (2012) noted that the quality of provider interaction and client should be improved by retraining the providers, provider knowledge and understanding of the methods and procedures should be improved, printed materials should be made available to interested clients. Friendliness of family planning staff had a marginal effect implying that the likelihood of respondents using family planning services was 19 percent higher if family planning staff was friendly than when they were not. The significance of this determinant could be explained by the fact that provision of certain types of family planning services requires performance of some procedures by the person administering the services.

5.5.6 Health workers available

The study also found that availability of trained health workers was not associated with modern contraceptive use. This is inconsistent with Katende et al., (2013) which showed that increased availability and uptake of FP methods, was positively associated with the presence of a number of trained FP service providers. This could be because the discussion of FP between clients and service providers during ANC of the first child was key to subsequent use of family planning methods and reduction of unmet need for family planning.

5.6 Conclusion

Generally, the prevalence of modern contraceptives was relatively low at 39.8% and the proportion of women using modern contraceptives was at 35.0%. The most preferred modern contraceptives were injectable at 41.9% by pill and condoms at 15.1% each. The study also found that the common reason why women used contraceptives was to prevent unwanted pregnancy at 55.3%. The demographic factors that significantly influenced modern contraceptives use were; age, marital status, employment status, level of education, monthly income, and religion and final decision makers. The knowledge factors that significantly influenced modern contraceptives use were; sources of information, knowing if contraceptive have side effects and the knowledge on the actual side effects of modern contraceptive. There was no significant impact of the knowledge on type of modern contraceptives methods and reason for using modern contraceptive. The health facility factors that significantly influenced modern contraceptives use were; distance to the nearest hospital, cost of modern contraceptives, provision of adequate information, comfort with the methods and health workers attitude. There was no significant influence of provision of alternatives modern contraceptives methods, availability of modern contraceptives and health workers.

5.7. Recommendations:

Redesigning and strengthening policy on contraceptive use to include young adolescent.

Advocating for strong leadership support both political and religious leaders.

Strong public private sector partnership in service provision.

Strong participatory approach to include all stake holders in service provision e.g. Men, VHTs, community leaders, satisfied users of family planning and well-wishers.

Strong communication network approach to promote community sensitisation and awareness on contraceptives use.

Capacity building like training health workers both private and government, distribution of on free family planning methods to all health units across the country.

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APPENDICES

APPENDIX I: CONSENT FORM

1. Title: Determinants ofWomen's Decision on modern contraceptives use among women aged 15 to 49 years in Lira municipality.

2. Introduction

You are being requested to volunteer for a research study.

The study is being conducted by **……** on the uptake of family planning among women aged 15 to 49 years in Lira municipality.

3. Length of your participation

The interview is likely to take an approximately 5-8 minutes

4. Study Procedure

Here insert a short introduction and how the respondent is likely to benefit from the study either short or long term

5. Possible Risks or Side effects of taking part in this study

This study does not intend to cause any kind of risk but if you feel uncomfortable with some of the questions you are free to refrain from answering or to withdraw from the study.

6. Possible Benefits to you for taking part in the study

There are no direct benefits but rather help researcher gather data for future academic purposes and this information will help in the improvement of reproductive health services

7. About Participating in this Study

Your participation in the study is fully voluntary and you can drop out at any time with knowledge of the researcher.

8. Confidentiality of Study records and Medical records

Information collected for this study is confidential. However, the Uganda National Council for Science and Technology (UNCST) will receive copies of the study records. The UNCST and the Uganda martyr's university Research Review Committee may see parts of your medical records related to this study. In the event of any publication regarding this study, your identity will not be disclosed.

9. Names of contact for questions about the study

In case you have any queries about the study, or if you think you are being affected by the study in any way, call **……...** If you still have any reservations about the study in terms of your rights you can call the Chairman Institutional Review Board at Uganda Martyrs University

10. Volunteer's Statement

I certify that I have fully read this study describing the benefits, risks and procedures for the study titled "Determinants of Women's Decision on Modern contraceptive use among women aged 15 to 49 years in Lira municipality*.",* or that it has been read to me and explained to me, and that I have understood it.

I hereby agree to participate in this study voluntarily.

Name of participant (print) _____

Date _____

Signature/fingerprint _____

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this study have been explained to the above individual.

Date _____

Signature of person who obtained consent _____

Name of person who obtained consent (print)_____

APPENDIX II: QUESTIONNAIRE

I would request to ask you some few questions to complete this questionnaire, please try to be as honestly as you possibly can.

1. Location……
2. Sub county/division…..……
3. Parish……
4. Village/zone……
5. Tribe……

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. How old are you?

    15 – 19 years old

    20–24 years old

    35years and above

2. What is your marital status?

    Single

    Married/cohabiting

    Widowed

    Divorced/separated

3. Are you employed?

    Yes

    No

4. What is your highest level of education?

    None

Primary level

Secondary level

Tertiary level/University

5. What is your monthly income?

50,000shs-200,000shs

200,000sh-350,000sh

350,000shs-500,000shs

Above 500,000shs

6. What is your religion?

Catholics

Protestants

Pentecostal

Muslim

Others

7. How many children do you have?

<4

>4

8. Does your partner have to make the final decision on modern contraceptive use?

Yes

No

SECTION B: KNOWLEDGE ON MODERN CONTRACEPTIVES

1. Have you ever heard of modern contraceptives?

Yes

No

2. What was the source of information on modern contraceptives?

Health workers

Radio

TV

Friend

Other (Specify)……...

3. What types of modern contraceptives methods you have ever heard?

Pills

Injectable

Condoms

IUD

Implant

Female sterilization

Vasectomy

Other (Specify)……...

4. What reasons for using modern contraceptives?

Prevent unwanted pregnancy

Allows child spacing

Prevent STI

5. Do you think modern contraceptives have side effect/disadvantage?

Yes

No

6. What are the side effects of modern contraceptives?

Weight gain

Weight loss

Amenorrhea

Secondary infertility

Heavy menses

Irregular menses

Encourage promiscuity

SECTION C: USE OF MODERN CONTRACEPTIVES

1. Have you ever use of Modern contraceptive methods?

Yes

No

2. Are you currently using modern contraceptive methods?

Yes

No

3. If YES, which one are you suing?

Pills

Injectable

Condoms

IUD

Implant

Female sterilization

Vasectomy

Other (Specify)……...

4. If NO, why?

Religious prohibition

Husband disapproval

Influence of others

Rumors

Fear of side effects

Fear of infertility

The need for more children

Other (Specify)……...

5. Use the list below to mention contraceptive method you are using. Use V to select your choice.

Modern Contraceptive Method	**Women's choice of modern contraceptive method**	**Reason for selected modern contraception method**
Contraceptive pills		
Injectable drugs		
Condoms		
Sterilization		
Intrauterine contraceptive device (IUDs)		

6. Would you have preferred to use another method?

Yes

No

SECTION D: HEALTH FACILITY FACTORS

1. How far is the nearby health facility with family planning services from your place of residence?

Within 5km

Above 5 km

2. How would you rate the costs for family planning in terms of affordability?

Affordable

Relatively affordable

Not affordable

3. Do health workers provide you with many modern contraceptive alternatives to choose from?

Yes

No

4. Do health workers provide you with adequate information on the various types of modern contraceptives?

Yes

No

5. What type of family planning method do HW easily make available you?

Pills

Injectable

Condoms

IUD

Implant

Female sterilization

Vasectomy

Other (Specify)……...

6. Are you comfortable with such a method?

Yes

No

7. At the health facility, are the health workers always available?

Yes

No

8. How would you rate the attitude of your health provider to you?

Good

Fair

Poor

Thank you for participating

ANNEX I: STUDY WORK PLAN

Item	2017 /2018						
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
Choosing the topic							
Writing concept paper							
Proposal writing							
Rectifying mistakes							
Designing data collection tools							
Data collection							
Data processing and report writing							
Report binding							
Submission of the final report							

ANNEX II: RESEARCH BUDGET

BUDGET ITEM	COST PER UNIT/Ugx	TOTAL COST/ Ugx
Stationary	Lump sum	**200,000**
Photocopying 250 questionnaires/6pages	**1000**	**150,000**
Photocopying 20 observational checklist	**100**	**2,000**
Subsistence allowance for 2 research assistants for 3days.	**30,000**	**180,000**
Binding of the 3 research reports (hard cover)	**50,000**	**150,000**
Transport	**75,000**	**150,000**
Facilitation of the researcher	**100,000**	**100,000**
Consultation for data analysis-statistician (data entry & analysis)	**275,000**	**550,000**
Printing & photocopying 3 research reports & spiral binding	**70,000**	**210,000**
Printing and Photocopying 3 research reports	**60,000**	**180,000**
Total		**1,872,000**