BASELINE SURVEY REPORT

ON

LEVEL OF KNOWLEDGE ON REPRODUCTIVE HEALTH

AMONG WOMEN OF CHILD BEARING AGE

AND THEIR LEVEL OF ACCESS TO FAMILY PLANNING SERVICES

IN MUMYUKA-WAKISO SUB COUNTY, WAKISO DISTRICT.

PRODUCED BY

Kyosiga Community Christian Association for Development

(KACCAD)

IN PARTNERSHIP WITH

Bbira Health Center

And

KACCAD Medical Centre Lusaze

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ABBREVIATION AND ACRONYMS

HPI	=	**Healthy Policy Initiative**
MOF	=	**Ministry of Finance**
NRC	=	**National Research Council**
TFR	=	**Total Fertility Rate**
UBOS	=	**Uganda National Bureau of Statistics**
UDHS	=	**Uganda Demographic Healthy Survey**
USAID	=	**U.S Agency for International Development**
WHO	=	**World Health Organization**
CHPS	=	**Community based Health Planning Services**
CHVs	=	**Community Health Volunteers**
CHO	=	**Community Health Officer**
KACCAD	=	**Kyosiga community Christian Association for Development**

1.0 INTRODUCTION

This report is an outcome of the survey that was conducted by KACCAD in conjunction with Bbira Health Center and KACCAD Medical Centre. The survey was prompted by the need to establish baseline parameters as regards level of knowledge on reproductive health among women of child bearing age, and their level of access to family planning services. The maternal and child health status are a function of level of knowledge about reproductive health among women of child bearing age (and their spouses), and level of access to family planning services. This is because the two aspects complement one another. Demographic diversity among Ugandans and peoples' divergent feelings are thought to be key determinants of peoples' knowledge of reproductive health, and their response towards family planning. The survey sought to examine the nature and extent of exposure to reproductive health knowledge and use of family planning services so as to make informed interventions for the good of women of child bearing age (the project's target group) in particular, and the entire public at large. The survey particularly used religious beliefs as its investigative base because religion has a significant influence on the number of wives a man should have and accordingly affecting the number of children a household is likely to have, hence an influence in family planning adoption by the public within the reproductive age group. Likewise, education level, occupation (and therefore income levels) was also examined as they are crucial in influencing peoples' attitudes towards adoption of family planning methods and accessing knowledge on reproductive health.

1.1 Background

Within the framework of the World Health Organization's (WHO) health is defined as the state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control. Also, access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant. Individuals do face inequalities in reproductive health and family planning services. Inequalities vary depending on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is evident that low income earners lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health.

1.1.1 Overview of reproductive health

Reproductive health affects the lives of women from conception to birth, through adolescence to old age, and includes the attainment and maintenance of good health as well as the prevention and treatment of ill health.

Comprehensive reproductive health care includes: counseling, information, education, communication and clinical services in family planning; safe motherhood, including antenatal

care, safe delivery care (skilled assistance for delivery with suitable referral for women with obstetric complications) and postnatal care, breastfeeding and infant and women's health care; gynecological care, including prevention of abortion, treatment of complications of abortion, and safe termination of pregnancy as allowed by law; prevention and treatment of sexually transmitted diseases (including HIV/AIDS), including condom distribution, universal precautions against transmission of blood borne infections, voluntary testing and counseling. Prevention and management of sexual violence. Active discouragement of harmful traditional practices such as female genital mutilation; and reproductive health programmes for specific groups such as adolescents, including information, education, communication and services.

1.1.2 Indicators for global monitoring of reproductive health related preventive practices

1 Total fertility rate
2 Contraceptive prevalence
3 Maternal mortality ratio
4 Antenatal care coverage
5 Births attended by skilled health personnel
6 Availability of basic essential obstetric care
7 Availability of comprehensive essential obstetric care
8 Perinatal mortality rate
9 Prevalence of low birth weight
10 Prevalence of positive syphilis serology in pregnant women
11Prevalence of anaemia in women
12Percentage of obstetric and gynaecological admissions owing to abortion
13Reported prevalence of women with genital mutilation
14Prevalence of infertility in women
15Reported incidence of urethritis in men
16 Prevalence of HIV infection in pregnant women
17 Knowledge of HIV-

According to the WHO, "Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women, and 14% for men." Reproductive health is a part of sexual and reproductive health and rights. Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Achieving universal access to reproductive health by 2015 is one of the two targets of *Goal 5* - *Improving Maternal Health* - of the eight Millennium Development Goals. To monitor global progress towards the achievement of this target, the United Nations has agreed on the following indicators:

- 5.3: contraceptive prevalence rate
- 5.4: adolescent birth rate
- 5.5: antenatal care coverage

- 5.6: unmet need for family planning

1.1.3 Overview of family planning

Family Planning refers to an agreement between couple on the number of children and when to have them. According to Ross (1992), Family Planning refers to an organized program often governmental in sponsorship, support, administration facilities and personnel but frequently involving private efforts (family planning associations phnease physicians) and commercial ones, designed to provide the information, supplies and survey a modern means of fertility contrail to those interested.

Family planning celebrated 74th anniversary in 2011. It started in 1921 when the First UK birth control clinic was founded in London by Maries topes (World Health Organization report, 1971). Family Planning Association of Uganda (which is an affiliation of International Planned Parenthood Federation) was established in 1957 to promote family planning particularly with modern methods of contraception (Kabwigu, 2001). The rapidly growing population and limited birth control are the challenging problems in Wakiso District. Family planning is one of the tools which can be used for birth control, however many people have limited knowledge regarding family planning. World Health Organization (2006) reported that, due to illiteracy, many households in Sub-Saharan Africa consider a child as a social security for parents at their old age. Children are seen as a source of labour. Family planning was considered as one of the high priority techniques for improving child health, along with growth monitoring, oral dehydration therapy, breast feeding, immunization and food supplements (Uganda Ministry of Health report, 1998).Issues affecting adolescent reproductive and sexual health are similar to those of adults, but may include additional concerns about teenage pregnancy and lack of adequate access to information and health services. Worldwide, around 16 million adolescent girls give birth every year, mostly in low- and middle-income-countries.

The causes of teenage pregnancy are diverse. In Uganda girls are often under pressure to marry young and bear children early .Some adolescent girls do not know how to avoid becoming pregnant, are unable to obtain contraceptives, or are coerced into sexual activity. Adolescent pregnancy in developing countries especially Uganda causes substantial health risks, and contributes to maintaining the cycle of poverty.

The current Ugandan population is 34.5 million (Uganda Bureau of Statistics report, 2007). According to the current population growth rates of 3.2%, of the population of Uganda is expected to increase to 49.2 million by 2022 (Uganda National Population Fund report, 2009), and up to 130 million in 2050 according to National Population Policy. So the population is increasing because reproductive health knowledge is not access by many married people and adolescents. According to Uganda demographic and health survey (2006), Infant Mortality Rate is 76 per 1,000 live births. There is considerable empirical evidence linking short birth intervals to elevated risk for infant mortality. Increasing death rates is due to high birth rate. According to increasing death rates is due to high birth rate according to (National Research Council, 1989). Therefore reproductive health may deal with care of providing antenatal services in protecting unwanted pregnancies. Despite the wide range of effective contraceptive

options available to women in developing countries, unintended pregnancies continue to occur in large numbers, and rates of sexually transmitted infections remain high.

A number of factors can affect a woman's access to, or effective use of contraception and family planning methods. The barriers to effective use of contraception have been well documented (Cramer, 1996; Lee and Jezewski, 2007). Among these barriers are personal beliefs and values that can be shaped by both culture and religion. The low levels of access to reproductive health knowledge are attributed to the nature of occupation that people are involved in, the high illiteracy levels, cultural rigidities, low levels of household income and religious beliefs. Although there are various methods of Family planning in Uganda today, still they are affected by religious beliefs.

1.2 Problem Statement

The rapidly growing population and limited birth control are the challenging problems in Wakiso District. Family planning is one of the tools which can be used for birth control, however many people have limited knowledge regarding family planning. World Health Organization (2006) reported that, due to illiteracy, many households in Sub-Saharan Africa consider a child as a social security for parents at their old age. Children are seen as a source of labour.

Low implementation of family planning has led to several challenges such as poverty, shortage of food and poor quality of education. In relation to this, more than a half of the Ugandan population is constituted by children (Uganda Bureau of Statistics, 2010), the remaining small percentages of working adults cannot perfectly sustain the percentage of old and young population in terms of food and education. High fertility rate has also increased the infant and maternal mortality (United States Agency for International Development report, 1999.

It is evident in Wakiso that women are bearing more children than the resources available to their households to cater for the endless needs of these children, and this is more common among the extremely poor households who have had no access to education, however even the educated women and men who have not had access to reproductive health training are being driven by the cultural beliefs and the religious beliefs. Religious leaders and the laity follow religious guidelines to produce children. Different religious beliefs have influenced the people to have different understanding regarding reproductive health, despite the fact that family planning is being promoted by different organizations such as Marie Stopes and United States Agency for International Development among others.

It is imperative to note the higher number of households living under extreme poverty, such households are incapable of using the contraceptives and other family planning methods as they cannot afford them, this is why they do not seek for modern family planning services.

This has even affected the physical, social and economic development of Wakiso District.

The adverse effects of lack of reproductive health knowledge and family planning:

- The accelerating number of adolescents dropping out of schools due to pregnancy.
- The increasing tension in families as men fight with their wives over responsibility of the children.
- Malnutrition among children and adults.
- Un decreasing maternal deaths resulting from complications related to pregnancy.
- Infant mortality especially villages far from nonprofit health centres.
- Children are unable to attend school due to large number available in the household.
- Poverty
- Inaccessibility to better medication
- Depression and anxiety among parents

This has instigated KACCAD to carry out a survey on the level of access to reproductive health and family planning services by women in the child bearing age.

1.3 Purpose of the survey

The purpose of the survey was to investigate the level of knowledge on reproductive health among women of child bearing age and the level of access to family planning services.

1.4 Specific objectives

1. To establish level of access to reproductive health knowledge by women of child bearing age.
2. To determine level of access by women of child bearing age to family planning services.
3. To identify challenges faced by women in trying to access Reproductive health knowledge and family planning services
4. To explore remedial measures to the challenges

1.5 Scope of the survey

In regard to terrestrial scope the survey was conducted in Mumyuka Wakiso Sub County which includes the following parishes: Buloba, Nakabugo, Ssumbwe, Bakka, Banda, Bukasa, Kyebando, Lukwanga and Naluvule. Of these parishes the survey covered only three of them as representative of the entire area. In each parish, some households were randomly selected and then targeted respondents were purposively selected and interacted with.

In terms of content scope, the survey restricted itself to issues related to exposure of women of child bearing age to reproductive health knowledge and access to family planning services. Whereas the survey mainly wanted to establish level of knowledge of reproductive health and level of access to family planning services, it went an extra mile to explore and examine the nature and extent of influence by various factors in relation to the subject matters under investigation. The survey further explored remedial measures to factors limiting target groups from accessing reproductive health knowledge and family planning services.

2.0 LITERATURE REVIEW

2.1 Introduction

The literature reviewed revealed a number of aspects responsible for rate of exposure to reproductive health knowledge and accessibility to family planning services among women of child bearing age. Among the noted aspects was the religious belief issue which was frequently referred to in much of the reviewed literature as a strong influencing factor. However this does not imply insignificance of other aspects like cultural beliefs, income levels, literacy levels etc.

2.1 Religious beliefs and the spacing of children.

The religion has an influence on children spacing though there is no religion that recommends an interval from one birth to another. However different religions have teachings on regulation of the children in the family (Cincinnati, 1980)

2.1.1 The Catholics and the spacing of children in a family

The catholic community recommends the use of the natural family planning methods in spacing of children. These methods include breast feeding; more pregnancies are postponed throughout the world through breast-feeding than through any of the methods that can be called conscious efforts at birth regulation. However, this is true only of"ecological" breast-feeding in which mothers are constantly with their babies who in turn suckle frequently. This natural form of pregnancy postponement is morally acceptable by the church. The usual spacing of babies with ecological breast-feeding ranges between18 and 24 months. Thus the Author of Nature

seems to have designed Natureso that mothers should be with their babies, nurse, and enjoy a natural spacing between pregnancies (Cincinnati, 1980)

In conclusion “Family planning services provide people with the knowledge and the means to plan when to begin having children, how many to have and how far apart to have them, and when to stop. Family planning is the responsibility of both men and women; everyone needs to know about the health benefits.” (Rutstein, 2003).

2.2. Religious beliefs and number of children in a family

There is no religion that specifies the number of children a married couple should have in a family. However the Christians have a hint on the family size and the number of children a family should have.(Gaudium et al, 1950).

2.2.1 The catholic teaching and the number of children in a family

The church does not allow a family to bear as many children as it can and the decisions about family size, the married couple "must thoughtfully take into account both their own welfare and that of their children, those already born and those which may be foreseen. For this accounting they will reckon with both the material and the spiritual conditions of the times as well as of their state in life. And in addition, they can consult the interests of the family group, of temporal society, and of the Church itself" (Gaudium et al, 1950).

In addition to the above, the Church has no specific teaching about an ideal family size but there is a general Christian warning against decision-making based solely on materialistic factors. Life is a gift to be shared, and the Christian couples are called to be generous in the service of life according to their circumstances. For example, Pope John Paul II noted that "decisions about the number of children and the sacrifices to be made for them must not be taken only with a view to adding comfort and preserving a peaceful existence. Reflecting upon this matter before God, with the graces drawn from the Sacrament, and guided by the teaching of the Church, parents will remind themselves that it is certainly less serious to deny their children certain comforts or material advantages than to deprive them of the presence of brothers or sisters who could help them to grow in humanity and to realize the beauty of life at all ages and in all its variety." (Pope, 1979).

2.3 The religious beliefs and the numbers of wives

Polygamy is the condition of having more than one spouse. There are many different opinions of different religions towards the number of wives. Islamic religion allows multiple wives, but this is subject to the secular laws in which any proposed marriage would take place. Muslims believe in having multiple wives as a reward for them when they pass on into the next life. Muslims allow up to four wives but the fundamentalist, Mormons, allow no upper limit. Islamic religion is the only religion that restricts, according to the holy book Quran, a Muslim man should not have more than four wives at one time.

2.3.1 Catholic religious beliefs towards the number of the wives

The Catholics, in earlier times, Christian men were not permitted to have as many wives as they wished, since the Bible puts no restriction on the number of wives. It was only a few centuries ago that the Church restricted the number of wives to one. According to Talmudic law, Abraham had three wives, and Solomon had hundreds of wives. The practice of polygamy continued till Rabbi Gresham ben Yehudah issued an edit against it. The Jewish Sephardic communities living in Muslim countries continued the practice till as late as 1950, until an Act of the Chief Rabbinate of Israel extended the ban on marrying more than one wife. (Genesis, chapter 1:28)

2.3.2 The Islamic religion and number of wives

The Quran is the only book that restricts a man to have a maximum of four wives. However, having more than wife is subject to one condition; if a man cannot do justice among his wives then he is not allowed to have more than one wife. (Quran, chapter 4 verse 3)

In addition, the chapter 4 (Nisa) of glorious Quran it stated: " Marry women of your choice, two or three, or four, but if you fear that you shall not be able to deal justly (with them) then only one."(Quran, chapter 4, verse 3)

Furthermore, it is also stated in the holy Quran that “every child is produced with his or her rizik”. Therefore the more children you produce the more the family gets rizik.(Quran, chapter 10, verse 6)

2.4. Religious beliefs, population growth and birth rates

Genesis Chapter 1:28 blessed them and said has many children so that your decedents will live all over the earth and bring into under their control. The population is increasing at high rate

yet the government cannot satisfy its people with quality of life. So we need family planning that is a good set up before a man and wife gets engaged in marriage. Uganda has a population of approximately 29.6 million people, of which almost 6 million are women of reproductive age (15-49 years) (Uganda Bureau of Statistics, 2007). The annual growth rate is approximately 3.2 percent (Uganda Bureau Of Statistics , 2006), and the total fertility rate (TFR) measured in the 2006 Uganda Demographic and Health Survey (Uganda Demographic Health Survey) remains high at 6.7 children per woman. Therefore, Uganda is the third fastest growing country in the world (UNPD, 2005). 24 % of married women were reported to use the contraception and 41 percent have an unmet need for family planning (Uganda Demographic Health Survey, 2011). Uganda has the highest level of unmet need for family planning among currently married women (Macro International Inc., 2008). In 2000-01, the UDHS results showed that approximately two of every five births were unplanned in the five years preceding the survey (UBOS and ORC Macro, 2001). Using indirect estimation techniques, the authors of another study found that one in five pregnancies in 2003 ended in an abortion in Uganda (Singh *et al*., 2005), so religious leaders need to come out with good interventions to avoid abortions and the use appropriate family planning methods.

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

Political support for the family planning movement in Uganda appears inconsistent. The Government of Uganda states that it will ensure that family planning services are accessible to all those who need them (Ministry Of Finance report, 2004). To ensure access to family planning services, the government has made several revisions to the 1995 national population policy and included provisions in its poverty eradication action plan designed to reduce the

unmet need for family planning (UDHS, 2006; MOF, 2004). However, reports from the Ugandan Population Secretariat appear to show that a growing population could serve as a demographic bonus for economic growth (Population Secretariat, 2006). This religious belief is not considering the factors production such as labor, land and capital (basing on riziki), some Muslim beliefs saying,

The definition of unmet need for family planning was developed and revised over the past three decades but its basic components have remained essentially unchanged (Westoff, 1978; West off and Pebley, 1981; West off and Ochoa, 1991; West off, 2006). The concept of unmet need for family planning is useful for identifying women who may want to use, but are not currently using, a method of contraception. In the broadest sense, a woman has an unmet need for contraception if she is not using a method of contraception and wants to wait to have more children. A religious belief empowers women to seek for family planning yet men should also be considerable.

The reduction of unmet need has significant outcomes. Studies have found that fulfilling unmet need helps couples achieve their reproductive intentions and improve broader social, economic, and developmental measures (West off and Bankole, 2002; Casterline and Sinding, 2000; Sedgh et al., 2007). Another study suggests that satisfying unmet need can directly contribute to reductions in maternal and child mortality averting an estimated 16,877 maternal and 1.1 million child deaths worldwide by the year 2015 (U.S. Agency for International Development (USAID, Health Policy Initiative, 2006). More than a half of Ugandan population has the age of 15 or young. The total fertility rate in Uganda for the three years preceding the survey is 6.2 children per woman. Rural women have almost twice as many children as urban women. Fertility declined only slightly between 2000-01 and 2006, from 6.9 children per woman to 6.7 children, and decreased further to 6.2 children in 2011. Childbearing begins early in Uganda. More than one-third (39 percent) of women age 20-49 gave birth by age 18, and more than half (63 percent) by age 20. About two thirds (66 percent) of births occur within three years of a previous birth; 25 percent occur within 24 months. Twenty four percent of women age 15-19 are already mothers or pregnant with their first child. Religious beliefs do not discriminate those in urban or rural yet illiterates are few in urban, that is why increasing population on

birth rate is mostly in villages where times they have free food, free education and water so some religious leaders allow them to produce the way they want (Sedgh et al., 2007)

2.4. 1 Contraceptive use in Uganda

Religious adherents vary widely in their views on control. Some religious believers find that their own opinions of the use of birth control differ from the beliefs espoused by the leaders of their faith, and many grapple with the ethical dilemma of what is conceived as "correct action" according to their faith, versus personal circumstance, reason, and choice (Srikanthan, 2008).

2.4.2 Contraceptives and Christian religion.

Among Christian denominations today there are a large variety of positions towards contraception. The Roman Catholic Church has disallowed artificial contraception for as far back as one can historically trace. Contraception was also officially disallowed by non-Catholic Christians until 1930 when the Anglican Communion changed its policy. Soon after, most Protestant groups came to accept the use of modern contraceptives as a matter of Biblically allowable freedom of conscience (Campbell et al., 1960).

2.4.2.1 Protestant

Today there are four categories as useful in understanding current Protestant attitudes concerning birth control. These are the "children in abundance" group, such as Quiverfull adherents who view all birth control and planning as wrong; the "children in managed abundance" group, which accept only natural family planning; the "children in moderation" group which accepts prudent use of a wide range of contraceptives; and, the "no children" group which sees itself as within their Biblical rights to define their lives around non-natal concerns(Dennis, 2002)

In addition, some Protestant movements, such as Focus on the Family, view contraception use outside of marriage as encouragement to promiscuity.Sex is a powerful drive, and for most of human history it was firmly linked to marriage and childbearing. Only relatively recently has the act of sex commonly been divorced from marriage and procreation. Modern contraceptive inventions have given an exaggerated sense of safety and prompted more people than ever before to move sexual expression outside the marriage boundary (Rodinne, 2005). The

Anglican Churchin 1930 at the Lambeth conference said contraception is acceptable in certain cases.(Lambeth,1930)

2.4.2.2 Catholic religion towards contraception

The Catholic Church is opposed to artificial contraception and orgasmic acts outside of the context of marital intercourse. This belief dates back to the first centuries of Christianity(Pope paul, 1968)Such acts were considered intrinsically disordered because of the belief that all licit sexual acts must be both initiative (express love), and procreative (open to procreation). The only form of birth control permitted was abstinence. However, in modern scientific methods of "periodic abstinence" such as natural family planning (NFP) were counted as a form of abstinence by Pope Paul VI in his 1968 encyclical Humanae Vitae (Pope, 1968)

Many documents provide more insight into the Church's position on contraception. The commission appointed to study the question in the years leading up to Humanae Vitae issued two unofficial reports, a so-called "majority report" which attempted to express reasons the Catholic Church could change its teaching on contraception, and a "minority report" which explains the reasons for upholding the traditional Christian view on contraception. In 1997, the Vatican released a document entitled "Vademecum for Confessors" (2:4) which states "The Church has always taught the intrinsic evil of contraception." Furthermore, many Church Fathers condemned the use of contraception. (Vatican, 1997)

The Vatican's opposition towards birth control continues to this day and has been a major influence of church policies concerning the problem of population growth and unrestricted access to birth control (Vatican, 2002)

2.4.2.3 Contraception and Islamic Doctrine

The interpretations of the Sharia, or Islamic law, set forth in this article reflect the Sunni Muslims and most of who abide by the Hanifiya or Shafiya schools of thought in their exegesis of Islamic law. (A greater range of scholarly opinions regarding family planning can be found within the body of Islamic hermeneutic writings than is presented here.)With respect to contraception, Muslim scholars universally accept the legitimacy of a hadith (or one of the

collected sayings of the Prophet Muhammed) in which the Prophet, when asked, noted that withdrawal is permitted, for "if God wanted to create something, no one could avert it."By analogy, this has been interpreted to imply that all nonpermanent methods are in keeping with Islam. Furthermore, a number of Qur'anicverses emphasize the notion that God does not wish to burden believers, with the implication that the quality of children overrides concerns about quantity. Additionally, marriage is portrayed in the Qur'an as a source of companionship and mutual protection, rather than as primarily for procreation (Sura, 30:21).

3.0 METHODOLOGY

3.1Introduction

The demographical diversity of the targeted survey population and the combination of qualitative and quantitative nature of required information necessitated adoption of a multi-dimensional approach in design, sampling, data collection, data analysis and subsequent drawing of inferences. The details of each of the mentioned aspect follow here below.

3.2 Survey design

The survey was conducted using a cross sectional survey design in order to be able to obtain both quantitative and qualitative information from the field. The implication here is that part of the study area was sampled using the simple random sampling techniques. The cross sectional survey design was also chosen because of the limited financial resources available to finance the expenditures involved in conducting the survey.

3.3 Population

Mumyuka-Wakiso sub-county consisted of the population which was divided into sub-populations. Random sampling was made for each subpopulation. The study population for purposes of this survey was ‘women of child bearing age residing in the terrestrial scope of the survey’. However, because we could not cover each and every woman of child bearing age in that area we had to select a representative sample for the survey. We also considered the fact that spouses play a great role in women’s accessibility to both reproductive health knowledge and family planning services, hence the subdivision of parishes into households for better representation. There was also the issue of the role which local leadership and health personnel play in influencing women of child bearing age to access reproductive knowledge and family planning services. Therefore the sample disaggregation was as follows:

- Women of child bearing age
- Health personnel in the survey area
- Religious leaders
- LC Secretary for women affairs

3.4 Sample size

The following parishes were visited and the total population of each was as shown in the table below. The sample sizes for each of the parishes were calculated using the sample selection

formula designed by Krejcie and Morgan (1970), and basing on the number of households in each parish.

Sample size by parish

Parish	House holds	Sample size	Samples achieved	% coverage
Buloba	134	52	52	100
Nakabugo	390	123	123	100
Ssumbwe	252	94	94	100
Total	**776**	**269**	**269**	**100**

Source: VHT Coordinator's report on total population by parish

However for purposes of collecting appropriately representative data we also collected information from the following categories:

- 1 Deputy District Director of Health Services – Wakiso
- 1 Health Information Assistant – Wakiso
- 3 LC Secretaries for Women Affairs
- 3 Religious Leaders

3.5 Data collection instruments

The survey was conducted using the following research instruments to obtain the quantitative information from the field on the level of reproductive health knowledge and access to family planning services among women of child bearing age in Wakiso Sub- County**.**

3.5.1 Semi-structured Questionnaire

This method was used to collect primary data from the Key respondents which included the local leaders, religious leaders, political leader and health officers from the study area. It involved the use of the questionnaire with semi-structured questions shown in the Appendix A. This method of collecting survey data using a semi structured questionnaire was considered to be appropriate because the questions of the questionnaire offered the key informants to choose from the given alternatives while the other part left them to give their own responses.

3.5.2 Interview guide

This was administered to women of child bearing age from the chosen households. The views were obtained by use of several questions in an interview guide and such questions sought to know; how many times you have attended education on reproductive health issues, where you received the Reproductive Health education from, What you learned during the Reproductive Health education, whether you use family planning methods in your household or not, etc. This technique involved the use of semi structured interview guide presented in Appendix B. This

method was chosen to be appropriate because the aforementioned respondents had very important information to provide yet they had no time to fill questionnaires.

3.5.3 Documentary Review

This was used to collect secondary data and was guided by a documentary review. Documents from Kyosiga Community Christian Association for Development, public libraries, village health teams and internet with relevant literature to the research topic were analyzed as secondary sources of data in order to supplement on the primary data from the interview and questionnaires.

3.6 Data collection procedure

As a matter of protocol we used to first notify the local leadership of each selected parish before collecting the primary data from the randomly selected respondents. With the consent of the local leaders the survey was carried out in the field. In the field the selected women were subjected to interviews and the Key Informants to the questionnaire.

4.0 FINDINGS OF THE SURVEY

4.1 Introduction

In this chapter, the back ground information of gender, age, occupation, marital status, daily income expenditure, level of education attained, religion of the respondents among others are presented. In addition, the effects of lack of knowledge on reproductive health on child spacing, number of children and the number of wives in a family are also presented in this chapter.

4.2 Background information of respondents of Mumyuka Wakiso Sub- County

Two hundred and sixty nine (269) respondents from Mumyuka Wakiso Sub County were contacted and their distribution by sex was represented by the frequency distribution table as shown below.

Table 4.1: Distribution of respondents by sex

Sex	**Frequency (f)**	**Percentage (%)**
Male	14	5.2
Female	255	94.8
TOTAL	**∑F=269**	**100**

The respondents of Mumyuka Wakiso sub County age group distribution as registered from the field by the researchers was shown in the figure 4.1 shown below.

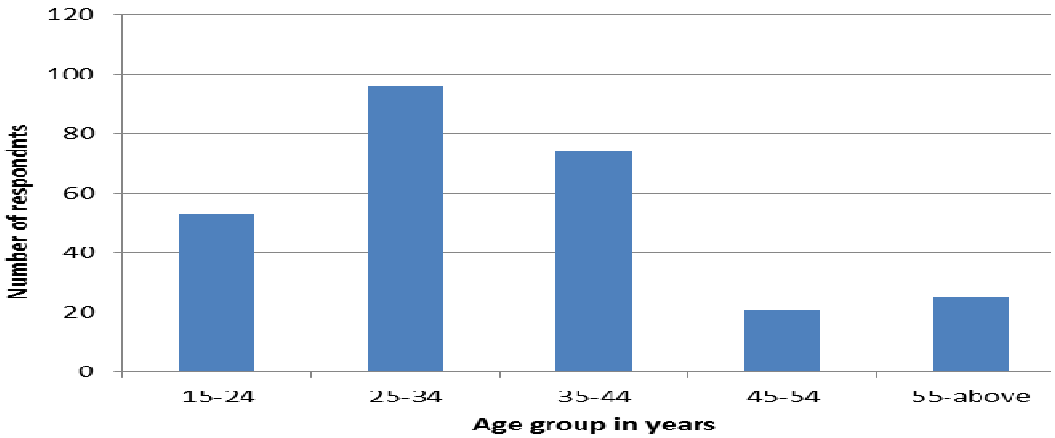


Figure 4.1. Distribution of the respondents by age

The majority of the respondents contacted by the researchers in Mumyuka Wakiso-Sub County were between the age group of 25 to 34 years followed by 35 to 44 years. The third age group was 15 to 24 years followed by those between 55 and above years. The last group was that of respondents between the age group of 45 to 54 years.

The respondents' marital status of Mumyuka Wakiso Sub County was shown below in the figure 4.2 below.

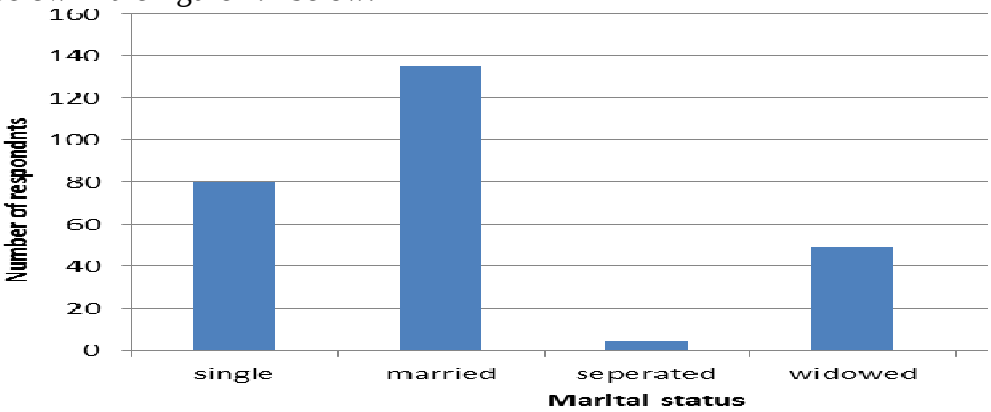
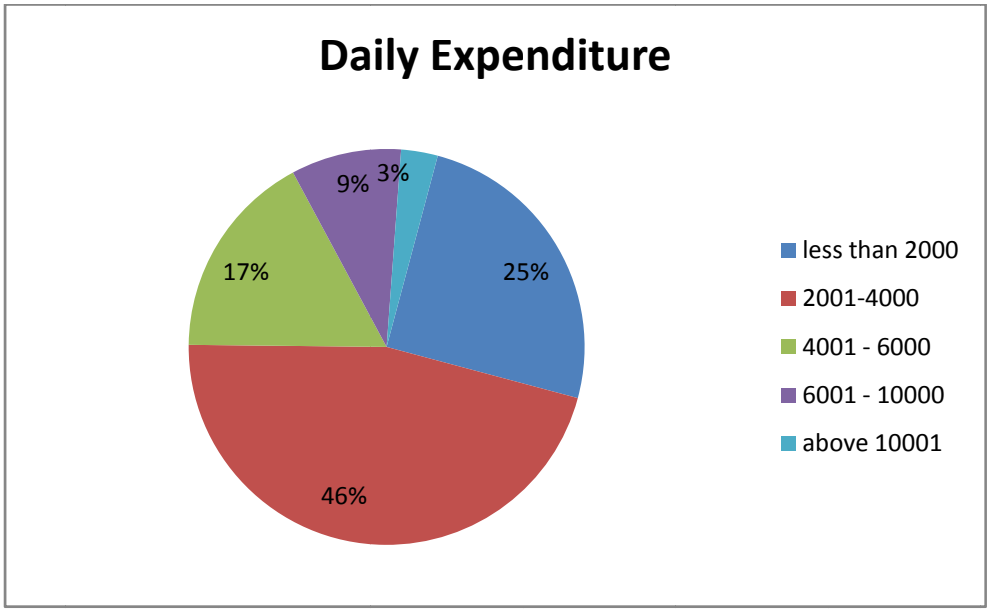


Figure 4.2: The marital status of the respondents

The majority of the respondents contacted by the researchers in the field were the married respondents followed by the single respondents. The widowed were few and the separated respondents were very few as shown in the figure 4.2 above.

The other category of the marital status were also seen important to be contacted by the researchers because these people though they are not married, they use family planning and they had good information of risks of family planning, advantages of family planning among others.

The daily expenditure of the respondents was represented in the figure 4.3 below.



It was found out that the majority of the respondents' daily expenditure was between 2,000-4,000 Uganda shillings with an occurrence of 46% of the total respondents contacted. The second range of the daily expenditure was less than 2,000 Uganda shillings with an occurrence of 25% of the total respondents contacted in the field by the researchers. There were very few respondents with a daily expenditure of above 10,000 Uganda shillings.

From the above results, it was observed that many families spend Uganda shillings between 2,000-4000 per day. When compared to the number of children per house hold, both biological and adopted is in the range of 8 to 11 children, which indicates that the money is not enough to feed their children daily with a balanced diet. This may lead to malnutrition, low weight of children and make them unable to buy some contraceptives for better family planning.

The level of education attained by the respondents that were contacted in the field by the researchers was represented in the figure 4.4 below.

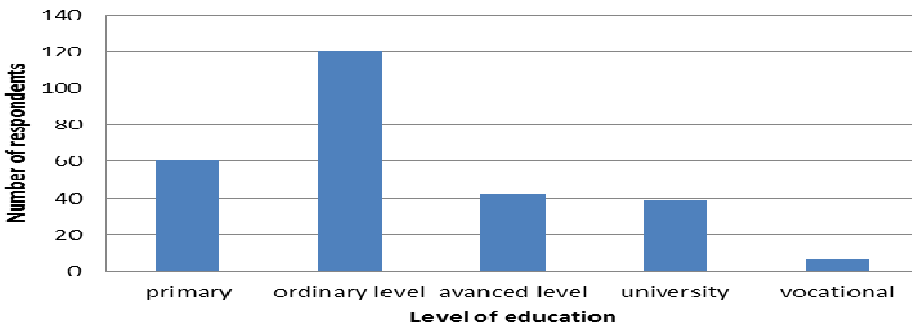


Figure 4.4: The level of education attained by the respondents

The majority of the respondents contacted in the field attained the ordinary level of education with percentage of 44.6 %(between S.1 and S.4) followed by those who attained the primary level education with the percentage of 22.3%. Those attained the Advanced level were ranked third with the percentage of 15.6%. 14.5% of the respondents had successfully completed university education. There were very few, 3% respondents that completed vocational education which included (carpentry, tailoring and mechanics) that were contacted in the field.

The level of education of the respondents was seen important to be considered as it was mentioned to be one of the intermediated factors affecting the family planning as it affects the peoples' attitude towards family planning. From the results, it was observed that a big percentage of people are primary and ordinary level graduates. This may be due to low income earnings per house hold. Therefore, if family planning was applied, they would be able to facilitate their children in academic issues to attain better educational levels.

The respondents' economic activities carried out by the respondents of Mumyuka Sub County were represented below in the figure 4.5.

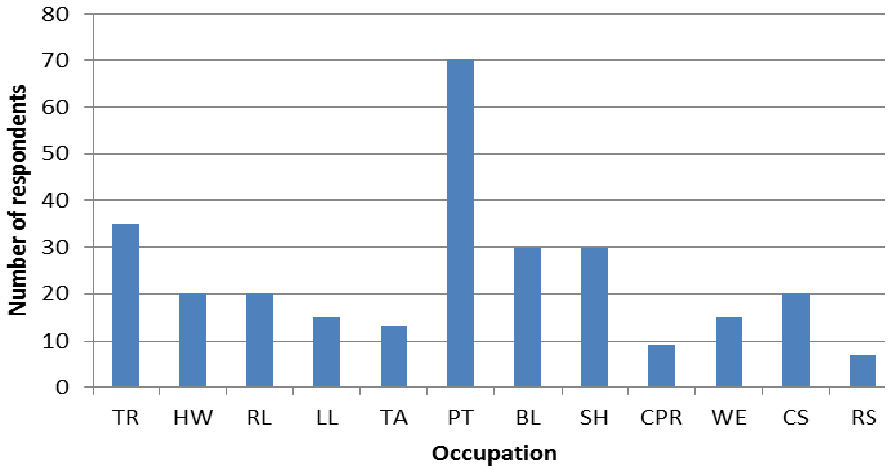


Figure. 4.5: The occupation of the respondents

KEY: TR=Teachers, **HW**= Health Workers, **RL**= Religious Leaders, **LL**=Local Leaders, **TA**=Tailors, **PT**=Public Transporters, **BL**=Builders, **SH**=Shop Keepers,**CPR**=Carpenters, **RS**=Roadside Venders, **WE**=Welders, **CS**=Charcoal Sellers.

The majority of the respondents contacted from the Mumyuka Sub County were the public transporters followed by the teachers, builders and shop keepers. The roadside vendors are the least contacted by the researcher in the field; this was due to the fact that these people normally come late on their work due to the fear of the Kampala Capital City Authority interference.

From the findings above, it was observed that a bigger percentage of the respondents are

self-employed with low income earning occupations as the majority were public transporters, builders and shop keepers among others. So such category of people cannot afford to buy contraceptive daily or monthly.

The religion of the respondents that were contacted in Mumyuka Sub County was resented in the table below.

Table 4.2: The respondents by religion

Religion	**Frequency (f)**	**Percentage (%)**
Anglicans	77	28.6
Catholics	103	38.3
Moslems	39	14.5
Born again	35	13.0
SDA	15	5.6
TOTAL	**∑f=269**	**100**

The majority of the respondents were Catholics with the occurrence percentage of 38.5% followed by the Anglicans with the percentage of 28.6%. The Muslims contacted had the occurrence of 14.5% followed by the Born again with the percentage of 13%. Few Seventh Day Adventists (SDA) were contacted and had a percentage of 5.6% of the total respondents.

4.3 Religious beliefs on spacing of children

The following were the health risks of not spacing children that were chosen by the Key informants from Mumyuka Wakiso-Sub County. They were represented in the table blow.

Table 4.3: Healthy risks of not spacing children

Health risk	**Frequency(f)**	**Percentage**
Premature babies	7	17.5
Low birth weight	5	12.5
Bleeding during pregnancy	8	20
Maternal death	20	50
Total	**∑f=40**	**100**

The majority of the key informants suggested that maternal death as the most likely risks of not spacing children with an occurrence percentage of (**50.0%)** followed by the bleeding during pregnancy **(20.0%).** Those that chose producing premature babies were ranked the third with a percentage of (**17.5%)** and very few chose low birth weight as a healthy risk of not spacing children with a percentage of (**12.5%)**

The following figure represents how the key informants of Mumyuka Sub County spaced their children in different births in their families.

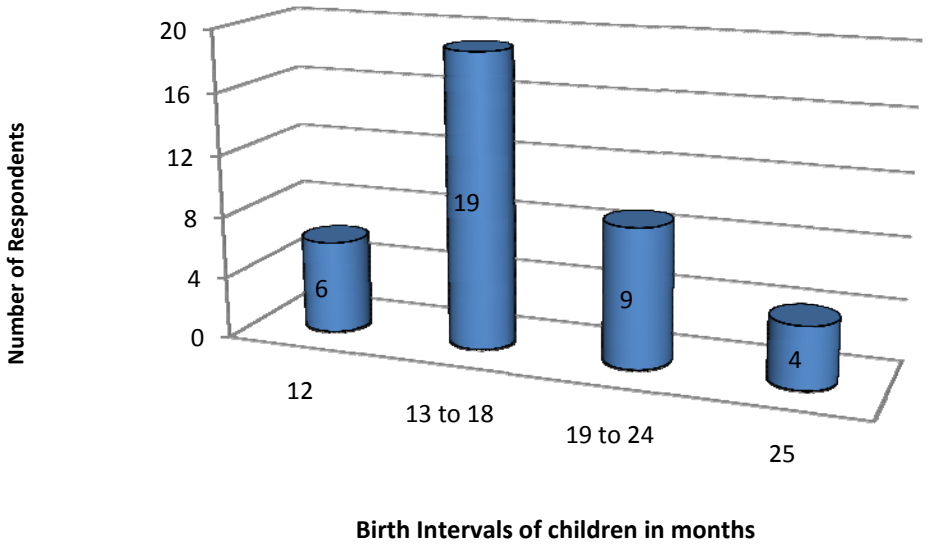


Figure. 4.6: Birth Spacing intervals

The majority of the key informants of Mumyuka Wakiso Sub County selected the birth spacing interval of 13-18 months with a percentage of 47.5% followed by 19-24 months with a percentage of 22.5%. Few key informants selected the spacing interval to be 12 months with a percentage of 15% and very few key informants chose the birth spacing interval as 25 months birth spacing interval with a percentage of 5%.

The following figure represents the strategies on spacing of children that were given by the key informants from Mumyuka Wakiso Sub County.

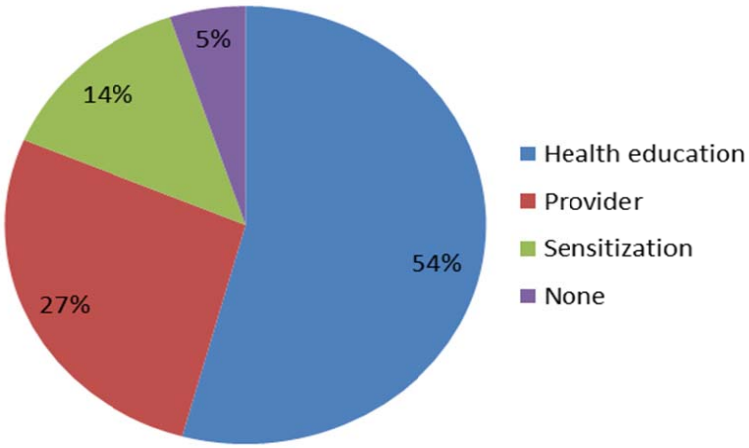


Figure. 4.7: The strategies on spacing of the children.

From the field it was noted that the majority of the key informants participated in birth spacing as Health educators (54.0%) followed by the Service providers (27.0%). Those that

participated in sensitizing the married couples about spacing of the children were 14.0% of the total key informants and very few key informants that did not participate in any strategy of spacing children with an occurrence of 5.0% the total that were contacted.

The following table represents the benefits of the child spacing reported by the respondents from the field.

Table 4.4: The benefits of child spacing

Benefit	Frequency (f)	Percentage (%)
Improvement in the health of new baby	28	70
Improvement in the health of the mother	19	47.5
Spiritual growth	06	15
Social growth	02	05
Financial stability of the stability	32	80

The majority of the key informants reported that financial stability of the family is the main benefit of family planning with the percentage of 80.0% followed by the improvement in the health of the new born baby with a percentage of 70.0%. Improvement in the mother's health was ranked the third as the benefit of children spacing with the percentage of 47.5%. The key informants that chose spiritual growth as the benefit of child spacing were 15.0% and very few key informants (5.0%) chose social growth as a benefit of child spacing.

4.4 Religious beliefs and number of children

The number of children that were present in the families of the key informants that were contacted by the researchers in Mumyuka -Wakiso Sub County was represented in the figure below.

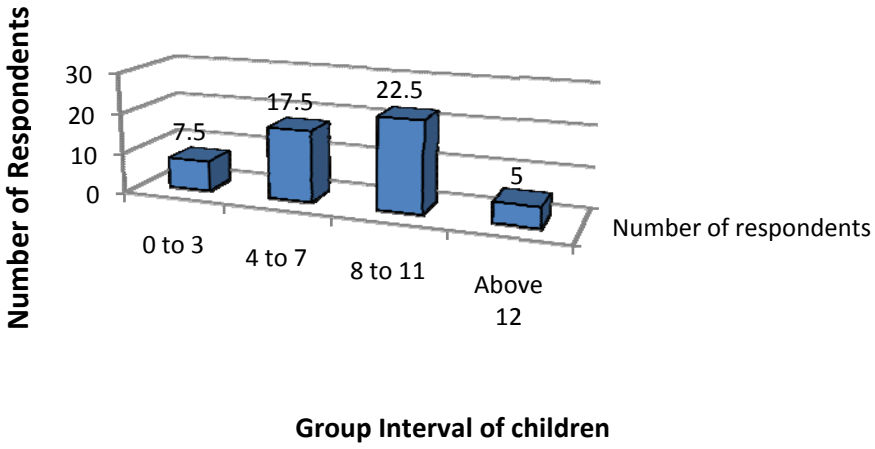


Figure 4.8: The number of children at home

Many key informants reported that they have 8 to 11 children in their homes followed by those with 4 to 7 children. Those that reported to have 0 to 3 children and very few reported to have children above 12.

The figure below shows the number of biological children of the key informants that were reported by the key informants in Mumyuka Wakiso Sub County.

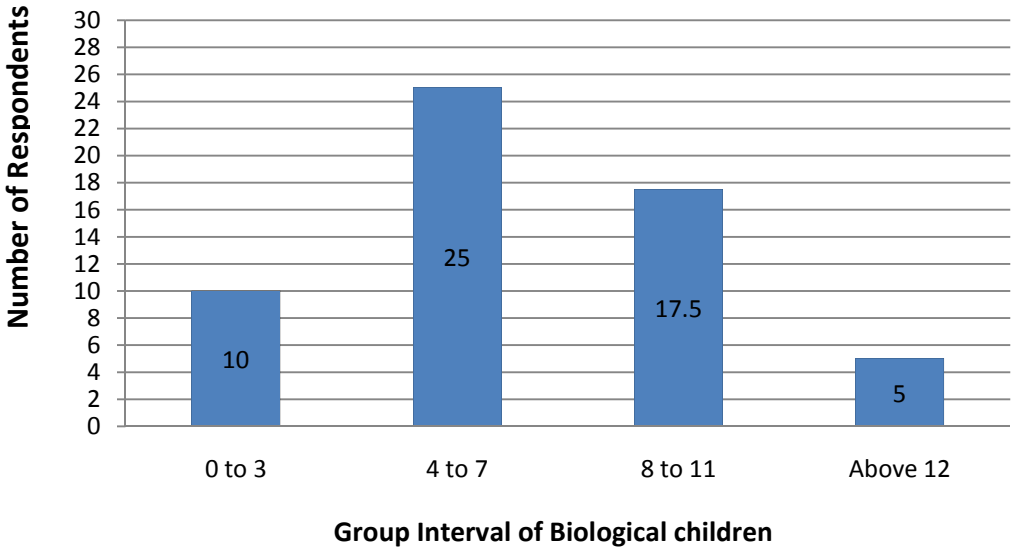


Figure 4.9: The number of biological children

Many key informants reported that they produced children between 4 to 7 in their families, followed by those that had 8 to 11 biological children at home. There were very few key informants reported to have above 12 biological children in their families.

The figure below represents the number of adopted children that were reported by the Key informants of Mumyuka Wakiso Sub County.

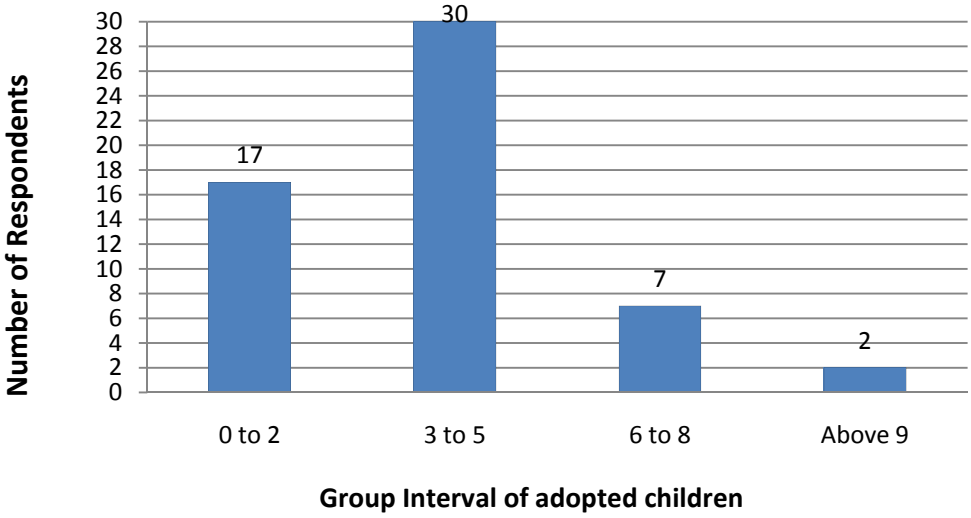


Figure 4.9.1: The number of adopted children.

The majority of the key informants reported to have 3 to 5 adopted children followed by those that reported that they had adopted 0 to 2 children. The key informants reported that they had adopted 6 to 8 children were ranked third and very few key informants reported to have adopted above 9 children.

The following figure shows the likely consequences of having many children in the family reported by the key informants in Mumyuka- Wakiso Sub County.

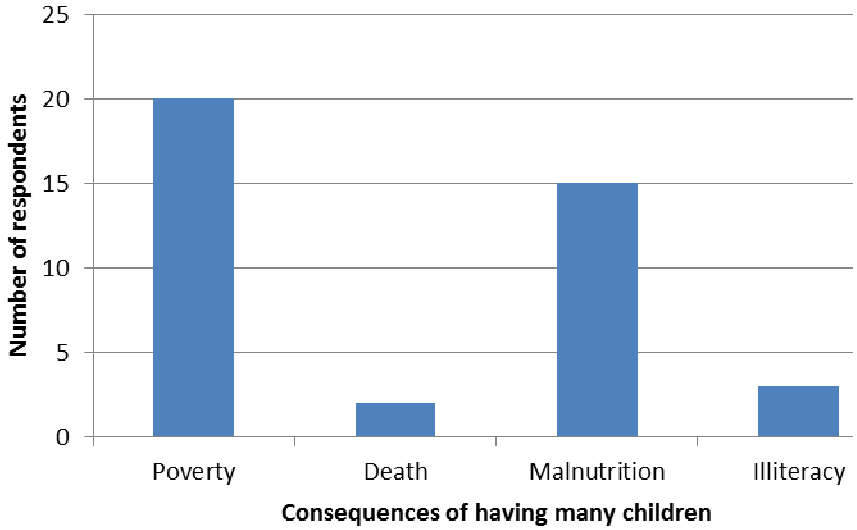


Figure.4.9.2: The likely consequences of having many children

The majority of the key informants reported that poverty is the most likely consequences of having many children in a family followed by those who reported that malnutrition as the consequence of having many children at home. There were very few respondents that pointed out death as the likely consequence of having many children.

4.5 Level of access to reproductive health knowledge

The level of access to reproductive health knowledge by women of child bearing age by is reflected in the table below.

Table 4.5: Level of exposure to RH knowledge

Frequency of exposure	**Respondents**	**Percentage**
Never attended any RH session	188	69.9
Once	60	22.3
Twice	12	4.5
3 times and above	9	3.3
Total	**269**	**100**

Source: Primary data

From the table above, a greater number of respondents had never been exposed to reproductive health knowledge. This could have been due to low literacy levels that might have influenced them in not bothering to attend RH education sessions organized in their localities.

4.6Contraceptive usage by respondents

The percentage usage of contraceptive methods (as birth control strategy) as was revealed by respondents is indicated in the table below.

Table 4.6: Contraceptive usage by respondents

Contraceptive method	Number of respondents	Percentage
Timely withdrawal	78	29
Male Condom	16	6
Female condom	3	1
Pilplan (1 month)	21	8
Emergency pill (72 hrs)	3	1
Injecta plan	30	11
Intra-uterine device	8	3
Implant	5	2
Non contraception	105	39
Total	**269**	**100**

Source: Primary data

From the table above it is clear that many couples never use any contraceptive method to ensure birth control in their respective families. Secondly, for those who adopt contraception in their birth control, most of them (29%) use withdrawal, followed by those who use injectaplan(11%), contraception pills of one month period (8%). Also a small percentage (6%) of couples use male condom for birth control. Female condom and emergency pill use ranked least (1% in each case). This is more likely so because of low income levels of respondents which in turn may be limiting them to buy female condoms since these are very expensive to obtain and in addition to that women are not knowledgeable about their usage. Respondents that used withdrawal method as a birth control methods had misconceptions about the modern family planning methods, and it was evident that withdrawal was not effective as these respondents revealed having more than two biological children yet they were low income earners.

4.6.2 Family planning access locations

The following table indicates the locations from where respondents said they sourced family planning services.

Table 4.7: Family planning access locations

Access location	Frequency	Percentage
Health Centres	79	30
Clinics	129	48
Pharmacies	29	10

Drug shops	32	12
Total	**269**	**100**

Source: Primary data

From the table above it is evident that most respondents were accessing family planning services from clinics (48%) followed by health centers (30%). This is explainable by the fact that most people use Inject plan, Pill plan and condoms as indicated in table 4.6 above. The pills and condoms are readily available for purchase from the clinics while at the same time the Inject plan services are provided there.

4.7 Challenges in accessing family planning services

The challenges which respondents were encountering when accessing family planning services are as indicated in the table below.

Table 4.8: Challenges in accessing family planning services

Challenge	Frequency of mention	Percentage
High cost of FP services	124	46
Limitation by spouses	76	28
Limitation by religion	53	20
Long distances to access points	16	6
Total	**269**	**100**

Source: Primary data

It is evident from the table above that most respondents complained of the high cost of family services. This may be due to low income levels among the respondents, a factor that limits them from paying for contraceptives and related services.

4.8 Remedial measures to challenges

A number of remedial measures were mentioned by the respondents as indicated in the table below.

Table 4.9: Remedial measures to challenges

Remedial measure	Frequency of mention	Percentage
Provision of low cost FP services	134	50
Including both spouses in advocacy campaigns	44	16
Sensitizing religious leaders	27	10
Promoting high income generation initiatives among the communities	64	24
Total	**269**	**100**

Source: Primary data

From the above table most respondents mentioned provision of low cost family planning services as the main way to mitigate their challenge of accessing family planning services. This suggestion coupled with promoting high income levels among the target communities would definitely enable the target people to easily access family planning services. However multipronged approach involving all the indicated remedial measures would be the best option to ensure success of the intervention.

5.0 CONCLUSION AND RECOMENDATIONS

5.1 Conclusions

5.1.1 Regarding level of access to reproductive health knowledge

The high percentage (69.9%) of people having never attended any education session about reproductive health implies low levels of reproductive health knowledge among the communities in the area. There is therefore need to conduct more sessions on reproductive health. Since people mainly visit health facilities when they are sick it would be better to conduct the sessions in convenient locations where a number of people of reproductive age can attend.

5.1.2 Concerning With levels of access to family planning services

It is evident from Table 4.6 that a higher percentage of women of child bearing age especially married ones don't use contraceptives. This could be due to a number of factors but the major issue here is that this is an indicator of low levels of accessibility to family planning services. Hence a need to increase women's access to family planning services.

5.1.3 Regarding challenges encountered in accessing reproductive health and family planning services

A number of challenges inclusive of high cost of Family Planning services, religious beliefs, cultural beliefs, limitation by spouses were mentioned. However, high cost of the services was earmarked as the most affecting issue limiting the women from accessing both reproductive health and family planning services. Therefore ability of a women or a couple to pay for family planning services is significant in influencing one's ability to access family planning services.

5.1.4 Concerning remedial measures to challenges

Whereas several remedial measures were mentioned, provision of low cost family services emerged the most preferred. Hence any initiative that leads to reduction in costs of accessing family planning services is definitely a welcome intervention. Also, since other measures were pointed out it implies that for effective intervention in this regard an integrated approach to dealing with the challenges would be the best option.

5.1.5 Overall conclusion

The overall conclusion in this regard is that there are low levels of access to both reproductive health and family planning services among women of child bearing age in the target area. Ability of a person to pay for family planning (particularly the contraception methods) seems to be the most influencing factor in accessing family planning services.

5.2 Recommendations

Following the above mentioned conclusions a number of recommendations are hereby outlined:

- Interventions leading to enabling women of child bearing age to access low cost family services need to be instituted through concerted efforts by the Government of Uganda and its development partners (including donor agencies). Such initiatives would ensure that low cost contraceptive methods are readily available in accessible facilities in order for the women to easily access them
- Availability and access to family planning commodities is essential in facilitating family planning acceptance and use as they are closely linked to strength and extent of programme coverage. The availability of accurate family planning information, quality services, and adequate supplies are crucial determinants in the level of male involvement and participation in reproductive health programmes.
- Advocacies for accessing reproductive health education and family planning services should be made. Reproductive health education sessions should be comprehensively organized and provided to tailored audiences like students, the out of school youths, the singles, the married couples etc)
- Religious leaders should get involved in sensitizing the public about family planning issues instead of leaving the task to the ministry of health practitioners and the government. It was observed that family planning is engineered more by the government and non-government organizations than the religious leaders in Mumyuka Wakiso Sub County. Therefore efforts by the religious leaders to engage in public sensitization will be an added advantage
- The religious leaders should encourage inter-spousal communication as this was suggested and identified by some respondents as an important consideration in encouraging couples to accept family planning and adhere to contraceptive use. This should be done even during preparation of their marriage by the Priest or Imam
- Community Based Health Planning and Services (CHPS) strategy (that is to say a top to bottom approach in the health sector planning) is the best strategy of attracting women to consider using family planning methods. This strategy emphasizes involvement of community members in the sensitization and provision of family planning services from the zone level to the Sub County level
- The availability of a wide range of contraceptive methods provides the opportunity for both men and women to make informed choices.
- The religious leaders, ministry of health and the government should collaborate with non-government and Community Based Organisations operating in the community of Wakiso Sub-County should train and deploy more community health officers. Besides that the community members should be involved in the deployment of staff to the community, this will arrest the challenge of deploying Community health officers that are not familiar with the local practices and norms within the community.

- Human rights talks are beneficial with the focus on both men and women in relation to family planning. This is viewed as a major intervention to increase usage and effectiveness of family planning. In such a talk the participants can be enlightened about reproductive freedom for women, since in such a patriarchy society like Wakiso sub county many men tend to dictate when it comes to reproduction which is an abuse of women's inherent rights.
- The government of Uganda through the ministry of Health should consider adding family planning lessons on the education curriculum right from primary to tertiary institutions.
- NGO's working towards promoting access to family planning knowledge should consider employing male public health workers to conduct family planning training since it is evident that it is men that have limited women's usage of family planning methods.

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APPENDIX 1

A questionnaire for the married couples in Wakiso sub-county

Dear sir/madam, our organization is conducting a survey to establish levels of access to reproductive health knowledge and levels of access to family planning services by women of child bearing age in your area. You have been selected to be one of the respondents for this purpose. Therefore I kindly request you to complete this questionnaire. The information given will be treated with the highest level of confidentiality.

SECTION A:

Name of sub county	
Name of the parish	
Name of the village	
Name of the zone	

Back ground data

A. What is your gender?
   Male ☐
   Female ☐

B. What is your occupation?
   ……

C. State your position on the occupation stated above
   ……...

D. What is your age?(Tick :✓)
15-24 ☐
25-34 ☐
35-44 ☐
45-54 ☐
55 – Above ☐

E. What is your marital status?
   Single ☐ Separated ☐
   Married ☐ Widowed ☐

F. What is your average household expenditure for a day?
   A. Less than 2000 ☐

B. 2000 - 4000
C. 4001 - 6000 ☐
D. 6001- 10000 ☐
E. Above 10000 ☐

G. level of education attained.(Tick :✓)
A. Primary ☐
B. Ordinary level ☐
C. Advanced level ☐
D. Vocational education ☐
E. University ☐

H. What is your religion? (Tick your religion:✓)
A. Anglican ☐
B. Moslem ☐
C. Catholic ☐
D. Born again. ☐
E. Others ☐

If others specify…….

SECTION B

The effect of religious beliefs on spacing of children

A. Do you believe in use of family planning?
   Yes ☐
   No ☐

B. What are the likely health risks of not spacing the children?
   A. Premature babies ☐
   B. Low birth weight of babies ☐
   C. Bleeding during pregnancy ☐
   D. Maternal death ☐
   E. Others ☐
   If others specify…….

C. How did you space your children according to your religion?
   A. 6 months ☐
   B. 7- 12 months ☐
   C. 13-18 months ☐
   D. 19-24 months ☐
   E. 25- above ☐

D. In your position what are your strategies on spacing of children?(Tick as many as applicable)
   A. Health educations ☐
   B. Provider ☐
   C. Sensitization ☐
   D. Others ☐
   E. None of the above ☐

   What are the benefits of child spacing?(Tick as many as applicable)
   A. Improvement in health of new born baby ☐
   B. Improvement in the health of mother ☐
   C. Social benefits ☐
   D. Spiritual growth ☐
   E. Financial stability of the family ☐

SECTION C

Religious beliefs and number of children

F. How many children do you have?
   A. 0-2 ☐
   B. 3-5 ☐
   C. 6-8 ☐
   D. 9-11 ☐

E. 11- above

E. How many biological children do you have?
   A. 0-2
   B. 3-5
   C. 6-8
   D. 9-11
   E. 11-above

F. How many adopted children do you have?
   A. 0-2
   B. 3-5
   C. 6-8
   D. 9-11
   E. 11- above

G. What are the likely consequences of having many children in a family? (Tick as many as possible)
   A. Poverty
   B. Death
   C. Malnutrition
   D. Illiteracy
   E. Others

If others specify…….

H. How have you planned for your children?
   ……
   ……
   ……
   ……....

I. What the appropriate age to have children according to your religion?
   A. 13-16 years
   B. 17-20 years
   C. 21-24 years
   D. 25-28 years
   E. 29- above

SECTION D:

The effect of religious beliefs on the number of wives in a family

J. How many wives does your religion recommends
   A. 1
   B. 2
   C. 3

D. 4 ☐
E. Others ☐

If others specify……

K. Does your religion accept polygamy?
Yes ☐

No ☐

L. Does your religion accept you to marry another wife in case of a divorce?
Yes ☐

No ☐

M. If yes, how many wives can you marry?
A. 1 ☐
B. 2 ☐
C. 3 ☐
D. 4 ☐
E. Others ☐

O. How do you support your wife/ wives in family planning according to your religion?

……

……

P. How have you participated in reproductive health?

……

……

Q. Do you use family planning methods in your family?

Yes ☐ No ☐

R. If Yes, (a) How often do you use family planning methods?

……

……

(b) What type of family planning did you use?

……

……

S. What are the side effects did you face?

……

……

T. In your position what are your strategies on family planning in your area?

……

……

U. What are your achievements in time you have served in this region?

……

……

V. What are you recommendations?

……

……

……

THANK YOU FOR YOUR TIME.

APPENDIX 2

Interview guide for the married couples in Wakiso sub-county

SECTION A

Back Ground Information

1. What is your name?
2. What is your religion?
3. What level of education did you attain?

SECTION B

The effect of religious beliefs on spacing of children

4. How many children do you have?
5. What interval of years does your religion recommends you to have?
6. Does your religion accept family planning?
7. How does your Holy Book say about family planning?

SECTION C

The effect of religious beliefs on the number of children

8. How many children does your religion recommend to have?
9. Does your religion accept you to stay with other children of your relatives?
10. How many children of your relatives do you have?

SECTION D

The effect of religious beliefs on the number of wives in a family

11. How many wives do your religion recommends?
12. Does you religion allow divorce?
13. Does your religion accept you to marry after divorce?
14. How many wives does it accept you to marry after divorce?
15. How does religion contribute to women receiving family planning counseling services?
16. What does the religion do for women to access low cost of family planning services?

SECTION E

Level of access to RH knowledge and family planning services

17. How many times have you attended education on reproductive health issues?
18. Where did you receive the Reproductive Health education from?
19. What did you learn during the Reproductive Health education?
20. How many times have you attended family planning counseling sessions?
21. Where do you go for family planning services?
22. Do you use family planning methods in your household?
23. What type of family planning do you use?
24. How often do you use family planning methods?
25. What challenges do you face in accessing family planning services?
26. What do you suggest as remedial measures to the challenges?