A Literature Review of the Current Status of Family planning in Uganda

Commissioned by

Health Communication Partnership

Author: Aggrey Mukasa

Final Draft

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The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of USAID or HCP.
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# Abbreviations and acronyms

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<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBC</td>
<td>British Broadcasting Corporation</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraception Prevalence Rate</td>
</tr>
<tr>
<td>DISH</td>
<td>Delivery of Improved Services for Health</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPAU</td>
<td>Family Planning Association of Uganda</td>
</tr>
<tr>
<td>FPRWG</td>
<td>Family Planning Revitalisation Working Group</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HCP</td>
<td>Health Communication Partnership</td>
</tr>
<tr>
<td>HH</td>
<td>Household</td>
</tr>
<tr>
<td>IC</td>
<td>Income Contraception</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
</tr>
<tr>
<td>LAPM</td>
<td>Long Acting and Permanent Methods</td>
</tr>
<tr>
<td>ICPD</td>
<td>The Cairo International Conference on Population and Development</td>
</tr>
<tr>
<td>NSP</td>
<td>The National HIV/AIDS Strategic Plan</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MHIV</td>
<td>Minnesota International Health Volunteers</td>
</tr>
<tr>
<td>MOFPED</td>
<td>Ministry of Finance Planning and Economic Development</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>NPP</td>
<td>National Population Policy</td>
</tr>
<tr>
<td>PATH</td>
<td>Programme for Appropriate Technology in Health</td>
</tr>
<tr>
<td>PEAP</td>
<td>Poverty Eradication Action Plan</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RHU</td>
<td>Reproductive Health Uganda</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>UAC</td>
<td>Uganda AIDS Commission</td>
</tr>
<tr>
<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
</tr>
<tr>
<td>UDHS</td>
<td>Uganda Demographic and Health Survey</td>
</tr>
<tr>
<td>UPE</td>
<td>Universal Primary Education</td>
</tr>
<tr>
<td>UPE</td>
<td>Universal Secondary Education</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WFR</td>
<td>Wanted Fertility Rate</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</tbody>
</table>
Executive summary

This is a report on the literature review on Family Planning in Uganda commissioned by Health Communication Partnership (HCP). HCP has been at the forefront in Reproductive Health campaigns in Uganda. Specifically, from April 2006 to June 2008, HCP provided technical assistance to the Ministry of Health (MOH) and the Family Planning Revitalisation Working Group (FPRWG) to develop and implement a national communication campaign to promote smaller, healthier and more prosperous families in Uganda. The campaign focused on men with the objective of increasing the proportion of men who discuss family planning (FP) with their partners because they believe is the best way to a healthier, more prosperous life.

Chapter 2 of this report gives an overview of population growth in Uganda – starting with the size, composition and trends in population growth rate over the years. The chapter highlights fertility at global, regional and country levels emphasizing Uganda’s extremely high fertility rates in comparison to other countries. It gives factors that determine fertility behavior in Uganda which range from education characteristics, marital status, economic characteristics and location (rural vs urban). It also highlights factors such as early parenthood and teenage pregnancies. The chapter contains a discussion of importance of Wanted Fertility Rate and how it compares with the Total Fertility for different population groups. Overall total WFR is less than TFR showing that Ugandan families have on average 1.6 unwanted pregnancies or children.

Chapter 3 highlights the rate of population growth of the country and its implications for poverty reduction. This chapter highlights the relationship between high fertility and how it increases inequality and poverty; and particularly how its effects the PEAP targets. It highlights effects of fertility on consumption per capita, per capita growth and the Cost of Child Index, a tool that assesses the cost of raising a child.

Chapter 4 gives an overview of the role the government of Uganda has played in developing a comprehensive set of policies, guidelines and strategies that are used by policy makers, implementing partners, donors, communities and individuals to reduce fertility levels in the country. This chapter gives a historic perspective of FP in Uganda which is closely linked with the Family Planning Association of Uganda (FPAU), showing that the earlier initiatives in FP were led by civil society. Policies were non-existent and resistance to FP was initially high. The first national population policy was enacted in 1995 and has since subsequently revised in 2008. The chapter gives an overview of other related frameworks and policies such as the PEAP, the HSSP and the NSP; and how each explicitly spell out the need to lower fertility in Uganda to achieve sustainable development. There are also strategies and guidelines in communication and advocacy that are useful for FP practitioners.

Chapter 5 gives an overview of FP in Uganda. It gives the definition of FP and its merits. It gives the legal basis of FP which is based on the National Population Policy and which is also in line with the 1994 ICDP Programme of Action. The chapter also outlines the essential elements that must be in place for delivery of quality FP services; the types of FP methods available in Uganda, the current uptake of FP in Uganda including the
Contraceptives Prevalence Rate (the CPR) as well as the trends in contraceptive use. The chapter is capped with an outline of factors that limit FP in Uganda.

Chapter 6 dwells on knowledge and gaps on FP in Uganda; and the general attitudes on FP which may either be positive or negative. One part highlights knowledge on contraceptive methods by various population categories; and particularly awareness of the fertility period of a woman. The latter point is important for those couples who rely on the rhythm method. It also highlights knowledge levels of FP amongst service providers which is important in terms of quality and range of FP services that are available. The section on attitudes gives an anecdotal summary of common reasons that keep people endeared to large families. Importantly, the section dwells on attitudes by political leaders which are contradictory to the current government FP policies. Beliefs on FP are also highlighted as those common certainties held in people’s minds that contribute to the pool of misconceptions related to FP. Highlighting the areas of low knowledge, negative attitudes and beliefs around FP helps to design strategies of reducing or eliminating them completely.

Chapter 7 discusses unmet need for family planning (FP) which is a key concern of this study. This chapter offers a definition of the concept of unmet need and how it varies by different population categories and by geographical location. The chapter also cites reasons for the unmet need as compiled from respondents in the DHS. It also makes a link between the unmet need and unintended pregnancies and induced abortion which are serious maternal health challenges in Uganda. Unmet need for FP was recognized as another indicator for Goal No. 5 of the MDGs and this chapter clearly explains why unmet need for FP increases the total cost of extending social services and hence increasing costs of meeting the MDGs. The argument is made that of how reducing the cost of achieving the MDGs can be achieved through addressing the unmet need for FP.

Chapter 8 makes a case for male involvement in family planning which is another key concern of this literature review. Under this chapter, it is noted that FP and reproductive health have generally targeted women and throughout history, FP has been regarded as a female preserve. Owing to recognition of the role of men in RH, there is a justification for involving men at wider level; not just as consumers of FP products. The chapter discusses the existing international conventions and policy frameworks such as the Cairo ICDP which has clear provisions for male involvement. For Uganda, it is a strategy embedded in all the government’s policies related to RH. The study highlights areas that illustrate low male involvement centred on the way couples communicate regarding FP and the levels of knowledge of types of female contraceptives and their application.
Chapter 1  Introduction

1.1 Health Communication Partnership and family planning in Uganda

This is a report on the literature review on Family Planning in Uganda commissioned by Health Communication Partnership (HCP). HCP has been at the forefront in Reproductive Health campaigns in Uganda. Specifically, from April 2006 to June 2008, HCP provided technical assistance to the Ministry of Health (MOH) and the Family Planning Revitalisation Working Group (FPRWG) to develop and implement a national communication campaign to promote smaller, healthier and more prosperous families in Uganda. The campaign focused on men with the objective of increasing the proportion of men who discuss family planning (FP) with their partners because they believe is the best way to a healthier, more prosperous life.

HCP support had the following objectives:

1. To improve family planning counselling and communication through development and production of job aides and tools for service providers
2. To develop and implement a media campaign with special focus on men to ensure they have accurate information about FP and value smaller families as a means to a better quality of life
3. To develop and test community based approaches to promote FP and smaller families among men

HCP particularly assisted in the development of communication materials that promote family planning in Uganda. These included radio talk shows, mini radio serial dramas and spots, ‘Everyday Health Matters’ newsletters, road stars (mini billboards), Rainbow over yellow flower signboards and placards for FP services, flipcharts for clinical workers and community reproductive health workers. HCP also updated and dubbed the two FP videos – ‘Seven Family Planning Methods’ and ‘Time to care: A question of children’ to a number of local languages in Uganda.

In June 2007, HCP also collaborated with Plan Uganda to implement community-based approaches to mobilise men. These include community-based family planning radio programs (Ekimeezza), worksite family planning discussions, competitive sporting events with men in the community, distribution of family planning IEC materials and conducting IEC materials facilitation, staff development and “Be a Man” trainings for volunteers as well as Stepping Stones sessions focusing on family planning. All these activities were in line with the National Population Policy (NPP) and the Communication Strategy to Accelerate Implementation of Reproductive Health in Uganda (2005).

MOH in collaboration with partners is in the process of designing a new family planning communication campaign strategy based on lessons learned from the men’s campaign. The new campaign will focus on men, but also have a separate message and media strategy for the 41% of Ugandan women who have an unmet need for family planning. HCP commissioned the Family Planning Literature review to inform this process.
1.2 Aim and objectives

The aim of the literature review is to highlight the family planning situation in Uganda from the period of inception of FP activities to present day including the population characteristics; population growth and effects on development; the current policies and strategies; the unmet need for FP and male involvement in FP.

1.3 Specific objectives

1. To review existing literature on FP in Uganda and globally to update the existing situation on FP in Uganda
2. To highlight the unmet need of Family planning and its effects on poverty in Uganda
3. To highlight the role of male involvement in FP in Uganda
4. To suggest a way forward to inform the process of developing communication interventions to address the unmet need and increased male involvement.

1.4 Structure of the report

This report contains nine chapters. Chapter 1 is the introduction. Chapter 2 gives an overview of population characteristics with emphasis on Uganda’s high fertility rates in comparison to other countries; and causes of high fertility such as early parenthood and teenage pregnancy. Chapter 3 assesses the effect of population growth on strategies of poverty reduction, particularly the PEAP targets. Chapter 4 highlights the comprehensive set of policies, guidelines and strategies that government of Uganda has developed for use by FP practitioners to reduce fertility levels in the country. Chapter 5 gives an overview of Family planning in Uganda, including definition, the essential elements of service delivery, types of FP, levels of uptake and coverage and factors that affect uptake of FP in Uganda. Chapter 6 contains knowledge, attitudes and beliefs related to FP. Chapter 7 discusses the unmet family planning needs and effects this has on fertility; Chapter 8 dwells on male involvement and its importance to the FP efforts in Uganda. The final chapter contains the analysis of key issues addressed in this paper, conclusion and recommendations for the new FP campaign.
Chapter 2  Population characteristics

2.1  Introduction

This chapter gives an overview of population growth in Uganda – starting with the size, composition and trends in population growth rate over the years. The chapter highlights fertility at global, regional and country level emphasizing Uganda’s extremely high fertility rates in comparison to other countries. It gives factors that determine fertility behavior in Uganda which range from education characteristics, marital status, economic characteristics and location (rural vs urban). It also highlights factors such as early parenthood and teenage pregnancy. The chapter contains a discussion of importance of Wanted Fertility Rate and how it compares with the Total Fertility for different population groups. Overall total WFR is less than TFR showing that Ugandan families have on average 1.6 unwanted/unintended pregnancies.

2.2  Size, composition and population growth in Uganda

The total population of Uganda is currently estimated at 28 million persons having grown from 2.5 million in 1911 to 5.0 million in 1948, from 9.5 million in 1969, 12.6 million in 1980 and 24.4 million in 2002 (UNFPA, 2008).

According to projections, the population of Uganda (in the low growth scenario) is estimated to increase from 28.6 million in 2007 to 40.6 million in 2017; while (in the high growth scenario), it is estimated to increase from 30.2 million in 2007 to 43.4 million in 2017 (UBOS, 2007). The annual births are projected to increase from 1.4 million in 2007 to 1.9 million in 2017. The annual population growth rate is projected to increase from an estimated 3.3 per annum in 2007 to 3.5% per annum in 2011. At a growth rate of 4.5 % per annum, the Northern Region experienced the fastest rate of population growth in the

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1 Since the future population cannot be predicted with absolute certainty, different scenarios are developed to reflect different assumptions e.g. fertility, mortality, net international immigration. These assumptions are then used to project separately into the future, resulting into 2 series of projections, the high and low growth (the major variation being in the assumption about HIV/AIDS.
country; the Eastern, Western and Central regions followed at 3.6%, 2.9% and 2.8%, respectively (MOFPED, 2004).

### Table: The population of Uganda 1911 – 2020

<table>
<thead>
<tr>
<th>Census Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Growth rate p.a.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>-</td>
<td>-</td>
<td>2,466,325</td>
<td>1.5</td>
</tr>
<tr>
<td>1921</td>
<td>-</td>
<td>-</td>
<td>2,854,608</td>
<td>2.2</td>
</tr>
<tr>
<td>1931</td>
<td>-</td>
<td>-</td>
<td>3,542,281</td>
<td>2.0</td>
</tr>
<tr>
<td>1948</td>
<td>-</td>
<td>-</td>
<td>4,958,520</td>
<td>2.5</td>
</tr>
<tr>
<td>1959</td>
<td>-</td>
<td>-</td>
<td>6,536,616</td>
<td>3.9</td>
</tr>
<tr>
<td>1969</td>
<td>4,769,863</td>
<td>4,686,603</td>
<td>9,556,451</td>
<td>2.7</td>
</tr>
<tr>
<td>1980</td>
<td>-</td>
<td>-</td>
<td>12,636,179</td>
<td>2.5</td>
</tr>
<tr>
<td>1991</td>
<td>8,185,747</td>
<td>8,485,958</td>
<td>16,671,695</td>
<td>2.6</td>
</tr>
<tr>
<td>2002</td>
<td>11,923,152</td>
<td>12,509,980</td>
<td>24,400,000</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: UNFPA, 2008

The composition of the population is predominantly a young population with 49.4 % of below the age of 15. With a high fertility rate, the outcome is usually a population structure that wide at the base (owing to the high numbers of younger age group (below 15 years). The proportion of the population in the working-age group (15-64) is relatively smaller, while the proportion of the elderly (over 65 years) is also negligible. This reflects a low life expectancy since very few members of the population often live to reach retirement age (UNFPA 2008).

### 2.3 Fertility

Fertility refers to the number of children procreated by a woman in her lifetime. Out of the demographic components contributing the most to population growth, fertility has played the greatest role far exceeding the contributions played by migrations or increased survival (UN 2006). By the 1950s, most countries in the world still experienced high fertility (of more than 5). Fertility trends have however shifted over the long term from this level to well below replacement (approx 2.1 children per woman) in recent years. In some cases they reached lowest levels of 1.3 children per woman in many developed countries and in a number of developing countries.

During the period in 2000-2005, total fertility for the world was 2.65 children per woman (UN 2006). 65 countries with a total population accounting for 42.8% of the world’s population had fertility levels of below 2.1 children per woman. On the contrary, 127 countries with population accounting for 57.2% of the world’s total population had total fertility levels at or above replacement. Among the latter, 35 countries had total fertility levels of at or above 5 children per woman. Below are ten countries or areas with the highest and ten countries with the lowest total fertility by level of development (2000 – 2005).
Table 2: Comparison of Total Fertility of developed and less developed countries Source UN (2006).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Less developed country or area (Highest)</th>
<th>Total fertility</th>
<th>Rank</th>
<th>More developed country or area (Lowest)</th>
<th>Total fertility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Niger</td>
<td>7.91</td>
<td>1</td>
<td>Ukraine</td>
<td>1.12</td>
</tr>
<tr>
<td>2</td>
<td>Democratic Rep. of Timor-Leste</td>
<td>7.79</td>
<td>2</td>
<td>Czech Republic</td>
<td>1.17</td>
</tr>
<tr>
<td>3</td>
<td>Afghanistan</td>
<td>7.48</td>
<td>3</td>
<td>Slovakia</td>
<td>1.20</td>
</tr>
<tr>
<td>4</td>
<td>Guinea-Bissau</td>
<td>7.10</td>
<td>4</td>
<td>Slovenia</td>
<td>1.22</td>
</tr>
<tr>
<td>5</td>
<td>Uganda</td>
<td>7.10</td>
<td>5</td>
<td>Rep. of Moldova</td>
<td>1.23</td>
</tr>
<tr>
<td>6</td>
<td>Mali</td>
<td>6.92</td>
<td>6</td>
<td>Bulgaria</td>
<td>1.24</td>
</tr>
<tr>
<td>7</td>
<td>Burundi</td>
<td>6.80</td>
<td>7</td>
<td>Belarus</td>
<td>1.24</td>
</tr>
<tr>
<td>8</td>
<td>Liberia</td>
<td>6.80</td>
<td>8</td>
<td>Greece</td>
<td>1.25</td>
</tr>
<tr>
<td>9</td>
<td>Angola</td>
<td>6.75</td>
<td>9</td>
<td>Poland</td>
<td>1.26</td>
</tr>
<tr>
<td>10</td>
<td>DR Congo</td>
<td>6.70</td>
<td>10</td>
<td>Latvia</td>
<td>1.26</td>
</tr>
</tbody>
</table>

While fertility has declined below 5 children per woman in 113 out of 148 of the Least Developed Countries, it remains high above 5 in 35 of these countries. In addition 5 countries still had a total fertility above 7 children per woman in 2000-2005; and the average number of children per woman is still between 6 and 7 in 11 additional countries including Uganda (see Table 2). The highest total fertility was for Niger (7.91 children per woman). Most of these countries are characterized by civil strife, and political instability in recent years; and are highly affected by HIV. All These factors militate against provision of basic services (UN 2006).

For Uganda, the UDHS (2006) used the TFR\(^2\) to measure of current fertility. The table 3 below shows that while the TFR has declined from 7.1 in 1969, on average, a Ugandan woman would have 6.7 children by the end of her reproductive years if the current fertility pattern for 2006 were to prevail. This is the third highest fertility rate in Sub-Saharan Africa and the fifth highest in the world (MOFPED. 2004).

Table 3: The total fertility rates (TFR), 1969 – 2002 from Uganda Census and UDHS

<table>
<thead>
<tr>
<th>Date of census/survey</th>
<th>TRF</th>
<th>Method</th>
<th>Data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1969</td>
<td>7.1</td>
<td>Indirect</td>
<td>Census</td>
</tr>
<tr>
<td>1988</td>
<td>7.1</td>
<td>Direct</td>
<td>UDHS</td>
</tr>
<tr>
<td>1991</td>
<td>7.1</td>
<td>Indirect</td>
<td>Census</td>
</tr>
<tr>
<td>1995</td>
<td>6.9</td>
<td>Direct</td>
<td>UDHS</td>
</tr>
<tr>
<td>2000</td>
<td>6.9</td>
<td>Direct</td>
<td>UDHS</td>
</tr>
<tr>
<td>2002</td>
<td>7.0</td>
<td>Indirect</td>
<td>Census</td>
</tr>
<tr>
<td>2006</td>
<td>6.7</td>
<td>Direct</td>
<td>UDHS</td>
</tr>
</tbody>
</table>

Source: 2002 Uganda Population and Housing Census: Analytical report

In comparison, the UDHS (2006) gives TFR of countries in eastern and southern Africa: with Rwanda at 6.1 (DHS 2005), Malawi 6.0 (DHS 2004), Tanzania at 5.7 (DHS 2004),

\(^2\) Total Fertility Rate denotes the number of live births a woman would have if she were subject to the current fertility patterns throughout her reproductive years.
Kenya at 4.9 (DHS 2003), Namibia (4.2) and Lesotho 3.5 (2004). The TFR in urban areas is much lower than the TFR in rural areas (4.4 and 7.1 children, respectively). However, because of the small proportion of the population living in urban areas (less than 20 percent), the low urban fertility has only minimal impact on the level of fertility for the country as a whole (UDHS 2006).

2.4 Factors that determine fertility behavior

There is evidence adduced from the MOFPED (2004) study illustrating the role of education in the context of fertility reduction; that households with higher education had fewer children. HHs whose head completed secondary and/higher education experienced lower fertility than their less educated counterparts. Detailed analysis reveals that higher education has larger (more than double) impact on fertility reduction than secondary education. The study suggests that the government support for education should go beyond universal primary education in order to have to have considerable impact on reduction in fertility. Other variables include:

- Fertility decreases dramatically with education, from 7.7 children among women with no education to 4.4 among women with secondary education.
- HHs with un-married, divorced or widowed heads experience lower fertility than their married counterparts; while the opposite is true for HH characterized by heads involved in polygamous relationships
- Male headed HHs experienced lower fertility than female headed HHs which points to the role gender inequalities i.e. women generally lack of control over reproduction.
- HHs who reported to be dependent on agriculture as the main stay experienced higher fertility than their counterparts involved in non-agricultural activities
- HHs whose composition was skewed in favour of girls had more children than whose composition was skewed in favour of boys. This reflects cultural/social economic parental preference for boys
- Fertility in urban areas is considerably lower than in rural areas. The total fertility rate (TFR) in urban areas is 4.4 children per woman compared to 7.1 in rural areas.
- Women in the poorest households have 8.0 children per woman compared to 4.3 children among women in the wealthiest households.

2.4.1 Early parenthood

Ugandan women start bearing children early and by the age of 26 an average woman will have given birth to 2.6 children and to more than 5 children by the age of 35. Since 1995, there has been a slight decline in the age specific fertility rate for age 15-19, from 204 to 178 births per 1000 women (ORC Macro, DFID, 2002). There has also been a decline in the percentage of young women who have started child bearing. In 1995, 43 percent of women 15-19 either were mothers or were pregnant; with their first child. In 2000-2001, this percentage had declined to 31% UBOS, ORC Macro, 2001:50). The age at initiation of childbearing has not changed much over time. Comparison of findings from previous UDHS surveys shows that the median age at first birth has remained around 18.5 for the past 30 years (ORC Macro, DFID, 2002). 2000-20001 figures also show trends in pregnancy rates by
age. 32% of women 15-19 and 88% of women 20-24 have ever been pregnant. This percentage generally increases with age, reaching close to 90% at the age of 22.

### 2.4.2 Teenage pregnancies

Teenage pregnancies and early motherhood are also major contributors to high fertility rates, and are a health and social concern in Uganda because of association with higher morbidity and mortality for both the mother and child. In Uganda, frequent and risky pregnancies, and teenage pregnancies are the major contributors to reproductive stress; and lead to high rates of maternal and infant mortality (MOH 2004). Overall, 25 percent of teenagers have begun childbearing, with 19 percent having had a child already and 6 percent carrying their first child (UDHS 2006). This is a continued decline from the 31 percent observed in the 2000-2001 UDHS and the 41 percent in the 1995 DHS, which had put Uganda at the top for teenage pregnancy among sub-Saharan countries. The percentage who started their reproductive life increases with age because of longer exposure, from 2 percent of 15-year-olds to 59 percent of 19-year-olds.

Teenage pregnancy varies with level of education. Although only 15 percent of girls with secondary education have begun their reproductive life, the corresponding proportion of those with no education is 50 percent. The early teenage pregnancies in Uganda fuel fertility (MFEPD, 2008). They are also risky pregnancies since they occur too early. They are also a result of low contraceptive use among adolescents. They also disproportionately contribute to the high maternal mortality ratio.

### 2.5 Wanted Fertility Rate

The wanted fertility rate (WFR) measures the potential demographic impact of avoiding unwanted births. WFR is calculated in the same manner as the conventional total fertility rate, except that unwanted births are excluded. A birth is considered wanted if the number of living children at the time of conception was less than the ideal number of children reported by the respondent. The gap between wanted and actual fertility shows how successful women are in achieving their reproductive intentions. A comparison of the total wanted fertility rates and total fertility rates for the three years preceding the DHS by background characteristics is presented in Table 4 above.

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<table>
<thead>
<tr>
<th>Background characteristics</th>
<th>Total wanted Fertility Rates</th>
<th>Total Fertility Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>3.6</td>
<td>4.4</td>
</tr>
<tr>
<td>Rural</td>
<td>5.5</td>
<td>7.1</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central 1</td>
<td>4.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Central 2</td>
<td>4.9</td>
<td>6.3</td>
</tr>
<tr>
<td>Kampala</td>
<td>2.9</td>
<td>3.7</td>
</tr>
<tr>
<td>East Central</td>
<td>5.8</td>
<td>7.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>5.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Northern</td>
<td>5.8</td>
<td>7.5</td>
</tr>
<tr>
<td>West Nile</td>
<td>(5.7)</td>
<td>(7.2)</td>
</tr>
<tr>
<td>Western</td>
<td>5.4</td>
<td>7.3</td>
</tr>
<tr>
<td>South Western</td>
<td>5.1</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>North sub region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IDP</td>
<td>(5.9)</td>
<td>(8.6)</td>
</tr>
<tr>
<td>Karamoja</td>
<td>(6.7)</td>
<td>(7.2)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>6.2</td>
<td>7.7</td>
</tr>
<tr>
<td>Primary</td>
<td>5.4</td>
<td>7.2</td>
</tr>
<tr>
<td>Secondary</td>
<td>3.6</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Wealth quintile</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>6.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Second</td>
<td>5.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Middle</td>
<td>5.4</td>
<td>7.0</td>
</tr>
<tr>
<td>Fourth</td>
<td>5.3</td>
<td>6.8</td>
</tr>
<tr>
<td>High</td>
<td>3.4</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Rural-urban differentials show that urban women prefer to have fewer children than rural women (3.6 children and 5.5 children, respectively). There were marked variations in the mean ideal number of children across regions, ranging from 2.9 children in Kampala region to 5.8 children in the North. The mean ideal number of children is highest in Karamoja sub-region (6.7). Considering the educational levels of the respondents, the mean ideal number of children declines with increased education. Women with no education prefer 6.2 children, while those with secondary or higher education want only 3.6 children.

The analysis by wealth quintiles shows a similar trend to that of education on women. The mean ideal number of children increases from 3.4 children for women in the highest wealth quintile to 6.0 children for those in the lowest quintile. The data shows that if all unwanted births are eliminated, the total fertility rate in Uganda would be 5.1 instead of the actual total fertility rate of 6.7 children per woman.

2.5 Summary of findings

This chapter has highlighted the population characteristics of Uganda. It portrays Uganda as one of the countries with the highest population growth rate in the world, at a rate of 3.4% per annum. This immediately points to the need to take action to reduce the population growth of Uganda. In terms of designing the overall message, there is need to highlight the population growth rate in comparison to Uganda’s neighbours. The messages need to be targeted to the regions with the highest growth rates, such as Northern Uganda. In recognition that the population is young, the messages should reach out to this category since these will also contribute to further population growth unless they are brought on board with FP messages right from their youthful years. One of the suggestions is to incorporate FP into the educational curriculum, right from primary school.

The chapter also highlighted Uganda’s fertility as one of the highest in Africa and at global level. Lowering of fertility should hence be a key communication message. Various messages should be crafted to target different population categories. The campaign should prioritize women in the poorest households with a fertility of 8.0. This group should be made aware of the advantages of lower fertility of their counterparts in the wealthier households (at 4.9). The campaign should also target rural rather than urban areas and households dependent on agriculture since these also experience higher fertility. The new FP campaign should focus on increasing the median age of first birth (at 18.5) and teenage pregnancies (25%) which are some of the highest in Sub Saharan Africa. These latter 2 facts could be packaged in the context of keeping the girl child longer in school, focusing on both parents and the girl child as the primary audience. Finally, the new FP campaign can also pick on the differences between the actual and wanted fertility rate. This chapter reveals that women in Uganda have more children than they would have wished – a fact that implies that many pregnancies are unwanted or unintended. FP messages should hence make a case to reduce the unwanted or unintended pregnancies.
3.1 Introduction

The rate of population growth of a country has implications for poverty reduction. This chapter highlights the relationship between high fertility and how it increases inequality and poverty; in particular its effects on the PEAP targets. It highlights effects of fertility on consumption per capita, per capita growth and the Cost of Child Index, a tool that assesses the cost of raising a child.

3.2.1 Fertility and the PEAP Goals

The Poverty Eradication Action Plan commits the Ugandan government to tackling poverty in the country. Successful implementation of PEAP is expected to reduce absolute poverty to less than 10% of the population by the year 2017 and to increase the well being for all Ugandans. Uganda’s population growth rate of 3.4% per annum is however a constraint achieving the PEAP goals. The PEAP (2004) cites fertility as one of the structural factors that increases inequality and poverty. Poor households tend to have more children and therefore their assets are subject to greater subdivision across generations. This fact is also echoed in the Uganda Participatory Poverty Assessment carried out in 2002, which identified large families as a cause of poverty. The UPPAP also linked large families to limited access to land or asset shortages. Many families were found to have very small plots of land that are grossly inadequate to meet their household needs; mainly due to the land fragmentation (MFPED, 2004).

High population growth is likely to reduce progress on achieving mortality reduction and education improvement. In an environment of high population growth, it is extremely difficult to extend services and improve the quality of services to the rapidly growing population (MFPED, 2004). Using education as an example, the cost of provision of Universal Primary Education (UPE) will rise rapidly. Consequently, this will also reduce the prospect of extending this support to secondary school. At HH level, families with large
number of children are associated with low human capital investment in each child since they have fewer resources to send children to school; or fewer resources to afford health care and even have fewer resources to save or invest in productive activities (MFPED, 2004).

3.2.2 Advantages of reduction in fertility rates

According to MOFEPD (2004), there are significant payoffs to Uganda if its fertility is reduced and population growth consequently slowed down from its current rate of 3.4% per annum. If no action is taken to reduce fertility, it is estimated that by 2013, 10.4 million Ugandans, approximately 28% of the total population will live in poverty, i.e. 1.3 million more Ugandans compared to 9 million in 2004. However if action is taken to reduce fertility and Uganda’s population growth rate slows by 1% to 2.4% p.a., the poverty head count can be reduced to 22%, which in absolute terms translated into lower numbers (7.1 million) living in poverty.

In addition, Uganda could also enjoy a number of other benefits from a slower rate of population growth. In terms of human development, lower fertility is likely to increase progress on achieving mortality reductions and improve maternal health. It will also help the government to further extend public services and improve quality by increasing the level of expenditure per head on sectors such as health and education (MOFEPD, 2004).

3.3.1 High fertility and real private consumption per capita

Household (HH) consumption expenditure data from the Uganda National Household Surveys Income is used to measure poverty. The key variable of HH consumption is real HH expenditure per adult equivalent. Data from MFPED shows that under the higher population growth scenario (3.62% per annum), real private consumption per capita is projected to increase from shs.332,770\(^3\) to shs.393,843 per annum, an increase of 18.4% or 1.7% on average per annum. In comparison, if Uganda’s total population over the next 10 years is on lower projection of 2.4% per annum, private consumption expenditure per capita would increase by 2.9% per annum, reaching shs. 447,953/= by 2013/14 (i.e. 14% higher than scenario1). Uganda’s road to poverty reduction with the 2 scenarios would hence be faster with the lower population growth rate of 2.4%. However the data also suggests that even with slower population growth rate of 2.4% Uganda shall be not be on track to achieve the PEAP target of reducing poverty to 10% of the population by 2017.

3.3.2 Population growth and per capita economic growth

In the MFEPD (2004) study, 2 models were used to generate results from both country and panel regressions\(^4\) to assess the effect of population growth on per capita. The results mainly show a negative impact of population growth on per capita economic growth. The study results further reveal that were Uganda to succeed in reducing its population growth by 1% point, from the current 3.4% to 2.4%, its annual growth of per capita GDP could rise by

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\(^3\) The exchange rate at the time of compiling the report was 1USD:UGX 2,100  
\(^4\) The study uses 2 models – The Harrod-Domar Growth Model and the Solow Growth Model
between 0.5-0.6 percentage points. Such a reduction would entail an increase of per capita economic growth between 1.4 and 3.0 percentage points per year. A comparison of some indicators of economic performance of the year 2000, with those of other countries in Africa and South East Asia in the same period reveals some of the constraints that population growth could be imposing on economic growth in Uganda:

Table 5 Per capita GDP and population of selected countries, 1998 – 2004

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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>3,020</td>
<td>3,066</td>
<td>3,080</td>
<td>3,098</td>
<td>1.5</td>
<td>1.7</td>
<td>1.8</td>
<td>1.9</td>
</tr>
<tr>
<td>Mauritius</td>
<td>3,870</td>
<td>3,750</td>
<td>3,740</td>
<td>4,120</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Malaysia</td>
<td>3,389</td>
<td>3,600</td>
<td>3,905</td>
<td>4,283</td>
<td>22.2</td>
<td>23.2</td>
<td>24.2</td>
<td>25.2</td>
</tr>
<tr>
<td>Thailand</td>
<td>1,819</td>
<td>1,780</td>
<td>2,060</td>
<td>2,232</td>
<td>61.2</td>
<td>62.4</td>
<td>63.6</td>
<td>64.8</td>
</tr>
<tr>
<td>Uganda</td>
<td>310</td>
<td>260</td>
<td>236</td>
<td>250</td>
<td>21.5</td>
<td>22.9</td>
<td>24.2</td>
<td>26.3</td>
</tr>
</tbody>
</table>

Source: MFPED. 2006

The table shows that for the period 1998-2004, Uganda was outpaced by countries like Botswana, Mauritius, Malaysia and Thailand. Uganda's per capita GDP was about one-eleventh of Botswana and Malaysia, and a mere one-fifth that of Thailand (MFPED, 2006).

3.2.3 The Cost of Child Index

The cost of Child Index is a tool that can be used to calculate the cost of raising a child. According to an article MOEFP (2009), most African Governments collect various demographic data for planning purposes. However most do not have data on the cost of raising a child. Yet, if this data was made available, it would facilitate advocacy campaigns for smaller families and also help in influencing people’s decisions on fertility. The calculation of the costs is by use of the Child Cost Meter Table (CCMT). This gives data that that would be used to help families, governments and other stakeholders to appreciate the cost of raising a child so as to plan to have affordable families. When families use the information to regulate their families, then income becomes a factor in contraception, hence the term Income Contraception (IC).

3.3 Summary of findings

The main focus on Chapter 3 is that rate of population growth of a country can greatly impact on poverty reduction targets as set out in the PEAP. For example, this document has targets of reducing absolute poverty to 10% of the total population by 2017. The PEAP however recognizes that these targets will be hard to achieve owing to high fertility which leads sharing out of existing resources at household level to a larger number of people. Hence the FP campaign can target such households, with messages that highlight the link between high fertility and poverty at household level. The campaign could also dwell on the effect of high fertility on social service delivery. For example, households should be aware that the large number of children they have will neither get access to quality education nor to
quality health services. This is all due to the higher costs requirements for delivering these services on part of the government.

The new FP campaign could highlight the payoffs to Uganda if population growth rates are reduced from the current rate of 3.4% per annum. The projections which give total population of 10.4 million people who will live in absolute poverty in 2013 can be compared side by side with the number of 7.1 million if current fertility rate was reduced by a mere 1% to 2.4%. The projections that show a higher consumption per capita growth of 2.9% per annum (in the lower population growth scenario of 2.4% p.a.), should be compared with the lower per capita growth of 1.7% per annum (in the higher population growth scenario of 3.4% p.a.). The 2 population growth rate scenarios can also be used to show the effect on per capita economic growth. The data available shows that were Uganda to succeed in reduction of its population growth by 1%, the annual growth per capita GDP would rise between 0.5-0.6% per annum. The FP campaign could also capitalize on the comparing the data on per capita GDP for some developing countries with a much lower fertility than Uganda such as Botswana, Mauritius, Malaysia and Thailand. Such figures could be very useful in convincing policy makers to contribute more attention and resources towards FP in Uganda.
Chapter 4 Policies, strategies and programmes for family planning in Uganda

4.1 Introduction

The government of Uganda has developed a comprehensive set of policies, guidelines and strategies that are used by policy makers, implementing partners, donors, communities and individuals to reduce fertility levels in the country. This chapter gives a historic perspective of FP in Uganda which is closely linked with the Family Planning Association of Uganda (FPAU), showing that the earlier initiatives in FP were led by civil society. Policies were non-existent and resistance to FP was initially high. The first national population policy was enacted in 1995 and has since subsequently revised in 2008. The chapter gives an overview of other related frameworks and policies such as the PEAP, the HSSP and the NSP; and how each appreciate the need to lower fertility in Uganda to achieve sustainable development. There are also strategies and guidelines in communication and advocacy that are useful for FP practitioners.

4.2.1 Evolution of Family Planning policies in Uganda

The history of FP in Uganda is closely linked with that of the Family Planning Association of Uganda (FPAU), renamed Reproductive Health Uganda. The FPAU formed in 1957 at a time when Uganda, like many other African countries was agitating for independence from colonialism. At that time, most Africans were in favor of large families and hence did not believe in FP. Even after independence, most African governments paid little attention to FP. Initially a group of volunteers, mainly members of Asian and African Mothers’ Union formed a loose association to advocate for FP. These were however from affluent families and hence it remained an almost exclusive practice among women who could afford services provided in private health facilities at fee. In order to have impact, these volunteers founded the Family Planning Association of Uganda in 1957. The FP devices that were provided to women included Intra Uterine Device (IUD), diaphragm, jells and condoms. This association gained legal status in 1963, when it was registered as an NGO.

Initially, the services were restricted to married women who were in addition required to have letters from their spouses. This was usually difficult since men were mostly in favour of large families. Childless women or those with less than 3 children were not allowed to use FP services. The advocates for FP also faced stiff opposition from traditional political and religious leaders who believe that large families were an asset and a fulfillment of God’s teachings; that FP would promote promiscuity and make women infertile. Condoms were said to cause cancer for women whose spouses used it during sexual intercourse, and this would presumably result in a huge number of women dying. To many Africans, FP was also seen as a hidden agenda to reduce the African population by the colonialists while theirs.

The narrative in this section is largely derived from Reproductive Health (2007) which gives a comprehensive history of FPAU right from its inception to the time the GOU came on board to take lead the FP programmes in Uganda.
grew, as a strategy to rule the country. In order to overcome resistance to FP, the association recruited influential people to become members of its board and its rank of volunteers.

The improvement in the environment came in the late 1960s when the government allowed FP advocates to promote the practice in government hospitals especially targeting women who had come for antenatal clinics and immunization programmes. Hence FP services were delivered indirectly in form of a package that included nutrition and child care.

4.2.2 Set back during the 1970s

When Idi Amin took over the government in a military coup, the government banned FP, arguing that it went against African culture. As a result, the FPAU clinics in government hospitals were closed down while lectures on FP were prohibited in institutions. However since the association was not banned, the members went underground and continued to operate clandestinely and registered successes. However the tide changed in 1975 when MOH accepted child spacing as an essential component of primary health care (PHC). The Ministry instructed medical units to once again start working with FPAU in offering child spacing information and commodities as an integral part of PHC and maternal and child health services. The association also offered training to health workers on FP at Makerere Institute of Public Health. By 1977, FPAU’s clinics rose to 4, besides another 13 located within government hospitals. The total number of acceptors had reached 20,214, with 7,918 being new acceptors (see Table 6).

| Table 6 – Disaggregated data of the number of acceptors – 1976 Source: RHU. (2007) |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Method                        | New acceptor    | Continuing       | Total acceptor  | Total fertility |
|                                |                 | acceptors        |                 |                 |
| Oral                           | 4,293           | 6,914            | 11,207          | 19,695          |
| Injectable                     | 1,137           | 2,987            | 4,724           | 13,897          |
| Condom                         | 136             | 349              | 485             | 615             |
| IUD                            | 622             | 1,329            | 1,951           | 3,019           |
| Sterilization (Male)           | -               | -                | -               | -               |
| Sterilization (Female)         | 32              | -                | -               | -               |
| Spermicides – Diaphragm         | 1,098           | 749              | 1,847           | 7,760           |
| Total                          | 7,918           | 12,328           | 20,214          | 44,986          |

4.2.3 The 1980 – onwards

In 1981, the government adopted the maternal and child health programmes, effectively bringing FP on board the maternal and child health programmes. In 1983, the government took over from FPAU the provision of services in government hospitals and other health units. This was because at this time, UNFPA and other partners had come in to support the government’s population agenda. FPAU was hence freed up to create more awareness and
to reach the underserved groups in the rural areas. Some of the strategies used include use of community based distribution services, outreach visits, development and distribution of IEC materials. Uganda’s first explicit National Population Policy was promulgated by Government in 1995. That Policy elaborated clear strategies with an overall goal of contributing to the improvement of the quality of life of the people of Uganda. In the 10 years or so of its implementation, a number of lessons were learnt and some of the important set targets were achieved. In 2008, the Government of Uganda launched the revised NPP and this is the current policy that guides all key players to develop FP interventions to reduce fertility and to ultimately achieve a sustainable population.

4.3 The current population policy framework

The Government of Uganda has in the last 10 years evolved a number of policies which provide the overall frameworks for improvement in the standard of living of the people of Uganda. These policy documents are comprehensive and deal with the technical, managerial and logistical aspects that contribute to the effective eradication of poverty, improving delivery of health care services and generally meeting the MDG targets of the country by 2015 (UNFPA, 2008). These include The National Population Policy for Social Transformation and Sustainable Development (2008); The National Health Policy (1999); The National Gender Policy (2007); HSSP II (2005/6 – 2009/10). There are also a number of sector strategies and guidelines specifically to promote reproductive health and family planning in particular. These policies and guidelines also are also drawn up in line with the international and regional dispensations, agreements, conventions and covenants such as the International Conference on Population and Development programme of Action (ICPD-PoA), 4th World Women’s Conference, Millennium Development Goals (MDGs) and the New Partnership for African Development (NEPAD).

4.3.1 The National Population Policy (NPP)

The National Population Policy was adapted by the GOU in 1995 and thereafter revised in 2008. It is a summary of the government’s commitment to population and development issues which takes into account the changing demographic, socio-economic and health environment. The NPP is in harmony with the Poverty Eradication Action Plan (PEAP). The goal of the NPP is ‘To improve the quality of life of the people of Uganda through policies and programmes that address population trends and patterns’. Some of the specific activities mentioned in the NPP related to FP include advocate for child spacing for the health of mothers and children; encourage male involvement in RH; and reduce the unmet need for family planning.

4.3.2 The Health Sector Strategic Plan (HSSP) II 2005/06 – 2009/2010

The GOU recognizes ill health as a leading cause and effect of poverty in Uganda. Health therefore continues to be an important element of the Human Development Pillar of the PEAP. The HSSP II is the common strategic framework to guide all interventions of the national health system for the period 2005 to 2010. Despite the achievements under HSSP I, it is noted that unmet need for FP, the percentage of adolescent pregnancies and the total fertility rate are all unacceptably high (HSSP II, P.33). Specifically, one of the HSSP II’s outcomes is the reduction of Total Fertility Rate from 6.9 to 5.4 by 2009. The specific targets
for Sexual Reproductive Health include increasing the Contraceptive Prevalence Rate from 23% to 40%; and reduce the percentage of teenage pregnancy rates from 37 to 20%.

4.3.3 The National HIV/AIDS Strategic Plan (NSP)

The National HIV/AIDS Strategic Plan (UAC, 2007:22) includes integration of FP as one of the strategic actions in SRH to reduce HIV/AIDS transmission from mother-to-child transmission. One of the guiding principles of the NSP is effective mutual integration and mainstreaming of HIV/AIDS in all SRH interventions and SRH in HIV/AIDS interventions. This is also in line with one of the strategies in the NPP—advocate for linking of RH and HIV/AIDS programmes and advocate for child spacing for the health of mothers and children. Objective 9 of the NSP is to integrate prevention into all care and treatment services by 2012 and a key strategy is to ensure availability of prevention and reproductive health services and supplies including family planning services. Sexual intercourse is recognized as a common denominator between pregnancy and HIV infection. It is therefore important that Reproductive Health and family planning services and supplies are made available at HIV/AIDS care and treatment service delivery points (NSP, 2007).

4.3.4 A Strategy to Improve Reproductive Health in Uganda (2004)

The Ministry of Health has in place The Strategy to Improve Reproductive Health in Uganda (MOH, 2004). The strategy is meant to address the current high levels of maternal mortality rate in Uganda. Reproductive health is a priority programme under the 1st and 2nd Health Sector Strategic Plans. Some of the underlying causes include the high unmet need for FP, leading to ‘mistimed and unwanted births, especially among the adolescents. Hence the strategy focuses on 3 areas, one of which - Strategic Output 2 - is Increased Access to Family Planning services.

4.3.5 The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006

This policy guideline was drawn up by MOH in conjunction with its partners in response to the recommendations of the International Conference on Population and Development (ICDP) of 2004. The Conference recommended that governments address all the comprehensive SRH components and not only focus on FP and Maternal Health. The document has 2 sets of guidelines: service policy guidelines and service standards that aim at making explicit the direction of reproductive health at all levels of health care. Under the FP chapter, the document explains various technical concepts, approaches and strategies that include definition of FP and contraceptive; the policy goal and objectives; the target and

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6 This is under objective 2: To reduce the HIV transmission from mother-to-child by 50% by 2012
7 The other 2 areas of focus of the strategy are – 1. Increasing access to institutional deliveries and emergency obstetric care and 2. Increasing access to antenatal care attendance.
8 These components include Safe Motherhood; Family Planning; Adolescent Health; Prevention and Management of Adolescent Ill-Health; Prevention and management of unsafe abortion; RH tract infections including STI/HIV/AIDS; infertility; reproductive organ cancers; menopause and andropause; obstetric fistulae; gender issues (gender based violence and female genital mutilation).
priority groups; strategies; eligibility for FP services; the FP service standards; types of FP methods to be made available; and eligibility for FP methods. The document is useful for planners, managers, supervisors, service providers and trainers at all levels.

4.3.6 National Family Planning Advocacy Strategy (2005)

The National Family Planning Advocacy Strategy 2005 – 2010 (MOH 2005) is designed to identify and highlight specific issues that need to be addressed in order to revitalize FP in Uganda. The mission of the National Family Planning Advocacy Strategy is to create an enabling environment that supports improved access to accurate information about FP; improved access to high quality FP services and the rights of individuals and couples to make informed choices about use of FP methods. The strategy has **6 key issues** which need to be addressed through advocacy efforts to increase access to and use of high quality FP information and services in Uganda. Some of the key concerns addressed by the Strategy include inadequate promotion and support for FP by leaders at all levels (under public leadership and support); inadequate support for IEC/BCC programmes that address male involvement, rumours and misconceptions, the benefits of FP, and information on sources of FP methods and services.

4.3.7 A Communication Strategy to Accelerate Implementation of Reproductive Health in Uganda (2005)

The Reproductive Health Communication Strategy is meant to guide the planning and implementation of advocacy, social mobilization and communication activities essential to changing the behavioral and social factors underlying the high rates of mortality and morbidity. The objective is increased access to and use of quality RH services among people of reproductive age (15-49 years), resulting into increased contraceptive use and reduction in unsafe abortions, maternal and infant mortality and incidence of HIV and STIs. The RH Communication Strategy uses 3 types of communication strategies i.e. advocacy social mobilisation and behavior change.

Under behavior change, the communication strategy aims to improve the attitudes and communication skills of service providers to offer quality FP services and to dispel rumours, myths and misconceptions about modern FP methods; to increase the proportion of men and women with accurate knowledge of FP methods, their benefits and safety to make informed decisions. The behavior change also targets to increase the proportion of women and men who act on their expressed desire for spacing and limiting and their stated intention to use a contraceptive. In addition, it targets to increase the proportion of men and women who understand the link between family size and poverty, and who approve of having smaller, manageable-sized families.

4.4 Summary of key findings

This chapter acknowledges the efforts of the Government of Uganda in developing a comprehensive set of policies, guidelines and strategies that are used by policy makers,
implementing partners, donors, communities and individuals to reduce fertility levels in the country. The National Population Policy 2008 has provisions in line with the PEAP and the Cairo ICDP Program of Action Plan. The policies are also cross-cutting – for example, FP is also a poverty issue addressed by the Economic planners in MoFEP; is a health issue and pointed out in the HSSP; an education issue and therefore of concern to education planners; is a requirement for people living with HIV/AIDS – hence mentioned in the NSP.

Some of the recurrent themes include – the need for child spacing; male involvement in RH; reducing the unmet need for FP a leading cause of unwanted or mistimed pregnancies especially amongst adolescents. The NSP specifically recognizes the link between sexual intercourse and HIV infection and therefore the need to make FP services an integral component of services available at HIV/AIDS care and treatment service points. For the planners of the new FP campaign, the policy frameworks and guidelines provide a useful reference point to enrich the campaign and help to reduce the high and unsustainable fertility rates experienced by Uganda.
Chapter 5  Overview of Family Planning in Uganda

5.1 Introduction

This chapter gives an overview of FP in Uganda. It gives the MOH definition of FP and its merits. It gives the legal basis of FP which is based on the National Population Policy and which is also in line with the 1994 ICDP Programme of Action. The chapter also outlines the essential elements that must be in place for delivery of quality FP services; the types of FP methods available in Uganda, the current uptake of FP in Uganda, the current use of contraceptives (the CPR) as well as the trends in contraceptive use. The chapter capped with an outline of factors that limit FP in Uganda.

5.2 Definition of FP

Family planning is the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods. Birth spacing promotes the health of the mother, children and the father (MOH .2006). Reproductive health is the right of men and women to be informed and have access to safe, effective affordable and acceptable method of FP of their choice. FP offers individuals and couples the ability to anticipate and attain the desired number of children through spacing and timing of their births. One of the guiding principles in the National Population policy states that:

‘Recognition that all couples and individuals have the basic right to decide freely and responsibly the number and the spacing of their children, and to have access to information and education in order to make an informed choice and the means to do so’.

This is also in line with the ICDP Principle 8 which states that reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so (ICDP Plan of Action, 1994).

5.3 Essential elements for quality FP service delivery

According to the Service Provision Assessment Survey (MOH. 2008), the following are essential elements that contribute to appropriate, efficient and continuous use of contraceptives:

- Availability of a variety of contraceptive methods to address client preferences and ensure client suitability of methods
- Counselling and screening of clients for appropriateness of methods
- Client education, using visual aids to increase information retention regarding options, side effects and appropriate use
- Availability of infrastructure and resources necessary for providing quality family planning services, including equipment for client examinations, guidelines and
protocols, trained staff, a service delivery setting that allows client privacy and procedures for preventing infections

- Availability of other health services relevant for FP clients, including education and services for sexually transmitted infections (STIs)
- Programmes for groups with special needs to improve their access to and appropriate utilization of family planning services

5.4 Types of FP methods

The types of FP can be broadly classified as natural and modern (artificial). Modern FP methods include the Hormonal contraception methods (i.e. oral contraceptives, injectables and implants); the Intra-uterine device (IUD); barrier methods (the male and female condom, spermicidal foam and jelly and foaming tablets) and permanent methods (tubal litigation and vasectomy). The natural methods include standard days (Calendar or beads); abstinence; withdrawal; and Lactational Amenorrhoea (LAM). In order to ensure a method mix and to promote informed choice, all FP methods are meant to be available throughout the country. Some methods such as IUD, tubal litigation, vasectomy and implants require authorization for use by a qualified health worker, while other methods such as pills, injectables, condoms and counseling on periodic abstinence can be offered by trained non-skilled personnel (MOH. 2006).

5.5. Availability of FP services in Uganda

Table 7 – Availability of FP services in Uganda

<table>
<thead>
<tr>
<th>Temporary methods</th>
<th>Number of facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background characteristics</td>
<td></td>
</tr>
<tr>
<td>% offering any modern method of FP</td>
<td></td>
</tr>
<tr>
<td>% offering counseling on rhythm method</td>
<td></td>
</tr>
<tr>
<td>% offering any temporary method of FP</td>
<td></td>
</tr>
<tr>
<td>% offering male or female sterilisation</td>
<td></td>
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<tr>
<td>Type of facility</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>19</td>
</tr>
<tr>
<td>HC-IV</td>
<td>27</td>
</tr>
<tr>
<td>HC-III</td>
<td>156</td>
</tr>
<tr>
<td>HC-II</td>
<td>287</td>
</tr>
<tr>
<td>Managing authority</td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>373</td>
</tr>
<tr>
<td>Private</td>
<td>119</td>
</tr>
<tr>
<td>Central</td>
<td>98</td>
</tr>
<tr>
<td>Kampala</td>
<td>9</td>
</tr>
</tbody>
</table>

9 The National Policy Guidelines and Service Standards for sexual and reproductive health and rights (MOH. 2006) outlines the conditions for use of each of the above methods.
As shown in the table above, approximately 80% of Ugandan health facilities offer some temporary modern methods of FP. Practically all HC IVs and 87% of HC IIIs offer these methods compared with about ¾ of hospitals and HC IIs. Government facilities are more likely to offer these methods than private facilities. The most commonly offered methods in Ugandan health facilities are combined oral contraceptives (93% of facilities offering any FP), progestin-only injectables (96%); and male condoms (93%).

5.6     Uptake of FP in Uganda

An indication of the uptake levels for FP methods in Uganda is highlighted in the UDHS (2006). All women who had ever heard of a method of family planning were asked whether they had ever used that method. Men were only asked about ever use of male methods, i.e., male sterilization, male condom, rhythm method, and withdrawal. The results show that just over half (52 percent) of currently married women have ever used a contraceptive method, 42 percent have used a modern method, and 21 percent have used a traditional method. The methods most commonly ever used by married women are injectables (27 percent), male condoms (16 percent), pills (14 percent), and rhythm (13 percent). Ever use of other methods does not exceed 10 percent. Ever use of any method is highest among sexually active unmarried women, 75 percent of whom have used a method at some time. Sexually active unmarried women are much more likely (55 percent) to have used male condoms than either all women (18 percent) or currently married women (16 percent).

Among married men, about two-thirds (68 percent) have ever used one of the four male-oriented methods. Just under half of married men age 15-49 have used male condoms (45 percent). An even higher proportion (46 percent) says they have used the rhythm method. Almost one-quarter of married men have used withdrawal. These figures are substantially higher than the proportion of married women who report having used these methods. In addition, only a tiny fraction of Ugandan men have been sterilized. The proportion of married women who have ever used any method has increased over time. By far the largest increase is ever use of injectables, which almost doubled from between 2000-01 and 2006. Ever use of male condoms by currently married women increased by 50 percent during the period between the surveys.
5.7 Current use of contraceptive methods – the Contraceptive Prevalence Rate

The contraceptive prevalence rate CPR is defined as the percentage of currently married women age 15-49 who are using any method of family planning. According to the UDHS (2006) this is only 24%. Eighteen percent of married women are using modern methods, while 6 percent use a traditional method. Current contraceptive use is higher among sexually active unmarried women (54 percent) than among married women (24 percent) and in turn, among all women (20 percent).

By far the most commonly used method among married women is injectables, which are used by 10 percent of women. The next most commonly used methods are pills (3 percent) and rhythm method (3 percent). Female sterilization, withdrawal, and male condoms are each being used by 2 percent of married women. The mix of methods is very different among sexually active unmarried women, for whom male condom is by far the most commonly used method (27 percent), followed by injectables (13 percent). Use of any contraceptive method generally rises with age, from 11 percent among married women age 15-19, to a peak of 29 percent at age 40-44, and then declines to 23 percent among women age 45-49. The most popular methods among the youngest women are injectables and male condoms. Women in their 20s and early 30s tend to use injectables, followed by the pill, while older women are increasingly likely to be sterilized.

5.8 Trends in contraceptive use

UDHS 2006 also reveals that contraceptive use has increased since 1995; from 15 to 24% of married women. The overall contraceptive prevalence rate has increased more rapidly over the past five years than in the late 1990s. However, use of modern methods has slowed somewhat, while use of traditional methods declined between 1995 and 2000-01 and then increased. There has been a sizeable increase in use of injectables over the past ten years, from 3 percent to 11 percent of married women. Changes in use of other modern methods are minor.

5.9 Factors limiting FP access in Uganda

Family planning remains limited by cultural factors, illiteracy and distance from government health units (MFPED, 2004). Male involvement in utilizing FP services is generally low; accompanied by negative attitude towards allowing their partners to access such services. One of the reasons given for this is that men often see children as a source of wealth (UPPAP, 2002). However people with many children are unable to save and find it prohibitive to provide adequate nutrition and health care for every member of the HH. High fertility has particularly negative impact of maternal health, thus influencing a mother’s ability to adequately care for her children during both ante- and post-natal phases (MFPED, 2004). MOH 2004 summarizes the key factors as follows:

- Shortage of skilled staff to provide FP
- Family planning is rarely at the top of a community’s list of priority issues given economic realities and educational levels
- Women, their partners, and other family members often have misconceptions about the safety and efficacy of modern methods
- Those who decide to use family planning often find services difficult to access
- Health centers are few and far between, and health professionals are overstretched and often unable to focus adequate effort on family planning;
- Logistical systems are underdeveloped, leading to frequent contraceptive shortages, and the private sector often has no incentive to invest in the provision of contraceptives

5.10 Summary of emerging issues

This chapter gives an overview of FP in Uganda whose guiding principles are in line with the NPP and the ICDP Programme of Action. The overview includes a definition of FP, definition of types of FP, and the right of individuals to be informed and make informed and voluntary decisions about the wide range of services. The implication for the new FP campaign is to focus on the right to information to ensure that couples can make the right decisions on both family size and the FP method of their choice.

The chapter also gives the FP service availability by type of facility; by managing authority (government/private); and geographical coverage (by region). The new FP campaign should publicise information regarding service delivery points as well as the types of services offered. The campaign should emphasize the importance of making use of HC IVs and HCIIIs since these are more likely to offer the temporary FP methods. For clients seeking permanent methods (sterilisation), the campaign should emphasize private facilities and higher level institutions HCIV and hospitals.

Regarding uptake of FP, the new campaign should consider several targets, for example the 40% of currently married women who have never used any FP method. It should target the sexually active married women who seem to be averse to use of male condoms (possibly owing to misconceptions about them). The uptake for FP seems to suggest that married men are more positive in the use of FP methods and hence the campaign to bring on board more men could be more successful. On CPR, the FP campaign should target raising this figure from the critically low level of 24% to 48% (HSSP II targets). It should also target married women who are at a mere 24% and all women (at 20%). The differences in the method mix between married women (10% injectables and 3% pills) and the sexually active unmarried women (27% male condoms and 13% injectables) could be an indicator that the latter are more willing to use male-oriented FP methods; while the former prefer to use female-oriented methods which are under their control and can be used in secrecy. The FP campaign to increase CPR should also be segmented by age – since CPR seems to vary with age; i.e. it is lowest amongst young women (11%) and rises by age category.

Research area: A possible area of inquiry that this study notes, is on drugs shops and pharmacies as source of contraceptives; an area which largely seems undocumented. This is not withstanding that these are major distribution points which are easily accessible by individuals seeking the commonest FP methods (male condoms and pills).
6.1 Introduction

A key area of concern for this paper is the level of information available or the gaps on FP; and the general attitudes on FP which may either be positive or negative. One section deals with knowledge on types of contraceptive methods by various population categories; and awareness of the fertility period when a woman may conceive. The latter point is important for those couples who rely on the rhythm method. It also highlights knowledge levels of FP amongst service providers which is important in terms of quality and range of FP services that are available. The section on attitudes gives an anecdotal summary of common and underlying reasons that keep people endeared to large families. Importantly, the section dwells on attitudes by political leaders which appear to contradict the current government policies. Beliefs on FP are also highlighted as those common certainties held in people’s minds that contribute to the pool of misconceptions related to FP. Highlighting the areas of low knowledge, negative attitudes and beliefs around FP helps to design strategies of reducing or completely eliminating them.

6.2.1 Knowledge on contraceptive methods

Knowledge refers to ways of understanding; or information available about a subject; or skills which have been gained by experience or through study; and are either in a person’s mind or possessed by people in general\(^\text{10}\). Availability of accurate knowledge about RH issues is key factor in promoting access to quality RH services. According to MOH (2005), lack of accurate information on RH and services results in widespread myths, rumours and misconceptions that discourage women and men from using RH services, particularly FP. Individuals who have adequate information about the available methods of contraception are better able to develop a rational approach to planning their families (UDHS, 2005). Hence it is important to provide wide access to accurate information on RH services and in particular, the benefits of seeking qualified assistance.

The 2006 UDHS assesses the level of knowledge of contraceptive methods among Ugandan women and men. According to this report, knowledge of family planning is nearly universal; with 97 percent of all women and 98 percent of all men age 15-49 having heard of at least one method of family planning\(^\text{11}\). Moreover, knowledge is widespread, with over 90 percent of women in all age groups, regions, and education levels having heard of at least one method; the only exceptions are women in the North (87 percent) and those in Karamoja, only half of whom say that they know any method. These results are also in line with the HCP and YEAH survey results which had 95% for male and 93% for females who knew a modern FP method (HCP, 2008).

\(^{10}\) Definition adapted from The Cambridge International Dictionary of English, 1995 Edition
\(^{11}\) The respondents were all women age 15-49 and men age 15-49, as well as among those who are currently married and those who are not married but sexually active.
In addition, modern methods are more widely known than traditional methods. For example, 96 percent of women have heard of at least one modern method, while only 70 percent know of a traditional method. Among all women, the male condom, pills, and injectables are the most widely known methods of family planning, with at least 90 percent of all women saying they had heard of these methods. The least widely known methods are LAM and emergency contraception. Over half of all women have heard of implants, female condom, and the rhythm method, while about four in ten know about male sterilization, IUD, and withdrawal. Contraceptive knowledge is higher among currently married women and sexually active, unmarried women than among all women. This is also true for each method (UDHS.2006). For HCP (2008) survey, the pill was most widely known (males 73% and females 86%); followed by injectables (males 72% and females 86%) and the male condom (males 72% and females 52%).

The mean number of methods recognized by all women is 6.8, compared with 7.2 among married women and 8.1 among sexually active, unmarried women. The gap in knowledge between women who are married and those who are unmarried and sexually active is most apparent for the IUD, female condoms, and withdrawal. Knowledge of at least one method is slightly higher among men than women. Men are generally more likely than women to know about male sterilization, male and female condoms, LAM, rhythm, and withdrawal, while women are more likely to know about such female-oriented methods as female sterilization, the pill, IUD, injectables and implants.

6.2.2 Trends in knowledge of FP methods

Trends in contraceptive knowledge since the 2000-01 UDHS are mixed. Overall, there is no change in the proportion of women and men who have heard of at least one method or one modern method. In 2006, 96.6% of the respondents had at least known one FP method. Knowledge of any modern methods stood at 96.2% in 2006 from 76.5% in 1988-89. For any traditional method, there was improvement from 58.6% in 1988-89 to 70.3% in 2006. However, the level of knowledge of several methods has increased slightly since 2000-01. For example, knowledge of implants has increased, as has knowledge of male sterilization among women. On the other hand, knowledge of the IUD and female condom has declined since 2000-01. The proportion of both women and men who say they have heard of LAM has declined significantly.

6.2.3 Knowledge of the fertile period

Successful use of the rhythm method depends in part on an understanding of when, during the ovulatory cycle, a woman is most likely to conceive. Among all women, less than one in five (16 percent) understand that a woman is most likely to conceive halfway between her

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12 This is probably because of the decision not to describe the method in the 2006 UDHS, since previous analysis had shown that respondents confused LAM with simple breastfeeding and thus over-reported use of the method.

13 In the 2006 UDHS, women were asked, “From one menstrual period to the next, are there certain days when a woman is more likely to get pregnant if she has sexual relations?” If the answer was “yes,” they were further asked whether that time was just before her period begins, during her period, right after her period has ended, or halfway between two periods.
menstrual periods. There has been no notable change in this indicator since the 2000-2001 UDHS. Almost one-half wrongly believe that the fertile period is right after a woman’s period has ended, while one-fifth of women say they do not know when the fertile period falls, and 10 percent believe that there is no specific fertile time. Users of the rhythm method are almost twice as likely as nonusers to know that the fertile time in a woman’s menstrual cycle is halfway between periods (31 percent vs. 16 percent). There has been little change since 2000-01 in knowledge of the menstrual cycle, although there has been a decline in the proportion saying they do not know when the most fertile time occurs and an increase in the proportion saying that it occurs just after the period has ended.

6.2.4 Knowledge and skills of FP amongst service providers

In the study by Mugisha et al (2007), service providers’ responses reflect lack of knowledge of the latest medical eligibility criteria and practice recommendations. This lack of training and skills limits methods they could offer. According to the report, many family planning clinics did not stock implants and intrauterine devices because they lacked trained providers who could insert them. Hence some providers were known to put conditions such as – a client must be menstruating before starting a contraceptive method. As noted by respondent in this study, this practice could result in unintended pregnancies. “To me, some providers believe that once a client is not in her menses they should go back [home without contraceptives].” (Manager) “[The client] said that ‘last time I went to the health facility for family planning and they told me to come back when I am in my menses, by the time I went back I was already pregnant!’” (Manager). The report raises concern that such providers could also administer an FP method to a pregnant woman.

6.3.1 Attitudes related to Family Planning

Attitude refers to feelings or opinions about something or someone; or a way of behaviour that follows from these feelings or opinions. The State of Uganda Population report quotes a number of authorities such as NCC, 1994, Ntozi, 2001, NCC, 1994, KIT, 2007; NCC 1994, MGLSD 2007; and Ejolu and Rehmer, 2006) all which highlight prevailing attitudes at community level related to family planning. These include:

- The main purpose of marriage is to have children. Women (and men) who are not able to bear children are hence ridiculed. Childbearing outside marriage, polygamy or arrangements where a woman can get a child from another man (if there are problems with the spouse) is preferred to not bearing children.
- Individuals are urged to bear children irrespective of their physical, economic or social conditions.
- Children are still viewed as a way of perpetuating lineage, form of status, recognition and a form of social security in old age.
- Traditionally, a woman’s role is strongly linked with fertility and motherhood and her status is largely measured by her capacity to reproduce, hence the pressure to have more children. Women many of who have limited rights awareness largely agree with the belief
• Parents hold the view that they can to some degree pass on the costs of raising children to others (e.g. their own older children or within the larger HH) and thus have impetus to give birth to more children than optimal

• Families in Uganda still highly value producing several sons, who would continue the lineage of the family. Hence, the search for sons makes many couples, including the highly educated ones end up with larger families than initially desired.

According to MFPED (2004), children are viewed as investment goods. Parents aim for a certain number of surviving children to ensure support during their old age. Given the high prevailing infant and child mortality, they plan to have large numbers of children to achieve their reproductive goal with a high degree of certainty. However in most cases many parents find themselves with more surviving children than anticipated

6.3.2 Attitude of the political leaders

Although FP is an official government policy, and is supported by both government and donor resources, there appears to be lack of a national consensus on FP. As a consequence, many contradictory arguments emerge from political and religious leaders about the role of FP in socio-economic development and improved maternal and child health (UNFPA, 2008). Political commitment to FP in Uganda has not yet fully merged with its written declarations. The country’s political leadership encourages large families to spur economic growth, which makes full implementation of FP policies challenging for national leaders and Ministry of Health staff (ACQUIRE Project, 2008). Burunde in MOFEPD, UNFPA (2009) also notes that statements and comments from leaders still reflect inadequate or lack of support for and commitment to address population issues. As an example, the Ugandan President, Mr. Yoweri Museveni openly advocates large populations arguing that a large population is good for a country. That,

"it is the best wealth a nation can have. As the population grows, more investment needs to be directed towards ensuring that the population is educated, skilled, healthy and in employment. By doing so, the people would get sufficient incomes from their employment. They would hence be in position to save and also provide a large market for Ugandan products".

The Ugandan First Lady, Mrs. Janet Museveni also has equally strong views on the use of the condom. In an article by the Washington Post (December 13, 2007), the First Lady while addressing students at the Uganda Christian University, Mukono is quoted to have said that:

"I would not be caught advising you to take any shortcuts or compromise your lives by using any device invented by man, such as condoms, in order to facilitate any desire to go against God’s clear plan for your life," "God’s plan for your life is that you should honour your body because it is His temple."

The BBC web page posted on 11th March 2009, quotes Planning Minister Ephraim Kamuntu entitled Uganda’s population explosion is being fuelled by electricity shortages - that ‘while the rest of the world is working in shifts, we in Uganda are going to bed early since more than 90% of Ugandans are without reliable access to electricity, without light or TV for entertainment. Couples hence go to
‘bed early and have sex, spending up to 12 hours a day in darkness’ (BBC website accessed 27th July 2009).

According to the Ministry of Health (2005), such messages send mixed signals to the population and affect perceptions related to family planning. The messages advocating large families do not necessarily apply to Uganda since over 70% of the total population is not in productive employment, they cannot meaningfully contribute to national development, hence are largely a burden to the economy. Hence a lot needs to be done to make Ugandans, including leaders and decision-makers to understand the implications of a rapidly growing population. They also need to embrace the approaches required to address these issues with policies, programmes, strategies and appropriate resources (MFEPD, UNFPA, 2009).

6.4 Beliefs associated with family planning in Uganda

Beliefs are a feeling of certainty among individuals that, something exists or is true. Mugisha and Reynolds (2008) quote some beliefs and misconceptions commonly held by clients which are used to frustrate efforts to expand FP services. These include associating contraceptives with infertility; loss of manhood (in the case of vasectomy); loss of libido and disability; menstrual blood accumulating in the body and developing fibroids.

Other beliefs as highlighted in the IPPF study (2008) include:

- Contraception is a women’s business
- That women using contraception promiscuous
- Disbelief that male condom can prevent pregnancy
- That condom reduces sexual pleasure
- Male sterilization affects sex pleasure
- When women request their partners to use condoms, the women are often viewed as promiscuous; while men perceive that the women think they are “dirty” (from MIHV key informant interview)
- Women do not like to use foam or cervical caps as they are unaccustomed to inserting things inside themselves (tampon use is nonexistent) MIHV.2004.

For the IUD common fears held by clients (ACQUIRE Project. 2008) include:

- It may disappear into the body
- Women cannot work hard with the IUD
- It can hurt or bother the husband during sex
- It causes prolonged bleeding.

A mid-wife in Hoima is quoted as follows: ‘Many women still have a low opinion about the IUD, despite counseling. Though we explain to them the procedure of insertion, [clients] still have misconceptions about having their private parts being viewed by health workers. Others fear for the IUD being put inside the uterus for a long period would lead to other diseases such as cancer of the uterus. Another common fear was that during sex, the man can easily feel it [the IUD]’. (ACQUIRE Project. 2008).
6.5 Dispelling misconceptions related to Family planning

The Community Based Approaches to promote family planning among men promoted by HCP and its partners (PLAN Uganda) were meant to in part to address lack of information and misconceptions about FP. According to HCP (2008), the CBAs were useful in clarifying what FP is; the various planning methods; to dispel myths and misconceptions about FP; and to provide information about permanent forms of contraception. One respondent is quoted to have said – “we learnt a lot; like how to use condoms and other methods of FP. We were also told about the advantages and disadvantages of each method. I felt this information was useful and I have started applying what I learnt in my own home’. The CBAs were also effective in providing information and influencing men’s views regarding family size and respondents indicated they had scaled down their views on the appropriate size of their family.

6.6 Summary of findings

This chapter dwells on the knowledge, attitudes and beliefs on FP in Uganda as these have serious consequences on the effectiveness on the FP campaign in Uganda mainly attributed to myths and misconceptions about FP. The existing data shows the almost universal level of knowledge of FP in Uganda with the exception of Northern Uganda and Karamoja which have significantly lower knowledge levels. The major knowledge gaps in the FP methods for women is for the IUD, the female condom and the withdraw method. Hence the new FP campaign should consider increasing the knowledge levels of these methods that are relatively unknown. It should also consider segmentation of messages by geographical region to prioritize Northern Uganda and Karamoja which also have relatively high fertility rates than other parts of Uganda.

The data available also reveals gender differences in knowledge of types of FP methods. The campaign should target the reduction in the gender disparities in knowledge levels – hence men need to be informed of female oriented FP methods and vice versa. The biggest challenge however, is that while knowledge is high, this is not translated into equivalent levels of uptake of FP services. Hence the FP campaign should be designed to change this anomaly to ensure that knowledge levels are equivalent to levels of application of FP services.

An interesting point in this chapter is on the knowledge levels of fertile period of women which stands at a mere 16%, implying that the majority of women does not have accurate information on their fertile period. Hence couples who rely on the rhythm method most probably get it wrong, thereby contributing to unwanted pregnancies. The campaign to educate couples on the fertile period is critical for certain population groups that discourage modern methods of FP, e.g. the Catholic Church or the Muslim religion who largely discourage believers from use of condoms and pills. There is also need to make use of these very religious leaders to champion acceptable FP methods (such as the rhythm method) amongst their congregations. They should hence be equipped with accurate knowledge on
use of the rhythm method in order to pass on the information to their congregations. The
data also reveals that service providers do not necessarily have accurate knowledge on the
latest methods and trends in FP approaches. Hence the campaign needs to direct attention
to this category to ensure that they have accurate information that enables them to provide
quality FP services.

This literature also highlights prevailing attitudes and beliefs held by the population that
hinder use of FP methods propelling couples towards large families. The FP campaign
messages should be developed to deal with each of the prevailing attitudes and beliefs in
order to turn them into positive attributes for FP. For political leaders, the data highlights
the conflicting roles of sections of the political leadership in Uganda who openly advocate
large families in contradiction of the policies. The FP campaign should formulate specific
messages that that target top leadership in the country. Since political leaders are also
charged with the task of reducing poverty and ensuring equitable development, the FP
messages should be largely derived from Chapter 4 above which dwells on various aspects of
population growth and implications for poverty reduction. The campaign should also be
aimed at recruiting those very political leaders who advocate large families to spearhead the
FP campaign rather than undermining it. Finally, it is important to develop strategic
partnerships with the media to ensure that accurate and timely information on FP is available
to promote FP and reduce overall fertility in Uganda.
Chapter 7  The Unmet Need for Family Planning in Uganda

7.1  Introduction

Unmet need for family planning (FP) is a key concern of this study. This chapter gives definition of the concept of unmet need, especially the level experienced by different population categories and by geographical location. The chapter also cites reasons for the unmet need as compiled from respondents in the DHS. It also makes a link between the unmet need and unintended pregnancies and incidences of induced abortion which are serious maternal health challenges in Uganda. It recognizes unmet need for FP as another indicator added to Goal No. 5 of the MDGs. This chapter clearly explains why unmet need for FP contributes to a high population, thereby increasing the total cost of extending social services to them, hence increasing costs of meeting the MDGs. The argument is made of how reducing the cost of meeting the MDGs can be achieved through addressing the unmet need for FP.

7.2.1  Definition of unmet need for FP

Unmet need for family planning (FP) is defined as a woman who is productive, sexually active, not using any contraceptive methods, and does not want a child for at least two years (spacers); or does not want more children at all (limiters) USAID. (2006). In 1960, the number of women in developing countries using a method of family planning was just 10% but this has increased to 63%. Despite this dramatic increase, about one in six married women still has an unmet need for family planning; that is, she wants to postpone her next pregnancy or stop having children altogether but, for whatever reason, is not using contraception (UNFPA, PATH, 2008). As a consequence of unmet need for FP, 76 million women in developing countries still experience unintended pregnancies each year, and 19 million resort to unsafe abortions.

For Uganda, the UDHS 2006 reveals that overall, 41 percent of currently married women have an unmet need for family planning services, 25 percent for spacing, and 16 percent for limiting14. In the 2000-2001 UDHS unmet need was found to be slightly lower: 35 percent for total unmet need, 21% for spacing, and 14 percent for limiting. About one-quarter (24 percent) of married women are using contraceptive methods, which constitutes the met need. The total demand for family planning is estimated at 64 percent, and the demand satisfied is 37 percent. The percentage of demand for family planning that is satisfied has decreased slightly from 40 percent in the 2000-2001 UDHS.

7.2.2  Characteristics of the unmet need for FP in Uganda

UDHS results for 2006 show that the level of unmet need was highest among currently married women (41%) and lowest among never married women (2%). The level of unmet

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14 Of the countries with a Demographic and Health survey (DHS), Uganda has the highest level of unmet need for FP among currently married women (Macro International Inc. 2008)
need has increased steadily over time among all groups of women, except never married women and formerly married women. The increase was sharpest among currently married women, from 29% in 1995 to 41% in 2006. Overall women in Uganda have a greater unmet need for spacing than limiting, though the demand for both has increased among all women between 1995 and 2006. Comparison of urban and rural areas reveals that rural areas have much higher levels of total unmet need, unmet need for spacing and unmet need for limiting. The rural-urban difference for unmet need in 2006 was 16%, having increased from 2% in 1995.

Geographically, the Northern Region has the highest level of total unmet need in the country (46%); whereas Central region has the lowest (31%). Similarly unmet need for spacing is highest in Northern region (31%) and lowest in Central region (20%). Unmet need for limiting is highest in Eastern Uganda (19%) and lowest in Central region (13%). The current use for any method is highest in Central region (38%) whereas Northern region has the lowest contraceptive use (12%). The Central region has the highest level of total demand satisfied (54%), followed by the Western region (38%), Eastern (32%) and Northern Region (20%).

7.2.3 Reasons for unmet FP need

There are several reasons as to why few women in Uganda who want to delay or avoid a future birth are not using contraception. The most frequently cited reason for not currently using a method is the fear of side effects (29%), followed by the woman who is breastfeeding (20%); or the woman who is having infrequent or no sex (14%). A number of women also said that they were not using a method because their husband or partner was opposed to the use of a method. The study notes that more than one in three currently married women who have an unmet need and do not intend to use a method in future mentioned fear of side effects as the main reason for not intending to use a contraception while 13% said they would not use a contraception in future because they had infrequent or no sex and 12% reported that they were sub fecund or infecund.

7.2.4 Unintended pregnancy, induced abortion and high unmet need

Under Ugandan law, induced abortion is permitted only when pregnancy endangers a woman’s life. Legal abortions are very rare owing to the demanding legal process involved in obtaining approval. Findings reveal that in 2003, 85,000 women received care for abortion complications arising out of induced abortion. However there is an estimated 2.5 women who either had abortions free of complications; had complicated or incomplete abortions for which they receive care; or received care outside the formal health care system. The actual number of women who had abortions in Uganda is estimated to be 297,000 which translates into an annual rate of 54 abortions for every 1,000 Ugandan women aged 15-49; or approximately one for every 19 women in this age group (Singh et al). The estimated abortion rate varies in different parts of Uganda – it is highest (70 per 1,000) in Northern Uganda, the region with the highest proportion of women living in poverty and the lowest level of modern contraceptive use (6%) and the smallest proportion of women with seven or more years of schooling.
Since abortion is largely covert, it is often unsafe and can entail serious physical risk for women. According to WHO unsafe abortions are characterized by the provider’s inadequate skills, unsanitary facilities and use of hazardous techniques. Health risks at the time of abortion include infection, hemorrhage, septic shock and abdominal injury. In the long run, chronic problems such as pelvic infection, ectopic pregnancy and infertility can occur. Unintended pregnancy is the primary immediate reason that women throughout the world obtain abortions. The estimated number of pregnancies ending in abortion and the high proportion of pregnancies that are unintended are consistent with the high level of unmet need for contraceptive services in Uganda. Where more women use modern FP to space and limit pregnancies, the number of unintended pregnancies will fall. This in turn will reduce the number of abortions and the number of unintended births (USAID, 2006). Meeting the current unmet need for FP can help countries achieve many of the MDGs by reducing the number of people needing certain services, such as child immunizations and primary schooling.

### 7.3.1 The Millennium Development Goals (MDGs) and the unmet need for FP

The MDGs are a set of 8 time bound goals that were agreed upon by many countries following the United Nations Millennium Summit in September 2000\(^\text{15}\). However meeting the MDGs presents a major challenge since many countries have a long way to go to meet them and the necessary resources are not readily available. Developing countries in SSA face a long term demographic challenge arising out of high population growth rates which threaten to reverse many of the development achievements being made. There is increasing recognition that meeting the unmet need for FP could lower the cost of meeting the MDGs.

In 2006, unmet need for family planning was subsequently added to the fifth Millennium Development Goal (MDG) as an indicator (indicator 5.6) for tracking progress on improving maternal health (UNFPA, PATH. 2008).

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| MDG 1: | Family planning alleviates poverty and accelerates socioeconomic development. With fewer, healthier children to provide for, families are less likely to become poor. They are also better able to feed and provide health care for their children, which create a healthier and more productive workforce that can contribute to the economic growth of the nation as a whole. On the national level, rapid population growth resulting from high levels of unmet need often outstrips economic growth and undermines a country’s ability to offer adequate educational, health, and other social services to its people. |
| MDG 2: | Family planning can help ensure that all children go to school. Families are more likely to be able to educate their children if they have smaller families. For example; some girls are forced to drop out of school early to care for younger siblings. Girls and young women may also be forced to leave school early if they get pregnant. |
| MDG 3: | Family planning promotes gender equality. Women have greater opportunities for education, training, and employment when they can control their fertility. This can increase their financial security, decision-making power in the household, and status in the community. Because so much of women’s work consists of unpaid household labor and poorly paid work in the informal economy, their increased productivity may go unnoticed and unmeasured. Yet it is still of enormous importance for moving families out of poverty. |
| MDG 4: | Family planning can reduce infant mortality by one-fifth to one-third or even more in some settings. Spacing births 36 to 60 months apart reduces malnutrition as well as neonatal and infant mortality. |
| MDG 5: | Family planning reduces maternal mortality in three ways. It decreases the total number of pregnancies, each of which places a woman at risk. It prevents pregnancies that are unwanted and hence more likely to end in unsafe abortions, which contribute to one in eight maternal deaths. Finally, it reduces the proportion of births that are at greater risk of complications because of the mother’s age, parity, or birth spacing. |
| MDG 6: | Family planning can slow the spread of HIV/AIDS. Condoms simultaneously prevent HIV transmission and unwanted pregnancy. Contraceptives also enable HIV-positive women to prevent unwanted pregnancies. This is as cost-effective as antiretroviral drugs in reducing mother-to-child transmission of HIV. |

Source UNFPA, PATH. 2008

### 7.3.2 Reducing the MDG costs through addressing the unmet need for FP

A multi-country study (Health Policy Initiative. 2009) looks at how one strategy—meeting the need for family planning—can reduce population growth and make achieving the MDGs more affordable in Uganda; and also directly contribute to 5 selected MDG goals namely:

- Achieve universal primary education
- Reduce child mortality
- Improve maternal health
- Ensure environmental sustainability
- Combat HIV/AIDS, malaria, and other diseases

The study estimates the extent of the cost-saving for the 5 MDGs goals above. Costs are calculated under two scenarios: when unmet need for family planning remains constant and
when all unmet need is gradually met by 2015. The total cost of FP is calculated under both scenarios, and the cost of maintaining FP at current levels is compared with the cost of meeting all unmet need for each country. For Uganda the total investment in FP required for the period is $97.4m. Although it may take Uganda longer than 10 years to satisfy all unmet need the analysis reveals that reducing the unmet need for FP services can help Uganda significantly reduce the costs of meeting the five selected MDGs.

For example, the cost of achieving the MDG for universal primary education is influenced by the number of children needing education. Fulfilling unmet need for family planning would result in fewer children requiring education and as a result, there would be lower costs for universal primary education. The analysis shows that cumulative cost savings to the education sector from satisfying unmet need of $157.8 million would be saved by 2015. Because the effects of family planning are not immediate, long-term benefits would be even larger if the timeline were extended past 2015. Similar methodology was applied to other sectors working to meet the MDGs, revealing cost savings in meeting the immunization ($52m), water and sanitation (59m), maternal health ($126m), and malaria ($13m) targets, hence total saving of $408M by 2015.

7.4 Strategies to address the unmet need for FP in Uganda

To reduce the unmet need for family planning, a number of strategies are stipulated in the NPP. These include – advocate for affordability, availability and accessibility of FP; promote provision of FP information and increased utilization of FP; and promote RH commodity security. MOH aims to translate the high unmet demand for FP into uptake of services by increasing the coverage of FP services. This will be achieved by:

- Increasing the number of health facilities that provide a full range of FP methods
- Ensuring that FP is incorporated into integrated outreaches.

According to the strategy, efforts are supposed to be made to ensure that contraceptive stock outs are minimized and a critical mass of service providers are trained to provide long and short term methods. In addition, sustained IEC should be carried out on the benefits of spacing/delaying births and encouraging male involvement in FP. Partnership with the private sector, including NGOs should be strengthened to improve service delivery as well as demand for FP services.

7.5 Summary of key findings

This chapter has addressed concerns related to the unmet need for FP and its effects on fertility in Uganda. The chapter starts by giving a definition of the concept of unmet need as well as the level in Uganda (41%) which is also one of the highest in the region (UDHS.2006). This figure is composed of 21% unmet need for spacing and 14% for limiting of child births. The report reveals that while the level of unmet need has increased sharply amongst all women in Uganda, it is highest among currently married women (41%); and also higher in rural areas as compared to urban areas. Geographically, the North has the highest unmet need (of 46%) while Central has the lowest (31%). Hence the new FP campaign has to reduce unmet need has to select priority targets – i.e. currently married women; women in rural areas; and women in Northern Uganda.
In addition the new FP campaign has to focus on allaying fears of side effects of contraception since this is the most frequently cited reason (29%) by those women who have unmet need. It should also consider targeting the large proportion of those who do not intend to use a method of FP in future who also cite fear of side effects. In addition the campaign should also consider developing messages for spouses who are opposed to the use of FP methods.

This chapter also contains a section that addresses unintended pregnancies and induced abortions which are a consequence of high unmet need. The existing data on induced abortion paints a grim picture of a large number of women who had abortions estimated at 54 abortions for every 1,000 Ugandan women (15-49 years) or 1 for every 10 women. Moreover the region with the highest abortion rate of 70 per 1,000 is Northern Uganda which is also the region with the highest proportion of women living in poverty.

The new FP campaign should hence link the high level of unmet need with the high level of unintended pregnancies which in turn leads to high rates of induced abortion. The focus of the campaign should be on working in earnest to reduce the level of unmet need for contraceptive services in Uganda. The key message should be that were more women to use modern FP to space children and limit pregnancies, the number of unintended pregnancies would fall and therefore reduce the number of induced abortions. The FP campaign should also clearly highlight the health risks associated with induced abortion which range from infection, haemorrhage, infertility or even maternal mortality. This could help in reduction of incidences of induced abortion in Uganda.

The FP campaign should also make a case for unmet need and the Millennium Development Goals. A positive note for the campaign is that unmet need for FP is now included as an indicator for tracking progress on improving maternal health (MDG no. 5). The new FP campaign should capitalize on messages that - reduction of unmet need would result in reduction the number of people in need of certain services in education or health. By investing in FP to reduce the unmet need, Uganda would reduce population growth and hence make achieving of the MDGs more affordable. This campaign would specifically be targeted to the government whose mandate is to drive the country towards making the MDGs a reality.

Were more women to use modern FP to space children and limit pregnancies, the number of unintended pregnancies would fall therefore reducing the number of induced abortions? 
Male involvement in family planning is another key concern of this literature review. This chapter notes that FP and reproductive health have generally targeted women, having been initially conceived to alleviate the burden of childbearing on women. Hence throughout history, FP has been regarded as a female preserve. Owing to recognition of the role of men in RH, there is a justification for involving men at wider level; not just as consumers of FP products. The chapter discusses the existing policy frameworks right from the Cairo ICDP which has clear provisions for male involvement; and for Uganda, it is a strategy embedded in all the government of Uganda’s policies related to RH. The study highlights areas that illustrate low male involvement centred on the way couples communicate regarding FP and the levels of knowledge of types of female contraceptives and their application.

Understanding the concept of male involvement in family planning

Population studies and reproductive health for much of history focused almost exclusively on women; and more specifically on their fertility and reproductive lives. Very little information was collected about men. As a result, few reproductive health services programmes reflect the specific needs and perspectives of men (UNFPA 2005). In recent decades, the most common means by which couples regulate fertility have changed from methods requiring control or cooperation by men, e.g., condoms, withdrawal and periodic abstinence, to those for which women bear primary responsibility e.g., virtually all-reversible modern methods. Ringheim (1996). Family planning programmes focused attention primarily on women because of the need to free women from excessive child-bearing; and to reduce maternal and infant mortality through the use of modern methods of contraception. Most FP services were offered within maternal and child health (MCH) centres. In addition, most research and information campaigns focused on women. This focus on women has reinforced the belief that FP is largely a woman’s business, with a man playing a peripheral role (Toure. 1996).

According to Toure (1996), male involvement is more than just increasing the number of men using condoms and having vasectomies. It includes the number of men who encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programmes. In this context, male involvement should be understood in a much broader sense than male contraception; and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family planning practice of either sex.
8.3 Recognition of male involvement in the policy frameworks

At global level, the 1994 Cairo International Conference on Population and Development (ICDP) is clear in its call for countries to promote men’s support in the struggle for gender equality and encourage their involvement and shared responsibility (UNFPA, 2005). The Programme of Action recognizes that ‘men need to take responsibility for their own sexual behaviour as well as respect and support the rights and health of their partners’. It urged that:

"... special efforts should be made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children". (paragraph 4.27)

In Uganda, male involvement in RH has been identified as a key strategy in all the GOU policies and plans to address RH in Uganda. For example, in the NPP, one of the key strategies under promoting positive health seeking behavior is to encourage male involvement in RH; and to promote awareness among men, women and communities on their roles and responsibilities in sexual and reproductive health and rights (MOH, 2008). However some studies have shown that that male involvement in FP is still lacking, or in some cases counterproductive. In this chapter, there are examples that illustrate how couples communicate regarding FP and in level of male knowledge of FP methods used by women.

8.4 Rationale for male involvement in FP

The CSA (2008) study makes a case for male involvement in FP- that there is need to increase better understanding of men’s central roles in determining women’s health. For instance men often dominate reproductive health decisions whereas they (men) generally have little access to information and resources for communication with and supporting their sexual partners. Some barriers to male participation in reproductive health activities are traditional gender roles, fear of losing respect from their peers, lack of communication skills. An understanding of men’s attitudes towards reproductive health as a first step to engaging them in taking action is required.

Generally men do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend labor or birth of their child. The exclusive use of RH services by women has to a great extent made RH services unfriendly for men. Often the commonest male contraceptives – the condoms can easily be obtained from clinics without contact with the service providers. In addition, men often feel embarrassed to obtain services for RTIs and STIs from institutional facilities.
8.5.1 Partner communication regarding women’s contraceptive use

The application of family planning methods is often facilitated when couples discuss and agree on the matter. To assess the extent to which women use contraception without telling their partners, the 2006 UDHS asked married women whether their husbands/partners knew that they were using a method of family planning. The table below shows that the majority of women (81 percent) say their spouses know that they are using contraception. Differences by background characteristics are not large as revealed by the education status of respondents.

Table 9: Knowledge by spouses of partner use of contraceptives

<table>
<thead>
<tr>
<th>Background characteristics</th>
<th>Knows</th>
<th>Does not know</th>
<th>Unsure/missing</th>
<th>Total</th>
<th>No. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 15-19</td>
<td>(87.2)</td>
<td>(6.6)</td>
<td>(6.2)</td>
<td>100.0</td>
<td>43</td>
</tr>
<tr>
<td>20-24</td>
<td>78.3</td>
<td>19.6</td>
<td>2.1</td>
<td>100.0</td>
<td>249</td>
</tr>
<tr>
<td>25-29</td>
<td>81.9</td>
<td>16.7</td>
<td>1.5</td>
<td>100.0</td>
<td>270</td>
</tr>
<tr>
<td>30-34</td>
<td>80.8</td>
<td>18.2</td>
<td>1.0</td>
<td>100.0</td>
<td>270</td>
</tr>
<tr>
<td>35-39</td>
<td>84.1</td>
<td>14.8</td>
<td>1.1</td>
<td>100.0</td>
<td>185</td>
</tr>
<tr>
<td>40-44</td>
<td>84.5</td>
<td>14.2</td>
<td>1.3</td>
<td>100.0</td>
<td>154</td>
</tr>
<tr>
<td>45-49</td>
<td>74.3</td>
<td>20.5</td>
<td>5.2</td>
<td>100.0</td>
<td>93</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>79.1</td>
<td>19.5</td>
<td>1.4</td>
<td>100.0</td>
<td>173</td>
</tr>
<tr>
<td>Primary</td>
<td>79.5</td>
<td>19.0</td>
<td>1.5</td>
<td>100.0</td>
<td>720</td>
</tr>
<tr>
<td>Secondary+</td>
<td>85.6</td>
<td>11.7</td>
<td>2.7</td>
<td>100.0</td>
<td>370</td>
</tr>
<tr>
<td>Total</td>
<td>81.2</td>
<td>16.9</td>
<td>1.9</td>
<td>100.0</td>
<td>1,263</td>
</tr>
</tbody>
</table>

While the UDHS results show high levels of partner communication, a contrasting result is highlighted by Mugisha and Reynolds (2008). Interviews with FP service providers revealed that some women secretly use contraceptive methods without knowledge of their spouses and hence administer contraceptives in a manner that could lead to reduced effectiveness or failure. For instance, some clients unpacked contraceptive pills from their original packs so that they appeared like ordinary pills. Providers feared that by doing so, clients might not comply with the instructions for pill use. Such women when faced with side effects of the contraceptive merely stop the method rather than switching to a method that might be detected by her husband, thereby making informed choice lose its meaning.

Providers also reported of cases of receiving threats from unsupportive husbands. “There have been cases where spouses verbally accuse us that their wives are not producing because we provide them with family planning pills”. (in-depth interview held in Iganga Town). Conversely, some men force their partners to seek family planning services and even dictate which methods they use. This means some clients seek family planning services with their minds
set on a particular method, which also makes informed choice counseling difficult (Mugisha and Reynolds. 2008).

### 8.5.2 Level of discussion of FP methods

The low status of male involvement is also highlighted by the level of discussion between spouses regarding use of family planning methods. To assess the extent to which couples discuss family planning, in the 2006 UDHS, married women, who know about family planning, were asked how often they had talked with their husbands/partners about family planning in the year preceding the survey.

**Table 10: Discussion of family planning with husband**

<table>
<thead>
<tr>
<th>Age</th>
<th>Never</th>
<th>Once or twice</th>
<th>More often</th>
<th>Total</th>
<th>No. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>53.8</td>
<td>32.3</td>
<td>13.9</td>
<td>100.0</td>
<td>374</td>
</tr>
<tr>
<td>20-24</td>
<td>41.9</td>
<td>32.3</td>
<td>25.7</td>
<td>100.0</td>
<td>1,130</td>
</tr>
<tr>
<td>25-29</td>
<td>39.0</td>
<td>34.5</td>
<td>26.2</td>
<td>100.0</td>
<td>1,104</td>
</tr>
<tr>
<td>30-34</td>
<td>37.4</td>
<td>32.3</td>
<td>30.3</td>
<td>100.0</td>
<td>971</td>
</tr>
<tr>
<td>35-39</td>
<td>41.7</td>
<td>25.6</td>
<td>32.6</td>
<td>100.0</td>
<td>709</td>
</tr>
<tr>
<td>40-44</td>
<td>54.2</td>
<td>24.3</td>
<td>21.6</td>
<td>100.0</td>
<td>527</td>
</tr>
<tr>
<td>45-49</td>
<td>69.8</td>
<td>16.1</td>
<td>14.0</td>
<td>100.0</td>
<td>387</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44.6</td>
<td>29.8</td>
<td>25.5</td>
<td>100.0</td>
<td>5,199</td>
</tr>
</tbody>
</table>

The results show that almost half of married women (45 percent) have not discussed family planning with their husbands at any time in the previous year, while 30 percent have discussed it once or twice, and 26 percent have discussed the issue three or more times during the past 12 months. The results also show that younger women as well as women in their 40s are more likely not to have discussed family planning with their husbands than women in the prime childbearing ages. A related result in the HCP (2008) study however shows that people who had been exposed to FP information discussed with their spouses the purpose of their visit to health centres (males 51% and females 59%) and the number of children they wanted to have (males 40% and females 40%). The least discussed issue was the use of FP methods (males 20% and females 13%) which showed that discussion of FP methods remains a challenge amongst men and women, with women less likely to discuss the issue. Another revelation was that men were more likely to discuss FP with other people other than their spouses.
8.5.3 Level of male knowledge on usage of different contraceptive methods

In a study commissioned by International Planned Parenthood Federation (IPPF) on knowledge levels of types of contraceptives, the results show that while most men knew that male condom can be used for only one sexual act, knowledge about FP methods often used by women is below average (Centre for the Study of Adolescents CSA. 2008).

Table 11: Specific knowledge of use of various FP methods

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>No. of respondents</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can Female sterilization be reversed?</td>
<td>Yes</td>
<td>28</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>117</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>103</td>
<td>42%</td>
</tr>
<tr>
<td>Does male sterilization have an effect on sexual performance?</td>
<td>Yes</td>
<td>56</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>96</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>101</td>
<td>40%</td>
</tr>
<tr>
<td>How often does a woman take oral pills?</td>
<td>Every day/weekly</td>
<td>127</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>Other response</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>102</td>
<td>42%</td>
</tr>
<tr>
<td>Where is the IUD placed?</td>
<td>Uterus</td>
<td>69</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>Other responses</td>
<td>22</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>143</td>
<td>61%</td>
</tr>
<tr>
<td>How often do women need to get injectables</td>
<td>Weekly</td>
<td>41</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Monthly/every 3 months</td>
<td>125</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>Once a year</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>74</td>
<td>31%</td>
</tr>
<tr>
<td>How many times can a male condom be used for sex?</td>
<td>Once</td>
<td>206</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>30</td>
<td>12%</td>
</tr>
<tr>
<td>How many times can a female condom be used</td>
<td>Once</td>
<td>90</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td>More than once</td>
<td>23</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>121</td>
<td>30%</td>
</tr>
<tr>
<td>Which days is a woman most likely to get pregnant?</td>
<td>Imm. before MC</td>
<td>25</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Imm. after MC</td>
<td>30</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>After 2-4 days of MC</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>At mid of 2 cycles of MC</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>156</td>
<td>67%</td>
</tr>
<tr>
<td>When should a man withdraw from a sexual act</td>
<td>Before climax</td>
<td>111</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>Other responses</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Do not know</td>
<td>110</td>
<td>46%</td>
</tr>
</tbody>
</table>

Source: Centre for the Study of Adolescents. 2008

8.5.4 Knowledge of signs of labour complications

The CSA 2008 study assessed knowledge levels of labour complications amongst men. A significant proportion (30%) of all the men in the study could not state any sign of complication or danger signs during labor or delivery. About 21% of the men knew one sign, 16% knew 2-3 sign and 30% knew 4 or more signs. Given that men are key decision makers in the family, this is critical especially as it touches on the health of women and children. Regarding knowledge of signs of complications after delivery, 22% of the men in the study
24% knew one sign, 20% knew 2-3 signs and 34% knew at least four signs.

The cases cited above are possible indicators of low involvement of men in issues related to FP. This is in spite of the fact that men play a key role in gender equality; exercise considerable power in decisions ranging from size of family to policy and programme decisions taken at all levels of Government (UNFPA, 1999).

8.6 Conclusion

This chapter focuses on the importance of male involvement in family planning especially since FP and reproductive health have traditionally targeted women. It highlights male involvement as having been recognized as part of the agenda of the ICDP 1994 Programme of Action and in Uganda it is in all GOU policies and plans that address RH. The new FP communication campaign should make this a point of focus to convince men to increase their involvement in FP. Male involvement should be promoted not just as a way of increasing the number of men using condoms or having vasectomies, but also in emphasizing men's shared responsibilities, active involvement in parenthood, sexual and reproductive health behavior. The campaign should endeavour to identify those barriers to male involvement (cultural, religious, economic, gender-based) and directly develop messages to address them.

On partner communication, the report reveals that some women use contraceptives without knowledge of men, with consequences that could reduce the effectiveness of the contraceptives and ultimately affect their health. The data also reveals that there is low level of discussion of FP between spouses (45% did not discuss FP in the previous year). In addition, men have limited knowledge on FP methods often used by women and cannot readily tell signs of labour complications or danger signs during labor or delivery.

The new communication campaign should include a component that targets increasing men’s knowledge about mode of operation and use of female based contraception so as to have increased acceptance of the female methods of FP. Male attitudes towards contraception also need to be changed from the common beliefs that contraception is a woman’s business or leads to promiscuity. The campaign should also promote communication between spouses so as to increase the level of shared commitment to family planning in their respective families.
Chapter 9  Conclusion and recommendations

9.1 Conclusion

This paper covers the current literature on family planning in Uganda and adduces evidence to suggest that there are significant payoffs to reducing fertility levels in Uganda. It has attempted to show that Uganda’s high population growth rate which is one of the highest in the world, is not sustainable. As observed throughout the paper if no action is taken and Uganda’s population continues to grow as projected figures show, then by the year 2013/14, 10.3 million Ugandans (or approximately 28% of the total population will live in poverty. If the current population growth were to reduce by 1% from the current 3.4 to 2.4% per annum by the year 2013, fewer Ugandans (7.1 million) or approximately 22% of the total population, would live in poverty. Below are some recommendations that the Family Planning Revitalisation Working Group could take into consideration as way of developing the new family planning campaign.

9.2 Population characteristics

Considering that Uganda is one of the countries with the highest population growth rates in the world (3.4% p.a.) the new FP campaign needs to:

- Highlight comparisons in the population growth rate of Uganda and its neighbours.
- The messages need to focus on the regions with the highest growth rates, such as Northern Uganda and to the young population groups since these are major push factors for further population growth.
- For Uganda’s high fertility, the campaign should prioritize women in the poorest households with a fertility of 8.0. This group should be made aware of the advantages of lower fertility of their counterparts in the wealthier households (at 4.9).
- Should target rural rather than urban areas and households dependent on agriculture since these also experience higher fertility
- Should focus on increasing the median age of first birth (at 18.5) and teenage pregnancies which at 25% are some of the highest in Sub Saharan Africa.
- These latter 2 factors could be in the context of keeping the girl child longer in school, focusing on both parents and the girl child as the primary audience.
- The new FP campaign can also pick on the differences between the actual and wanted fertility rate to show that women in Uganda have more children than they would have wished to have.

9.3 Population growth and poverty reduction

This chapter addresses how the rate of population growth of Uganda can impact on poverty reduction targets of the PEAP of reducing absolute poverty to 10% of the total population by 2017. Some recommendations for the FP campaign include:

- Craft messages targeting households which highlight the negative link between fertility and poverty at household level.
• The campaign should dwell on the effects of high fertility on social service delivery. For example, households should be aware that the large number of children in their HHs will neither get access to quality education nor to quality health services.
• Highlight the payoffs to Uganda if population growth rates are reduced from the current rate of 3.4% per annum such as the reduced number of people who will live in absolute poverty in 2013; a higher consumption per capita growth; the rise in per capita GDP.
• The FP campaign could also capitalize on the comparing the data on per capita GDP for some developing countries with a much lower fertility than Uganda such as Botswana, Mauritius, Malaysia and Thailand. These figures could be very useful in convincing policy makers to pay more attention and contribute resources towards FP in Uganda.

9.4 Policies, guidelines and programmes

This chapter acknowledges the efforts of the Government of Uganda in developing a comprehensive set of policies, guidelines and strategies for use by policy makers, implementing partners, donors, communities and individuals to reduce fertility levels in the country. The FP campaign should dwell on highlighting some of the recurrent themes include which include:
  • The need for child spacing
  • Male involvement in RH
  • Reducing the unmet need for FP which is a leading cause of unwanted or mistimed pregnancies especially amongst adolescents.
  • The need to make FP services an integral component of services available at HIV/AIDS treatment service points.
  • The campaign should promote the policy frameworks and guidelines as a useful reference to enrich the campaign.

9.5 Overview of FP

The overview of FP in Uganda includes a definition of FP, the types of FP, and the right of individuals to be informed and make informed and voluntary decisions about the wide range of services. The implication for the new FP campaign is to highlight the right to information to ensure that couples can make the right decisions on both family size and the on the FP method of their choice. Other areas of concern for the new FP campaign include:
  • Where to obtain services by type of facility; by managing authority (government/private); and by geographical coverage by region.
  • Publicise information regarding service delivery points as well as the types of services offered.
  • Emphasize the importance of making use of HCIVs and HCIIIs since these are more likely to offer the temporary FP methods.
  • For clients seeking permanent methods (sterilisation), the campaign should emphasize private facilities and higher level institutions HCIV and hospitals.
Regarding increasing uptake of FP, the new campaign should consider the following:

- The 48% of sexually active married women who seem to be averse to use of male condoms.
- Target to bring on board more married men who seem more positive in the use of FP methods hence making the campaign even more successful.
- On CPR, the FP campaign should target raising this from the critically low level of 24% to 40% (HSSP II targets). It should also target married women who are at a mere 24%.
- The differences in the method mix between married women and the sexually active unmarried women could be an indicator married women prefer to use female-oriented methods which are under their control and can be used in secrecy.
- The FP campaign should also be segmented by age since uptake is lowest amongst young women (11%) and rises by age category.

A possible area of inquiry that this study notes, is on drugs shops and pharmacies as source of contraceptives; an area which largely seems undocumented. This is notwithstanding that these are major distribution points which are easily accessible by individuals seeking the commonest FP methods (male condoms and pills).

### 9.6 Knowledge, Attitudes, Beliefs and Practices

This chapter dwelt on the knowledge, attitudes and beliefs on FP in Uganda. These variables have serious consequences on the effectiveness on the FP campaign in Uganda due to promotion of myths and misconceptions about FP. Existing data shows that knowledge of FP in Uganda is almost universal, with the exception of Northern Uganda and Karamoja. The major knowledge gaps in the FP methods for women is on the IUD, the female condom and the withdraw method. Hence the new FP campaign should consider:

- How to address the challenge of turning the universal knowledge levels into practice i.e. explore strategies of ensuring that knowledge levels are equivalent to levels of application of FP services
- Segmentation of messages by geographical region to prioritize Northern Uganda and Karamoja which have the highest fertility rates on Uganda.
- Increase knowledge levels on the FP methods that are relatively unknown e.g. IUD, or the female condom.
- Targeting the reduction in the gender disparities in knowledge levels so that men are informed about female oriented FP methods and vice versa.
- Educating couples on the fertile period which stands at 16%. This is critical for certain population groups that discourage modern methods of FP, e.g. the Catholic Church or the Muslim religion who largely discourage believers from use of condoms and pills.
- Make use of religious leaders to champion acceptable FP methods such as the rhyme method amongst their congregations since they not favor certain contraceptive methods. They should hence be equipped with accurate knowledge on use of the rhythm method in order to pass on the information to their congregations.
• For service providers the FP campaign should ensure that they have accurate information that enables them to provide quality FP services.

On prevailing attitudes which propel couples towards large families, the FP campaign messages should be developed to:

• As for prevailing attitudes and beliefs held by the population that hinder use of FP methods, the new FP campaign should also designed to ensure that each of the commonly held attitudes and beliefs are exposed as a fallacy so as to help couples increase uptake of FP.

• To address the conflicting roles of the political leadership in Uganda, the FP campaign should formulate specific messages to specifically target this group. The messages should largely dwell on effects of population growth and implications for poverty reduction.

• The campaign should aim at recruiting those very political leaders who promote large families to spearhead the FP campaign, rather than undermine it.

9.7 The unmet need for Family Planning

This chapter is concerned with the unmet need for FP and its effects on fertility in Uganda. The new FP campaign has to reduce unmet need by prioritizing selected targets such currently married women; women in rural areas; and women in Northern Uganda. In addition the new FP campaign has to:

• Focus on allaying fears of side effects of contraception since this is the most frequently cited reason (29%) by those women who have unmet need.

• Consider targeting the large proportion of those who do not intend to use a method of FP in future who also cite fear of side effects.

• Consider developing messages for spouses who are opposed to the use of FP methods.

Regarding unintended pregnancies and induced abortions which are a consequence of high unmet need, the new FP campaign should consider:

• Messages that link the high level of unmet need with the high level of unintended pregnancies; which in turn leads to high rates of induced abortion. Hence the focus of the campaign should be to reduce the level of unmet need for contraceptive services in Uganda.

• The audience should be made aware that were more women to use modern FP to space children and limit pregnancies, the number of unintended pregnancies would fall and therefore reducing the number of induced abortions.

• Highlighting the health risks associated with induced abortion which range from infection, haemorrhage, infertility or even maternal mortality. This could help in reduction of incidences of induced abortion in Uganda.

The FP campaign should also make a case for unmet need and the Millennium Development Goals. The new FP campaign should capitalize on messages that - reduction of unmet need would result in reduction the number of people in need of social services e.g. education or health. By investing in FP to reduce the unmet need, Uganda would reduce population growth and hence make
achieving of the MDGs more affordable. This campaign would specifically be targeted to the
government whose mandate is to drive the country towards making the MDGs a reality.

9.8 Male involvement in Family Planning

The final chapter in this report focuses on the importance of male involvement in family
planning especially since FP and reproductive health have traditionally targeted women. The
new FP communication campaign should make this a point of focus to convince men to
increase their involvement in FP:

• Male involvement should be promoted not just as a way of increasing the number of
men using condoms or having vasectomies, but also in emphasizing men’s shared
responsibilities, active involvement in parenthood, sexual and reproductive health
behavior etc.
• Endeavour to identify those barriers to male involvement (cultural, religious,
economic, gender-based) and directly develop messages to address them.
• Increase men’s knowledge about mode of operation and use of female based
contraception so as to have increased acceptance of the female methods of FP.
• Focus on changing the commonly held (male) beliefs and attitudes that
contraception is a woman’s business or leads to promiscuity.
• Promote communication between spouses so as to increase the level of shared
commitment to family planning in their respective families.
References:


Minnesota international Health Volunteers. 2004. Uganda Family Planning Programmes, Lessons from the field: Partnering with Communities and District Health Teams. MHIv, ADRA.


The Ministry of Health (July 2004), A strategy to Improve Reproductive Health in Uganda (2005 – 2010), Reproductive Health Division, Dept. of Community Health, MOH, Kampala
Ministry of Health (2005), A Communication Strategy to Accelerate Implementation of Reproductive Health in Uganda, Reproductive Health Division, MOH


The Ministry of Health (2006), The National Guidelines and service standards for sexual and reproductive health rights, Reproductive Health Division, Dept. of Community Health, MOH, Kampala


Uganda Bureau of Statistics, Macro International Inc., August 2007, Uganda Demographic and Health Survey, 2006, Uganda Bureau of Statistics, Calverton, Maryland, USA, Kampala, Uganda,


ORC Macro, DFID, July 2002, Reproductive Health of Young Adults in Uganda, report based on the 2000-2001 Demographic and Health Survey) ORC Macro, Calverton, Maryland USA


Republic of Uganda, UNFPA, 2009, Population and Development, Empowering Communities to overcome the challenges of poverty, Vol.10 No. 17, July 2009