

THE POPULATION OF AND FAMILY PLANNING IN UGANDA

BY

DIANA NAKINTU NSIMBE



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DECLARATION

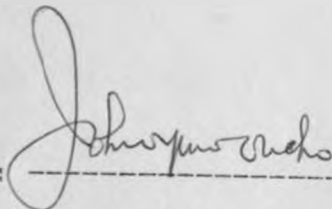
This project is my own original work and has not been presented for a degree in any other University.

DIANA NAKINTU NSIMBE



This project has been submitted for examination with my approval as a University Supervisor.

Signed :



Prof. J.O. OUCHO

September 30, 1988.

Date

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THE POPULATION OF AND FAMILY PLANNING IN UGANDA

INTRODUCTION

The Demographic Background of Uganda

1.1. Population Growth

The population of Uganda grew extremely fast between 1959 and 1969; at an annual rate of growth was close to 3.9 per cent over the 10 year period. The rapid growth between 1959 and 1969 could be attributed to the positive economic climate that followed independence. Even this very high figure was masked by the population growth of some districts, for instance Bunyoro, with an annual growth rate of nearly 6.3 per cent. The intercensal period between 1969 and 1980 recorded a remarkable decline in growth changes from the previous 3.9% to 2.8% per annum. This could probably be explained in the period following 1971 when a military regime took over power, expelled the Asians who were virtually controlling the country's economy which from then onwards started dwindling downwards. First, the departure of this group contributed a big portion to emigration and thus a big fall in total numbers; then, there was selective emigration of the native males due to insecurity and in search of better economic opportunities outside the country. Large numbers of male household heads were killed in remarkable numbers during Amin's regime leaving widows who could not support themselves and their families sufficiently. These women, plus the other group separated from their husbands who left the country, were no longer exposed to the risk of pregnancy as was the case before

when they were in permanent marital unions. This could be seen as fertility inhibitor that could have contributed to falls in the birth rates.

Table 1 shows the recorded changes in population sizes of Uganda.

1.2. Population Size

Table 1 : Population Size by National Censuses

Year of Census	Total	Urban Population	
		Total	Urban Proportion
1948*	4958520	--	--
1959	6536531	315000	4.8
1969	9535051	747000	7.8
1980	12636179	1100000+	8.7

* 1948 Population was not analysed for rural -urban distribution.

+ This is the overall total urban population including small urban centres of 400+ people.

Source : 1983 Ministry of Economic Planning, Entebbe, Uganda.

Annex 1 gives the recorded population changes per district for the intercensal period 1959-1969.

Annex 2 gives the recorded population changes per district for the period 1969-1980.

Population projections of the 1969 population up to the year 2000 based on the data in Table 1. are given in Table 2.

Table 2 : Population Projections to the Year 2000 based on the 1969 Census Fertility and Survival Indices

Year	Males	Females	Total	
1970	4948402 .	4857968	9806370	Actual
1975	5821239	5728129	11549368	
1980	6890998	6798214	13689121	12636179
1985	8189971	8098163	16288134	
1990	9804630	9712230	19516860	
1995	11832936	11736575	23569511	
2000	14372483	14266217	28638700	

Source : Uganda Census Reports

Table 3 :Age and Sex Distribution of the Population [1969]

Age Group	Population		Percentages	Sex Ratio	
	males	females		M	F
0-4	904392	925080	19.35	98	
5-9	731289	729787	15.45	100	
10-14	568079	517416	11.47	109	
15-19	411381	410920	8.70	100	
20-24	334705	378689	7.55	88	
25-29	348866	377535	7.68	92	
30-34	302073	297211	6.34	101	
35-39	256454	236022	5.21	108	
40-44	196729	190591	4.10	103	
45-49	167982	148746	6.67	112	
50-54	147735	143904	3.09	102	
55-59	96717	80870	1.88	119	
60-64	98455	90731	2.00	108	
65+	203003	159101	3.85	128	
Total	4769860	4686603	100.00		

Source : 1969 Population Census Report Vol. III

1.3. Population Distribution

Annex 4 and Figure 1 give population densities by districts.

The national population density for 1969 was recorded as 48

persons per sq km, with variations between 8 persons/km as in Kotido in Northern Province (Karamoia), 12 persons/km in Moroto still in Karamoia, through 118 persons/km Mukono, 135 persons/km Tororo, 168 persons/km Mbale, 174 persons/km Kabale, shooting upto 1044 persons/km in Jinja, and 1674 persons/km in the capital, Kampala. These variations could be explained in : Karamoia having 8-12 persons/km being due to its remoteness both environmentally and culturally. The Karamoiondo up in north eastern Uganda are known to lead a nomadic-pastoral life uniquely different from the rest of the country; again they have a unique culture [still primitive] which they jealously guard to themselves alone and do not welcome any outsiders mingling within their society. They react with physical aggression to any outsiders approaching them even to their immediate Teso neighbours-whom they claim to have stolen the cattle they are keeping from Karamoia. Because of their backward style of pastolism, their environment is presently under forces of desertification. Kotido only recorded density changes from 1969 to 1980 as from 8-12 persons/km and Moroto from 12-13 persons/km. This was most probably because these are areas that are still backward in socio-economic development and there are no factors acting to attract in-migration or changing the mortality and fertility levels that have always prevailed on the high side levelling off each other.

Mukono 118 persons/km is situated about 20 km from Kampala, on very fertile land bordering a tropical forest reserve-Mabira Forest- and Lake Victoria. This is a town whose density has

risen from 118 to 138/km from 1969 to 1980. Assuming a continued rate of growth there is bound to be pressure on the amenities -on the health facilities, schools, roads, housing and water supply for this expanding urban centre. Greater emphasis on the need for family planning programmes would suffice in the efforts to affect rapid population growth in the area.

Mbale district is located on higher altitudes than the rest of country, on the slopes of Mt. Elgon, has densities 168/km in 1969 and 223/km in 1980. This area has rich volcanic soils that favours particularly arabica coffee-growing. The high densities could be explained in the healthy environment on the higher altitude that is not very favourable to malaria-carrying mosquitoes. It is a major urban centre situated on the rail-road line connecting the eastern and northern provinces. Another factor that could have contributed greatly its growth is the coffee boom of the years 1977-78 that witnessed a big movement in coffee smuggling across the Kenya-Uganda borders with Mbale the central town in the business. If this rate of growth in densities continues there is a risk of land fragmentation that will eventually lead to deterioration of value of land; and pressure on the social and economic facilities available. The message on population awareness to the people of this area could serve as a solution, by the family planning field communicators.

Tororo district is situated close to the Kenyan border but of relatively much poorer soils in comparison to Mbale. The soils are mainly of lime content and the rocks around famous for their cement content thus accounting for the location of the country's

national cement industry—a factory relying on a whole mountain of solid cement for blasting. A number of sister industries like asbestos factory, also the jute factory, a region of sleeping sickness and thus credit for location for an East African Trypanomiasis Research Centre: all these rather than the climate attribute for the heavy densities for the labourers and staff, in these factories and research centre. Because of the nature of the landscape —rocky and non-arable— the densities here are bound to be even higher on arable land which is also of marginal value. This high man/land ratio is bound to affect greatly the social amenities and land quality if the continuing rise in densities is not checked. Government policy could help in encouraging family planning and land settlement schemes a little further out of town spreading the town's wings outward.

Moigi district as a whole covers more local administration centres than commercial ones. The district recorded 115 persons/km in 1969 and 147 persons/km in 1980. This high ratio on land is attributable to the fact that the district covers all the capital's suburbs plus Entebbe Municipality. The area therefore enjoys an attractive environment that caters for a wide range of schools, health facilities, social facilities and transport and other communications: still given fixed land continued population growth in this area is bound to exert pressure on the social infrastructures and on the land itself. An integration of population education in schools curriculum plus some informal programmes for the out-of-school populations would help enlighten the masses of the prevailing population

situation and in turn change their attitudes to accepting practicing family planning.

Kabale district, further south-west of the country, is located on a range of rather steep mountains. The densities here for 1969 were 174 persons/km and 197 persons/km in 1980. The soils here are known to be rich volcanic soils that favour mainly Irish potatoes, cabbages and other vegetables rather than any other crops. Since these soils are selective in the type of crops, most probably because of the altitude and steepness of the slopes that also in turn select the type of farming—terracing and inter-cropping—, continued additions in the land ratio are bound to result in land erosion and uneconomical fragmentation. The area is not easy to be covered by the family planning field educators because of the steepness of its paths and because of this landscape, few roads; the best solution to preach the population awareness message would be through mass media and audio-visual aids.

Rukungiri district shares some similarities in climate, soils and environment with neighbouring Kabale but slightly lower altitudes. Its densities for 1969 were 95 persons/km and 115 persons/km in 1980.

Kampala district embraces the capital, recorded densities of 1674 persons/km in 1969 and 2320 persons/km in 1980. This is the highest record in the country, this is expected because of its inclusion of the capital, with all the socio-economic opportunities it offers. The rate of its growth is on the high

side as compared to the rate of socio-economic development of the country [Ministry of Planning 1980]. Greater efforts are required of the family planning staff to affect the fertility levels of this capital city.

Jinja district is number two on the record with densities of 1064 for 1969 and 1001 for 1980. It is the only district in the whole country that recorded a decline in density for the intercensal period. An explanation for this could be in the economic decline that the country went through following the expulsion of the Asians who were in full control of the factories that make up this industrial town. As the Uganda Breweries, the Uganda Steel Corporation, the Bottle and Glass Factory, the Nvtil Jinja Textiles Mills, the Sugar Factories all collapsed, Jinja also saw a major decline in its population. Its location was dictated by the easy access of electricity supply, the Owen Falls Dam, just a couple of kilometres from the town centre.

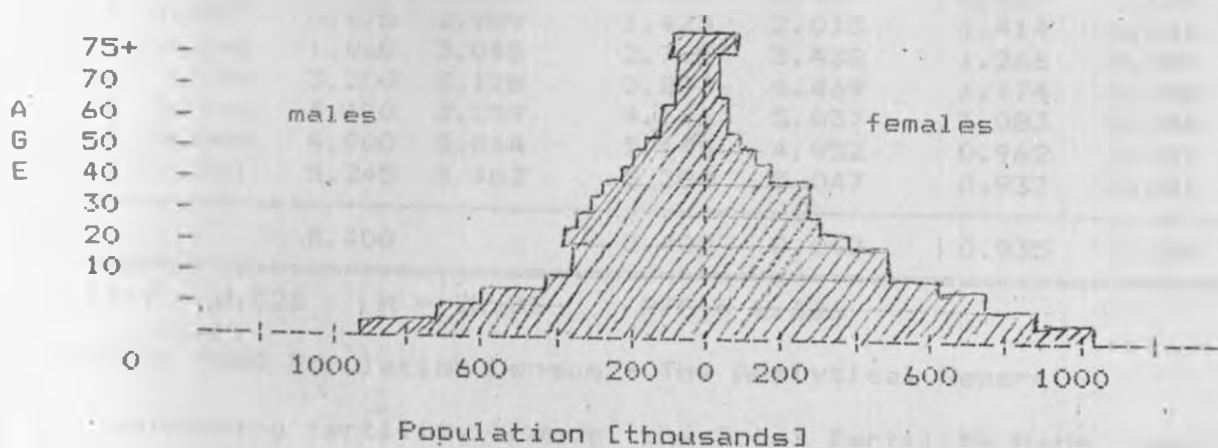
1.4. The Age-Sex Structure

On examining the age-sex structure from the youngest to the oldest we find that Table 2 above shows that relatively large numbers have been reported as aged 0-9 followed a sharp cutback in the 10-14 age group. This could be a genuine feature of African age distributions [Kpedekpo 1986]. Age-groups 20-24 and 25-29 have fewer men probably because emigration for further education abroad, for better economic opportunities, and/or because of large numbers of deaths during the military regime. Adolescent pregnancies the lead to labour complications because

of immature bodies could be the explanation for a fall in number of females in group 25-29 as compared to the previous group. Complications that are of the common nature that could have been detected in anti-natal clinics had these girls gone there, and from induced abortions. The continuing dominance of men in the proceeding age groups could be a result of under reporting on females, or, since a large proportion of females are illiterate or with very few years of education, due to age-heaping, which could be explained in cultural values regarding age, and thus attributing wrong people to wrong age groups.

In order to have a total picture of the population by sex and age, a population pyramid is constructed in Table 4.

Table 4 : Age/Sex Pyramid of Ugandan Population 1969



Pyramids are of different shapes. These shapes are determined by three factors : fertility, mortality and migration. Therefore, each rectangle representing an age group has a length that depends on : a) the total at birth of the corresponding cohort or group of cohorts, b) the amount of reduction by mortality, and c)

the amount of migration.

Table 4 is an example of a pyramid with a broad base [the primitive type] which tapers towards the older age groups. Such a pyramid is typical of a country in an early stage of demographic development with high birth rates, high death rates and a youthful age structure.

1.5. Fertility

Fertility Levels

Table 5 : Application of Brass's P/F ratio method to Uganda Fertility Data

Age Group	i	Pi	ki	Fi	Pi	Pi/Fi	Adjusted fi
15-19	0.135	-	2.471	0.334	0.477	1.427	0.179
20-24	0.257	0.675	2.909	1.423	2.013	1.414	0.341
25-29	0.248	1.960	3.045	2.715	3.438	1.266	0.329
30-34	0.194	3.200	3.128	3.807	4.469	1.174	0.258
35-39	0.146	4.170	3.259	4.646	5.037	1.083	0.194
40-44	0.069	4.900	3.544	5.145	4.952	0.962	0.091
45-49	0.031	5.245	4.483	5.384	5.047	0.937	0.041
TFR		5.400		5.400	5.047	0.935	7.159
$f_i/f_2 = 0.526$		$M = 28.33$		$P/F = 1.326$			

Source : 1969 Population Census - The Analytical Report

For analysing fertility trends, the Total Fertility Rate indice was employed as in Table 3 above. TFR being the number of children a woman would have from age 15-49 if she were to bear children at the prevailing age-specific fertility rates.

Fertility is high because of socio-cultural factors. In Uganda marriage to a barren woman is not considered as permanent: and son preference is high in all tribes. The value of a woman is in her fertility, she is honoured more if she gives birth to many sons, to carry on the family name and to ensure 'parents immortality' for a man is always remembered [after his death] through his children and grand children [Nsimbi 1977]. Several girls would mean a lot of wealth coming in, in the form of bride price, and this same wealth would help the sons pay for their brides. More intensive population education programmes could help in changing people's attitudes regarding family size with the ultimate goal in changing their behaviour to adopt smaller families. In teaching population education to the potential and the to-be parents, stress should be put on the respect for various cultural and religious beliefs, and more emphasis on the need to adopt new technology and cultural values to fit in the changing socio-economic and cultural environment of present times.

Fertility is also high because of low age at first marriage which ranges between 16-17 years in the rural areas [NSIMBI 1980]. As a woman spends most of her reproductive life in marriage with minimal pregnancy inhibitors like lactation, only she is bound to have a high parity number by the time menopause sets in. Again as a woman marries early, at an age that is considered immature, [most probably a primary school drop-out],

she is bound to experience more infant deaths as she is unaware of the need to utilise the available medical services. For instance, primary health clinics where vaccinations against the identified child-killer diseases are given free, can be ignored by these young mothers who have partly broken away from their traditional backgrounds yet not fully alert of the challenges posed, by modern era. As these women get more of their children dead, they tend to reproduce with very short intervals between births, with a view that at least out several births a few will survive. Such group of women would be very hard to convince to contracept before their can get assurance for survival of their children to adulthood.

The primary step leading to a decline in infant mortality would an increase in primary health care especially at village levels. Unfortunately the case with present Uganda is the entire opposite. UNICEF-1987 relates years of instability and economic decline to have led to the deterioration of the country's health system. Hospitals have been run down physically, equipment and drugs are scarce, and skilled manpower has left the country.

Tropical diseases such as sleeping sickness and malaria which had been controlled have become endemic. There is a well established network of facilities including dispensaries, health centres and rural district hospitals that all need funds for their rehabilitation. Malnutrition is not an endemic problem, but the damage done to farm economies by political insecurity has resulted in widespread food shortages mainly in urban areas and this where population densities are highest. Until these

problems are solved it is not very easy to assure women survival of their children and in turn encourage them to adopt small family sizes.

Annex 2 gives the Total Specific Fertility Rates and Crude Birth Rates by District from 1969 Census.

The level of fertility is very high high in Uganda by international standards. Africa has the highest fertility amongst all the continents, but Uganda's fertility is still high even by African standards [United Nations Demographic Yearbook 1988].

1.6. Fertility Differentials

In investigating differentials in fertility of women the analysis used [in all census/surveys] education of mothers, her birth place and place of actual residence. Fertility by education group shows a pattern very similar to that found elsewhere in Africa. The level of fertility seems to rise very slightly with primary education, the mean of the fertility distribution remaining almost constant. The level of fertility falls significantly for women with secondary education, the estimated total fertility rate being one whole child lower than the country average. The really startling difference with the women with higher education is in the mean of the age-specific fertility distribution which one and half years higher for this group than for others.

The differentials by birthplace are rather puzzling, for every little difference appears between those living in their 'home' districts [where they were born] and those born outside Uganda, the total fertility rate and the mean of the age-specific fertility distribution are found much the same for both groups.

Differential by place of residence show that rurals have higher total fertility rates than urban dwellers. [Census 1969].

1.7. Mortality Levels

Table 6 : Infant Mortality Rates 1959 and 1969

District	Infant Mortality Rate		Crude Death Rate		
	1959	1969	1959	1969	
	W.Mengo	130	82	16	
E.Mengo	140	114	17	18	
Masaka	160	108	21	18	
Mubende	170	92	24	16	
Tesq	150	94	19	15	[Eastern Province]
Bugisu	180	148	25	19	
Bukedi	200	161	30	20	
Busoga	180	154	24	22	
Karamoja	150	139	19	23	
Kigezi	130	105	18	19	[Western Province]
Ankole	170	121	24	19	
Toro	170	143	23	21	
Bunyoro	180	113	25	19	
West Nile	150	150	19	23	[Northern Province]
Madi	200	151	26	22	
Acholi	180	165	24	22	
Lango	170	124	22	18	
Uganda	160	120	20	19	

Source : Uganda Census Reports 1959, 1969.

The census records show an increase in infant mortality levels in East Mengo District from 17% to 18% during the 1959-1969 intercensal periods. An explanation for this could possibly be due to under-reporting in deaths in 1959 because other socio-economic factors in this particular district would have brought about a decline rather than an increase. The other areas that recorded a rise in infant deaths are Karamoja District and West Nile—here one could say with some confidence that the 1959 estimates of infant mortality were too low—the large differential between West Nile and Madi districts with much in common, including people of the Madi tribe who are resident in significant numbers in both districts, would require a lot of explanation, and the conditions of life in Karamoja would lead one to expect high infant mortality—indeed, much higher than the 1969 estimate [Uganda Census Report vol. iv, 1969].

Differentials in the Levels of Mortality

The level of childhood mortality falls with rising level of education of mother. [Uganda Census Reports 1969].

Differentials by birth place show significant variations — children born outside the country [bordering countries] experience higher levels of childhood mortality than those born to mothers within Uganda. It is possible that the migration process that involves crossing of national borders with no clear destination, with no adequate food or sanitary and health facilities.

Table 7 gives the proportion of children dead by age-group of

mother for the whole of Uganda for the purposes of estimating the level of child mortality by education level of mother and birth-place category of the mother, place of birth and that of actual residence.

Table Z : Estimates of Childhood Survivorship and Expectation of Life at Birth by Education and Birthplace

Mother's Education	BRASS				
				Smoothed	
	I[2]	I[3]	I[5]	I[2]	LEX[Yrs]
None/not stated...	819	794	758	815	44
Primary 1-3	850	816	812	853	49
Primary 4-7	892	881	854	892	54
Secondary	944	934	925	943	64
Mother born where enumerated	839	813	776	833	46
Mother born elsewhere in Uganda...	858	825	786	845	48
Born outside Uganda	802	775	724	794	42

The value of beta assumed to be 0.9 throughout.

Source: Uganda Census Report 1969.

Mortality is continuously rising as a result of deteriorating health, nutritional and general security conditions: while fertility has not changed much. It is therefore assumed that as socio-economic conditions improve and living standards rise again, mortality will again start declining, giving rise to a growth rate higher than the current estimate. (UNICEF, Uganda Country Office 1987).

Table 8 shows the government's priorities and allocation to the basic needs.

Table 8 : Development Budget by Ministry by percentage of totals

	1984-85	1985-86	1986-87	1987-88
Health	5.73	0.82	1.44	0.19
Education	3.91	5.10	9.20	2.01
Defence	7.53	4.68	17.68	27.03

Table 8 dispels the view that the economic strains and insecurity in the country affects the government's allocation of resources to the basic needs ministries—a situation which in turn affects the welfare of the entire society and down to the family unit and consequently their attitude to the family planning programme.

Over the past two decades, major population policy efforts in many developing countries in particular have been centered on large-scale family planning programmes. (United Nations Secretariat-Population Division, Manual ix).

In the case of Uganda, evaluation cannot take a smooth course since the data available on fertility levels is minimal, and on the family planning activities, though more continuous data is more obtainable, this is only the case for some districts. Data here is scanty in some areas and even lost due to insecurity and war in some regions.

In Uganda, the majority of people who resort to family planning do so in order to reduce the frequency of pregnancy, but that group of men and women whose problem is exactly the opposite. A couple who cannot have children and those who cannot have the

desired family size can be assisted by family planning workers who will direct them to the right specialists who deal with such problems.

1.8.STATEMENT OF THE PROBLEM

Uganda's population growth currently presents a problem to its socio-economic development. With an annual growth rate of 3.2 per cent, the country ranks among the highest growth rates on the continent. If this rate continues constantly, Uganda's 1988 estimated population of 16.1 million will reach a figure 23 million by the year 2000.[Ministry of Planning 1988].

Whatever efforts taken either by the government or by private non-governmental organisations, [NGO's], to control fertility levels, it has to be remembered and considered, that "decisions on family size rest with parents—a basic human right. These decisions taken together determine the rate of population growth in the nation. While the government is concerned about the rapid rate of population growth, it is also convinced that as these concerns come to be understood in terms of effects of family welfare and quality of life, parents will adjust their decisions in favour of smaller families...".[Kenya : 4th Development Plan].

In order to control the rate of population growth, most developing countries are intensifying programmes of informing and educating actual and potential parents regarding the benefits of smaller family sizes particularly since the fertility of less educated women is found to be higher.

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In order to control the rate of population growth, most developing countries are intensifying programmes of informing and educating actual and potential parents regarding the benefits of smaller family sizes particularly since the fertility of less educated women is found to be higher.

The purpose of this paper is to examine the demographic background of the population of Uganda and how the family planning programmes have affected the related demographic variables. In the introduction the factors responsible for the high rate of population growth have been identified as urbanisation, low education levels of mothers, early age at first marriage, traditional values with regard to large families and son-preference, and a poor health system.

The family planning effort to lower fertility levels is being realised by the Family Planning Association of Uganda, [FPAU]. This study, therefore in examining the relationship between family planning programmes and fertility levels (under the prevailing circumstances in Uganda), will portray how much the Information-Education-Communication, [IEC], unit of this association has done so far; what remains to be done; and what is required to be done on top of the existing efforts and those in the pipeline to affect the population.

By proper use of family planning methods a mother can postpone her next pregnancy until such time when she is fit physically and mentally to carry another pregnancy. But, before setting off with any family planning programme, the officials involved do descend down to the family level with a purpose to influence the family size. And before all this is done, there is the requirement for assessing the needs of the target community as a prime step to the programme.

The FPAU, therefore through its IEC unit provides that awareness

required of the family units to change their attitudes in accordance with the prevailing population situation and in the end change their reproductive behaviour.

The field educators seek to assess the community's needs by finding answers to questions like :

- *Do the great masses ever think about the population problem that exists in their country ?
- *How many of them worry that their family is getting too large for them to support ?
- *How many couples have enough knowledge about the methods of contraception to take action should they want to ?
- *How many couples are making use of contraception ?
- *How many couples have resorted to abortion because family planning services were not available or because they knew no other alternative ?

1.9. JUSTIFICATION OF THE STUDY

The present government-1988 in Uganda does recognise, and consider the population factor very seriously in its development planning. In its current Rehabilitation and Development Plan [1987-91] several population development programmes have been incorporated including the Uganda Government/UNFPA Population Programme launched on 27 May 1988. The Programme consists of ten priority projects to be implemented by the various ministries that include : Health, Agriculture, Local Government, Education, Women, Information and Broadcasting, Labour, and Planning and

Economic Development.

The projects include : Population Policy and Planning, Population and Manpower Development and Research, Demographic Data Collection and Analysis together with the forthcoming 1990 National Census, Information-Education-Communication-[IEC] activities, and Maternal/Child Health and Family Planning Service Delivery.

FPAU has stressed its stand on the importance of the IEC Unit by declaring how the programme would have been impossible without motivation, education and information of the public. However, from the very beginning of each programme, it is worth noting that each family planning programme faces a unique set of problems determined by cultural, demographic and historical trends and changes of any given society.

In tropical Africa postpartum infecundability results from the practice of lactation and postpartum abstinence from sexual unions. The primary reason given by African women for abstinence is their concern for the health of the child. A new pregnancy soon after a child is born will interrupt lactation and remove the child's most important source of nutrients.

Unfortunately, with the present rapid rate of urbanisation and modernisation-requiring a couple to stay within the same room, with four interlocking walls the year round, has put an end to these valuable old traditional practices. At present date, therefore, birth spacing and fertility control by traditional practices have to be assisted by other fertility regulating

methods of modern days-and thus arises the need for family planning programmes. The question then arises as to how much the family planning movement has done in fulfilling the role once fulfilled by traditional practices in fertility control.

The level of fertility in any given population is directly determined by a set of biological and behavioural factors called the intermediate fertility variables or the proximate determinants of fertility. These factors are, in turn, a function of socio-economic, cultural and environmental variables which are the indirect determinants of fertility.

1.10. METHOD OF RESEARCH

Use of Secondary Data from Uganda National Census 1969.

There was a national census carried out in 1980. Unfortunately this census was carried out during a period of social and political instability, without careful preparation. Much of the data was lost before being analysed. Only population totals by sex and administrative areas had been extracted, which were later published as Provisional Results. Volume 1, 1982.

The only surviving records were for some 7 districts that constitute only 11 per cent of the total census population. [Background to the Budget 1988-89].

Data from national censuses, for rates on Total Fertility Rates,

[TFR]: Crude Birth Rates, [CBR]: man/land ratios for all districts; and district urban proportions.

Some data from the 1980 Census will be utilised to show the rate of population growth at district levels during the intercensal periods. Unfortunately, the 1980 Census was not analysed. Only population totals and urban population were recorded for various administrative levels [Ministry of Planning, Entebbe 1988]. For this reason it was not possible to get the age-specific fertility and mortality rates to establish whether there were declines or growths in these variables in various districts between 1969 and 1980.

Other data and information will come from the Family Planning Association of Uganda, [FFAU]. The data available here is scanty for some areas under the programme. There is some data on number of acceptors for a two year reporting period for the Kampala District clinics: then data on contraceptive requirements for projected periods between 1988 upto to 1990 and data on clinic attendances.

The study will be carried out on a national, macro level because family planning practice in the country does not cover such a big percentage of the female reproductive age population. In order to get a big enough sample of affected groups the macro level was selected using districts as units of analysis.

The family planning movement has been affected by a variety of factors ranging from misconception of the problem by different regimes in powers due to both their religious backgrounds and their lack of adequate information and education on the need of these programmes. Some areas have experienced temporary closures

of the programme services due to insecurity and wars in their areas. In some cases important family planning records were lost completely with no hope of ever resurrecting them.

1.11. DATA ANALYSIS

Data Analysis will be done by simple tabulations to show the trends of the Ugandan population from 1959 to 1980 [where relevant data is available from the 1980 Census Records]. otherwise in some places trends will only be displayed for the intercensal period between 1959 and 1969 only.

Tables showing the district growth rates and the overall country mean: age-specific-fertility levels are given in rates: and in order to give a clearer illustration of the country's age-sex structure a population pyramid was constructed.

Other tabulations will include the population densities per district from 1969 and 1980 Censuses. This will explain display how the country's population is distributed. A map of Uganda showing population distribution accompanies this tabulation. as an appendix.

On the family planning side, tables showing contraceptive requirements and acceptor projections are given.

**Appendix 3 : Total Specific Fertility Rates and Crude
Birth Rates by District 1969**

District	TFR 1969	CBR 1959	CBR 1969
W.Mengo	6.7	38	41
E.Mengo	5.6	34	38
Masaka	7.7	38	49
Mubende	6.4	37	43
Kampala City	5.2	38	46
BUGANDA	6.3	36	42
Teso	5.2	31	37
Bugisu	7.5	48	50
Bukedi	7.2	50	46
Busoga	6.9	40	51
Sebei	8.3	48	51
Karamoja	6.0	50	42
Jinja	5.7	40	49
Mbale	5.5	48	48
EASTERN	6.6	42	49
Kigezi	8.1	50	54
Ankole	8.5	53	55
Toro	7.7	41	52
Bunyoro	7.2	32	47
WESTERN	8.2	45	53
West Nile	7.8	45	53
Madi	8.0	50	54
Acholi	8.5	50	54
Lango	7.3	50	49
NORTHERN	8.1	48	52
Uganda Totals	7.1	42	49

Source : Uganda Population Census Report 1969

CHAPTER II

The History of FPAU

The beginning of family planning activities in Uganda was marked with the opening of the FPAU in 1957 with major assistance and support from IPPF, and The Pathfinder Fund, USA, represented by a Miss Edith Gates. Through her contacts with the progressive women of the Mothers' Unions, a small group of family planning volunteers started. At this stage work included general advice to parents in Kampala, with limited use of contraceptives now and then, and was entirely on voluntary basis. [FPAU HANDBOOK].

Meetings were being held in private homes, most of them after office hours. The first years saw very little activity and there is very little on record.

The arrival in 1963 of Dr. and Mrs. George Saxton from USA marked a second stage in the growth of the Association. Dr. Saxton was attached to the Makerere University Medical School. He started research on family planning and tried to interest his students to undertake family planning studies and work. FPAU [FPAU History].

The first FPAU clinic was opened in Kampala City Council in 1963 with Mrs Allidina Visram as its Administrator General. It was run by Dr. and Mrs. Saxton and two midwives who worked as both field workers and midwives. Branches were also opened in other Kampala suburbs like : Kiswa, Naguru, Nakawa, Mengo, and at the anti-natal clinic at the Mulago National Hospital.

During the same year, FPAU became an affiliate member of the

IPPF. At the beginning there were few clients, mostly Europeans, Asians, and the elite Africans until that time when field work was increased and more clinics opened in other urban centres like Mukono, Jinja, Mbale, Fort Portal and in missionary hospitals elsewhere.[FPAU 1982].

FPAU suffered a major set back in 1972 when a circular was issued by the Amin Military Government to all medical units, instructing them to stop offering family planning services. This was followed by the expulsion of asians. The biggest and most progressive clinic at that time was situated at the Institute of Public Health, run by Makerere University Medical School/Mulago Hospital/USAID/FPAU. The closing up of this clinic was a real blow to FPAU activities.

In 1975, after a quiet battle, the Ministry of Health issued another circular instructing all government medical units to work hand in hand with FPAU and offer family planning services once again.

FPAU was able to provide technical staff and material in 1976 when the government, through the Ministry of Health, allowed family planning to be integrated with MCH services in the government hospitals, it was found that in some hospitals the idea was very welcome but staff and contraceptives were the next question. This was reported by FPAU staff who visited Government and Missionary hospitals to monitor the hospital staff's reception of this integration idea. FPAU undertook to cater for the provision of contraceptives and the training of staff to run

the family planning clinics within these hospitals.

In the area of training, FPAU was able to participate in early training programmes. An MCH Project was started and designed to serve in the teaching of family planning to different cadres of the medical profession. One of such projects that was in process of benefitting from such training courses was the Ankole Pre-school Protection Programme [PPP]. This was a project in Ankole District [Western Uganda] whose services were geared to pre-school children. Services were in the form of immunisations to these children, mobile clinics and nutrition education to mothers. Family Planning was realised by its authorities as one of the necessities which mothers could from.

The constant guidance and devotion of Medical experts in different relevant fields, who formed the majority of the FPAU Medical Advisory Committee was a major factor in the foundation and growth of family planning. The activities of FPAU could be trusted and respected and this was a major breakthrough especially in the late 60's and early 70's when the awareness of family planning was just beginning to spread. They being teachers at the Medical School became the apostles of family planning in that they could generate interest in family planning among young doctors and students. Some of these students took keen interest in family planning and were later to assist FPAU as sessional doctors for some of FPAU clinics.

In the area of recruiting acceptors to family planning, FPAU has done very well. The number of clients since the inception of FPAU has been growing. Whereas in the 1960's the annual number

of clients served averaged 5,000, by 1980 the number had grown to an average of 30,000. Obviously this was a great step in the growth of demand of family planning services. The question is what this figure reflects in relation to the target population that FPAU should serve. The statistics show that the female population is more than a half [6,904,000 of the total population 13,676,000]. Of that half, [3,038,000] are within the range of the reproduction age, that is, 15-49 years. The target of this total population for FPAU is a quarter. FPAU as of 1981 serves only 10 per cent of the target population annually[FPAU Handbook].

A look at some of the problems that are related to population might help to shed more light on what FPAU has been faced with. In a past study carried out on abortions in Mulago National Hospital, the incidence of induced abortion was found to be the highest amongst women aged between 16-20 years, followed by those between 21-25 years. The incidence of abortion was estimated to be 15-20 per cent of the total Uganda population[FPAU 1982]. This is merely what was recorded in one hospital. A large number of such abortions do occur without being recorded in hospital. The same applies to maternal deaths. What is to be noted in this reference is the probable lack of knowledge and availability of family planning services; for the first highest category of these victims is comprised of adolescents. If family life education was being taught in schools and parents themselves aware of such a problem and how to prevent it, the figures would, probably, be lower. It was also noted that before 1968 the rate of infection

resulting from induced abortion was minimal and curable but at the time of the study, November 1973-74, the rates had risen and resulting in a number of maternal deaths.

The location of FPAU clinics give it an urban bias. Most of the clinics are based in towns and even those that are attached to government hospitals are mostly in towns. This means that family planning services are available to people who stay in towns and within a certain radius of towns in the country. In Uganda 91 per cent of the total population live in rural areas. The sector forms the portion of the population which would also benefit from family planning advice and services. But in a situation where transport problems are remarkable, these rural dwellers cannot neither manage nor afford to travel to the available clinics to seek services. Mobile clinics would have been the answer to such a problem.

In the area of family planning awareness the task is still great. In the study conducted around Kampala in the early 1970's by a Doctor R.E. Brown, the findings revealed that 90 per cent of those interviewed did not know ways of preventing births. In a later study, mid-1970's, by Dr. P.W. Tsekooko, it was found that 81 per cent of the clients interviewed had heard of family planning through relatives and friends. Information through mass media was only 3.6 per cent of the clients. In a more recent study in the 1980's by a Makerere University student in Social Work, 85 per cent of the clients interviewed did not know of ways of preventing births.[FPAU Handbook].

The Work of FFAU :

2.1. Distribution

(i) Buganda Area

This area covers the districts of : Kampala, Entebbe, Mukono, Mpigi, Iganga, Luwero, Hwebende, Masaka, and Rakai; and has its headquarters in the Institute of Public Health at Mulago National Hospital. In Buganda area there are 15 field educators whose main task is to create an awareness to the people for family planning activities with a goal of winning them to become acceptors of the programme. The region has seven clinics namely at : Mulago National Hospital's Institute of Public Health, Mukono Maternity Hospital, Kasunguli Health Centre, Masaka Family Planning Clinic, Entebbe Family Planning Clinic, Katwe Martyrs' Community Centre, and the Kampala Main Clinic at Plot 90 South Street, Kampala.

(ii) Busoga Area,

This area has a total of five field educators who motivate people in the districts of Iganga, Jinja, and Kamuli. The main Family Planning Clinic is situated at Plot 20 Luban Road, Jinja and coordinates the family planning activities in all the government hospitals in the above three districts.

(iii) Kabale Area

This is comprised of Kabale and Ruhungiri districts and is under supervision of the Area Officer who coordinates the family

planning activities in all government hospitals with a working team of six field educators and one midwife.

[iv] Fort Portal Area

This area, under supervision of the Area Officer, caters for Kabarole, Kasese, Bundibugyo, and Masindi districts, and has a team of six field educators.

[v] Bugisu Area

This area covers the districts of Mbale, Kapchorwa, and Tororo. The main office is found in Mbale town on Nkokonjeru Terrace Plot 24. It has a team of six field educators that are involved in the information and education work for the area.

[vi] Soroti Area

This covers the districts of Soroti, Kumi, and Moroto with its main office and clinic situated in Soroti town; and under supervision of the Area Officer who is assisted by two field educators.

[vii] Gulu/Lira Area

This area covers the districts of Gulu, Lira, Kitgum, and Apac. It is under supervision of the Area Officer and has its main office and clinic in Gulu Hospital with a total of five field educators for the four districts.

3.2. Field Work

The whole of Uganda has a total of forty four field educators

covering 27 of the country's 33 districts. The major task facing this staff is to ensure that family planning messages are carried to the people. Besides the Area Officers responsible for the individual areas, the association has an overall field work supervisor who moves widely throughout the country to monitor the success of field work programmes for in-coming months so that these are submitted to the head office to be scrutinised by the field work supervisor. Monthly reports are also submitted to head office so that success or failure of the programmes submitted earlier can be evaluated and recorded. The field educators' main task is to penetrate deep into the rural areas and take messages to those who have not yet heard about family planning. This is done through person-to-person communication by home and follow-up visits. Radio and other mass media are used to reach those who can utilize such facilities.

The main problem facing field work are lack of transport and the areas being too vast to be covered by such a small number of people involved in family planning work. In Kigezi and Bugishu areas, for instance, the areas are mountainous making difficult to work in. The family planning personnel have to walk up steep paths and roads, and where transport is available, is so costly that only limited journeys can be afforded in a single month to a particular area. Religious and traditional norms and beliefs are another big obstacle to the family planning movement. [FPAU no date].

Population education as an indispensable requirement in the family planning campaign has been adopted by the Ugandan

Government.[UNICEF 1987].

The Government believes that as primary science curriculum[*] changes to stress the importance of health, the teachers' goals must also change to stress the reality of applying the science of health to real life. A teacher's first job, therefore, is to teach, for the purpose of making the student learn, be aware and able to overcome problems from adolescence; to change their attitudes [from the old religious and traditional beliefs] in the prevailing social set up so that they learn to keep themselves and those they care for healthy. In addition to this new move is the old department of FPAU, the IEC Unit, where the field staff is engaged in the initiation of programmes suitable for their clients. These are in turn submitted to head office to implement the approved work programmes of the Association.[FPAU 1987].

The immediate and future goals of the Association are, therefore, to collaborate and integrate family planning work into the programmes of the government and other NGO's working in the field of family planning. The main direction is the intensification of programmes aimed at sensitizing the rural masses into family planning work by involving other relevant extension workers. Having realised this approach, the FPAU staff have already began to work hand-in-hand with those extension workers who are willing to help. With collaboration, integration and a more competent and qualified field staff, the future of the Association looks brighter.[FPAU 1987]. On the other hand, past studies show that the socio-economic conditions prevailing in Uganda are quickly readjusting people's beliefs and traditional customs where the

good of the past is being married to the good of modern times thereby increasing the number of family planning acceptors. [FPAU 1987].

3.3. Services Available at Family Planning Clinics in Uganda

The primary objective is to give contraceptives to clients who request for them, either after motivation from family planning field educators, medical staff in hospitals or from friends.

The FPAU employs the non-doctor distribution method of contraception, as do most developing countries. The contraceptives are distributed by nurses and midwives of different calibre after an intensive training in contraceptive techniques and distribution procedures. The staff with less basic training act as distributors, while those with more training act as supervisors. Clients are only referred to the doctors when they have serious side effects or any medical history.

In general, the FPAU staff are charged with the following duties :

1. Supply of Contraceptives

This includes demonstration of contraceptives, medical examination services and dispensing of contraceptives. During demonstration all methods of contraception available on the market are explained; how they are used and expected side effects, clients suitable to use each method, contra-indications and the effectiveness against pregnancy of each method.

The role of the personnel supervising distributions is to assist the couple involved to make sound personal decisions by providing information and guidance on the relative methods under consideration. The personnel will need to relate the facts to the contraceptive requirements and social and educational background.

2. Preventive Medicine and Medical Examination

For many healthy people, the seeking of contraceptive advice may be on of the very few occasions where they come in contact with members of medical profession. It is therefore common to use this opportunity to perform physical examinations, to detect certain diseases at a stage early enough to treat them. All this information is considered when contraceptives are being dispensed to clients on their first visit.

Family planning objectives emphasize the fact that responsible parenthood means : "not bringing into the world children that will not be reared, and educated properly". Trying to help people towards a happy family life also means assisting those couples whose marriages are not complete without a child get one. In the family planning clinics, therefore, investigations and treatment are carried out for both subfertility and infertility among couples. [FPAU IEC Unit no date].

3. Training

Facilities for training of medical personnel in contraceptive delivery techniques are available within the medical department. Practical instructions and demonstrations are given at some of

Table 9 gives the 1988 Contrastive Requirements and Acceptor Projections upto 1990 :

Table 8 : Contrastive Requirements and Acceptor Projections for the Period Between 1988-1990.

Method 1988 1989 1990 1990 1990
 [2] [accept] [requirement] [accept] [requirement] [accept] [requirement]

Injctable	17000	26800	17850	78600	18750	82500
Lw-Fem. DC	18250	113300	19200	274600	20200	89000
Fem. DC	32000	77600	33600	480500	35300	65000
M.gyion DC	22750	141000	23900	342000	25100	59000
Condom[4]	6000	adequate	6300	adequate	6600	26000
IJD	4000	1200	4200	4200	4500	4500

Notes:

the FPAU clinics-and it is at these clinics where most information on the FPAU activities can be obtained. Each clinic keeps records and statistical data on contraceptive usage in its own area and acts as a mini documentation centre in that respective area.

As we have already seen in the introduction, the rural population of Uganda covers the portion of 91 per cent of the entire total, leaving only 9 per cent for the urban population, yet almost all family planning activities only exist in the urban centres with a few tributaries penetrating into the rural areas, and yet fertility is known to be highest in the rural areas.

Past studies show that the acceptance of contraceptive use is influenced by many socio-economic factors such as manpower availability, health infrastructure, literacy levels, general level of development and other factors. Acceptance is also influenced by programme effort.[Freedman and Berelson, 1976].

1. Projections are based on current FPAU service data and assumes 5% annual growth.
 2. It has been decided to limit the number of OC brands to 3 instead of the current 10 brands.
 3. Requirement estimates take into account stocks on hand.
 4. Condom supplies currently in stock are adequate until 1989 but demand may change with the activities of AIDS Control Programme.
 5. Annual method requirement per couple includes 104% wastage.
-

Source : FPAU Documents 1988.

3.4. The Achievements and Problems of FPAU

As inputs the FPAU has put labour and effort through its staff and clients. The field staff go out with a goal to influence their clients attitudes towards family planning acceptance and eventually adoption of the practice. The Association also puts in knowledge and skills through its administrative, medical, and educational service and also research and training workshops. In the form of materials, FPAU provides facilities through their clinics, and equipment as well as supplies. The main factor holding back the work of this Association is funds; there has been voiced a remarkable lack of funds that so far only come in form of fees and grants.

In the form of outputs, the FPAU provides services in the form of contacts, visits, diagnoses, medical examinations, tests, and treatment. Unfortunately, because of lack of funds these outputs are minimal as the number of trips the field staff can carry out

are very limited because of high costs involved.

With regard to goods that would be in the form of letters, pamphlets and contraceptives, only the latter is provided to a considerable proportion of the target population. Printing costs are on the high side in Kampala and so the FFAU head office is finding it difficult to publish the required posters and pamphlets for its target group of the population.

In its achievements the family planning association can count on a reasonable degree of awareness created among those few approached, knowledge passed on, and some attitudes and opinions changed. Continuously growing records of acceptors imply that some of those women in their reproductive years have been motivated to accept family planning programmes. Unfortunately, there are no available records of the prevalence of contraceptive use and drop-out levels. This gap could again be blamed on lack of funds to carry out the necessary surveys for this important evaluation.

On programme impact, the Association's work has helped, in those areas where it has reached, improve the health standards of mothers through its IEC unit programmes. Diseases that can be detected during the clinical routine examinations have also been arrested at the stage where detected. A lot remains to be done regarding fertility and subfecundity, and improvement in the status of women who are the major decision-makers in reproduction.

All this work would be facilitated with more financial assistance

to the Association as well as technical assistance in the form of research work.

3.5. Work done during the Reporting Period 1987-88

A checklist to facilitate comprehensive management and monitoring of Primary Health Care (PCH) activities by District Health Managers has been developed and discussed with heads of Primary Health Care components at national level and the Assistant Directors of Medical Services.

During the period 1969-1987 more than half of the visitors to family planning clinics accepted contraceptive methods. [FPAU Report 1987].

There is no complete data available to date covering the period under study on the prevalence of contraceptive use. Statistical data from FPAU records, though, show in general, that the pill, the IUD, and the injection are the most popular methods in that order. The condom, of late is catching up not directly as a way of contracepting-although it serves the purpose in the end- but as a means of preventing the spread of the deadly disease AIDS which is rampant in the urban centres that lie along the major rail-road route crossing Uganda and joining it to Kenya on one end and to Rwanda/Tanzania/Zaire on the other hand.

3.6. Effectiveness of Contraceptive Methods

These reversible contraceptive methods named above can fail, either because the method is not completely effective, or because the client does not follow the rules correctly. Table 3 gives the

theoretical effectiveness of different methods in percentages.

However, irrespective of the reason for the failure, from the point of view of the couple trying to plan thier family, an unwanted pregnancy may have occurred, and all methods of family planning are assessed both on the grounds of their effectiveness and acceptability. Effectiveness (when required data is available) is usually measured as the number of pregnancies which would be averted if 100 women used the method correctly for one year. Some methods of contraception are more effective than others. The range of effectiveness is quite wide and varies from less than one pregnancy in 100 women over one year's use of the pill, when taken properly, to 10-40 pregnancies in 100 during one year, when the rhythm method is used.[1]

It is probable that if 100 women have regular sexual unions for a year with no form of contraception, 80-90 of them would become pregnant within 3-4 months.[FPAU Handbook].

Expected side effects of oral contraceptives

Some women using oral contraceptives experience unpleasant side effects that are not dangerous and are not likely to damage their health. Some of these are quite temporary and are frequently experienced during the first three months of using oral contraceptives. Breasts may feel tender, nausea and vomiting may occur. There may be some weight loss or gain.

[1] The Catholic Church advocates the rhythm method and condemns all others as unnatural-75% of Uganda are members of the Catholic Church.

Some women who are breastfeeding may experience a reduction in flow of breastmilk. More serious side effects include worsening of migraine, asthma, epilepsy, kidney and heart diseases, hypertension, etc... But, above all that, in a country where maternity services are not readily available like the case is with Uganda, having a baby may be hundreds of times more dangerous than taking the pill.

Side effects of the Intra-Uterine Device-IUD-

- * infection is common if the aseptic technique is not followed;
- * the uterus can reject and expel the IUD, if this is not noticed then pregnancy may take place;
- * pregnancy can occur with an IUD in place and the baby will grow normally, the IUD will be found on the outer surface of the placenta or membranes;
- * the uterus may be perforated when a device is inserted or the device may work its way through the wall of the uterus spontaneously -a rare event though- especially with open ended types like Lippes Loop and copper devices used in Uganda;
- * Heavy and prolonged menstrual bleeding or abdominal discomfort may be experienced during the first few months. Clients are advised to return to the clinics two or three months after insertion and thereafter annually.

Side Effects of Depo-provera

This injectable contraceptive is another popular method in Uganda. Though considered one of the most effective methods of contraception, and convenient for most women aged above 30 years, it also has its side effects. First, it is not recommended for

clients with no children because it is highly potent and a single dose of 150 mg may result in amenorrhea and secondary infertility for up to 24 months.; and in some cases eventual complete amenorrhea. Other side effects are mild -these include headaches, abdominal discomfort, limb pain, vaginal discharge and others common with other methods. [FPAU 1982].

Some Moral Aspects of Family Planning

There is a moral obligation to plan the number of children in a family.[FPAU 1982]. The Roman Catholic Church whose membership is no smaller than 75% of the total population, though always mistaken to be pronatalist, agrees with the family planning goals, but, accepts only some certain methods -the natural methods. The family planning field staff therefore find it important to respect other people's religious and traditional beliefs in the circumstances of their work. Individuals and couples are left to choose that method they find morally suitable for them.

Sociologists believe that one of the most important sets of factors influencing the level of fertility in a population are the "ideals of reproduction". These have been summarised as follows :

- * ideal age at time of marriage,
- * ideal interval between marriage and first child,
- * ideal interval between births,
- * ideal age to end child-bearing,
- * ideal size of family.

Source : Community and Family Planning Study Center, University of Chicago, USA.

It is believed that both the husband and the wife of each couple have an opinion concerning each of these ideals and that these opinions influence child-bearing. Moreover, these opinions are thought to influence the behaviour of others through informal conversation. Within each population these ideals are distributed according to some frequency pattern which permits us to say what the "average" or "typical" adult regards as ideal and how much variation away from this average exists. Therefore, the pattern of attitudes towards these topics that characterises a population at a given moment constitutes an "attitude climate" for fertility. If this attitude climate is one that favours high fertility, birth rates should be high.

Sociologists who have studied social change have emphasized that innovations and new ideas are not adopted as quickly as they are proposed, but diffuse throughout the population by a slow process. [J.L. COPP : Iowa University, 1974].

When the adoption process is viewed from the perspective of the individual adopter/acceptor, this process has been said to have five stages as follows :

1. **AWARENESS** : discovery of the existence of an idea or practice;
2. **INFORMATION** : accumulation of basic information concerning the new practices : how and why it works, how it compares with other ideas purporting to

accomplish the same result, and what effort is required to use it;

3. EVALUATION :weighing the alternatives of use or non-use of the practice in terms of the person's own situation and needs, resulting in a decision to try the new practice;
4. TRIAL : first use of the idea or practice usually on a small scale or in a tentative way. This may involve observing use by others;
5. ADOPTION : full-scale use of the idea and satisfaction with the results.

After completing the adoption process the acceptor comes out with some new attitude for instance postponement of age at first marriage. It has already been established that the level of educational attainment of women is a major determinant in fertility.

Thanks to the family planning programme, a great number of clinics have been opened in district and missionary hospitals, health and welfare centres, and a number of private clinics run by the Family Planning Association of Uganda.

The number of acceptors has continued to rise although there are gaps in the data regarding these -figures are likely to be higher had complete data been available.

The programme has two main objectives : health and demographic. The health objective is to enhance the health of the mother and

child; for instance by reducing the number of preventable diseases cases, provision of both anti-natal and post-natal health care and services. The demographic objective is contained in reducing the population growth rate by recruiting new acceptors in order to avert a certain number of births, increasing service and delivery points, increasing numbers of enrolled nurses and midwives, by extending improved information and educational activities.

The programme's major objectives continue to be child-spacing and reduction of infant mortality as the main paths leading to a reduction in the rate of population growth.

CHAPTER IV

Summary of Findings, Conclusions and Recommendations

4.1. Summary

The level of contraceptive use in Uganda is still low; covering only about 10 per cent of the target population of women aged between 15-49 years.

The task that the FPAU is facing is a gigantic one in view of constant growing populations and the difficult circumstances that have been prevailing in the country for the last 17 years (since the country entered political in 1971). The Association has faced more difficulties still by having to shoulder most of the responsibility of educating the population about the need for family planning and dispensing such services ; yet this organisation has limited funds and personnel that cannot cater for family planning at national level [FPAU 1987]. In the area of recruiting acceptors of family planning, FPAU has done very well for the number of clients is constantly growing from an annual number of 5000 in the 1960's to an annual average of over 30,000 acceptors in the early 1980's. FPAU considers this a big step made and a great achievement in the demand of family planning services [FPAU 1982].

The question that remains is the relationship between this figure and the eligible population that should be served by the Association. Statistics from the 1980 Census show that 51 per cent of the total population were females and of his female populaion 40 per cent were in their reproductive age [15-49 years]. FPAU's target was a quarter of this reproductive-age

population, but due to limited funds and personnel the Association can only serve 10 per cent of their target group.[FFAU Handbook 1982].

In Uganda, the first population policy was contained in the Third Five Year Development Plan of 1971/72 to 1975/76. It was envisaged that at the then prevailing rate of growth of 3 per cent per year, only 64 per cent of the school age population would be enrolled in primary schools by the year 2000 and that universal primary education would only be attainable 100 years from this plan period.[FFAU Handbook no date].

Government involvement as defined in that Plan was rather limited. The government was convinced that in view of the social, economic and health problems arising from high birth rates, it was necessary to institute a programme of advice to women on family planning and child spacing.

The policy stated that the Ministry of Health was to take over full responsibility, coordination and administration of all aspects of health and family planning to make effective and meaningful the integration of family planning, MCH and nutritional services. The Ministry was to work in conjunction with FFAU, the Women's Council and private organisations -NGO's- to plan and provide personnel and training, equipment and drugs needed for the required national health and family planning programme projects and activities.

Achievements so far in implementing this population policy

include : a number of courses that have been offered and are still being offered in clinical skills for nurses and midwives recruited from government and other health units.

4.2. Conclusion

The discussion in chapters two and three indicate that the desired goal of lowering the prevailing fertility levels will not be achieved by the present level of performance by the family planning programme. The task facing this programme, run by a non profit-making organisation, -NGO- is too much to accomplish the desired results. The government should put in more effort, both financial and technical to assist the FPAU. So far the government in conjunction with UNICEF.

Although Total Fertility Rates, TFR, seem to have fallen in some areas - the whole credit cannot be attributed to family planning programmes; for instances in areas like :

It is also believed that civil war and conditions of insecurity that forced to the departure of great numbers of the male population or to their ultimate deaths contributed a lot to declines in birth rates as the women experienced temporary/indefinite separations from their husbands while others became widows. This fertility inhibitor of non-exposure to risk of pregnancy cannot be attributed to family planning efforts. The same areas termed as insecure areas were also known to be suffering from temporary or indefinite termination of family planning services.

Unfortunately data on contraceptive use, numbers of acceptors, numbers of drop-outs, age-specific rates of acceptors, etc., is scanty if not available at all and where existent it is not continuous.

According to FPAU IEC Unit, there is a high desire for family planning services especially proved in the urban centres where research has been done, and this is a result of the information-education-motivation campaigns of the programme. The main problem, especially in regard to the adolescents is still the public view of their participation in the programme where, if discovered, are always considered immoral, and this public includes some FPAU clinic staff (A shared opinion of Kampala adolescents). The adolescents claim that these staff ask them some questions 'intended' to embarrass them rather than encourage them, wearing accusing gestures on their faces when serving these adolescents. The end result of all this is for the teenagers to shy away and try to look for other means that major in abortions. For those who got to the back-street doctors clinics to buy the 'pill' they find themselves paying exorbitantly for these small packets that most times happen to have been stolen from the family planning clinic stores. Finding their pockets too thin to accommodate this expense, some teenagers surrender and wait for what fate will bring.

The other main problem for the back street sales is that these clients miss the professional doctor's consultation on the appropriate method and examination of their prevailing health situation which are offered at the family planning clinics. In

case of any side effects, such clients are more likely to drop out of the programme carrying a lot of propoganda on the related method in particular, not knowing that some side effects are temporary and disappear within two or three months of usage, and that there are a lot of other alternative methods they have not been exposed to. All this result in negative propoganda against the programme.

4.3. Recommendations

More and more seminars on family planning should be held with a goal of involving other people in communicating family planning messages to the different people they serve. However, the field educators should always remember that each family planning programme faces a unique set of problems determined by cultural, demographic or historical conditions; for instance in some cultures it would be hard to convince a couple with all children belonging to the same sex to join family planning. At the same time it would be unwise to preach the family planning gospel in places where big numbers of people are being killed constantly, as it is the case with Uganda. The field educator would have to be very careful in the way he address people on the need for family planning. In this way the family planning communicators should find themselves offering quite different solutions to different areas.

When the family planning communicator identifies a problem, he should know which audiences to address in order to solve this particular problem - is it women who are dying because of

unplanned pregnancies and adolescent pregnancies ? or is it men running away from their responsibilities of looking after their families ? or are children causing a lot of suffering in the community because they have nothing else to do -the problem of delinquency- ? The audience could therefore be women, men, parents, the youth, teachers, farmers, the church etc.. It is the duty of the field educator to select the appropriate messages that are to be passed onto the identified audience. Since the subject is bound to be new to most of the audience, the message must be kept simple, stressing on only a few [two or three] important points. The entire presentation should be relatively short and the audience should not be burdened with a stream of difficult statistics. In the address speech to the people the field educator must remember to tell his/her audience that "himself/herself and the FPAU are offering the people of Uganda a chance to plan their families and they are left with their freedom of choice. In short, they should have it clear that they are not being told of which choice to make, but are only being asked to realise the prevailing situation.

The field worker should simply outline how family size relates to community development, how family size relates to national progress and social well-being. A few references can be made with regards to what it would mean to this audience, to their families, each month in terms of money or food or school fees, if there are two children instead of ten. Talk of the differences that would occur in Uganda between a family of two children and one of eight children a being ability versus disability to afford

a radio, a bicycle for the children's transport to school, a greater probability for higher education for all children, etc... The audience would be made more aware of the seriousness of the population problem if the educator talked of "the chance if all families in Uganda had two children instead of eight, there would be three million less unemployed" than they would stretch their minds to understand what is meant by "If the growth rate of Uganda remains at 3.3% per annum, then the population would double in 23 years".

One important tool of the communicator is the 'ears of his/her audience'. This tool he uses by speaking; but another important tool is the 'eyes of the audience'. The communicator must use this tool too, so he must be more than a mere speaker, he must be a presenter of his message - and this is best done through the use of VISUAL AIDS.

Whatever visual aids is used, it must relate to the verbal presentation though does not essentially need to have a professional appearance. Presentations are always good so long as the presenter remembers his purpose is to communicate a specific message, understands the message himself and relates his entire presentation to that purpose. The conclusion should summarize the main point of the message and suggest strongly once more, the action the communicator wishes the audience to take. The main purpose of the communicator is to make sure that he creates awareness among the people of the need for family planning services.

Information giving means providing the client with facts about family planning services. It does not mean being judgemental and sharing the field worker's biases and opinion with the client.

Providing support means doing so for the client in her efforts to obtain sustained medical care of high quality and permitting the client to air her feelings, especially when these are negative

Problem clarification is done through discussions and consideration of the alternatives, and clarification of the ambivalent feelings and attitudes of clients in relation to obtaining medical care to prevent conception.

Training

In order to determine whether any practice changes have occurred in the family planning service area, and if so, what these changes are, a session should be arranged for participants two to three months after completion of the course. The entire course can be reviewed and discussed at this time, and suggestions elicited from workers about improvements in format and content. Suggestions can be invited, based on problems field workers have experienced in the field.

Each participant should be provided with a copy of the evaluation form and sufficient time to complete it.

Based on the results of the evaluation, staff training personnel should evaluate the need for further staff in-service training and set up an appropriate plan for continuing in-service training based on this expressed need.

Responsibility for the continuing in-service training programme in family planning may best be delegated to unit supervisors to be organized on a unit basis; the departmental supervisors would then work closely with the supervisors to ensure continued uniformity in this continuing in-service training.

Systematic orientation for all new fieldworkers added to staff should be planned, possibly through replication of the basic training programme at periodic intervals, as part of their orientation to the department.

On the national population policy.

Fertility control and population policy are far too important to be left entirely to demographers, churches, and that whole lot of interest groups formed on all sides of the subject. Judith Blake argued that families cannot be persuaded to have smaller families voluntarily until there has been fundamental social change beyond technology. Challenging the assumption that excess fertility was due to births that couples would have preferred to avoid, Judith Blake recommended a 'lifting' of pressures to reproduce-by changing the occupational roles of women ["the social organization of reproduction"] rather than an imposition of pressures not to do so. She was of the opinion that the poor have large families for reasons other than the mere unavailability of contraceptives : they are so occupied with the problems of obtaining food and shelter today that they do not easily focus on or worry about the future. The long-range implications of having another mouth to feed, five or ten years

from now, are too remote to command much systematic attention. Other studies have examined the psychological satisfactions of childbirth to a mother who is troubled and alienated from society. The ultimate goal therefore for any national population policy is the promotion of the status of women - thus the reasons for the growing acceptance of government-supported birth control programmes targeted at the poor and less educated.

Planned Parenthood and the Churches

Of the total Ugandan population 75 per cent are members of the Catholic Church. This church's stand on birth control has always been :

"If, then, there are serious motives to space out births,....., the church teaches that it is then licit to take into account the natural rhythms, for the use of marriage in the infecund periods only, and in this way to regulate birth without offending the moral principles which have been recalled earlier." [Pope Paul VI, 1968].

Of the remaining 25 per cent of the population, 20 per cent belong to the protestant church [Church of Uganda] and this church's stand on family planning has been recorded as follows :

"The responsibility for deciding upon the number and frequency of children has been laid down by God upon the consciences of parents everywhere;.....The choice must be made by parents together, in prayerful consideration of their resources, the society in which they live, and the

problems they face.... for proper ends." [Lambeth Conference of Anglican Bishops 1959].

The above churches' attitudes appear anti-natalist in their content; the churches could therefore be utilised more in the struggle to convey the message of 'responsible parenthood' to their congregations. These churches could be encouraged to intensify (if already existing) their programmes on family life education and so forth...since they reach further the interiors of the masses of all classes than any other organisation does.

The availability and collection of demographic data

Simultaneously with the launching of a national family planning programme, each nation needs to establish a long-range and integrated programme of evaluation and review which will :

- (a) measure the level of fertility and changes in the level of fertility; and
- (b) provide a prompt and steady flow of information with which to develop and improve the national family planning programme.

The first priority must be to get an overall picture of the national situation--rapidly and fully. This calls for a central national evaluation unit with autonomy to collect data for the nation as a unit. In order to provide details both at the national and provincial/district levels, heavy emphasis has been laid on sampling'. First priority is given to establishing a national sample covering the whole nation.(if there is none in existence).

The Ministry of Health should organise a further consolidation of rural, urban, curative and preventive/promotive service. This should include services on communicable and vector-borne disease control, environmental health, maternal-child health/family planning, health education and nutrition. These services should be integrated with rural health programmes with major aims of reducing morbidity, mortality and fertility rates.

The Ministries of Health, Information and Education should increase awareness of the population situation through their education programmes and in turn the need for family planning, and how and where to get the services.

With respect to nutrition, specific activities should include identification, production and dissemination of appropriate nutrition education materials, improving infant feeding practices, monitoring and evaluation, and research. Emphasis should be placed on use of local food sources and only those new food technologies appropriate to local communities.

Rural health service should have family planning clinics in all their visits. In order to reduce pressure on existing static health facilities in rural areas, the approach of Community Based Health Care, [CBHC], should be promoted for MCH/FP services and contraceptive deliveries in the rural sector.

The Ministry of Health in collaboration with other governmental and non-governmental organisations, [NGO's], should facilitate the increase in number of family planning clinics in a decentralised manner, spreading from urban centres outwards into the villages.

Annex 1 : Recorded Population Changes, 1959-1969

District	Population		Annual Growth Rate%	
	1959	1969		
West Mengo	508410	803605	4.7	
East Mengo	606694	846986	3.4	[Buganda Province]
Masaka	440180	637018	3.8	
Mubende	215739	329998	4.3	
Teso	453474	565936	2.3	
Bugisu	311998	415827	2.9	
Bukedi	397650	524723	2.8	[Eastern Province]
Busoga	660507	933270	3.5	
Sebei	49320	64432	2.7	
Karamoja	171945	283776	5.1	
Kigezi	493444	646726	2.7	
Ankole	529712	859113	4.9	[Western Province]
Toro	347479	567907	5.0	
Bunyoro	189980	350286	6.3	
West Nile	383926	572289	4.1	
Madi	50627	89842	5.9	
Acholi	285530	462095	4.9	
Lango	352943	502637	3.6	
TOTALS	6449558	9456466	3.9	

Source : Uganda Census Reports

Note : The 18 districts that appeared in the 1959 and 1969 Census reports were split up in 1980 Census to form 33 districts as follows in :

Appendix 2

1969	formed--->	1980	1969	Census 1980	Growth%
1. West Mengo		1. Kampala	351796	479792	3.0
		2. Mpiqi	492402	639919	2.6
2. East Mengo		3. Luwero	315204	412474	2.6
		4. Mukono	541016	634275	1.5
3. Masaka		5. Masaka	458024	631156	3.0
		6. Rakai	182572	274558	4.0
4. Mubende		7. Mubende	330955	510260	4.2
5. Iese		8. Kumi	190715	239539	2.1
		9. Soroti	379913	476629	2.2
6. Bugisu		10. Mbale	421433	556941	2.8
7. Bukedi		11. Tororo	527090	668410	2.3
8. Busoga		12. Iganga	470189	643881	3.0
		13. Jinja	196262	228520	1.5
		14. Kamuli	278296	349549	2.3
9. Sebei		15. Kapchorwa	64464	73967	1.4
10. Karamoja		16. Kotido	105576	161445	4.2
		17. Moroto	164695	188641	1.4
11. Kigezi		18. Kabale	403400	455421	1.2
		19. Rukungiri	244588	296559	1.9
12. Ankole		20. Bushenyi	410683	524669	2.4
		21. Mbarara	450462	688153	4.2
13. Toro		22. Bundibugyo	79420	112216	3.4
		23. Kabarole	327962	519821	4.6
		24. Kasese	164132	277708	5.2
14. Bunyoro		25. Hoima	184057	294301	4.7
		26. Masindi	167846	223230	2.8
15. West Nile		27. Arua	369620	472283	2.3
		28. Nebbi	204142	233000	1.3
16. Madi		29. Moyo	89978	106492	1.6
17. Acholi		30. Gulu	223708	270085	1.8
		31. Kitgum	240136	308711	2.4
18. Lango		32. Apac	225413	313333	3.1
		33. Lira	278902	370252	2.8
Uganda			9535031	12636179	2.8

Source : Ministry of Planning and Economic Development, Entebbe.

Appendix 3 : Total Specific Fertility Rates and Crude Birth Rates by District 1969

District	TFR 1969	CBR 1959	CBR 1969
M. Meno	6.7	38	41
E. Meno	5.6	34	38
Masaka	7.7	38	49
Mubende	6.4	37	43
Kampala City	5.2	38	46
BUGANDA	6.3	36	42
Teso	5.2	31	37
Bugisu	7.5	48	50
Bukedi	7.2	50	46
Busoga	6.9	40	51
Sebei	8.3	48	51
Karamoja	6.0	50	42
Ginia	5.7	40	49
Mbale	5.5	48	48
EASTERN	6.6	42	49
Kigezi	8.1	50	54
Ankole	8.5	53	55
Toro	7.7	41	52
Bunyoro	7.2	32	47
WESTERN	8.2	45	53
West Nile	7.8	45	53
Madi	8.0	50	54
Acholi	8.5	50	54
Lango	7.3	50	49
NORTHERN	8.1	48	52
Uganda Totals	7.1	42	49

Source : Uganda Population Census Report 1969

Annex 4 : Population Density by District - 1969 and 1980
Censuses

District	Area [Sq Km]		Population		Density[land area]	
	Total	Land	1969	1980	1969	1980
Apac	6488.3	5886.8	225413	313333	38	53
Arua	7830.2	7595.4	369620	472283	49	62
Bundibugyo	2337.7	2096.8	79420	112216	38	54
Bushenyi	5395.9	4905.1	410683	524669	84	107
Bulu	11734.9	11560.4	223708	270085	19	23
Hoima	9896.4	7463.1	184057	294301	25	39
Iganga	13113.5	4822.9	470189	643881	98	134
Jinja[a]	733.6	632.0	148390	183460	235	289
[urban]		45.0	47872	45060	1064	1001
Kabale	2488.8	2315.1	403400	455421	174	197
Kabarole	8360.9	8107.8	327962	519821	40	64
Kampala	238.0	197.6	330700	458503	1674	2320
Kamuli	4348.3	3332.2	278296	349549	84	105
Kapchorwa	1738.3	1738.3	64464	73967	37	43
Kasese	3205.5	2723.8	164132	277708	60	102
Kitgum	16135.9	16135.9	240136	308711	15	19
Kotido	13207.8	13207.8	105576	161445	8	12
Kumi	2861.2	2456.7	190715	239539	78	97
Lira	6752.8	6151.3	278902	370252	45	60
Luwero	9198.0	8539.2	315204	412474	37	48
Masaka	16326.9	5963.1	458024	631156	77	106
Masindi	9640.1	8766.0	167846	223230	19	26
Mbale[b]	2545.8	2503.6	421433	556941	168	223
Mbarara	10839.2	10587.2	450462	688153	43	65
Moreto[c]	14113.3	14113.3	164695	188641	12	13
Moyo	5006.1	4668.3	89978	106492	19	23
Mpigi	6221.8	4485.9	513498	661208	115	147
Mubende	10309.7	9819.7	330955	510260	34	52
Mukono	14241.8	4593.5	541016	634275	118	138
Nebbi	2890.7	2731.3	204142	233000	75	85
Rakai	4973.1	3889.3	182572	274558	47	71
Rukungiri	2752.6	2584.4	244588	296559	95	115
Soroti	10059.6	8526.2	379913	476629	45	56
TBFBF	4553.1	3889.3	527090	668410	135	171
Uganda	240539.6	197044.3	9535051	12636179	48	64

Notes:

- Jinja District includes the Municipality and a largely semi-urban surrounding area and the Industrial Kakira Sugar Estate; hence the high rural density of population.
- Mbale District includes Mbale Municipality Council.
- Moreto population excludes that of Karasuk, transferred to Kenya after 1969 [1969 population was 13796].

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