“The true number of persons with disability in Uganda is not really clear since there is no clear definition of disability and the statistics keep on widely varying from one study to another (*National Council for Disability, 2010*). Disability statistics from censuses typically ask questions about impairments and provide estimates that seem very low by any standards. For instance the 2002 Population and Housing Census estimated that 3.5% of the total population, (equivalent to less than 1 million people), were considered to have a disability while the 2005/06 Uganda National Household Survey estimated that 7.1% of Uganda's total population (equivalent to approximately 2.1 million people) were living with a disability.

Family Planning in Uganda

The Government of Uganda is committed towards improving Family Planning use and access as reflected in its National Development Plan 2010/11-2014/15 and acknowledges that limited access to family planning services hinders development of the country especially that of women (*SUPRE, 2013*). Although the coverage and reach of Family Planning (FP) services has improved over time, there still exists a high unmet need for comprehensive family planning and reproductive health services. Only 26 percent of the married women are using modern FP methods (*UBOS 2012*). Family planning is an important component of sexual and reproductive health that empowers men and women to determine the number and spacing of their children. It includes all methods of preventing and regulating conception and should be equally accessed by all. Despite the universal right to access the ‘same range, quality and standard of free or affordable health care and programs as provided to other persons, people with physical disabilities experience challenges in accessing sexual and reproductive health (SRH) services (*Ahumuza, 2013*).

Family Planning and disability

Women with disabilities encounter various social, attitudinal and physical barriers to accessing safe motherhood and reproductive health services (*Smith, 2004*). A study on the challenges of accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda (*Ahumuza 2007*) revealed that women with disability were marginalised by societal perceptions ‘should not be sexually active’ which perceptions influenced the way disabled people were treated in the community on issues of sexual reproductive health and to the extent of withholding sex education on the assumption that persons with disability ‘wouldn’t need it’.

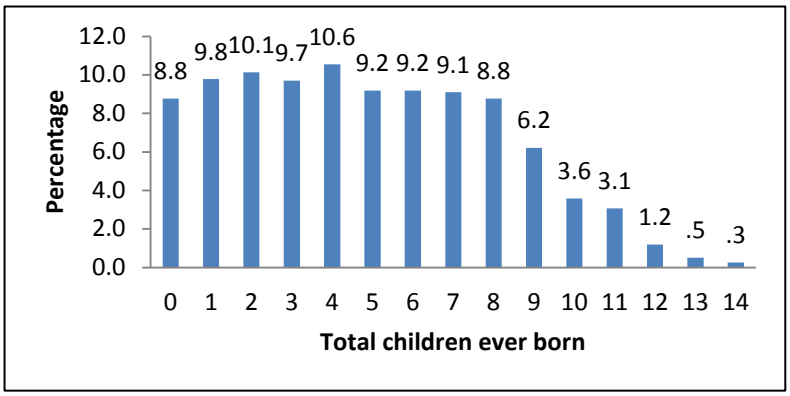
Knowledge and use of contraception amongst women with disability.

There appears to be no evidence of studies undertaken to establish the ‘unmet need’ amongst women with disability in Uganda and no explicit conclusions have been derived on the use of contraceptives amongst women with disability in Uganda. Data was analysed using SPSS version 22 software. Analysis was done at the univariate, bivariate and

multivariate level. These findings based on computation of the proportion of disabled women in the UDHS 2011 citing the total number of women who expressed difficulty (some difficulty, a lot of difficulty, inability) in; Sight; Walking; Hearing; Communication and Concentration revealed that 1,175 women expressed difficulty. This means about 17.2 % of the women respondents expressed some level of difficulty. Key findings of fertility and family planning amongst women with disability in Uganda

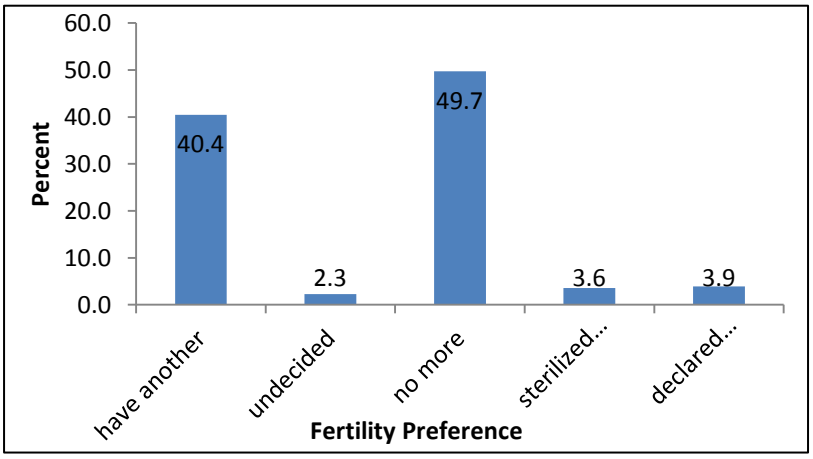
i. Total children even born to women with disability

Figure 1 Percentage distributions of women with disability by total number of children ever born.



The mean ideal number of children desired was 4 children.

Figure 2 Fertility preferences of women with disability



Nearly half (49.7%) of women with disability reported that they did not want any more children, 40.4% said they wanted another child and 3.6% and 3.9% reported that their partner was sterilized and they were infecund respectively. Only 2.3% of the women said they were undecided. The result suggests that unmet need for family planning was very high among women with disability in Uganda.

iii. Current contraceptive use for women with disability

Table: Current contraceptive use by method for women with disability

FP method	Frequency	Percent
no method	569	69.1
Traditional / folkloric method	32	3.9
modern method	222	**27**
Total	823	100

iv. Knowledge and uptake of family planning profile

Family planning use increases with age amongst women with disability. The FP use per age group peaks at age 30 – 34 years then begins to drop till it reaches 41% for 45 – 49 year olds. This pattern is similar to ageutilisationpattern amongst women without disability.

There is a strong significance between family planning use and the number of children desired. 56% of those who desired no children were using family planning; 48% who desired one to three children were using family planning; 60% of those who desired four to six children were FP users in comparison to 47% of those who desired more than seven children. The analysis shows that number of children desired impacts greatly on the family planning utilisation and the percentage of users keeps growing. Family planning use amongst those who desired more than seven children at 40% also indicates that this group can be targeted for child spacing and for better health of the mother and child.

Ethnicty is a strong predictor for the utilisation of family planning commodities. The use of FP by ethnicity shows Baganda / Basoga at 66%, Banyankole / Bakiga at 60%, Iteso / Karimajong at 50% and Luo / Lugbara at 40%. This utilisation pattern can be explained by the concentration of family planning programmes in the central region of the country which is majorly inhabited by certain ethnicities. This calls for improved programming and increased attention of family planning programmes for the ethnic groups with the lowest percentage.

Other strong predictors for family planning use amongst women with disability that were revealed through the bi-variate analysis included type of place of residence and access to radio. The analysis shows that only 53% of women living in rural areas were using family planning in comparison to 64% of women living in urban areas who used family planning. These findings show that urban areas had a higher affiliation towards the use of family planning than those women living in rural areas.

However at multi variate level, religion, place of residence, ethinicity, occupation of the women, access to radio and current working status of women with disability did not emerge as major determinants of utilisation of contraceptives amongst women with disability. In addition, fertility intentions did not show any strong significance towards contraceptive use amongst women with disability who were not in union. Women with disability who were married or in union women with partners that had higher than primary education were one and a half times more likely to use because they did not want any more children.

Women with disability from the middle wealth group are 1.5 times more likely to use contraception than their counterparts in the poorest income group. The model showed that

women with disability from the richest wealth group were three times more likely to use contraception than their counterparts from the poor group. This analysis suggests that contraceptive use amongst women with disability increases with wealth. There was also a high significance of contraceptive use amongst wealthy women with disability that were in union.

Marital status on its own did not reveal a big significance on the utilisation of family planning products amongst women with disability. It was only when marital status or union was correlated with the education status of the partners that there was a strong significance. This probable explanation for this could be that the level of education of the partners contributes to greater understanding of the implications of planning for the family and hence greater likelihood to use contraception.

Women with disability with primary education were 2.3 times more likely to use contraceptives than their counterparts with no education. Similarly women with disability with secondary education were five times more likely to use contraceptives than women with disability with no education. Level of education of women with disability showed a very strong significance towards their utilisation of contraceptives. The women that were married to partners with secondary level were twice more likely to use contraception than their counterparts.

The greater the number of children ever born for women with disability, the higher the odds for utilisation of contraception amongst women with disability. Women with disability with two to four children were three times more likely to use contraception than their counterparts with no children, women with five to six children were almost six times more likely to use contraception than their counterparts without children, which odds became much higher for those women with seven children or more who were almost nine times more likely to use contraception than their counterparts without children.

There is a low contraceptive prevalence rate amongst women with disability. The analysis showed contraceptive prevalence rate of 27% amongst women with disability. This is quite a low prevalence rate in light of the challenges that women with disability are faced with in the attainment of health.

The unmet need for spacing and limiting expressed by women by disability from the analysis was 12.5% and 12.9% respectively. The combined unmet need for women with disability derived from the two unmet needs is 25.4%. This means that over 25% of women with disability would wish to limit or stop bearing children but are unable to access family planning commodities.