

**FACTORS ASSOCIATED WITH LOW FAMILY PLANNING SERVICE
UTILISATION AMONG WOMEN ATTENDING BUMOOLI HEALTH
CENTER IN NAMAYINGO DISTRICT-EASTERN UGANDA**

**BY
WANDERA RONALD
DCM/0075/143/DU**

**A RESEARCH REPORT SUBMITTED TO THE SCHOOL OF ALLIED
HEALTH SCIENCES IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF DIPLOMA IN CLINICAL
MEDICINE AND COMMUNITY HEALTH OF KAMPALA
INTERNATIONAL UNIVERSITY
UGANDA**

JULY, 2017

DECLARATION

I hereby declare that this research proposal is entirely as a result of my own effort, and has not been presented in any other University/institution for any academic endeavors.

Wandera Ronald

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...../...../.....

RESEARCHER

Signature

Date

APPROVAL

This proposal has been written under my supervision and is being submitted for examination with my approval as a university supervisor.

Signaturedate...../...../.....

Mr. MUSUMBA MOSES

Clinical Officer

(SUPERVISOR)

DEDICATION

This work is dedicated to **GOD** Almighty, who granted me the knowledge, strength and courage throughout this programme and from where I started schooling upto this level. And to my beloved uncle **Mr. Mangeni Fred Makhaali** for his endless financial support since when I started knowing the value of education till now.

ACKNOWLEDGEMENT

In the course of this research work, I have derived a lot of support from various Individuals and articles. In the first place, I am sincerely grateful to my supervisors, **Mr. Musumba Moses** and **Mr. Tutamwebwa Thomas** and Research coordinator **Mr. Atuheire Collins** for their guidance, patience, comments and suggestions at each stage of the work which has helped me to come out with the thesis.

Secondly, I also wish to express my thanks to Uncle **Mangeni Fred Makhaali** for supporting me financially, may you live to see your ancestors. To the following for their support in all ways, Tuhairwe Susan, Isiko Yasin, Bagalana George, Lwanga Gerald and all my classmates for their courage and guidance in one way or the other while at campus. To my parents for making me reach on this planet and to **Mama Delishia** in a special way for you have been there for me. To Mr. Musumba Moses (clinical officer) and Brother Luhair Alex (RIP) for your guidance and support in the medical field.

Finally, my sincere thanks go to Kampala international university especially school of allied health sciences for granting me opportunity to study my dream course, and the DHO Namayingo district, incharge Bumooli HC III and all mothers who participated in this study

May God bless you all.

LIST OF ABBREVIATIONS

| | |
|---------------|--|
| BHC | Bumooli Health Center |
| COCs | Combined Oral Contraceptives |
| CPR | Contraceptive Prevalence Rate |
| DHO | District Health Officer |
| DHRO | District Health Records Officer |
| DHS | Demographic and Health Survey |
| FP | Family Planning |
| FPAU | Family Planning Association of Uganda |
| HMIS | Health Management Information System |
| IMR | Infant Mortality Rate |
| IUD | Intra Uterine Device |
| KIU | Kampala International University |
| LAM | Lactational Amenorrhea Method |
| MC | Modern Contraception |
| MDGs | Millennium Development Goals |
| MoH | Ministry of Health |
| NGO | Non-Governmental organization |
| NPP | National Population Policy |
| PHC | Primary Health Care |
| POPs | Progestosterone Only Pills |
| RHU | Reproductive Health Uganda |
| TFR | Total Fertility Rate |
| UBOS | Uganda Bureau of Statistics |
| UDHS | Uganda Demographic and Health Survey |
| UNEST | Uganda Newborn Study |
| UNICEF | United Nations Children's Fund |
| USA | United States of America |
| USAID | United States Agency for International Development |
| VHT | Village Health Team |
| WHO | World Health Organization |

DEFINITIONS

Family planning utilization: This refers to the act of using any form of either modern or traditional family planning (FP) method.

Family planning: Is where individuals/couples use birth control measures to determine the number of children, their spacing, and timing their births.

Family planning methods: These are birth control measures such as pills, injectables (Depo-Provera), condoms, implants, Intra uterine contraceptive devices, vasectomy, and bilateral tubal ligation used in child spacing.

Factors: A factor is a circumstance, a fact or influence that contributes to a result (Oxford Dictionary, 2002).

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ABSTRACT

Family planning was cited as essential to achievement of millennium development goals (MDGs) by 2015. However this was not achieved.

Problem statement: Low utilisation of FP services has led to a high fertility rate of 6.2 children per woman in her lifetime in Uganda, and in Namayingo district only 10% use FP compared to the national coverage of 40%.

Purpose of the study: To assess the factors associated with low FP service utilization among women at Bumooli health center III in Namayingo district, eastern Uganda.

Study design: A descriptive cross sectional study using quantitative data collection among 201 women of child bearing age was employed. Data was collected using pretested researcher administered questionnaires and analyzed manually by tally counting and results presented in form of tables.

Finding: A total of 201 women were recruited, the major factors associated with low utilization of FP services were; cultural beliefs (98.5%), low socio-economic status (80.1%) with 45.2% peasants, 27.9% house wives and 12.4% employed. Peer influence (42.5%), and low level of education where 7.1% of 29.9% of the non-educated were using FP. The finding also identified that most of the respondents were housewives 42% with no stable financial support.

Conclusions; The study showed that; cultural beliefs, low socio-economic status, Peer influence and low level of education are the major factors affecting utilization of FP services at Bumooli Health Center III in Namayingo district.

CHAPTER ONE: INTRODUCTION

1.1 Background

Family planning (FP) is a voluntary and informed decision made by families, couples or sometimes individuals on how they will regulate their reproduction (WHO 2008). Effective FP service utilisation results into significant reduction in the number of unwanted pregnancies, abortions, maternal mortality rate and dramatic drop in the population size (Arnold et al, 2006; Hudson et al 2010).

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

It has been foreseen that if FP utilization is not effective, the world population is expected to double in 20years time and mostly the socio-economically disadvantaged. (Wilson et al, 2013). Some of the decisions that families have to make in the control of their reproduction include; when to begin and end having children, how many children to have, at what intervals to have children and what method of fertility control to use, and means of inducing fertility acceptable to them. Note that all these decisions have to be voluntary.

Globally, it has been reported (WHO, 2010) that an estimated 358,000 maternal deaths occurred in 2008 with 87% in SubSaharan Africa and South Asia as a result of low FP utilisation.

In Uganda, approximately 156 infant and maternal deaths per year and an exponential population growth can be prevented if the FP services are effectively utilized (Royson, 2013).

According to Aggrey (2009), the history of family planning in Uganda is closely linked to that of the family planning association of Uganda (FPAU), renamed Reproductive Health Uganda (RHU). The FPAU was formed in 1957 at a time when most Africans were in favour of large families and hence did not believe in family planning. Initially a group of volunteers, mainly members of Asian and African Mothers' Union formed a loose association to advocate for FP, which was an exclusive practice among women who could afford services provided in private health facilities at a fee. The FPAU gained legal status in 1963 when it was registered as a Non-Governmental Organization (NGO). And the FP devices that were provided to women included Intra Uterine Device (IUD), diaphragm, jells and condoms.

However the advocates faced some challenges like; men were mostly in favour of large families, Childless women or those with less than 3 children were not allowed to use FP services, stiff opposition from traditional, political and religious leaders who believed that large families were an asset and a fulfillment of God's teachings; that FP would promote promiscuity and make women infertile, Condoms were said to cause cancer for women whose spouses used it during sexual intercourse, and this would presumably result in a huge number of women dying. And to many Africans, FP was also seen as a hidden agenda to reduce the African population by the colonialists while theirs grew, as a strategy to rule the country. In order to overcome such resistance to FP, the association recruited influential people to become members of its board and its rank of volunteers.

In 1970s When Idi Amin took over the government in a military coup, the government banned FP, arguing that it went against African culture. However the tide changed in 1975 when MOH accepted child spacing as an essential component of primary health care (PHC). By 1977, FPAU's clinics rose to 4, besides another 13 located within government hospitals. The total number of acceptors had reached 20214, with 7918 being new acceptors. In 1981, the government adopted the maternal and child health programmes, effectively bringing FP on board. In 1983, the government took over from FPAU the provision of services in government hospitals and other health units.

In 2008, the Government of Uganda launched the revised National Population Policy (NPP) and this is the current policy that guides all key players to develop FP interventions to reduce fertility and to ultimately achieve a sustainable population.

An estimated 225million women in developing countries like Uganda would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include limited choice of method, limited access to contraception, particularly among young people and poorer segments of populations, fear or experience of side-effects, cultural or religious opposition, poor quality of available services, users and providers' bias and gender-based barriers. (WHO 2011). Most Ugandan women need FP services but they are not accessing them due to lack of knowledge, costs and resistance from the husband (Peter, 2014)

In general, there are two major determinants of fertility in Uganda. First, underlying or indirect factors known as socio-cultural and economic (intermediate) determinants including education, the desire for large families, extended family influence, economic value of children, occupation, property ownership, and residence. Second, immediate or direct determinants include marriage patterns, sexual customs, and frequency of sexual activity, access to and use of contraceptives, length of postpartum amenorrhea, sterility, and abortion.

Therefore, this study is aimed at assessing the factors associated with low utilization of FP methods among women attending Bumooli Health Center in Namayingo district eastern Uganda.

1.2 Problem Statement

Globally, the continuous growth in the population by 7% annually and an increase in the fertility rate of 69% have been attributed to low uptake of FP services (Olivia et al, 2012). And in 2009, WHO (2011) revealed that 90% of the world abortion related mortality could have been averted if women wishing to postpone or limit further child bearing used effective FP methods. More than 100 million women in low developing countries (LDC) would prefer to use FP to avoid pregnancy but are not using any form of FP method. In Uganda, research has shown high fertility rate of 6.2 children per woman in a lifetime, which is estimated to be due to poor use of family planning methods, resulting into an estimated 536,000 maternal death from pregnancy-related causes each year, and about 15 million women suffering from related complications that can have life-long consequences (UDHS 2011). These complications and 35 % of all maternal deaths could be eliminated if women and men had access to FP to prevent unintended pregnancies (WHO, UNICEF and World bank 2007). In a study carried out in 2015 at Bumooli HC by a team from office of the Health inspector Namayingo district to assess the level of utilisation of FP services, showed that, out of the 200 respondents, only 75 (37.5%) reported to have used one of the FP

methods and 125 had not. This showed a low level of utilisation of FP services, and posed a question as to why this low turn up (HMIS FP Namayingo, 2015).

The ministry of Health (MOH) through the government of Uganda opened more health units to improve on access of health services; more than 70% of the population of Namayingo is within 5 km distance from health unit, and all levels of health facilities provide FP services for free. Sensitization of the community on use and importance of FP has been ongoing by village health team (VHT) under the Uganda Newborn Study (UNEST) and Marie stops Uganda. But the level of utilization of FP is still very low. (HMIS FP Namayingo, 2015). Hence the need for this study to assess the factors contributing to this low utilisation of FP services given all the available services for free at all levels of health services in Namayingo district particularly Bumooli health center III.

1.3 Justification

This study was designed to provide information on the factors associated with low utilization of various family planning methods in Namayingo district, specifically among women attending Bumooli Health Center III in Namayingo district eastern Uganda. The results were disseminated to concerned authorities especially District Health Officer (DHO) of Namayingo district to help the district for effective service delivery in the area of study and district at large, leading to effective utilisation of FP services, since the study assessed the factors hindering FP utilisation and dealt with through health education and sensitization.

1.4 Study objectives

1.4.1 General Objective

To assess the factors associated with low family planning service utilization among women attending Bumooli health center in Namayingo District, Eastern Uganda.

1.4.2 Specific Objectives

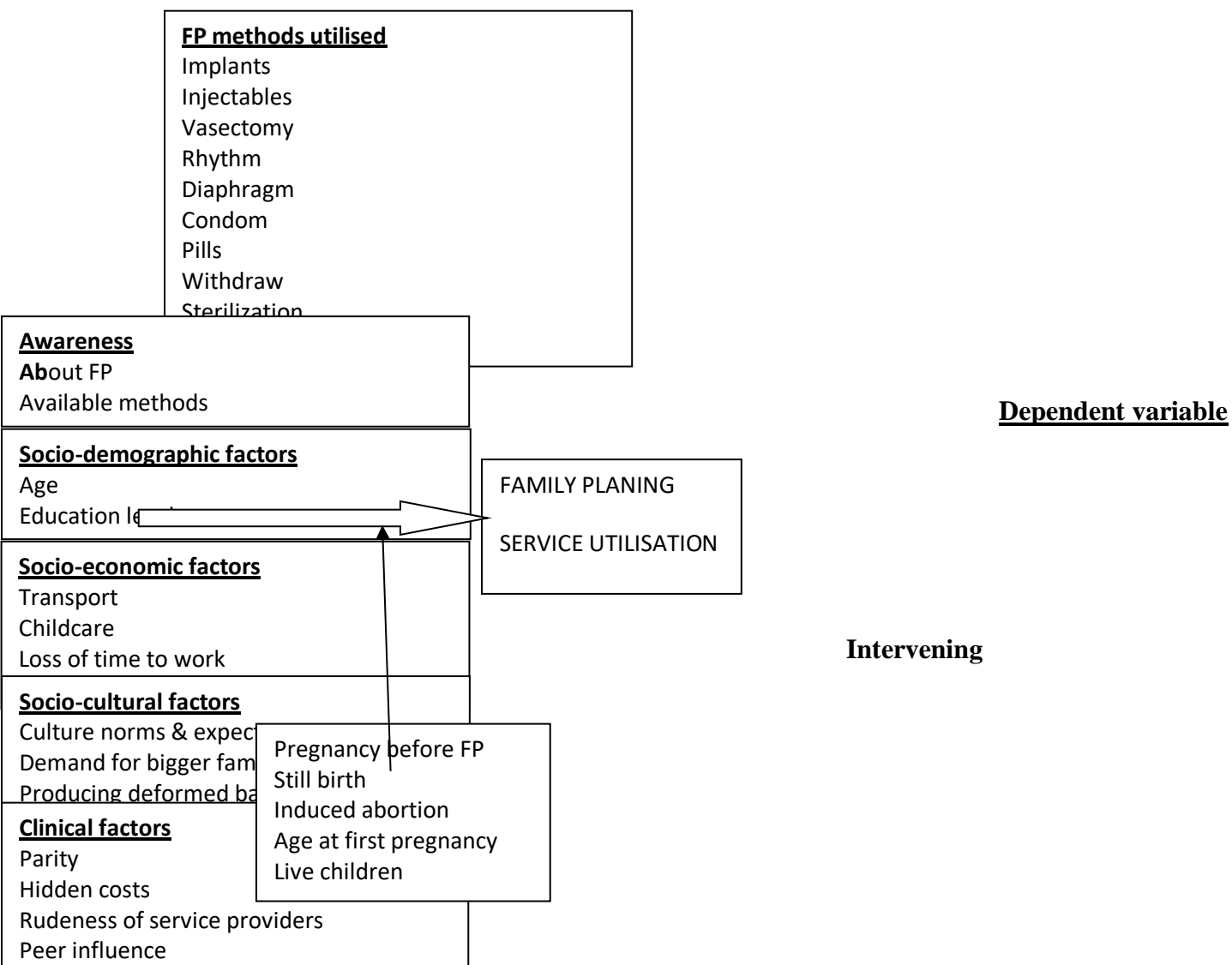
1. To assess various family planning methods utilized by women attending Bumooli Health Center in Namayingo, district eastern Uganda.
2. To determine the factors affecting FP service utilisation among women attending Bumooli Health Center in Namayingo district eastern Uganda.

1.5 Research Questions

1. What various FP methods are utilised by women attending BHC in Namayingo district eastern Uganda?
2. What are the factors associated with low family planning service utilization among women attending BHC in Namayingo district eastern Uganda?

1.6. Conceptual Framework

Independent variables



CHAPTER TWO: LITERATURE REVIEW

2.0 INTRODUCTION TO FP

Family planning (FP) is a voluntary and informed decision made by families, couples or sometimes individuals on how they will regulate their reproduction (WHO, 2008), It also refers to having children by choice and not by chance and It is most adopted by couples who wish to space their

children (Olaitan, 2009). Family planning measures are designed to regulate the number and spacing of children within a family, largely to curb population growth and ensure each family has access to limited resources. (Olaitan et al, 2011). Ugandan women from a low socio- economic and demographic background experience unwanted pregnancies that usually result into abortions. Their experiences however considerably, compared with women who are well off generally have access to a wider range of health service providers, and are more likely to be able to visit them, some of whom may be trained and able to provide safe procedures (Prada et al, 2005).

2.1 FP methods utilized by women

WHO (2011) reports that western countries forexample Europe, Germany, Asia, Australia, and America have a wide coverage and utilisation of FP services compared to African countries. The worldwide commonly utilized methods of FP are implants 67%, injectables 45% and vasectomy 30%. Fertility awareness method is the least utilized and the few who are utilising it say it is ineffective as most of them are getting pregnant (WHO, 2011). In the USA, Injectaplan is the most utilised method of FP with 58% and implants 30%. The study also found out that barrier methods like diaphragms and condoms are the least utilised method (Mackey et al, 2011).

In developing countries like Uganda, condoms, pills and injectable contraceptive are among the most utilized methods of FP and are mostly in the rural parts of the country (Huntington, 2009). In Tanzania, condom method is the commonly utilized method of FP 45%, followed by injectable contraceptive and lastly pills (Wilson et al, 2012).

However in Uganda, there has been a low level of FP service utilization since 2006, where only 10 of every 50 women attending ANC are using one or more of the FP method while the rest have never used any of the available FP methods (Christine, 2010).

In Namayingo district, the most commonly used method of FP is Injectaplan followed by pills and condoms in the islands of sigulu (HMIS FP Namayingo, 2015).

2.2 Factors associated with low FP service utilisation

2.2.1 Awareness about available methods of FP.

Knowledge of at least one contraceptive method is nearly universal in Uganda among women. Among all women, the male condom, pills, and injectables are the most widely known methods of family planning, with at least 90% of all women saying they have heard of these methods (UDHS, 2006). And the least widely known methods were LAM and emergency contraception. Over half

of all women have heard of implants, female condom, and the rhythm method, while about four in ten know about male sterilization, IUD, and withdrawal. Contraceptive knowledge is higher among currently married women and sexually active, unmarried women than among all women (UDHS, 2006).

2.2.2 Sociodemographic factors

2.2.2.1 Age and FP utilisation.

In support of the influence of predisposing characteristics such as age on health behavior, research indicates that younger adult women are more likely to use FP services than older adult women (Mburu, 2011 and Stephenson et al., 2007).

Rob et al (2007) in their study on influence of modern contraceptive use among women in six countries in sub-Saharan Africa that included Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso and Ghana showed that young age especially age group (20-29) years was more likely to be associated with use of modern contraceptives. For example findings in Tanzania the likelihood of contraceptive in age group (20-29) were higher compared to age group (15-19) and age group (40-49). Utomo et al. (2007), in their study on factors affecting use and non-use of contraception among women of reproductive age following analysis shows that older age was one of the four major independent factors associated with the use and non-use of FP.

2.2.2.2 The level of education and FP

According to studies conducted in Uganda, post-primary education and urban residents are strong predictors of knowledge and favourable attitudes towards FP services. A study on fertility and FP trends among women in urban Karachi-Pakistan, shows a strong trend toward declining fertility and increasing utilization of contraceptives among relatively well-educated, middle-class population (Hagen et al., 2009). Mothers who attain Secondary or higher education are more likely to use FP services compared to those with lower educational attainment (Rob et al. 2007). Current users of FP are more educated or have spouses who are more educated than their counterparts who are not current users. (Utomo et al, 2006)

2.2.3. Socio-economic factors and FP

While FP services in Uganda are offered free to all women, other indirect costs, such as transportation to the clinic, childcare, and loss of time to work, are commonly cited as barriers to accessing different forms of health care in qualitative studies conducted in Uganda, making income an important determinant to consider. (Geng et al, 2010).

The wealthy have more knowledge about FP methods and with a higher Contraceptive Prevalence Rate (CPR) compared to the poorest; consequently the richest have a Total Fertility Rate (TFR) of 4.3 far less compared to the poorest of 8.0 (UDHS 2006).

2.2.4 Sociocultural factors

Often culture shapes perceptions of the individuals belonging to that culture on matters of fertility including the use of FP. Cultural norms and expectations are varied and include among others; fatalism attributed to HIV disease, fear of infecting the unborn child, gender roles designated by society such as the role of women in child bearing and the demand for bigger families (Srikanthan et al, 2008).

In a qualitative study to identify and describe perceptions of Swazi women shows that, cultural expectations override individual factors such as knowledge about ones HIV sero-positivity for example pressure from in-laws forces women to have children despite their status, the desire to portray femininity and fulfill womanhood contribute to low use of FP (Shabangu et al, 2006)

2.2.5 Clinical factors

Lack of availability of other FP methods due to hidden costs hinder mothers from using FP service in Uganda (Tuller et al., 2010). Rudeness of the service providers, peer influence, inaccessible services, and lack of pleasure during sexual intercourse are also attributed to low FP service utilisation in Uganda (MOH, 2004).

CHAPTER THREE: METHODOLOGY

3.1 Study design.

A descriptive cross sectional method was used during the study.

3.2 Study area.

The study was conducted at Bumooli Health Center III in Buswale s/c Namayingo district, eastern Uganda among women. The population of females in Buswale s/c is 1396 women (UBOS, 2014) and was mostly peasants with low education levels and living in low socio-economic status.

3.3 Study population.

The study was conducted among women of reproductive age (15-49years) at outpatient department (OPD) of Bumooli health center III, who were mentally healthy and consented to the study.

3.4 Sample size determination

Given the population of females in Buswale of 1396, the study sample size was determined using Krejcie and Morgan table, and was to be 300 females. However only 201 females turned up and participated in the study.

3.5 Quality control.

The questionnaires were pretested to ensure that all the study objectives are captured and that the study is significant to the target population and the relevant authority. Meeting with research supervisors were done to sort out data collection problems.

3.6 Data collection method.

Researcher administered questionnaires prepared in English were used during the study.

3.7 Inclusion and exclusion criteria

3.7.1 Inclusion criteria.

All women (single and married) of child bearing age who attended Bumooli Health Center during the time of data collection, whether using FP services or not, and who consented were involved in the study.

3.7.2 Exclusion criteria.

Women who were critically ill during data collection, the mentally ill and those above 50 years of age were excluded from the study.

3.8. Data Analysis

Quantitative data was collected and analyzed manually by tally counting results.

3.9. Data Presentation Methods

Data was presented in form of tables. Descriptive statistics were used where percentages for each response were calculated to give the lesson learnt and conclusion from the response.

3.11. Ethical considerations.

An introductory letter for data collection was obtained from KIU School of allied health sciences after approval of the proposal by the supervisor. The permission to carry out the research at

Bumooli HC III was obtained from the DHO of Namayingo district to the incharge of the health center. Informed consent was obtained from the respondents after explaining the nature and purpose of the study. It was emphasized that participation was voluntary and that they were to withdraw from the study at any time without penalty. Data collection was carried out in a skilled manner without asking questions which could stigmatize the research participants. The information from respondents was kept confidential for only study purposes.

CHAPTER FOUR: RESEARCH FINDINGS

4.1 Section A: Socio-demographic characteristics.

A total of 201 mothers were enrolled in this study. Majority (80.1%) of them were aged between 15-34years and few (2.5%) were aged between 45-49years, 48.8 were catholic and 6.4% were moslems, 78.6 were married and 1.5% were widowed, 50.2% had five and more children and 4% had only two children, 62.2% acquired primary education and 2.5% reached tertiary institution, 45.2% were peasants and 4.5% were business ladies, 60.7% were Basamia and 2.5% were Baganda, all as shown in table 1 below.

Table 1: Shows socio-demographic features of respondents (n=201)

| Factors | Frequency | Percentage (%) |
|---------------|-----------|----------------|
| 1. Age | | |

| | | |
|------------------------------|-----|------|
| 15-19 | 28 | 13.9 |
| 20-24 | 51 | 25.4 |
| 25-29 | 52 | 25.9 |
| 30-34 | 30 | 14.9 |
| 35-39 | 20 | 10.0 |
| 40-44 | 15 | 07.4 |
| 45-49 | 05 | 02.5 |
| 2. Religion | | |
| Catholic | 98 | 48.8 |
| Anglican | 70 | 34.8 |
| Moslem | 13 | 06.4 |
| Others (Born again) | 20 | 10.0 |
| 3. Marital status | | |
| Married | 158 | 78.6 |
| Single | 30 | 14.9 |
| Divorced | 10 | 05.0 |
| Widowed | 03 | 01.5 |
| 4. Number of children | | |
| Five and more | 101 | 50.2 |
| Four | 72 | 35.8 |
| Three | 20 | 10.0 |
| Two | 08 | 04.0 |
| 5. Education level | | |
| None | 60 | 29.9 |
| Primary | 125 | 62.2 |
| Secondary | 11 | 05.4 |
| Tertiary/University | 05 | 02.5 |
| 6. Occupation | | |
| Student | 20 | 10.0 |
| Employed | 25 | 12.4 |
| Housewife | 56 | 27.9 |

| | | |
|-------------------|-----|------|
| Peasant | 91 | 45.2 |
| Others (Business) | 09 | 04.5 |
| 7. Tribe | | |
| Basamia | 122 | 60.7 |
| Basoga | 30 | 14.9 |
| Bateso | 18 | 09.0 |
| Badama | 12 | 05.9 |
| Baganda | 05 | 02.5 |
| Others | 14 | 07.0 |

4.2 Section B: family planning methods utilised

Out of 201 mothers, only 70 (34.8%) were using family planning. And mostly utilised methods were Injectaplan 39.2%, pills 18.6%, implants and condoms at 17.1%, and the least utilised method was rhythm at 1.5%, as shown in table 2 below.

Table 2 Shows FP methods utilised by respondents (n=70)

| Response | Frequency | Percentage (%) |
|--------------|-----------|----------------|
| Condoms | 12 | 17.1 |
| IUDs | 05 | 07.1 |
| Pills | 13 | 18.6 |
| Injectaplan | 23 | 32.9 |
| Implants | 12 | 17.1 |
| Withdraw | 00 | 00.0 |
| Abstinence | 00 | 00.0 |
| Rhythm | 01 | 01.5 |
| Moon beads | 00 | 00.00 |
| Others (LAM) | 04 | 05.7 |

4.3 Section C: Awareness about FP

92% of the mothers had ever heard of family planning and 8% said they didn't know of it. The mostly known methods were Injectaplan (32.4%), condoms (22.7), pills (15.1%) and the least known methods were rhythm and moon beads at 0.5%, all as shown in the table below.

Table 3 Shows respondent's knowledge about FP and methods known to them.

| Response | Frequency | Percentage (%) |
|--|--------------------|----------------|
| Ever heard of family planning (n=201) | Yes: 185 No: 16 | 92.0 08.0 |
| Known methods (n=185) | | |
| Condoms | 42 | 22.7 |
| IUDs | 15 | 08.1 |
| Pills | 28 | 15.1 |
| Injectaplan | 60 | 32.4 |
| Implants | 20 | 10.8 |
| Withdraw | 02 | 01.1 |
| Abstinence | 12 | 06.5 |
| Rhythm | 01 | 00.5 |
| Moon beads | 01 | 00.5 |
| Others(LAM) | 04 | 02.2 |

4.4 section D: Socio-demographic factors

In the table below, out of the 70 women who were on family planning, majority (60%) were in the age group of 20-29years, and minority were in 40-49years. It also shows that primary school leavers utilised FP most at 75.7% followed by secondary school leavers.

Table 4 shows how socio-demographic characteristic affect FP use

| | Factor | No. using FP | Percentage (%) |
|----|--------|--------------|----------------|
| 1. | Age | | |
| | 15-19 | 10 | 14.3 |
| | 20-24 | 20 | 28.6 |

| | | | |
|----|---------------------|----|------|
| | 25-29 | 22 | 31.4 |
| | 30-34 | 08 | 11.4 |
| | 35-39 | 06 | 08.6 |
| | 40-44 | 03 | 04.3 |
| | 45-49 | 01 | 01.4 |
| 2. | Education level | | |
| | None | 05 | 07.1 |
| | Primary | 53 | 75.7 |
| | Secondary | 10 | 14.3 |
| | Tertiary/University | 02 | 02.9 |

4.5 Section E: Socio-economic factors

Out of 201 mothers enrolled, 161 (80.1%) reported that their economic status hinder them from utilising FP services. majority (43%) reported wastage of time for work, 31% transport and 26% child care while away for FP, as shown in the table below.

Table 5 Shows how respondent's economic status affect FP utilisation (n=161)

| Response | Frequency | Percentage (%) |
|----------------------|------------|----------------|
| Transport | 50 | 31 |
| Child care | 42 | 26 |
| Loss of time to work | 69 | 43 |
| TOTAL | 161 | 100 |

4.6 Section F: Socio-cultural factors

198 (98.5%) mothers reported influence of their culture on FP. And majority (35%) said they fear producing deformed babies, 32% reported cultural norms and few (07%) reported that they desire to portray femininity. This is shown in the table below.

Table 6 Shows effect of culture on FP service utilisation (n=198)

| Response | Frequency | Percentage (%) |
|----------------------------|-----------|----------------|
| Cultural norms | 63 | 32 |
| Demand for bigger families | 51 | 26 |

| | | |
|-----------------------------------|----|----|
| Fear of producing deformed babies | 69 | 35 |
| Desire to portray femininity | 15 | 07 |

4.7 Section G: Clinical factors

200 mothers of 201 reported some barriers to use of FP being personal and health care based, and these were: 42.5% peer influence, 18.5% hidden costs, 16% loss of sexual pleasure, 12.5% rudeness of service providers and 12% inaccessible services, as shown in the table below.

Table 7 Shows effects of clinical factors on FP use (n=200)

| Response | Frequency | Percentage (%) |
|-------------------------------|-----------|----------------|
| Hidden costs | 37 | 18.5 |
| Rudeness of service providers | 25 | 12.5 |
| Peer influence | 82 | 42.5 |
| Loss of sexual pleasure | 32 | 16.0 |
| Inaccessible services | 24 | 12.0 |

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATION

5.0 Introduction

In this chapter, the collected data is to be interpreted and discussed in accordance to the study specific objectives and literature review in order to answer research questions, suggest recommendations and conclusions on the factors associated with low utilization of family planning services among women of child bearing age attending Bumooli health Centre III in Namayingo district.

5.1 Discussion

5.1.1 Bio-graphic information

A total of 201 participants were enrolled, categorized in seven age groups, and these were: 15 – 19 years, 28(13.9%). 20 – 24 years, 51 (25.4%). 25-29, 52 (25.9%). 30-34, 30 (14.9%). 35-39,

20(10.0%). 40-44, 15(07.4%) and 44-49 were 5(2.5%) mothers. Majority (60.7%) of these women were samias, followed by 14.9% who were Basoga, 09% were Bateso, belonged to other tribes like Bagwere, Bagisu and Banyole, 5.9% were Baganda and 2.5% were Badama. There were more Catholics at 48.8%, followed by Anglicans (34.8%), 10% were born again and 6.4% were Muslims. The majority of the respondents (62.2%) were primary school leavers, followed by 29.9% who did not study at all, 5.4% were secondary school leavers and lastly 2.5% had attained tertiary education. The study findings also revealed that 78.6% of the women were married, 30% were single, 10% had divorced and only 3% had lost their husbands. Among the married ones, majority (50.2%) had more than 5 children, followed by 35.8% who had four children, 10% had three children and 4% had two children. Majority 45.2% were peasants, followed by 27.9% who were house wives, 12.4% were employed, 10% were students and 4.5% had other businesses in the trading centers.

5.1.2 Knowledge about family planning methods.

There was adequate knowledge about FP, where 92% of the respondents had ever heard of FP and minority (8%) reported having not heard of FP services at all. The most known methods were injectables (32.4%), condoms (22.7%) and pills (15.1%), the least known methods were IUDs (08.1%), rhythm and moon beads each at 0.5%. And this is in line with a report from UDHS (2006), which shows that 96% of all women have heard of condoms, injectables and pills, and 4% knows rhythm, moon beads, LAM and IUDs.

5.1.3 Utilised methods of FP.

Generally, the level of FP utilisation was low where only 70 (34.8%) of 201 women reported utilising FP, and this correlates with a study done by Christine (2010) in Uganda which found out a low level of FP service utilization since 2006, only 10 of every 50 women attending ANC are using one or more of the FP method while the rest have never used any of the available FP methods.

The common methods utilised were Injectaplan (32.9%), pills (18.6%), implants and condoms each at 17.1%, while the least utilised were IUDs (07.1%), LAM (05.7%) and rhythm (1.5%). These findings are similar to Huntington (2009) where in developing countries like Uganda, condoms, pills and injectable contraceptive are among the most utilized methods of FP and are mostly in the rural parts of the country, and in Tanzania, condom method is the commonly utilized method of FP 45%, followed by injectable contraceptive and lastly pills (Wilson et al, 2012).

5.1.4 Social demographic factors.

5.1.4.1 Age and FP.

Majority of respondents (60%) who were using FP were in the age groups of 20-29years. And those who were in the age groups of 40-49 reported decline at 05.7% in utilisation of FP services. This indicates that young adults are more likely to use FP than older adults, and this could be due to the fact that they are exposed to various sources providing information about FP utilisation and its importance. And this is in line with a study carried out by Rob et al (2007) in their study on influence of modern contraceptive use among women in six countries in sub-Saharan Africa that included Kenya, Malawi, Tanzania, Ivory Coast ,Burkina Faso and Ghana showed that young age especially age group (20-29) years was more likely to be associated with use of modern contraceptives and in Tanzania that the likelihood of contraceptive in age group (20-29) were higher compared to age group (15-19) and age group (40-49).

5.1.4.2 Education and FP.

Family planning use was high among the educated and low (07.1%) among those who did not study at all. It was at 75.7% among primary school leavers, 14.3% among those who attained secondary education and 02.9% among tertiary education women. However the study showed that all women reported to have reached secondary and tertiary education were on FP methods, hence making the educated to have a high level of FP utilisation compared to their counter parts. This is similar to Rob et al (2007), that shows that Mothers who attain Secondary or higher education are more likely to use FP services compared to those with lower educational attainment . And also similar to Utomo et al (2006) that Current users of FP are more educated or have spouses who are more educated than their counterparts who are not current users.

5.1.5 Socio-economic factors

Among those women who were not utilising FP reported some factors preventing them from utilising and among them were; lack of transport to the health centers (31%), loss of time that they

would do other works (43%) and need to take care of the children at home (26%). The findings are similar to qualitative studies conducted in Uganda which shows that, other indirect costs, such as transportation to the clinic, childcare, and loss of time to work, are commonly among the barriers to accessing different forms of health care including FP, making income an important determinant to consider (Amuron et al., 2009; Geng et al., 2010; Mutyaba et al., 2007; Tuller et al., 2010).

5.1.6 Socio-cultural factors

Majority of the women who were not utilising FP reported their cultural believes hindering them from using the service, and among them were; fear of producing deformed babies (35%), cultural norms and expectations (32%), demand for bigger families (26%) and minority (07%) reported their need to portray femininity. The results are in line with Srikanthan and Reid (2008), who found out that often culture shapes perceptions of the individuals belonging to that culture on matters of fertility including the use of FP, and that Cultural norms and expectations are varied and include among others; fatalism attributed to HIV disease, fear of infecting the unborn child, gender roles designated by society such as the role of women in child bearing and the demand for bigger families.

5.1.7 Clinical factors

42.5% of those women who were not on FP reported having been influenced by their peers, 18.5% feared hidden costs which they said get them unaware, 16% reported fear of losing sexual pleasure foreexample with condom method, 12.5% said that the service providers are always rude to them, and 12% said that some methods of their choice were not available at the health center at the time of their visit. This is in accordance with Amuron et al (2009), Geng et al (2010), Mutyaba et al (2007), and Tuller et al (2010) who found out that some women prefer using FP but the methods of their choice are always not available either due to hidden costs or level of health care. The results are also similar to MOH (2004) that cites some of the barriers to FP service utilisation being; Rudeness of the service providers, peer influence, inaccessible services, and lack of pleasure during sexual intercourse.

5.2 Conclusion

Unemployment among the mothers with no income generating activities was among the major factors that led to low FP utilisation. Mothers reported that they loss their little time to go for FP instead of doing shamba work to earn a living and others said that they don't have transport to the

health facility since they stay far from it, and therefore mostly depend on their spouses who don't support them.

The myths and misconceptions in the community is one other key factor affecting utilization of the service due to lack of community education and poor health seeking behavior to demystify them, since some women reported that they fear producing deformed babies after using FP and many were influenced by their friends not to use FP, while others said that their culture doesn't support use of FP.

Low level of education where all secondary and tertiary educated women who turned up for the study were on FP and very few of illiterates were using FP, yet they were the majority of respondents. This severely affected FP since majority of mothers were not educated to secondary.

5.3 Recommendations.

Due to the above factors, there is need to increase health education talks in the health facilities and the community through VHTs by emphasizing the importance of FP and methods available in order to increase up take and demystify the myths and misconceptions about FP services. Promotion of the girl child education by letting them stay longer in school because an educated girl would make better decisions for herself and her own reproductive health choices since all those who were educated were on FP, unlike their counterparts. Also encouraging women to engage in income generating activities like forming village savings and credit cooperatives (SACOs) to handle issues of their own health because she would be able to afford to pay for her own service fees and transport if there is need.

Lastly, further studies are preferred to dig deep since a small sample of the population was used and the information gotten here may not provide accurate data for generalizing the factors associated with low FP utilisation among women at Bumooli health center III.

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APPENDICES

APPENDIX 1: CONSENT FORM AND INTRODUCTION

I am WANDERA RONALD, a student of Kampala International University pursuing a Diploma in Clinical Medicine and Community Health, doing a research to assess the factors associated with low family planning service utilisation among women attending Bumooli HC III in Namayingo district, eastern Uganda.

I am inviting you to take part in this study but before we discuss more about the study, I ask you to reflect on whether you want to participate or not. In case you do not understand, some words, I will explain them to you, and feel free to ask me any questions as we go along.

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I therefore consent voluntarily to participate in this research.

Participant's code.....Signature/Thumbprint.....Date...../...../..... (Day/Month/Year)

APPENDIX 2: DATA COLLECTION TOOL

You are kindly requested to answer the following questions whose answers are strictly for research purposes only. You can tick in the boxes provided or fill in the gaps in the way you understand the question because there are no restrictions to any of them.

PART ONE: BIO GRAPHIC DATA

1. **Respondents age;** Years

2. **What is your main occupation?**

Housewife ☐ Employed ☐ Student ☐ Peasant ☐ Other ☐ specify.....

3. **What is your tribe?**

Musamia ☐ Musoga ☐ Muganda ☐ Muteso ☐ Mudama ☐ Others ☐ specify.....

4 .**What is your Religion?**

Muslim ☐ SDA ☐ Protestant ☐ Catholic ☐ Others, ☐ specify

5. **What is your education level?**

Primary ☐ Secondary ☐ Tertiary ☐ None ☐

6. **Marital status.** Single ☐ Married ☐ Divorced ☐ Widowed ☐ Others, ☐...

7. **How many children do you have?**

Two ☐ Three ☐ Four ☐ Five and more ☐

PART 2: FAMILY PLANNING METHODS UTILISED

8. Are you using FP now? Yes ☐ No ☐

9. If yes, what method of family planning are you using now? And if NO refer to parts 4,5,6,7

☐ Condoms ☐ IUDs ☐ Moon beads ☐ pills ☐ withdrawal ☐ abstinence

☐ Injectables ☐ rhythm ☐ Implants ☐ others.....

PART 3: AWARENESS ABOUT FP METHODS

10. Have you heard about family planning? Yes ☐ No ☐

11. If yes, which family planning methods do you know of? Tick where applicable

Condoms ☐ IUDs ☐ Moon beads ☐ pills ☐ withdrawal ☐ abstinence ☐

Injectaplan ☐ rhythm ☐ Spermicides ☐ implants ☐ LAM ☐ Depo-Provera ☐

Emergency contraceptive ☐ Norplant ☐ others specify.....

PART 4: SOCIO – ECONOMIC FACTORS

12. Basing on your economic status, which challenges do you face in using FP

Lack of transport ☐ child care ☐ Loss of time to work ☐

PART 5: SOCIO-CULTURAL FACTORS

13. Please tick reasons as to why you don't use family planning

Cultural norms and expectations ☐ Demand for bigger families ☐

Fear of producing deformed babies ☐ Desire to portray femininity ☐

PART 6: CLINICAL FACTORS

14. What prevents you from using FP?

Hidden costs ☐ Peer influence ☐ Rudeness of service providers ☐

Lack of sexual pleasure ☐

15. Do you always find the family planning methods you need at the health unit?

Yes ☐ No ☐

THANK YOU FOR YOUR TIME AND PARTICIPATING.

APPENDIX 3: INTRODUCTORY LETTER



School of Allied Health Sciences (SAHS) Ishaka,
P.O. BOX 71 Bushenyi,
Tel: 0703786082/0773786082
Email: christinekyobuhaire@gmail.com

OFFICE OF THE ADMINISTRATOR –SAHS

The Incharge Bumooli Health III
NAMAYINGO DISTRICT

11th April 2017

Dear Sir/Madam,

SUBJECT: DATA COLLECTION

Academic research project is an Academic requirement of every student pursuing a 3 year Diploma in Clinical Medicine & Community Health (DCM) of Kampala International University- Western Campus (KIU-WC). DCM program is housed in the School of Allied Health Sciences (SAHS).

The students have so far obtained skills in Proposal writing especially chapter one, Three & Questionnaire design. The student's topic has been approved by SAHS Research Unit and is therefore permitted to go for data collection alongside full proposal & dissertation writing. As you may discover the student is in the process of full proposal development. However, the student MUST present to you his questionnaire and his research specific objectives that he wishes to address. We as academic staff of Allied Health Sciences are extremely grateful for your support in training the young generation of Health Professionals. I therefore humbly request you to receive and allow the student **WANDERA RONALD** Reg.No. **DCM/0075/143/DU** in your hospital to carry out his research. His topic is hereby attached. Again we are very grateful for your matchless support and cooperation.

Topic: **FACTORS ASSOCIATED WITH LOW FAMILY PLANNING SERVICE UTILIZATION AMONG WOMEN ATTENDING BUMOOLI HEALTH CENTRE IN NAMAYINGO DISTRICT-EASTERN UGANDA.**

Sincerely yours,

Christine Kyobuhaire
Christine Kyobuhaire, Administrator- SAHS

CC: Dean SAHS
CC: Associate Dean SAHS
CC: Coordinator, Research Unit- SAHS
CC: H.O.D Dept. Public Health
CC: H.O.D Laboratory Sciences
CC: Coordinators; TLC & DEC

LMCO - Bumooli Htc III
Take note & support the student accordingly
beginning
11/4/17
**For District Health Office
NAMAYINGO DISTRICT**
Date:.....

APPENDIX 4: MAP OF UGANDA SHOWING LOCATION OF NAMAYINGO DISTRICT

APPENDIX 5: KREJCIE AND MORGAN TABLE FOR SAMPLE SIZE DETERMINATION.

| <i>N</i> | <i>S</i> | <i>N</i> | <i>S</i> | <i>N</i> | <i>S</i> |
|----------|----------|----------|----------|----------|----------|
| 10 | 10 | 220 | 140 | 1200 | 291 |
| 15 | 14 | 230 | 144 | 1300 | 297 |
| 20 | 19 | 240 | 148 | 1400 | 302 |
| 25 | 24 | 250 | 152 | 1500 | 306 |
| 30 | 28 | 260 | 155 | 1600 | 310 |
| 35 | 32 | 270 | 159 | 1700 | 313 |
| 40 | 36 | 280 | 162 | 1800 | 317 |
| 45 | 40 | 290 | 165 | 1900 | 320 |
| 50 | 44 | 300 | 169 | 2000 | 322 |
| 55 | 48 | 320 | 175 | 2200 | 327 |
| 60 | 52 | 340 | 181 | 2400 | 331 |
| 65 | 56 | 360 | 186 | 2600 | 335 |
| 70 | 59 | 380 | 191 | 2800 | 338 |
| 75 | 63 | 400 | 196 | 3000 | 341 |
| 80 | 66 | 420 | 201 | 3500 | 346 |
| 85 | 70 | 440 | 205 | 4000 | 351 |
| 90 | 73 | 460 | 210 | 4500 | 354 |
| 95 | 76 | 480 | 214 | 5000 | 357 |
| 100 | 80 | 500 | 217 | 6000 | 361 |
| 110 | 86 | 550 | 226 | 7000 | 364 |
| 120 | 92 | 600 | 234 | 8000 | 367 |
| 130 | 97 | 650 | 242 | 9000 | 368 |
| 140 | 103 | 700 | 248 | 10000 | 370 |
| 150 | 108 | 750 | 254 | 15000 | 375 |
| 160 | 113 | 800 | 260 | 20000 | 377 |
| 170 | 118 | 850 | 265 | 30000 | 379 |
| 180 | 123 | 900 | 269 | 40000 | 380 |
| 190 | 127 | 950 | 274 | 50000 | 381 |
| 200 | 132 | 1000 | 278 | 75000 | 382 |
| 210 | 136 | 1100 | 285 | 100000 | 384 |

Note.—*N* is population size.
S is sample size.