FACTORS ASSOCIATED WITH THE LOW UTILIZATION OF MODERN METHODS FAMILY PLANNING SERVICES AMONG WOMEN IN BUMUFUNI, MANAFAWA DISTRICT

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UGANDA CHRISTIAN UNIVERSITY

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DECLARATION

I, **NEKESA JOYCE** hereby declare that this work "Factors Associated With the Low Utilization of Modern Methods Family Planning Services Among Women in **Bumufuni, Manafawa** district" is my own original work and has never been published or submitted for any award to any institution of higher learning.

Signature:……  …….. Date:……30/04/2024…….

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APPROVAL

This is to certify that this research dissertation has been carried out under my supervision and now is ready for submission for the evaluation of the award of a Masters of Public Health.

Signature:……  **……Date……30/04/2024……**

REV CANON EVATT MUGARURA

(Supervisor)

DEDICATION

This dissertation is dedicated to my parents, my Uncle for the support that cannot be exhaustively defined. May God's blessings be multiplied for their parental love and care.

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My appreciation goes to my supervisor, **REV CANON EVATT MUGARURA** for his willingness to guide me across the whole of the research journey. Also special appreciation to Uganda Christian University for offering me the opportunity to study in this University and much more so conduct research in my field of study.

Special thanks go to my respondents from Bumufuni, Manafawa district that spared their time to give me the data required to accomplish this study.

ACRONYMS

FP	:	Family Planning
SDGs	:	Sustainable Development Goals
DHS	:	Demographic and Health Survey
SPSS	:	Statistical Package for Social Scientist
GoU	:	Government of Uganda
MOFPED	:	Ministry of Finance, Planning and Economic Development
MoH	:	Ministry of Health
NARHS	:	National HIV/AIDS and Reproductive Health Survey
NSMP	:	National Safe Motherhood Program
UNFPA	:	United Nations Fund for Population Activities
WHO	:	World Health Organization

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ABSTRACT

Introduction: This study assessed the factors associated with the low utilization of modern methods of family planning services among women of 18–39years in Bumufuni, Manafawa district, and specifically sought to establish the demographic factors associated with the low utilization of Family Planning services among women of 18–39 years, the Socio- cultural factors associated with the low utilization of Family Planning services among women of 18–39 years, and the health-related factors associated with the low utilization of Family Planning services among women of 18–39 years.

Method: This was a cross sectional study design employing quantitative methods. A total 133 women aged 18-39 years were enrolled in the study. interviewer administered questionnaire was used to collect quantitative data from the respondents. Data was then analyzed at univariate, bivariate and multivariate level using SPSS version 20.

Results: Majority 64 (48.1) of the respondents were aged 25-29years and 88(66.9%) of them were married. At bivariate level of analysis, age (X^2=17.17, df =4, P-value=0.001),, educational level (X^2=16.77, df =3, P-value=0.000), religion(X^2=23.39, df =2, P-value=0.000), and occupation (X^2=14.51, df =1, P-value=0.002), who makes decision on the type of family planning and number of children (X^2=17.16, df =1, P-value=0.002), if the community have taboos about modern family planning methods (X^2=13.13, df =1, P-value=0.001), and men's feeling about family planning (X^2=19.69, df =1, P-value=0.001), where to get family planning services (X^2=12.33, df =1, P-value=0.003), distance to the nearest facility (X^2=21.01, df =1, P-value=0.000), and waiting time (X^2=19.80, df =2, P-value=0.001), were found to be statistically significant P-value<0.05

At multivariate level of analysis, age (AOR=1.8; 95% CI: 1.23-3.10; p= 0.002), educational level (AOR=0.3; 95% CI: 1.12-2.04; p= 0.000), religion (AOR=4.3; 95% CI: 1.08-5.66 p= 0.000), decision about family size and family planning (AOR=0.4; 95% CI: 1.24-4.00; p= 0.000),, distance to the health facility (AOR=0.4; 95% CI: 1.11-5.34; p= 0.003), and waiting time at the facility (AOR=0.3; 95% CI: 1.99-4.91; p= 0.003),were found to independently associated with the low uptake of family planning p-value <0.05

Conclusion: The study established that the prevalence of contraceptive use stood at 38.3%. The findings of this study demonstrate a multitude of factors that affect women's up take of family planning. These factors limit the women's overall utilization of modern family planning methods. As such, addressing them is imperative in enhancing the effective utilization of modern family planning methods by women

Recommendations: There is need for the government through the ministry of education to promote girl child education so as to have them empowered with knowledge to make independent decision about family planning, The health worker should partner with religious, cultural, political leaders and carry out intensified behavior change campaigns specifically putting emphasis on benefits of family planning and also address the traditional beliefs, which tend to discourage women from using modem methods of contraception and family planning out reaches to be organized so as to take the services near to the populations

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Globally, family planning (FP) is widely acknowledged as an important intervention towards achieving Sustainable Development Goals (SDGs) as it has been proven to reduce maternal and child mortality and entrench human rights for women and girls (Agrawal, (2020).). Family Planning covers a wide range of services concerning women, children and their families including access to birth control, contraceptives, sexual education, and other health resources. Access to Family Planning services can be a major source of knowledge.

According to Population Reference Bureau report, over the past decade use of family planning among married women in West Africa has increased from 6.3% to 13.9% (PRB, 2016). Chirchir, (2018), found in Ghana that 96% of respondents had heard of Family Planning, most named; injectable, oral contraceptive pills as Family Planning methods used and 48% used Family Planning method in the past 1 year. Low Family Planning methods utilization in Ghana were concerns about the side effects, religious/cultural reasons, and partner opposition (Chirchir, 2018).

The Demographic and Health Survey (DHS) of Uganda found that the overall Contraceptives prevalence rate in the country was 24%, with 18% Contraceptives prevalence rate for modern methods (Uganda Demographic and Health Survey (2019). Consequently, according to MoH, (2019), while women in Bumufuni, Manafawa Sub-County the unmet need in the district is very low at the rate of 33.7% moreover, 36.6% had ever used contraception while 29.7% had never.

1.2 Problem Statement

Family planning is critical in safeguarding individual health rights but also in improving the quality of life for women (WHO, 2017). The World Health Organization observes that with low contraceptive use coupled with high fertility rates can always contribute to women and young children's ill health, and yet family planning can avert up to 25-30% of all maternal deaths that occur. In Uganda 44% of the pregnancies are unplanned for, the unmet need for family planning stands at 41.5% for the past five years. When

women of childbearing age don't receive family planning education they are likely to get unwanted pregnancies and by the time they receive information on sexual reproductive health its already too late to exercise their right to choice, keeping their partners and children healthy (UNEFPA REPORT) hence having a great strain on the family on unplanned children who they might not be in position to take care of many children, sometimes due to economic hardships.

In addition, women with inadequate health literacy tend to be less knowledgeable of their health conditions are less likely to use preventive health care measures due to this gap poor acceptance and low uptake of various recommended family planning methods are likely to occur (Kassim. M, Ndumbaro BMC Public Health 2022).

Despite the government providing free family planning services at health facilities, contraceptive use still remains low at 33.7% (MOH Report 2019) among women in Manafwa district and there was no documented evidence on why there's low utilization of family planning services in Bumufuni, Manafawa district. The study was aimed at contributing to the information gap as far as barriers of low utilization of family planning services modern methods among women in Bumufuni Sub-county are concerned.

1.3 General Objective

The main objective of the study was to identify the factors associated with the low utilization of modern methods family planning services among women of 18-39years in Bumufuni, Manafawa district.

1.3.1 Specific objectives

1. To establish the demographic factors associated with the low utilization of Family Planning services among women aged 18–39 years in Bumufuni
2. To explore the Socio- cultural factors associated with the low utilization of Family Planning services among women aged 18-39years in Bumufuni.
3. To identify the health-related factors associated with the low utilization of Family Planning services among women aged 18–39years in Bumufuni.

1.4 Research questions

1. What are the demographic factors associated with the low utilization of Family Planning services among women aged 18-39years in Bumufuni?

2. What are the cultural factors associated with the low utilization of Family Planning Among women?

3. What are the health related factors associated with the low utilization of Family Planning?

1.5 Justification of the study

The current population of Uganda was reported at 45,741,007 people and growth rate was estimated to be 3.32 (UBOS 2020). Which still remain the highest as per the government target. This is an indicator that utilization of family planning services is low and needs to be addressed with great attention to avert the situation.

Government and other agencies have come up with various strategies and policies but these have fallen short of achieving the intended objectives. This can be attributed to these policies and strategies failing to focus on essential and key determinants and how to address these hindering factors associated with non-use of family planning services among women of reproductive age.

Results obtained from this study would therefore enable policy makers, Programme designers and other interested stakeholders to come up with interventions that are result oriented hence improving accessibility and utilization of family planning services, reducing maternal and infant mortality rate, improving maternal health and controlling population growth for economic development.

1.6 Significance of the study

Successful family planning effort is essential in alleviation of global poverty by positively contributing to socio-economic development. Controlling both the number and timing of births through utilization of contraception is associated with improved maternal and neonatal health outcomes (Kripa, & Shetty, 2017).

The promotion of family planning in countries with high birth rates has the potential to avert 32% of all maternal deaths and nearly 10% of childhood deaths. This particularly applies to the situation in Uganda where the persistent high fertility (6.7 children per woman) is contributing to the high maternal morbidity and mortality rates (435/100,000 live births) as well as the rapidly growing population (3.2%) Despite this great need for family planning, women in Uganda continue to take contraceptives at very low rates (Shetty, 2017). Despite this high need for family planning, it's paramount and urgent to examine factors affecting the low utilization of family planning services among women in Bumufuni, Manafawa district.

1.7 Scope of the study

1.7.1 Time Scope

The study was limited to the period of research including data collection and report writing

1.7.2 Geographic scope

The study was limited to Bumufuni, Manafawa Sub-County among women aged 18-39years in Bumufuni sub-county.

1.7.3 Content Scope

The study was limited to low utilization of family planning among women including demographic factors, the socio cultural and the health-related factors affecting the low utilization of Family Planning.

1.8 Conceptual framework

Narrative for the conceptual framework

Health service factors such as stock outs of Family Planning supplies and inadequate number of healthcare workers in the health facilities lead to a lack of effective communication with the mothers during the child health clinics and following deliveries, waiting time, human resource availability, and the attitudes of the health workers. Consequently, mothers have limited awareness of Family Planning services and, thus, low demand for such services. This may also be a consequence of excessive

workload and limited motivation, resulting in the provision of lower-quality services and missed opportunities.

The socio-cultural factors that may be associated with Family Planning services include religion, polygamy, and cultural norms. Individually related factors, which also incorporate social demographic factors, have an association with the use of Family Planning services, and these include age, level of education, occupation, place of delivery, parity, mother's occupation, and that of spouse, among others, and education, whereby the lack of education of mothers also limits their awareness of the importance, and hence the low utilization of family planning services.

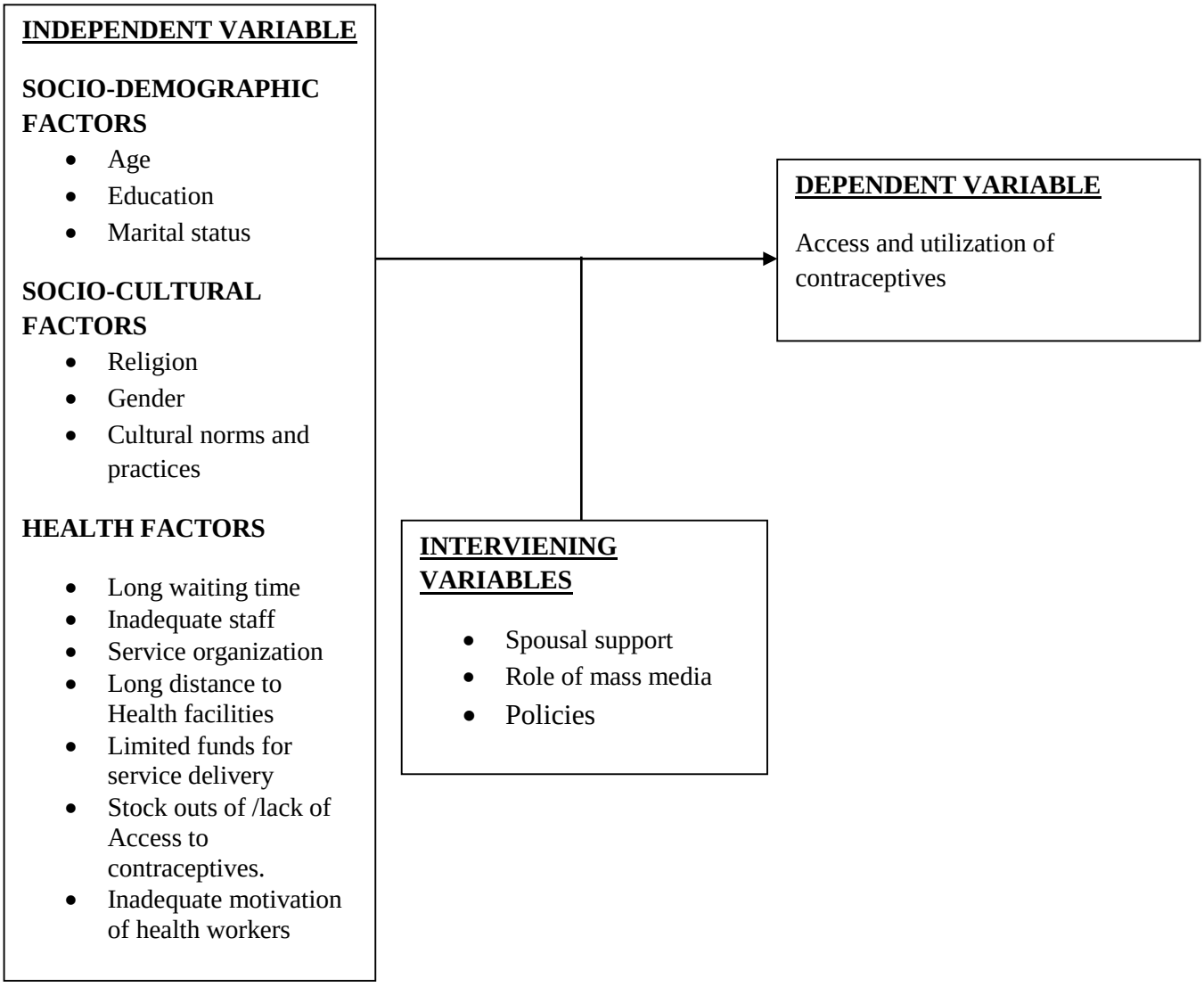

Figure 1: Conceptual framework

CHAPTER TWO: LITERATURE REVIEW

2.0 Factors associated with low utilization of Family Planning Services

2.1 Age and Family Planning

According to Oladosu, M. (2017), 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 younger age especially age group (20-29) years was more likely to be associated with use of modern contraceptives.

In a study of differences in factors associated with current modern contraceptive use among youth and adult women Petra et al established that women aged 25–49 years (66%) were more likely to be currently using modern contraceptives than women aged 15–24 years (48%) Patra et al 2016). Similarly, Nieves et al in their study of The influence of partnership on contraceptive use among HIV-infected women accessing antiretroviral therapy in rural Uganda also established that women age 15-19 were markedly less likely to be using any method of family planning than women age 20-24 (5% and 23%, respectively) (Nieves et al 2020)

According to Frost, a study was done to assess factors affecting utilization of family planning, results for low utilization of services included having less than a college education, being black, being 35–44 years old, having infrequent sexual intercourse, not being in a current relationship, being dissatisfied with one method and believing that contraceptive service providers were not available to answer method-related questions (Frost *et al*., 2007).

Furthermore, Weston *et al*., (2012) assessed barriers and facilitators to uptake of the intrauterine device (IUD) among prima gavidas of African American adolescent mothers and reported that; twelve participants did not obtain IUDs and instead used condoms, used no method, or intermittently used hormonal methods, resulting in 3 repeat pregnancies. Outdated IUD eligibility requirements, long wait times, lack of insurance coverage, and fear of IUD-related side effects precluded or delayed uptake. Facilitators to IUD uptake included strong recommendations from providers or family members, planning for IUD during pregnancy, and perceived reproductive autonomy.

Malalu et al. (2014) conducted a study in Kenya's Baringo North District to determine the factors that influence the adoption of modern family planning methods, and the findings showed that of the 344 respondents, (80.8%) were aware of these methods. The most often cited and used procedures were pills and injections, which were mentioned by 66.2% and 64.4 % of survey participants, respectively.

While just 32.3% of respondents currently use contemporary contraception, 62% of respondents approved of its usage. The respondents' age, marital status, understanding of the treatments and their side effects, and method approval by oneself and a partner were significant predictors of usage of these techniques ($p< 0.05$).

Among all ages, the interpersonal factors associated with Family Planning uptake were contraceptive accessibility perception, contraceptive knowledge, and self-efficacy

2.2 Educational level and Family Planning

People in Bumufuni community come in a variety of educational backgrounds. There are people with no formal education, those with only a primary education, those with secondary education, and those with university education. Higher educated people typically have a better awareness of their reproductive health than less educated people do.

Allen et al 2019 established that The relationship between education and the use of family planning is mixed. They established that Young women with no education were slightly less likely than women with secondary or higher education to use a modern method of family planning (93% versus 100%) (Allen et al 2019)

Kushwah et al who showed that the use of family planning was slightly higher among women with secondary or higher education (17%) than among women with no education (15%), while use is lowest among women with primary education (11%) (Kushwah, 2020)

Similarly, another study of Factors associated with modern contraceptive use among young and older women in Uganda which used nationally representative data, a woman's educational attainment showed a positive association with use of contraception. The study showed that education alone, irrespective of the effects of a woman's mobility and decision-making role, had a significant effect on use of

contraception. Women with higher educational attainment were more likely to be users of contraception (Asiimwe et al, 2021)

The act or practice of giving or obtaining general information is known as education. It entails strengthening one's ability to reason and make decisions, as well as generally preparing oneself or others cognitively for adulthood (Varma &Rohini, 2008). Indeed, among women in informal settlements, education plays a significant role in modern family planning. It is important to remember that education is the basis of every society. The quality of a nation's educational system directly affects the welfare of its populace (Barrett, 2005). Indeed, the health of women, children, and communities improves dramatically as investments in women's education are made (Ethiopia Demographic and Health Survey, 2011). The level of education of women in a given area is significantly influenced by the location in which they live. In light of this, women in informal settlement areas tend to have lower education levels compared to their counterparts in other areas (David & Lucile, 2011).

Women's education especially in the informal settlements is the "single most influential investment that can be made in the developing world. This is because education improves the ability of women in these areas to make important decisions on fertility (World Bank, 2019). In this regard, many governments now support women's education not only to foster economic growth, but also to promote smaller or manageable families.

In a number of less developed and in informal settlements, women with no education have about twice the number of children as women with ten or more years of school (Diamond, Newby &Varle, 2010). The reason is that women with more education usually make a healthier transition into adulthood.

Women who are better educated tend to marry later, have fewer children, and delay having their first sexual encounter. In comparison to their peers with lower levels of education, they are also more likely to utilize contraceptives (Diamond, Newby, &Varle, 1999). Decisions about having children are greatly influenced by the environment in which schooling is provided. Where primary school enrolment is nearly universal or where schooling is widely available, fertility rates tend to fall more quickly (Bledsoe et al., 1999). Even a minimal level of education may be linked to a drop in

reproduction when a bigger section of the population is included in the educational system. Indeed, social standards surrounding child rearing and parenting shift as overall education levels grow (Hennink, 2005).

According to a study by Casterline (2011), a woman's education level and use of contraceptives are significantly correlated. Women's education levels are a sign of socioeconomic progress and are inversely correlated with infant mortality, which lowers the total demand for children (Addai, 2017). The cultural lack of knowledge for women still promotes the desire for large families and discourages women from having the necessary number of children. Since educated women are more likely to seek sufficient prenatal care, expert attendance during birthing, and usage of contraception, education promotes reproductive health.

There have been studies showing a strong trend towards declining fertility and increasing utilization of contraceptives among those more educated, middle-class population. (Audam, 2016). Observed the uptake of modern contraceptive methods was high among women with post-tertiary education.

Women's empowerment for family planning decision-making is correlated with their partners' educational status, occupation, and employment status. Women who are working and those with better educational level are more likely to have greater decision-making authority regarding their fertility, either independently or jointly with their partners (Belay et al., 2016). Women who have control over their income and who can discuss family planning with their partners are more likely to utilize contraception (Wegs et al., 2016).

Another survey of a similar nature found that 89% (249/280) of respondents were aware of family planning services and that 18% (50/280) of respondents had utilized such services in the past. The use of family planning services was strongly correlated with respondents' parity and educational level (P 0.05). 94% (47/50) of those who used family planning services did so to space out their children, and 84% (42/50) did so to avoid becoming pregnant and acquiring STDs. 90% (207/230) of women cited their husbands' opposition as a major deterrent, while 83% (191/230) cited misconceptions about family planning as a deterrent. (2015) Apanga et al.

In a research carried out in Canada, informants cited schools as the cornerstone for public family planning knowledge, but noted inconsistent sexual education as a common problem in schools. Those working with strong school sexual education programs saw this as a major strength, whereas weak school programs were seen as contributing to major knowledge gaps. School curricula were often characterized as: “not standardized, taught by some teachers that don't want to talk about it, a very small number of hours, and not a very good program” (Public Health Nurse, British Columbia) (Halme et al., 2015).

The World Health Organization (WHO) refers to family planning (FP) as a process that allows people to attain their desired number of children and determine the spacing of pregnancies, which is achieved through the use of FP methods and treatment of infertility (WHO 2019) Of the 1.9 billion women of reproductive age group (15-49 years) worldwide in 2019, 1.1 billion needed FP methods; of these, 842 million were using contraceptive methods, and 270 million had an unmet need for contraceptives (WHO 2019). The modern contraceptive prevalence among married women of reproductive age increased worldwide between 2000 and 2019 by 2.1% from 55.0% to 57.1% (WHO 2019). The explanations for this slow increase include the limited choice of methods; limited access to services particularly among young, poorer, and unmarried people; fear or experience of side effects; cultural or religious opposition; poor quality of available services; users and providers bias against some methods; and gender-based barriers to accessing services.

In addition, it was discovered that the wealthy had a higher Contraceptive Prevalence Rate (CPR) than the poorest; as a result, the richest had a Total Fertility Rate (TFR) of 4.3, which was much lower than the poorest's TFR of 8.0 (UDHS 2016).

2.3 Culture and family planning use

Individual factors that determine a person's use of services such as Family Planning are mediated by the characteristics of the community in which the individual lives. It is important to look beyond individual factors when examining Family Planning use or non-use. 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 (Audam, 2016).

Women to use health services that are not familiar to them or that are different from their traditional approaches to medicine cultural beliefs or folk methods may trump doctor's orders. For example, in rural parts of Mexico some women give birth in a cement dome called a temazcal. A*temazcal*is a heated "sweat lodge" or steam room used for giving birth, healing the sick, and purifying the body (Keesara *et al.*, 2018)

Different cultures have their standards by which sexual issues are considered and judged as acceptable or deplorable. According to Van Der Kwaak*et al.* (2017) pastoral communities are characterized by negative SRH outcomes often due to early sexual debut, early marriage, low access to reproductive health services, and the prevalence of potentially harmful traditional practices such as polygamy and female genital Mutilation (FGM). Karamoja sub-region is not an exception to some of these challenges as it is marked with social inequality and gender discrimination against females. Poor Sexual Reproductive Health is a common problem among adolescent girls not only in the study communities but in the whole of Karamoja sub-region; this results in school dropouts, inability to sufficiently provide for the child, and maternal deaths (UBO 2019)

Further, the Karamojongs are historically pastoralists as well as agro-pastoralists who traditionally depended on cattle and utilized a transhumance system. They live in traditional settings often, cattle are seen as necessary for the family and its propagation through marriage. Females aspire to be fully married with cows as this gives them recognition as members of the husband's family and clan. This need can influence adolescent girls to find suitors who are wealthy, so as to have a full marriage status. Further, this society is permissive; girls can have sex with men who intend to marry them. Often, this is unprotected sexual intercourse (Keesara *et al.*, 2018). This is particularly so because of the cultural practice of bride capture where a man has sex with the girl to show his intention of marriage.

Cultural myths about IUDs penetrating the body, malformed babies as a result of contraception, infertility, paralysis, and the need for hysterectomy are further reasons why FP isn't used (Keesara et al., 2018; Ochako et al., 2015). Some people worry that even if they were willing to use contraceptives against their spouses' wishes, side effects like excessive and irregular bleeding and libido loss would reveal them.
Fortier (2013) in her article stated that the following are some examples of socio-cultural barriers to family planning among some countries in the sub-Saharan Africa.

Although each community has its own socio-cultural barriers to family planning, many of the same issues that exist in one country are similar in other African countries; Traditionally, having many children symbolized high social status, adolescents are not considered adults until they have a child, Bride price suggests that women must bear many children as a way to repay it, women become a man's property after marriage, therefore having little say in family planning and lastly in impoverished areas, women have few choices other than becoming a mother and wife at home (.Fortier, L. (2013).

2.3.1 Polygamy as a cultural factor

More than 20% of married women in West and East Africa are participating in polygamous unions, according to a Baschieri (2013) poll. Although polygamy has decreased across Kenya, according to KDHS (2008–2009) data, it is still prevalent in Nyanza and has an impact on sexual behavior and fertility. Compared to Central Province's 0.5%, Nyanza Province has the highest rate of polygamous relationships among men (15.4%), according to KDHS (2008-2009) data.

According to the 2014 Census of Uganda, around 8.35% of all women aged 18 years or more, were currently married or cohabiting in a polygamous relationship **(**UBOS Report 2014)

Zee (2017) claims that places with high and low fertility coincide with specific ethnic groups, with high fertility areas being associated with polygamy. This occurs because a high population growth rate may come from multiple women competing for pregnancies. The Luo, Mijikenda, and Kamba communities can clearly see the situation. The ability of the man to offer bride cash for multiple women as well as the increased labor provided by women and children that increases the family wealth while assuring a continued lineage are two ways that wives signify wealth. As a result, having multiple wives raises one's social standing. Early marriages and insufficient exposure to contraceptives are the causes of this.

Contraception usage was much less common among women in polygamous marriages in Malawi compared to monogamous ones (Baschieri, 2013). The characteristics of polygamous relationships, the study finds, make polygamous women less likely to utilize birth control than monogamous women. The polygamous women's older, non-primary-educated husbands usually desired more children than their monogamous

counterparts. In polygamous couples, monogamous couples, or both, contraceptive usage was negatively correlated with age and positively correlated with educational attainment and the number of live offspring. Researchers speculate that women's ability to share responsibilities (including childcare) with their co-wives may minimize women's vulnerability to the effects of an unexpected delivery, even if the study was not meant to identify the exact causes of this.

2.3.2 Religion as a cultural factor

Despite Islamic theology emphasizing the spiritual worth of offspring (Ziyane and Ehlers, 2007), some Muslim women in Swaziland refused to regard the birth as a sign of fatalism since, in their eyes, it represents humility (Izugbara and Ezeh, 2010). The theological divides are most pronounced in Africa, where 20% of the population holds Catholic teachings that highlight the necessity of allowing all sexual actions for reproduction. Therefore, artificial means of contraception are unacceptable. Permanent procedures like vasectomy for males and tubal ligation for women are those that are most negatively impacted. M. Mandara (2010) the only birth control techniques recognized by the church were outlined in the late Pope John Paul VI's 1968 encyclical Humanae Vitae.

Although religious doctrine emphasizes the spiritual significance of progeny, some Muslim women in Swaziland refused to view the birth as fatalism because, in their eyes, it represents humility (Izugbara and Ezeh, 2010). In Africa, where 20% of the population practices Catholicism, where its principles emphasize that all sexual behaviors must be permissible for procreation, the religious obstacles are particularly noticeable. As a result, artificial insemination has become more common. The only birth control techniques approved by the church were stated in the 1968 encyclical Humanae Vitae, written by the late Pope John Paul VI and supporting natural family planning methods such as intermittent abstinence.

A study of Factors affecting family planning use among women of childbearing age by kassim et al who established that Religious beliefs were found to affect women’s family planning use. In their study, participants reported that catholic religion discouraged them to use family planning because doing so prevented eggs fertilization by the sperm thus preventing pregnancy. This, according to them, is against God’s will

for people to fill the earth. Family planning thus constitutes interfering with God's plan (Kassim et al 2022)

2.4 Accessibility of Family Planning Services Centers

If there are no contraceptives accessible, knowledge is pointless. Other challenges that women have while attempting to receive contraceptives are highlighted by the Centers for Disease Control (CDC), such as traveling to clinics. According to Dickinson et al. (2010) and Campbell et al. (2006), women of all ages who live the furthest from clinics take contraceptives less frequently than those who have easy access to them.

Oftentimes, poor individuals have little alternative but to turn to sexual activity as a source of revenue. Therefore, during this procedure, unwanted children would also be born. In contrast, wealthy families can afford to spend a lot of money on things other than sex, such traveling, drinking, and other forms of entertainment. The impoverished may find it difficult to afford transportation to family planning clinics since they spend the bulk of their cash on necessities.

Emphasis is placed on helping couples achieve their reproductive goals in family planning services. To assist clients in achieving these goals, family planning services should be tailored to their requirements. The ability and attitudes of the providers are crucial for the successful implementation and acceptance of modern family planning techniques, particularly for the long-term and permanent approaches. According to Kasedde S. (2000), some of the difficulties experienced in delivering family planning services include a lack of skilled personnel or the transfer of trained and motivated professionals, which lessens the commitment of the remaining staff. Furthermore, there is insufficient information sharing, including poor instructional and communication materials, limited disclosure of methods, and insufficient counseling of modern FP techniques, particularly the long-term ones.

Extended wait times, unofficial fees in the public sector, and a lack of information provided during care are additional service aspects that could make it more difficult for people to use FP services (Jitta 2008). If providers of family planning services consider the other service requirements, such as long wait times, unofficial fees in the

public sector, and a lack of information supplied during care, it may be possible to improve the quality of FP services.

According to a study by USAID (2020), being adjacent to a healthcare facility that provides services reduces the opportunity costs of receiving such treatments, such as a reduction in travel time and transportation costs, increasing the chance that one will do so. Women, being rational decision-makers, typically think about going to a medical institution only when they believe they have a more serious illness. Since individuals would have to give up other economically beneficial jobs, especially in rural areas, FP is usually not regarded as a serious illness or a requirement that merits going to a distant medical institution (UN, 2019).

Due to their close friendships and limited sexual interactions, the adolescents said they did not utilize contraception. However, teenagers who are sexually active face the risk of unintended pregnancy regardless of how frequently they have sex or if they are married. Other reasons given by the youth for not utilizing FP were organizational difficulties, accessibility problems, health challenges, and concern over negative impacts (Woog et al., 2015).

The geographical proximity of a person's home influences how frequently they use services, according a study by Jalu et al. (2019). One of the challenges is physical inaccessibility. The location, distance, and cost of transporting services in the rural environment are typically worse than in the urban setting (David & Allan, 2018; Silumbwe et al., 2018). Facilities may exist, but they might not have adequate inventory of the goods and materials necessary to perform services, and they might not have flexible enough hours to accommodate a range of customers (Benson et al., 2017). According to Silumbwe et al. (2018), low usage was caused by a lack of the chosen technique, great physical distances to the facilities, and negative provider attitudes.

Patients admitted to just having brief interactions with the doctors and their spouses in certain study done in different African nations (Ajong et al., 2016; Prata et al., 2016). Even though they waited a long time to see the healthcare providers, several patients felt that their contacts with them were limited and that they were unable to ask many questions. Therefore, the effectiveness of counseling may have an impact on

the knowledge and fitness of clients to make decisions. As a result, even interactions with medical experts, FP beliefs and misconceptions continue.

Women are less likely to utilize contraception when it is difficult for them to access it (Keogh et al., 2015). The availability of experienced health care providers to deliver a variety of techniques, the integration of contraceptive services, and the availability of couples counseling all favorably affect the adoption of services (Amo-Adjei et al., 2017; Silumbwe et al., 2018). According to Jalang'o et al. (2017), easy access to contraceptives in a health facility and a positive opinion of the services promote FP uptake.

Access to reproductive health care is measured indirectly by family planning availability. Access to family planning services is an objective that was included in both the Millennium Development Goals and the Sustainable Development Goals, with CPR serving as the indicator (United Nations, 2017). Despite significant advancements in women receiving FP and other maternal health treatments, more has to be done to ensure universal access (Kissoon et al., 2015).

According to a research conducted in Kenya, the contraceptive prevalence rate (CPR) among married women in that country has decreased over the previous ten years and is now at a low of 46%, with just 39% of the women utilizing a contemporary form of family planning. According to estimates, 24% of the population lacks access to family planning services, particularly among the poor and other socially disadvantaged groups including adolescents and young adults (Republic of Kenya, 2012).

2.5 Health factors associated with low utilization of Family Planning services

Some of the challenges faced in providing family planning services, according to Kasedde S. (2018), include a shortage of trained employees or the transfer of skilled and motivated workers, which reduces the commitment of the remaining staff.Additionally, there is a lack of adequate information supply, ranging from a lackluster presentation of educational and communication materials to restricted disclosure of techniques and counseling on contemporary FP methods, particularly the long-term and permanent ones (Kasedde 2019).

The limited accessibility to services, unsatisfactory family planning supplies at the health facilities, and unfavorable attitudes of service personnel are all noted as well (Mbonye 2018). Long wait times, unofficial costs in the public sector, and a dearth of information offered during care are additional service aspects that may discourage the use of Family Planning services (Jitta 2018).

When considering expenses, family planning services may be made more affordable and practical for customers if they also consider their other service requirements. The costs to clients would be cheaper and there would be fewer lost chances for service delivery if family planning services for female clients were integrated with regularly utilized MCH and reproductive services (Katherine 2017).

A study by sato et al in their study of Effect of distance to health facilities and access to contraceptive services among urban Turkish women they established that the effect of distance to a health facility on contraceptive use significantly differed according to contraceptive availability at the facility. They established that Further distance to a health facility decreased the use contraception (sato et al 2021)

Bilikisu et al a study of The distance-quality trade-off in women's choice of family planning provider in North Eastern Tanzania showed that Only 33% of woman received contraception from a health facility nearest to them. According to their study, Women, may not seek contraception from the nearest facility, rather opting for a more distant facility with better quality services or to ensure greater privacy and anonymity (Balikusu et al 2022)

2.6. Policy on family planning.

The government of Uganda's goal is to provide information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have so as to increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs contraception but also to promote strong integrated family planning information and services in the health sector at all levels and within various ministries.

In its policy All sexually active males and females in need of contraception are eligible for family Planning services provided that they have been educated and counseled on

all available family-planning methods and choices; attention has been paid to their current medical, obstetric contra-indications and personal preferences.

Also Every individual who is sexually active can receive family planning and contraceptive services irrespective of age or mental status. Everyone in need of contraception is to be targeted however the priority groups will be, women who have had 1 or more pregnancies; post abortion and post-partum clients; women who are over 35 years old among others

But also No verbal or written consent is required from parent, guardian or spouse before a client can be given family planning service except in cases of incapacitation (intellectual disability). Clients should give written consent to long-term and permanent family planning methods.

All personnel involved in the provision of FP services must be adequately trained and equipped to provide quality service. The training in the FP and RH will be based on the curriculum approved by the MOH among other guidelines.

2.6 A summary of the literature review

A lack of effective contact with women during child health clinics and after delivery is caused by health service issues including stock outs of contemporary family planning materials and an insufficient number of healthcare staff in the facilities. The low demand for family planning services is a result of mothers' inadequate awareness of these options. This might also stem from an excessive workload and low motivation, which leads to the delivery of subpar services and the loss of chances. The socioeconomic issues that may influence the need for family planning services include the mothers' and their spouses' poverty and low income, which leads in a lack of funds for other expenses such as transportation. Mothers who lack knowledge may not be as conscious of the significance, which has negative effects.

CHAPTER THREE: RESEARCH METHODS

3.0 Introduction

This section presents the methodology that was used in the study as indicated below, and covers research ethics, study population, sample size, data gathering instruments, and research design.

3.1 Study design.

This study used a cross-sectional study design that employed quantitative method

3.2 Study area

The study was conducted in Manafwa district, Bumufuni. Bumufuni is located in Eastern Uganda in the sub-region of Bugisu that consists of the Districts of Bududa, Bulambuli, Manafwa, Sironko, Mbale and Namisindwa. It is bordered by Namisindwa District in the East; the District of Bududa in the North West, Mbale to the West and Tororo in the Southwest. It is located between the longitudes of 34^0 E, 35^0E and latitudes 00^0 & 45^0N; and has the total surface area of about 231 sq km. Manafwa district was chosen because it is one of the rural districts of Uganda were literature has indicated low contraceptive use but also it is in the eastern region of the country where national statistics have indicated low contraceptive use if compared to other region like central and western (UDHS 2016)

3.3 Study Population

The study population comprised of women aged 18-39 years

3.4 Selection Criteria

3.4.1 Inclusion Criteria

The study included young women aged 18-39 years who were willing to participate in the study with formal signed consent and were residents of Bumufuni, Manafawa district.

3.4.2 Exclusion Criteria

Those who at the time of the study were critically ill or were not in their right state of mind were excluded from the study

3.5 Sampling Procedure and Sampling Techniques

3.5.1 Sample size

In sample size determination the formula adopted by (UBS's DGS 2016) this formula was chosen because Cochran formula allows to calculate an ideal sample size given a desired level of precision, desired confidence level, and the estimated proportion of the attribute present in the population. Cochran's formula is considered especially appropriate in situations with large populations. Therefore;

$$n = \frac{Z^2Pq}{d^2}$$

n=Desired sample size

Z= Standard normal deviation usually setas1.96for maximum sample size at 95%confidence interval.

P=50% (constant) or 0.5% since there is no measures estimated Q=1-p =1-0.5= 0.5 and,

d=degree of accuracy desired 0.10 or 0.10 probability level (at 95% Confidence level)

Therefore by substitution in the formula 1.96^2x0.5x0.5

0.10x0.10=96

Thus the sample size was 96respondents

Additional 10% allowance (non response) was considered for incomplete questionnaire. Thus and refusal to participate in the study was considered thus 96+37=133 was the sample size.

For qualitative data: an in-depth interview was conducted among women of reproductive age between 18-39years until saturation is attained.

3.5.2 Sampling Techniques/procedure

This study used multistage sampling. In Manafwa district, Bumufuni subcounty was purposively chosen, the sub county has 16 villages.

3 villages of Bwirusa, Bumwangu and Bubwaya were randomly chosen using simple lottery.

In the 3 randomly selected villages, a list of house household were listed using the name of the household head.

A total of 1513 house hold with at least a woman aged 18-39 were listed and this formed the sampling frame. Only one female in the selected house hold who met the inclusion criteria was interviewed.

To arrive at the sample size of 133, I used systematic sampling where every 11th house hold on the list were a female who met the inclusion criteria was found was included in the study. The first households to be sampled was the first on the list.

3.6. Study variable

The study had both independent and dependent variables

3.6.1. Dependent variable

The dependent variable was low use of family planning

3.6.2. Independent variables.

Independent variables include

Demographic factors such as age, sex, marital status religion, educational level etc, **socio-cultural factors** such as myth and taboos, decision on use of family planning, cultural norms.
Health related factors such as Long waiting time, Inadequate staff, Long distance to Health facilities, Limited funds for service delivery, Stock outs of /lack of Access to contraceptives.

3.6 Data Collection Methods and instruments

Data was collected quantitatively; upon consenting. self-administered questionnaires were administered to the respondents who could read and write on which they circled answers as applicable to them. For the respondents who were unable to read and write, the questions and responses where read and interpreted to them by the research assistants and their responses filled in in the questionnaire

3.6.3 Validity and Reliability

3.6.4 Validity of instrument

Validity refers to the truth or accuracy of the research while Saunders et al (2009) adds that it is the extent to which data collection instrument measures the appropriateness so as to come to accurate conclusions. The study used triangulation to ensure validity of the results before administering the research instruments. The instruments were checked by the supervisors of the researcher. Content validity ratio was used to calculate the content validity index using the formula below:

CVI=Total No. of items rated by all respondents divided by Total No. of items in the instrument

Thus if a content validity index of 0.7 and above is obtained, then instrument is suitable for the study (Amin, 2005)

3.6.5 Reliability of instruments.

According to Creswell (2013), test administration and scoring procedures must be consistent in order for results to be considered reliable. Internal consistency relates to whether item answers on an instrument are constant across constructs.

The researcher preserved the consistency and reliability of the tools by inspecting them to make sure that any transcription mistakes were not present (Gibbs, 2007). When evaluating pre-test clusters, an internal consistency approach was applied. We can determine how interconnected the questionnaire's components are using this technique. The reliability of the quantitative research tool was assessed using the "Cronbach Coefficient Alpha," which was used in this.

3.7 Data Analysis

Data was first checked manually for completeness. Data was cleaned, coded, and entered into Excel. The data was then exported to Statistical Package for Social Scientists (SPSS) version 20 for statistical analysis.

The analysis was done at Univariate, Bivariate, and Multivariate levels. At the univariate level, the researcher obtained summaries, frequencies, percentages of the variables under study.

At the bivariate level, Pearson's Chi-square (x^2) tests were used to determine the relationship or association between the dependent and independent variables. The corresponding P-values were obtained, variables with P-values less than 0.05 were considered statistically significant. At the multivariate level, logistic regression of variables that were statistically significant at the bivariate level was analyzed. The corresponding P-values, Adjusted Odds ratio, and Confidence Intervals were also obtained.

3.7.1 Ethical Considerations

The researcher sought an approval letter to go and collect data from Research Ethics Committee of Uganda Christian University and National Council of Science and Technology for review and approval of research proposal and afterwards actual data collection began. In addition, a number of ethical guidelines and procedures were followed by the researcher notably; permission will be sought from Manafwa District local government research committee, and local council leaders of Bumufuni sub-county. While with actual respondents, the researcher sought for information having shared with all the important information concerning the study (including but not limited to aims, benefits, procedures, risks and confidentiality related to the study. While writing the dissertation, the information concerning participants remained anonymous and be held confidential in that their names and personal identifiers did not appear anywhere be it in the final write of the dissertation but instead results was in aggregated form.

CHAPTER FOUR: STUDY RESULTS AND FINDING

4.0. introduction

this chapter presents the findings from the study. It includes descriptions of the background characteristics of the respondents, Socio- cultural factors associated with the low utilization of Family Planning services among women aged 18-39years in Bumufuni and the health-related factors associated with the low utilization of Family Planning services among women aged 18–39 in Bumufuni.

4.1. **Demographic characteristics of respondents**

Table 1: Demographic characteristics of respondents

Respondent characteristics	Frequency	Percentage (%)
Age		
15-19	5	3.8
20-24	39	29.3
25-29	64	48.1
30-34	18	13.5
35-39	7	5.3
Marital status		
Single	27	20.3
Married	89	66.9
Divorced/separated	12	9
Widowowed	5	3.8
Number of children n=106		
1-2	11	10.4
3-4	59	55.7
>5	36	33.9
Level of Qualification		
Primary education	61	45.9
Secondary education	43	32.3
Tertiary education	19	14.3
Never been to school	10	7.5
Religion		
Catholic	21	15.8
Muslim	20	15.0
Protestant	92	69.2
Occupation		
formal employment	28	21.1

informal	105	78.9
Income Per Month		
<100,000	96	72.2
100,000-250,000	18	13.5
260,000 - 350,000	12	9.0
>350,000	7	5.3

According to table 4.1 above, the majority 64 (48.1) of the respondents were aged 25-29years and 88(66.9%) of them were married.

More than half 59(55.7%) of the respondents had 3-4 children and only 11(10.4%) of the respondents had 1-2 children

On the level of education, a total of 61(45.9%) of the respondents had completed primary level of education, 19(14.3%) of the respondents had attained tertiary level of education and only 10(7.5%) of the respondents had never been to school

More than half 92(69.2%) of the respondents were protestant and 105 (78.9%) of the respondents were informally employed

In regards to monthly income majority 96(72.2%) of the respondents earned less than 100,000sh as their monthly income and only 7(5.3%) of the respondents earned an income that was above 350,000sh

4.2 The cultural factors associated with the low utilization of Family Planning Among women

Table 2: The cultural factors associated with the low utilization of Family Planning Among women

Variable	Frequency	percentage
Are there cultural beliefs about family planning in this community		
Yes	36	27.1
No	88	66.1
I don't know	9	6.8
Who in your home who makes the decision about family planning and the number of children		
I do	44	33.1
My spouse	78	58.6
Me and my spouse	11	8.3
What is the attitude of community members towards family planning		
Positive	53	39.8
Negative	74	55.6
Neutral	6	4.5
Do you think the attitude of the community modern contraceptives can hinder use of contraceptives.		
Yes	82	61.7
No	51	38.3
Does your community have any taboos about use of modern contraceptives?		
Yes	28	21.1
No	105	78.9
Do you have cultural beliefs about family planning?		
Yes	15	11.4
No	118	88.6
Do you have religious believes about family planning?		
Yes	25	18.8
No	108	81.2
Do you think some of the cultural and religious believes about family planning are true?		
Yes	41	30.8
No	92	69.2

What do men feel about family planning		
Accept it	88	66.2
Don't accept it	45	33.8

from the table above, majority 88(66.1%) of the respondents reported that there were cultural belief about family planning in their community and more than half 78(58.6%) of the respondents reported that its their spouse that decides the type of family planning and the number of children.

More than half 74(55.5%) of the respondents reported that the community members had a negative attitude towards family planning and 82(61.7%) of them reported that the negative attitude hinders the use of contraceptives

Majority 105(78.9%) of the respondents reported that the community doesn't have taboos in relation to family planning and 118(88.6%) of the respondents also reported that their community doesn't have cultural belief about family planning

Slightly more than a half 82(61.7%) of the respondents indicated the attitude of the community modern contraceptives cannot hinder use of contraceptives by married women.

Majority of respondents 105(78.9%) indicated that the community has no any taboos about use of modern contraceptives.

Also 118(88.6%) of the respondents indicated there are no cultural beliefs about family planning.

Further, 108(81.2%) of the respondents indicated that there are no religious beliefs about family planning 108(81.2%).

More than half 92(69.2%) of the respondents don't think that some of the cultural and religious beliefs about family planning are true.

4.3 Health factors associated with low utilization of family planning among women

Table 3: Health factors associated with low utilization of family planning among women

Variable	Frequency	Percentage
Are you currently using any modern family planning method		
Yes	51	38.4
No	82	61.6
Did anyone ever explain to you the advantages and disadvantages of using family planning ?		
Yes	47	35.3
No	86	64.7
Have you noticed any side effects as a result of using the family planning method n=51		
Yes	46	90.2
No	5	9.8
Will these side effects affect your use of modern contraception in the future? n=46		
Yes	35	76.1
No	11	23.9
Do you know of a place where you could access family planning services?		
Yes	116	87.2
No	17	12.8
Distance to the nearest health facility		
<5Km	48	36.1
>5Km	85	63.9
How long do you wait before getting services at the health facility		
<30min	12	9
30min-1 hr	49	36.8
>1hr	72	54.1
What is the attitude of health workers towards women seeking family planning methods		
Positive	101	75.9
negative	32	24.1
Are the different family planning methods always available at health center where you seek services		
Yes	38	28.6
No	87	65.4
I don't know	8	6

From the table above 82(61.6%) of the respondents reported not currently using modern family planning and only 51(38.4%) of the respondents reported using modern family planning

More than half 86(64.7%) of the respondents reported that they have never had any one ever explaining to them the advantages and disadvantage of family planning

Of those who reported using family planning,46(90.2%) of them reported experiencing side effects and majority 35(76.1%) of them reported that the side effects will affect their future use of family planning

More than three quarters 116(87.2%) of the respondents reported that they knew where to access family planning method

Also majority 85(63.9%) of the respondents reported staying more than 5km away from the nearest health facility

Also majority 72(54.1%) of the respondents reported spending more than one hour before receiving services at the health facility and 87(65.4%) of the respondents reported that the different types of family planning methods are not always available

4.4. Bivariate analysis of demographic factors associated with the low use of family planning.

Table 4. Bivariate analysis of demographic factors associated with the low use of family planning.

		Contraceptive use		X^2	Df	p-value
Variable		**Yes 51(38.3%)**	**No 82 (61.7%)**			
Age						
15-19	5	1	4	17.17	4	0.001
20-24	39	24	15			
25-29	64	17	47			
30-34	18	7	11			
35-39	7	2	5			
Marital status						
Single	27	9	18	3.49	3	0.017
Married	89	37	52			
Divorced/separated	12	3	9			
Widowowed	5	2	3			

Number of children n=106						
1-2	11	2	9	2.66	2	0.093
3-4	59	43	16			
>5	36	6	30			
Educational level						
Primary education	61	8	53	16.77	3	0.000
Secondary education	43	29	14			
Tertiary education	19	11	8			
Never been to school	10	3	7			
Religion						
Catholic	21	4	17	23.39	2	0.000
Muslim	20	13	7			
Protestant	92	34	58			
Occupation						
formal employment	28	19	9	14.51	1	0.002
informal	105	32	73			
Income Per Month						
<100,000	96	38	58	4.19	3	0.170
100,000-250,000	18	6	12			
260,000 - 350,000	12	5	7			
>350,000	7	2	5			

From the table above, age (X^2=17.17, df =4, P-value=0.001),, educational level (X^2=16.77, df =3, P-value=0.000), religion(X^2=23.39, df =2, P-value=0.000), and occupation (X^2=14.51, df =1, P-value=0.002), were found to be statistically significant p-value <0.05

4.5. Bivariate analysis of socio- cultural factors associated with the low use of family planning.

Table 5. Bivariate analysis of socio-cultural factors associated with the low use of family planning.

Variable	**F**	**Contraceptive use**				
		Yes 51(38.3%)	**No 82 (61.7%)**	**X^2**	**df**	**p-value**
Are there cultural beliefs about family planning in this community						
Yes	36	8	28	2.23	2	0.063
No	88	39	49			

I don't know	9	4	5			
Who in your home who makes the decision about family planning and the number of children						
I do	44	19	25	17.16	2	0.002
My spouse	78	24	54			
Me and my spouse	11	8	2			
What is the attitude of community members towards family planning						
Positive	53	35	18	4.99	2	0.091
Negative	74	14	60			
Neutral	6	2	4			
Do you think the attitude of the community modern contraceptives can hinder use of contraceptives by married women?						
Yes	51	16	35	2.60	1	0.072
No	82	35	47			
Does your community have any taboos about use of modern contraceptives?						
Yes	28	19	9	13.13	1	0.001
No	105	32	73			
Do you have cultural beliefs about family planning?						
Yes	15	3	12	2.00	1	0.062
No	118	48	70			
Do you have religious believes about family planning?						
Yes	25	4	21	1.09	1	0.095
No	108	47	61			
Do you think some of the cultural and religious believes about family planning are true?						
Yes	41	9	32	4.32	1	0.057
No	92	42	50			
What do men feel about family planning						
Accept it	88	43	45	19.69	1	0.001
Don't accept it	45	8	37			

From the bivariate analysis of socio-cultural factors in the table above, who makes decision on the type of family planning and number of children (X^2=17.16, df =1, P-value=0.002), if the community have taboos about modern family planning methods (X^2=13.13, df =1, P-value=0.001), and men's feeling about family planning (X^2=19.69, df =1, P-value=0.001), were found to be statistically significant P-value <0.05

4.6. Bivariate analysis of health factors associated with the low use of family planning.

Table 6: Bivariate analysis of health factors associated with the low use of family planning.

Variable		Contraceptive use				
		Yes 51 (38.3%)	No 82 61.7%)	X^2	Df	p-value
Are you currently using any modern family planning method						
Yes	51	51	0	-	-	-
No	82	0	82			
Did anyone ever explain to you the advantages and disadvantages of using family planning ?						
Yes	47	44	3	8.67	1	0.061
No	86	7	79			
Have you noticed any side effects as a result of using the family planning method n=51						
Yes	46	46	0	-	-	-
No	5	5	0			
Will these side effects affect your use of modern contraception in the future? n=46						
Yes	35	35	0	-	-	-
No	11	11	0			
Do you know of a place where you could access family planning services?						
Yes	116	43	73	12.33	1	0.003
No	17	8	9			
Distance to the nearest health facility						
<5Km	48	39	9	21.01	1	0.000
>5Km	85	12	73			
How long do you wait before getting services at the health facility						
<30min	12	9	3	19.80	2	0.001
30min-1 hr	49	37	12			
>1hr	72	5	67			

What is the attitude of health workers towards women seeking family planning methods						
Positive	101	46	55	1.47	1	0.091
negative	32	5	27			
Are the different family planning methods always available at health center where you seek services						
Yes	38	31	7	4.16	2	0.006
No	87	18	69			
I don't know	8	2	6			

From the bivariate analysis of health factors above, where to get family planning services (X^2=12.33, df =1, P-value=0.003), distance to the nearest facility (X^2=21.01, df =1, P-value=0.000), and waiting time (X^2=19.80, df =2, P-value=0.001), were found to be statistically significant P-value<0.05

4.7. Multivariate analysis of factors associated with the low use of family planning

Table 7. Multivariate analysis of factors associated with the low use of family planning

Variable	AOR	95%CI	P-value
Age			
15-19	0.3	1.23- 3.10	0.002
20-24	0.4	2.33- 4.70	
25-29	1.8	0.44- 1.64	
30-34	0.2	1.10- 2.11	
35-39	1	1.99- 2.78	
Educational level			0.000
Primary education	0.3	1.12-2.04	
Secondary education	0.4	1.03-2.86	
Tertiary education	1		
Never been to school	0.2	0.47-2.02	
Religion			0.000
Muslim	2.9	1.67-4.79	
Catholic	1		
Protestant	4.3	1.08-5.66	
Occupation			**0.006**

Formal **Informal**	1 0.3	1.07-2.22	
Who in your home who makes the decision about the type of family planning and the number of children			
I do **My spouse** **Me and my spouse**	0.4 0.2 1	1.24-4.00 1.80-3.66	0.001
Does your community have any taboos about use of modern contraceptives?			
Yes **No**	0.4 1	0.91-2.68	0.068
What do men feel about family planning			
Accept it **Don't accept it**	1 0.6	1.49-3.88	0.053
Do you know of a place where you could access family planning services?			0.072
Yes **No**	1 0.6	2.24-4.09	
Distance to the nearest health facility			
<5Km **>5Km**	1 0.4	1.11-5.34	0.000
How long do you wait before getting services at the health facility			
<30min **30min-1 hr** **>1hr**	1 4.1 0.3	2.21-5.06 1.99-4.91	0.001

From the table of multivariate analysis above, age (AOR=1.8; 95% CI: 1.23-3.10; p= 0.002), educational level (AOR=0.3; 95% CI: 1.12-2.04; p= 0.000), religion (AOR=4.3; 95% CI: 1.08-5.66 p= 0.000), decision about family size and family planning (AOR=0.4; 95% CI: 1.24-4.00; p= 0.000),, distance to the health facility (AOR=0.4; 95% CI: 1.11-5.34; p= 0.003), and waiting time at the facility (AOR=0.3; 95% CI: 1.99-4.91; p= 0.003),were found to independently associated with the low uptake of family planning p-value <0.05

Study limitations

The study acknowledged the potential for social desirability bias, where respondents might have provided socially acceptable answers rather than their true experiences or beliefs.

Additionally, reliance on self-reported data could have introduced response bias, with participants possibly providing inaccurate or incomplete information.

CHAPTER FIVE: DISCUSSION OF RESULTS

5.0 Introduction.

This chapter presents a discussion of the study findings in relation to the specific objectives of the study as analyzed and presented in chapter four. It tries to relate the finding in this study with findings from other related studies reviewed in literature

5.1 Demographic characteristics of respondents

This study established that age was significantly associated with the use of contraceptive (AOR=1.8; 95% CI: 1.23-3.10; p= 0.002). the younger women were less likely to use family planning compared to the older women. this finding is consistent with a finding in a study by Prata et al who in their study of differences in factors associated with current modern contraceptive use among youth and adult women established that women aged 25–49 years (66%) were more likely to be currently using modern contraceptives than women aged 15–24 years (48%) (patra et al 2016). Similarly, Nieves et al in their study of The influence of partnership on contraceptive use among HIV-infected women accessing antiretroviral therapy in rural Uganda established that women age 15-19 were markedly less likely to be using any method of family planning than women age 20-24 (5% and 23%, respectively) (Nieves et al 2020) a finding that is consistent with the finding in this study.

This study established that religion was independently associated with the use of family planning (AOR=4.3; 95% CI: 1.08-5.66 p= 0.000) where the protestants were four times more likely to use family planning than the Catholics this finding is in agreement with the finding in a study of Factors affecting family planning use among women of childbearing age by kassim et al who established that Religious beliefs were found to affect women's family planning use. In their study, participants reported that catholic religion discouraged them to use family planning because doing so prevented eggs fertilization by the sperm thus preventing pregnancy. This, according to them, is against God's will for people to fill the earth. Family planning thus constitutes interfering with God's plan (Kassim et al 2022)

Allen et al 2019 established that The relationship between education and the use of family planning is mixed they established that Young women with no education were

slightly less likely than women with secondary or higher education to use a modern method of family planning (93% versus 100%) (Allen et al 2019) similar finding was established by Kushwah et al who showed that was slightly higher among women with secondary or higher education (17%) than among women with no education (15%), while use is lowest among women with primary education (11%) the finding from the above studies are in agreement with the finding in this study that established that educational level (AOR=0.3; 95% CI: 1.12-2.04; p= 0.000) significantly influenced the use of family planning where by those with no or primary level education where less likely to use family planning compared to those with tertiary level education (Kushwah,2020)

Similarly, another study of Factors associated with modern contraceptive use among young and older women in Uganda which used nationally representative data, a woman's educational attainment showed a positive association with use of contraception. The study showed that education alone, irrespective of the effects of a woman's mobility and decision-making role, had a significant effect on use of contraception. Women with higher educational attainment were more likely to be users of contraception a finding that was in agreement with a finding in this study (Asiimwe et al)

5.2 The cultural factors associated with the low utilization of Family Planning Among women

This study established that decision about family size and type family planning (AOR=0.4; 95% CI: 1.24-4.00; p= 0.000) significantly influenced the use of family planning where those spouses who jointly agreed on the size and type of family planning where more likely to use family planning compared to those who singly too the decision. This finding is consistent with the finding in a study of cultural barriers to use of family planning by Chekole et al. 2019 who showed where males approval of family planning was also significantly associated with male involvement hence improved uptake of family planning. He further showed that Some women worry that even if they were willing to use contraceptives against their spouses' wishes, side effects like excessive and irregular bleeding and libido loss would reveal them (Chekole et al. 2019)

5.3 Health factors associated with low utilization of family planning among women.

This study established that the distance to the nearest health facility significantly influenced the use of family planning (AOR=0.4; 95% CI: 1.11-5.34; p= 0.003) where by those who resided more than 5km away from the health unit were less likely to use family planning compared to those who resided less than 5km from the facility this finding is consistent with the finding in a study by sato et al in their study of Effect of distance to health facilities and access to contraceptive services among urban Turkish women they established that the effect of distance to a health facility on contraceptive use significantly differed according to contraceptive availability at the facility. They established that Further distance to a health facility decreased the use contraception (sato et al 2021)

However, the finding in this study is not in agreement with a study of The distance-quality trade-off in women's choice of family planning provider in North Eastern Tanzania by Bilikisu et al who showed that Only 33% of woman received contraception from a health facility nearest to them. According to their study, Women, may not seek contraception from the nearest facility, rather opting for a more distant facility with better quality services or to ensure greater privacy and anonymity (Balikusu et al 2022)

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presented the conclusion and recommendations of the study based on the study results /findings and in line with the study objectives.

6.1 Conclusion

The study established that the prevalence of contraceptive use stood at 38.3%. this is low compared to the national prevalence target of 39.6% by 2025

The socio demographic factors independently associated with this low contraceptive prevalence rate were, age (AOR=1.8; 95% CI: 1.23-3.10; p= 0.002), educational level (AOR=0.3; 95% CI: 1.12-2.04; p= 0.000), religion (AOR=4.3; 95% CI: 1.08-5.66 p= 0.000),

Socio-cultural factors associated with low contraceptive use was decision about family size and family planning (AOR=0.4; 95% CI: 1.24-4.00; p= 0.000),

Finally distance to the health facility (AOR=0.4; 95% CI: 1.11-5.34; p= 0.003), and waiting time at the facility (AOR=0.3; 95% CI: 1.99-4.91; p= 0.003), were the health related factors independently associated with the low uptake of family planning p-value <0.05

6.2. Recommendation

This study established that educational level influenced the use of family planning where by those with lower level of education were less likely to use family planning compared to those with higher level of education as such, there is need for the government through the ministry of education to promote girl child education so as to have them empowered with knowledge to make independent decision about family planning

The health worker should partner with religious, cultural, political leaders and carry out intensified behavior change campaigns specifically putting emphasis on benefits of family planning and also address the traditional beliefs, which tend to discourage women from using modem methods of contraception.

This study also established that the one who decides about family planning and the number of children in a home influenced the use of family planning where by women who decided on their own or their spouse decided for them the type of family planning and number of children were less likely to use family planning compared to those who decided as a couple. Therefore, there is need for the government with the help of other implementing partners to promote men's involvement in family planning

From this study, the distance to the facility was associated with use of family planning where by those who stay far away from the facility were less likely to use family planning.so there is need for the district health office of bududa district to extend family planning services nearer to the population by carrying out family planning out reaches with an aim of reaching out the hard to reach population

Area of further study

This study recommends Future research to explore the perspectives of men on their overall uptake of various family planning methods.

REFERENCES

Adeyemi, M., Ijadunola B., Orji T, Kuti. O, & Alabi, (2015). *The unmet need for contraception among Nigerian women in the first year post-partum*. European Journal of Contraception and Reproductive Health Care, Lagos.

Ankomah, A., Anyanti, J., & Oladosu, M. (2017).Myths, misinformation, and communication about family planning and contraceptive use in Nigeria.*OpenAccessJournal of Contraception*, 2017 (2), 95-105.

Bankole, A., &Audam, A. (2016).Fertility preferences and contraceptive use amongcouples in sub-Saharan Africa.*African Population Studies*, *25*(2), 173-188.

Kripa, S., &Shetty, H. (2017).Knowledge, attitude and practice of contraception among the postnatal women in a tertiary care hospital in a rural area in Southern Karnataka, India. International Journal of Reproduction, Contraception, Obstetrics and Gynecology, 6(5), 1821-1824.

Kushwah, B., &Agrawal, S. (2020). Knowledge, attitude and practice of contraception: a study from rural tertiary health care center. International Journal of Reproduction, Contraception, Obstetrics and Gynecology, 4(2), 329-333.

Lau, C. (2019). Preventing childhood obesity through occupational therapy. *OT practice*, pp 11-17. Retrieved from www.AOTA.org

Malalu, P. K., Alfred, K., Too, R., &Chirchir, A. (2018). Determinants of use of modern family planning methods: A case of Baringo North District, Kenya. Science journal of public health, 2(5), 424-430.

Marston C (2017) WHO technical consultation and scientific review of birth spacing. Geneva: World health Organization.

Smith, T. J., & McKenna, C. M. (2017). A comparison of logistic regression pseudo R2 indices. *Multiple Linear Regression Viewpoints*, 39 (2): 17-26.

Uganda Bureau of Statistics (UBOS) and ICF International Inc. (2019).*Uganda Demographic and Health Survey*. Kampala, Uganda: UBOS and Calverton, Maryland: ICF International Inc.Uganda Demographic and Health Survey (2019). "Family Planning "Kampala, Uganda: UBOS and Calverton, Maryland: ICF International Inc., chapter 7, page 77-93.

UN. (2019). *Reproductive Rights are Human Rights: A Handbook for National*

USAID, (2020). *Islam Somali Refugee Attitudes, Perceptions, and Knowledge of Reproductive Health, Family Planning, and Gender-Based Violence*. Washington, DC: The Extending Service Delivery (ESD) Project.

World Health Organization (2017). Family planning Available from: http:// www.who.int. Geneva. Accessed on 19th December 2017.

African Population and Health Research Centre. (2019). Population and Health Dynamics in Nairobi's Informal Settlements. *Report of the Nairobi Cross-Sectional Slums Survey*. Nairobi.

Allen, M. & Janet F. (2019). *International Family Planning, A Common-Ground Approach to an Expanded U.S. Role*. A Report of the CSIS Global Health Policy Center, Illinois.

Amos, C. Megan L. Ying C. and Claire B. (2019). *Breaking down cultural barriers to modern contraceptive use*: A review of targeted interventions, University of Southampton, UK.

Baker, J & Anchor U. (2018). *Meeting the challenge of urban poverty and slums*. New York.World Bank Press.

Becker, C. M & Morrison A. (2018). Urbanization in transforming economies: *Handbook of regional and urban economics*. Amsterdam. North-Holland.

Benschop, M. (2018). *Rights and Reality*. Nairobi. University of Nairobi press.

Billah, M. (2016). *Rising slums and role of NGOs*. Chicago. University of Chicago Press.

Bongaarts, J. M (2018). *The measurement of wanted fertility*. Population and development review, Washington.

Centres for Disease Control (2019): *Family planning methods and practice:* Africa. 2nd edition. Atlanta: US Department of Health and Human Services

Cleland, J. and Bernstein S. (2016). *Family Planning: The Unfinished Agenda*. The Lancet: Series on Sexual and Reproductive Health: 47 – 67

Cleland, J. G., R. P. Ndugwa, and E. M. Zulu (2019). Family planning in sub-Saharan Africa: progress or stagnation? *Bulletin of World Health Organization* 89(2):137-143

Clements, S. and Madise, N (2014). „Who is being served least by family planning providers? A study of modern contraceptive use in Ghana, Tanzania and Zimbabwe", *African Journal of Reproductive Health*, 8(2): 124–36.

Cathy, R. (2011). *The evolution and role of family planning Programs in fertility change in Kenya*. African population and health research centre, Nairobi.

Centre for Urban Studies. (2016). Squatters in Bangladesh cities: *A survey of urban squatters in Dhaka. Chicago*. University of Chicago Press.

Kasedde, S. (2000). Long-term and permanent family planning methods in Uganda. A literature review, Delivery of Improved Services for Health.

Katherine W, C. W., Ian Askew (2010). Planning and Implementing an Essential Package of Sexual and Reproductive Health Services. Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services., Population Council.

Mbonye, A. K. (2018). "Delivering Family Planning Messages through Prenatal Care Clinics in Kumi District, Uganda." The International Electronic Journal of Health Education 6: 34-40

MOH (2000). "HEALTH SECTOR STRATEGIC PLAN III 2010/11-2014/15.

MoH (2000b). "The National Reproductive health Policy Guidelines 2001, Ministry of Health, Uganda." Ministry of Health.

Nattabi B, J. L., Sandra C Thompson, Christopher G Orach, Jaya Earnest (2011). "Family planningamong people living with HIV in post-conflict Northern Uganda: A mixed methods study." Conflict and Health 5(1): 18.

Ndola Prata, A. G., Alice Cartwrightc, Ashley Frasera (2011). "Provision of injectable contraceptives in Ethiopia through community-based reproductive health agents." Bull World Health Organ 2011 89: 556-564.

Kassim, M., Ndumbaro, F. Factors affecting family planning literacy among women of childbearing age in the rural Lake zone, Tanzania. *BMC Public Health* **22**, 646 (2022). https://doi.org/10.1186/s12889-022-13103-1

Sato R, Rohr J, Huber-Krum S, Esmer Y, Okçuoğlu BA, Karadon D, Shah I, Canning D. Effect of distance to health facilities and access to contraceptive services among urban Turkish women. Eur J Contracept Reprod Health Care. 2021 Oct;26(5):374-382. doi: 10.1080/13625187.2021.1906412. Epub 2021 Apr 20. PMID: 33874821.

Prata N, Bell S, Weidert K, Nieto-Andrade B, Carvalho A, Neves I. Varying family planning strategies across age categories: differences in factors associated with current

modern contraceptive use among youth and adult women in Luanda, Angola. Open Access J Contracept. 2016 Jan 28;7:1-9. doi: 10.2147/OAJC.S93794.

Nieves CI, Kaida A, Seage GR, et al. The influence of partnership on contraceptive use among HIV-infected women accessing antiretroviral therapy in rural Uganda. *Contraception*. 2020;92(2):152–159.

Asiimwe J.B, Ndugga P, Mushomi J, Manyenye Ntozi JP. Factors associated with modern contraceptive use among young and older women in Uganda; a comparative analysis. *BMC Public Health*. 2021;14:926.

APPENDICES

APPENDIX 1: CONSENT FORM

SUBJECT CONSENT TO PARTICIPATION IN RESEARCH

Dear respondent, I am **NEKESA JOYCE**, a student at Uganda Christian University School of nursing and midwifery pursing a Masters Degree in Public Health As a course requirement, a research study is supposed to be carried out to fulfill the requirements for me to attain the a masters Degree. You are invited to participate in the study under the title, "**FACTORS ASSOCIATED WITH THE LOW UTILIZATION OF MODERN METHODS FAMILY PLANNING SERVICES AMONG WOMEN IN BUMUFUNI, MANAFAWA SUB-COUNTY**". The information will be confidentially treated and strictly used for research purpose. Results from this study will enrich ground information about awareness among the **modern methods family planning services among women** to add data for further research. For the respondent I am agreeing to participate in a research project with a purpose of assessing factors associated with the low utilization of modern methods family planning services. The information I will give will be the basis for measurement of my awareness about low utilization of modern methods family planning services. I will be asked a series of interview questions, the investigator will record my answers, and all remain confidential. The whole exercise will take about 15-20 minutes depending on how the questions will be answered. My privacy and safety will be maintained. I can decline to answer any question or withdraw from the study any time. The interview is voluntary and does not entail any foreseeable risks and direct benefits. All data will be maintained in a safe place by the researcher. My refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled. I will not be compensated for my participation. An offer is to answer all the questions about the study. I will be given a copy of the dated and signed consent form to keep a record.

Signed.....

Date.....

Investigator.....

Date.....

Thank you so much for your time

APPENDIX II: QUESTIONNAIRE

Dear respondent,

I am NEKESSA JOYCE, a student at Uganda Christian University Department of Public Health, Nursing &Midwifery pursing a Master's Degree in Public Health. As part of my research for the attainment of my Master's Degree in my course, I request you to respond to the questionnaire on the topic about "The factors associated with the low utilization of family planning services among women in Bumufuni, Manafawa district)". The information will be used purely for academic purposes. Your response will be treated with utmost confidentiality.

RESPONDENTS' QUESTIONNAIRE

THE FACTORS ASSOCIATED WITH THE LOW UTILIZATION OF FAMILY PLANNING SERVICES AMONG WOMEN IN BUMUFUNI, MANAFAWA DISTRICT			
s/n	**respondents identification particulars (RI)**	**Responses**	
RI01	Date of interview		
RI 02	Respondents sample number		
RI 03	Location		
SECTION A. RESPONDENT SOCIO-DEMOGRAPHIC CHARACTERISTICS (RD)			
no.	Question	**Response and coding categories (circle the code that is given by the respondent)**	**Skip patterns and important notes**
RD01	Age in years	……..	

RD02	3. Marital status	1= single , 2= married, 3= divorced/separated 4= widowed	
RD03	No of children	1= 1-2 2=3-4 3= >5	
RD04	What is your highest level of qualification?	1= Primary education, 2= Secondary education 3= Tertiary education 4=Never been to school	
RD05	Religion	1=catholic , 2=Muslim ,3=protestant	
RD06	Occupation	1= formal employment 2= informal employment	
RD07	Income per month	1=>100,000ugx 2=100,000ugx-250,000ugx 4=260,000ugx-350,000ugx and above 5= >350,000ugx	

Section B2: FACTORS ASSOCIATED WITH LOW UTILIZATION OF FAMILY PLANNING AMONG WOMEN- CULTURAL FACTORS

Question	**Response**
Are there cultural beliefs about family planning in this community	1=Yes 2= No 3=I don't know
Who in your home who makes the decision about family planning and the number of children	1=I do 2=My spouse 3=Me I and my spouse
What is the attitude of community members towards family planning	1=Positive 2=Negative 3=Neutral
Do you think the attitude of the community modern contraceptives can hinder use of contraceptives.	1=Yes 2=No
Does your community have any taboos about use of modern contraceptives?	1=Yes 2=No
Do you have cultural beliefs about family planning?	1=Yes 2=No
Do you have religious believes about family planning?	1=Yes 2=No
Do you think some of the cultural and religious believes about family planning are true?	1=Yes 2=No
What do men feel about family planning	Accept it Don't accept it

Section B3. FACTORS ASSOCIATED WITH LOW UTILIZATION OF FAMILY PLANNING AMONG WOMEN- HEALTH FACTORS

Question	Response
Are you currently using any modern family planning method	1=Yes 2=No
Did anyone ever explain to you the advantages and disadvantages of using family planning ?	1=Yes 2=No
Have you noticed any side effects as a result of using the family planning method n=51	1=Yes 2=No
Will these side effects affect your use of modern contraception in the future? n=46	1=Yes 2=No
Do you know of a place where you could access family planning services?	1=Yes 2=No
Distance to the nearest health facility	1=<5Km 2=>5Km
How long do you wait before getting services at the health facility	1=<30min 2=30min-1 hr 3=>1hr
What is the attitude of health workers towards women seeking family planning methods	1=positive 2=Negative
Are the different family planning methods always available at health center where you seek services	1=Yes 2=No 3=I don't know

THANK YOU

UGANDA CHRISTIAN UNIVERSITY

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SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date. 30/4/2024

Name of Candidate: NEKESA JOYCE Reg. No: REG. NO: RJ20M21/098

Title of Dissertation. FACTORS ASSOCIATED WITH THE LOW UTILIZATION OF MODERN METHODS FAMILY PLANNING SERVICES AMONG WOMEN IN BUMUFUNI, MANAFAWA DISTRICT

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	conclusion should be reformatted to properly address the research questions /objectives	Conclusion reformatted to address the research questions /objectives	37
2	Recommendation should be reformatted to first state a negative finding in result and then recommend how to address such for the future of family planning	Recommendation reformatted to first state a negative finding in result and then recommend how to address such for the future of family planning	38

3			
	COMMENTS BY INTERNAL EXAMINER	**ACTION TAKEN**	**INDICATOR**
1	You have to update the abstract in line with the updates made on the data analysis.	Abstract updated accordingly	XI
2	Research design not well written	Research design rewritten	19
3	Sampling procedure not systematic	Sampling procedure rewritten to make it systematic	19
4	Redo data analysis to include all levels i.e bivariate and multivariate	Data analysis redone to include univariate, bivariate and multivariate level of analysis	34-39
5	Remove qualitative data and update the methodology accordingly	Qualitative removed and methodology updated accordingly	18
	Discussion using the right statistical figures from bivariate and multivariate level of analysis	Discussion written using findings at multivariate level of analysis	34

SN	**COMMENTS BY VIVA VOCE PANNEL**	**ACTION TAKEN**	**INDICATOR**
1	what is the most reason as to why people are not using family planning	The most reason why women are not using family are well displayed in table 4.2 (cultural belief about family planning, negative attitude of community members etc) table 4.3 (side effects and long distance to the facility among others	Page 26 and 28
1	How are the findings relevant to those of other research done by other people	The finding indicate low use of modern contraceptive among women just as is in many other studies cited in literature	Page 8-11
2	Limitation should come after the results and before recommendation	Adjusted accordingly	Page 34
3	What was the level of utilization before the study	The level of utilization was 33.7% as indicated in the problem statement	Page 1

4	What are the policy in place that talk about family planning	The policies on family planning are well explained in section 2.6 of chapter 2	Page 17
5	What new knowledge does the study employ or add as far as family planning is concerned. This should come clearly and should and they should be informed by existing policy	The new knowledge generated is that there is suboptimal men's involvement in family planning and hence this study recommends further research in that line	Page 38
	The choice if the district should be justified in the book	The choice of manafwa district well justified in the book	Page 3
6	What is the contribution your study? This study should come out clearly	The contribution of this study is well explained in section 1.5 and1.6 of chapter one	Page 2-3
7	What does the figure of38.3% tell you? The conclusion should be presented in your 3 objectives. Each objective should have its conclusion	The prevalence of 38.3% is below the national prevalence of 39.6 by 2025. Conclusion presented per objective	Page 50
	Look at national policy on family planning to inform your recommendations	Recommendations based on policy described in page 30	Page 37-38

……NEKESA JOYCE…… **……** **……** **……REV .CANON EVATT M .**

MUGARURA…..…… **……** **……**

Candidate's Name Signature Supervisor's Name Signature