

**ASSESSING BARRIERS AND FACILITATORS FOR CONTRACEPTIVE  
UTILIZATION AMONG ADOLESCENT GIRLS AND YOUNG WOMEN AGED  
(15-24 YEARS) IN KIYINDI TOWN COUNCIL, BUIKWE DISTRICT**

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**A DISSERTATION SUBMITTED TO THE FACULTY OF PUBLIC HEALTH, NURSING AND  
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**UGANDA CHRISTIAN  
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## **Declaration**

I, Bahima K. Alex hereby declare that this research report entitled “Assessing Barriers and Facilitators for Contraceptive Utilization among Adolescent Girls and Young Women aged (15-24 Years) in Kiyindi Town Council, Buikwe District” is entirely my own original work, and has never been submitted to any other University or Institution of higher learning for any award.


Signature: 

Date: 20<sup>th</sup> December, 2025

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## Approval

This research report titled “Assessing Barriers and Facilitators for Contraceptive Utilization among Adolescent Girls and Young Women Aged (15-24 Years) in Kiyindi Town Council, Buikwe District” was approved as the original work for the award of Master of public health of Uganda Christian university and has never been submitted to any Institution for any award.

Signature: 

Date: 20<sup>th</sup> December, 2025

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## **Dedication**

I dedicate this research report to my three daughters and son Nomusinguzi Daniela, Amutuhaire Alexecer, Angel Hope Fortune and Nomwesigwa Isaiah. I also dedicate this valuable research report to my dear wife Naus Katushabe in appreciation to her support while I was pursuing this master's course.

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## List of abbreviations

ANC:	Antenatal Care
AGYW:	Adolescent Girls and Young Women
ECs:	Emergency Contraceptives
DHIS 2:	District Health Information System 2
DHO:	District Health Officer
HCIII:	Health Centre III
HIV:	Human Immunodeficiency Virus
HMIS:	Health Management Information System
IUD:	Intra-Uterine Device
KI:	Key Informant
KDHS:	Kenya's Demographic Health Survey
LAM:	Lactational Amenorrhea Method
LMICs:	Low and middle-income countries
MOH:	Ministry of Health
REC:	Research Ethics Committee
VHT:	Village Health Team
UBOS:	Uganda Bureau of Statistics
UDHS:	Uganda Demographic Health Survey
UNFPA:	United Nations Population Fund
USA:	United States of America
SDG:	Sustainable Development Goal
SRH:	Sexual and reproductive health
SSA:	Sub Saharan Africa
STI:	Sexually Transmitted Infections
TFR:	Total Fertility Rate
WHO:	World Health Organization

## **Operational definitions**

### **Adolescent Girls and Young Women definition (15-24 years).**

According to UNFPA, these are female youths. And youths are persons between the ages of 15 and 24 years, without prejudice to the other.

### **Access to family planning services:**

Access to Family Planning is “the degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of population. Access can be measured in terms of levels of uptake, factors associated and different forms of family planning available in the area.

### **Perceptions to access and utilization of family planning methods:**

In the context of family planning, perception refers to the personal and community-held opinions, views, and beliefs (both positive and negative) regarding contraceptive practices, services, and their potential outcomes. These perceptions, often rooted in cultural, religious, and social norms, significantly influence an individual's or couple's decisions regarding access and utilization of family planning methods.

### **Contraceptive utilization**

Contraceptive utilization refers to the extent to which individuals and couples use contraceptive methods to control the number and spacing of their children. It encompasses the adoption and consistent use of modern or traditional methods to achieve desired family size and spacing.

### **Family planning barriers**

Family planning barriers are obstacles that prevent individuals and couples from accessing and utilizing the family planning services and information they need to achieve their desired family size and spacing. These barriers can be broadly categorized into individual, community, health system, and socio-cultural factors.

## **Facilitators to contraceptive access and utilization**

Facilitators to the uptake of contraceptives among female adolescents and young adults are supportive factors that enable and encourage them to use contraception, including accessible services, positive social support, accurate information, and personal agency.

## Abstract

**Introduction:** The study focused on establishing Barriers and Facilitators for Contraceptive Utilization among Adolescent Girls and Young Women Aged (15-24 Years) in Kiyindi Town Council, Buikwe District. Specifically, to understand AGYW perceptions of family planning access and utilization, explore barriers for family planning use among adolescent girls and young women and to understand facilitators for family planning use among adolescent girls and young women.

**Methods:** The study adopted a narrative research design while applying qualitative methodologies. The study interviewed 40 adolescent girls and young women and 10 Key Informants as the sample size that were selected using purposive, snow ball and convenience sampling. Data was collected using interview Method and focus group discussion. The researcher used NVivo software and thematic analysis where the interview responses were transcribed, sorted, classified into themes and categories in order to answer the pertinent research questions.

**Results/Findings:** The study found out that AGYW perception and attitude towards contraception is generally good. Some AGYW use herbs, while others take pills, and others use monthly injectable contraceptives (Depo-Provera). Another section of AGYW use implants while a cross-section of other AGYW use condoms majorly provided by their male counterparts. This implies that at least the majority AGYW have access to their preferred contraceptive methods and the ability to determine if, when and how often to reproduce. However, the study also found out that culture influences the usage of family planning because large families are still valued, and the use of contraception is viewed as contrary to these norms. Economic factors also influence the use of family planning and worse still, AGYW from especially lower-income families face barriers to accessing family planning services due to costs such as transport and cost of the method itself. The study also revealed that facilitators for contraceptive uptake in Kiyindi Town council among AGYW

include individual factors like knowledge and perceived benefits, interpersonal factors such as partner/peer approval, and health system factors like accessibility and provider attitudes.

**Conclusion:** Individual, interpersonal, community, and health systems factors all play a significant role in shaping contraceptive use. Understanding barriers and facilitators to contraceptive use among AGYW aged 15-24 is crucial for improving their reproductive health outcomes in Kiyindi Town council.

*Key words: Family planning, Adolescent girls and young women, access and Utilization.*

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Introduction

Family planning refers to a conscious effort by an individual or a Couple to limit or space the number of children they have through the use of contraceptive methods (UBOS, 2016). According to All answers Ltd (2018), Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilization, male sterilization, the pill, intrauterine contraceptive device (IUD), implants, injectable, male condoms, female condoms, emergency contraception and standard days method (SDM). A method such as abstinence, Cervical Mucus Method, withdrawal (Coitus interruptus), Lactational Amenorrhea Method (LAM) and calendar or rhythm method are considered traditional (UBOS, 2016). An estimated 225 million women in developing countries would like to delay or stop child bearing but are not using any method of contraception. Reasons for this include; Limited choice of methods, limited access to contraception, particularly among young people, poorer segments of populations or unmarried people, fear of experiencing side effects, cultural or religious opposition, poor quality of available services, users and providers bias and gender-based barriers among others.

This chapter presents the background to the study, which is sub-divided into; historical, theoretical, conceptual, and contextual backgrounds. It also states the research problem, general objective, specific objectives, research questions, significance, justification as well as the study scope.

## **1.2 Background to the study**

The background to the study provides an overview of the study, and it is presented under historical, theoretical, conceptual, and contextual backgrounds.

### **1.2.1 Historical perspective**

Family planning remains one of the most cost-effective ways of preventing unplanned pregnancies for many adolescent girls and young women across the globe (Sserwanja, Musaba & Mukunya, 2021). Correct and consistent use of the available modern contraceptives enables couples to realize the desired birth intervals, ideal family size, and control fertility (Tessema et al., 2021). Beyond control of fertility, use of modern contraceptives has got several non-contraceptive benefits such as contributing to poverty reduction, increasing gender equity, preventing the spread of STIs such as HIV (barrier methods), reducing unwanted teenage pregnancies, and lowering infant deaths but also contributes to the progress towards achieving the Sustainable Development Goals (SDGs) (Sserwanja et al., 2022). Although modern contraceptives are known to be safe and effective, major disparities in uptake/utilization exist all over the world (Borges et al., 2021). Globally, sexual and reproductive health (SRH) needs of adolescent girls and young women have remained largely unmet with about 20 million female adolescents and young women (AGYW) aged 15-24 years in need of modern contraceptive methods (Casey et al, 2020).

Sub-Saharan Africa has the highest rates of adolescent pregnancy and the lowest utilization of modern contraceptives (Campbell et al, 2016). A third of adolescent pregnancies in Sub-Saharan Africa are unintended, with over a third of these unintended

pregnancies being unwanted and end up as unsafe terminations (Woog et al, 2015). The sexual and reproductive health (SRH) of AGYW aged 15-24 forms a key component of the global burden of sexual ill health (Morris and Rushwan, 2015). This is because neglecting SRH of AGYW has detrimental effect on their transition to adulthood (Patton et al, 2016).

It has been estimated that 16 million girls aged 15-19 give birth each year, and this constitutes about 11% of all births worldwide and 95% of these births occur in low-and middle-income countries (LMICs), mainly from Sub Saharan Africa (SSA) where Uganda lies (<http://www.who.int/medacentre/factsheets/fs364/en/>). Forty-four (44%) of the total unintended pregnancies occurring in SSA are estimated to be among AGYW (Geda, 2019) and these unquestionably accounts for the high unsafe abortion rates among them without forgetting facing additional risk of exposure to HIV and other sexually transmitted infections STIs- (Morris and Rushwan, 2015).

In Sub-Saharan Africa, the low uptake of family planning methods in adolescents remains a public health concern and an estimated 120 out of every 1,000 girls aged 15 to 19 years have experienced an unplanned pregnancy that often lead to unsafe abortions and school drop-out (Atuhaire, 2019).

Uganda has a young population (52% are below the age 15, and 17% are aged 15-24) and a significantly high total fertility rate (TFR), estimated at 4.7 children per woman (UNFPA, 2020). As this large cohort of young people enter the childbearing years, their reproductive behavior will determine the growth and size of Uganda's population for decades to come. Uganda still struggles with a low contraceptive prevalence rate (CPR)

of 30%, which is lower than that of her neighbors, Kenya, Rwanda, and Tanzania, which had a CPR of 46%, 52%, and 34%, respectively, at the time of their last surveys (UDHS, 2012). A study was conducted in Uganda investigating the prevalence and factors associated with modern contraceptive utilization among Ugandan female adolescents aged 15-19 years. It was found that prevalence of modern contraceptive utilization was at 9.4%. Kabagenyi and Habaasa (2016) analyzed the 2011 UDHS and suggested that the high numbers of adolescents giving birth at an early age partly contributes to Uganda's high fertility levels.

The situation in Buikwe district regarding modern contraceptive utilization level is estimated at 27.3% for all women a rather significantly lower rate (UNFPA, 2019). Worse still In Buikwe district alone as according to UBOS, 2017 One in every 16 (6%) of the girls aged 12 to 17 years had already given birth; One in every 15 (6.5%) of the girls aged 12 - 17 had ever been in a marriage union. This translates in to high levels of vulnerability especially for the female adolescents that end up in situations of early marriage and child birth with all associated consequences. The prevailing high levels of vulnerability in Buikwe District puts these AGYW in risky circumstances, suffering significant physical, emotional, or mental harm that may result in their human rights not being fulfilled.

### **1.2.2 Theoretical perspective**

This study was guided by Marxist perception theory (1959) presented by Macquillan (1982). The theory has several underlying assumptions of community perception and usage of family planning methods. The underlying assumption of this principal is that

family planning is necessary for birth control for reasons of maternal and child health to free women to participate more actively in development of national resources for social construction. It asserts that, Sex, Cultural Beliefs, and level of education have the direct effect on usage of family planning methods. The Marxist perception theory pictures the world's problems as caused by exploitation of man rather than by an imbalance of man and material resources. He believes that if social ills and exploitation are removed, education and technology can solve the world's problems.

Malthus (1998) asserted that people's sex, cultural beliefs and level of education affect usage of family planning methods and hence population increase. The population has the tendency to increase beyond the means of subsistence and if not checked, goes on doubling itself every 25 years. Halpern (2006) studied strategies to improve adherence to hormonal contraceptive regimens, while Lopez (2008) examined the use of theory in trials of communicating contraceptive effectiveness. Most trials included pregnancy prevention as an objective and the majority also focused on contraceptive use (other than condoms). For interventions to reduce unintended pregnancies among adolescents, DiCenso (2002) abstracted the theoretical basis, but not all the strategies addressed specific contraceptive methods. According to Malcolm (1993), China's family planning model is the most rational and extensive experiment in any country in which community support is given to the whole spectrum of birth control activities and where social norms are created to exert social pressure and to give social support for small families.

### 1.2.3 Conceptual background

Family planning refers to the deliberate effort of the couple or individuals to regulate fertility by delaying or spacing birth or limiting their number of children. It is a voluntary and deliberate action of avoiding conception or a live birth in order to plan the number of children one will bear and when to have them (Family Planning Association of Uganda 1995). Family planning has been practiced in one form or the other throughout man's history but it was not publicly advocated until early 19th century. Family planning methods are divided into two categories: Traditional methods and modern methods of birth control. Traditional methods comprise of the use of herbs and the natural family planning techniques while modern methods use such techniques as condoms, intra-uterine devices; injections; sterilization, spermicides female and male sterilization methods among others. This was studied looking at the variables of gender, cultural beliefs and education levels.

Regarding gender, this refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviors, values, relative power and influence that society ascribes to the two sexes on a differential basis (Esplen & Jolly, 2006). For cultural beliefs, these ideas and thoughts common to several individuals that govern interaction - between these people, and between them, their gods, and other groups and differ from knowledge in that they are not empirically discovered or analytically proved. In general, cultural beliefs become identical and commonly known through the socialization process by which culture is unified, maintained, and communicated (Greif, 1994). And for education level, this refers to academic attainment of the individual (NICHCY, 2010).

#### **1.2.4 Contextual perspective**

The study looked at barriers and facilitators of family planning services among adolescent girls and young women aged (15-24 years) in Kiyindi town council, Buikwe district. This is where one in every 16 (6%) of the girls aged 12 to 17 years had already given birth; One in every 15 (6.5%) of the girls aged 12 - 17 had ever been in a marriage union translating in to high levels of vulnerability especially for the female adolescents that end up in early marriage and child birth with all associated consequences. The prevailing high levels of vulnerability in Buikwe District puts these AGYWs in risky situations, suffering significant physical, emotional, or mental harm that may result in his/her human rights not being fulfilled.

Buikwe District lies in the Central region of Uganda, sharing borders with the District of Jinja in the East, Kayunga along river Sezibwa in the North, Mukono in the West, and Buvuma in Lake Victoria south wards. Buikwe District is one of the 28 districts of Uganda that were created under the local Government Act 1 of 1997. By the act of parliament, the district was initially one of the Counties of Mukono district but later declared an independent district in July 2009.

#### **1.3 Problem Statement**

The sexual and reproductive health (SRH) of adolescent girls and young women aged 15-24 forms a key component of the global burden of sexual ill-health (Morris & Rushwan, 2015), and neglecting it has detrimental effect on their transition to adulthood (Patton et al, 2016). Sexual Reproductive Health of AGYW has become critical because it has been estimated that 16 million girls aged 15-19 give birth each

year, and this constitutes about 11% of all births worldwide. Ninety-five (95%) of these births occur in low-and middle-income countries (LMICs), including Sub-Saharan Africa where Uganda lies (Ahinkorah, 2020). Challenges in ensuring youth-friendly, voluntary, informed choice and access to a range of contraceptive methods for youth remain unanswered due to social economic factors such as lack of knowledge and financial constraints (Ninsiima, Chiumia & Ndejjo, 2021). Similarly, in Uganda 44% of pregnancies are unplanned; not a much variation from the SSA picture and in levels of unmet need for family planning across women's age groups. One-third of adolescents (15-24 years) have an unmet need, compared to about 36% of women between the ages of 20 and 39 due to demographic factors like age, education levels and inaccessibility of the services (UDHS, 2016).

In Kiyindi town council-Buikwe district alone as according to UBOS, 2017 and UBOS statistical abstract 2022, One in every 16 (6%) of the girls aged 15 to 24 years had already given birth; One in every 15 (6.5%) of the girls aged 15 - 24 had ever been in a marriage union. The rates of unintended pregnancies, early marriages, and teenage births are concerning. These challenges lead to increased maternal mortality, high rates of school dropout, and limited opportunities for economic advancement among young women. With a growing population of young women, this problem continues to strain health resources and perpetuate poverty cycles (Kiyindi town council Report, 2022). This translates in to high levels of vulnerability especially for the female adolescents that end up in such circumstances of early marriage and child birth with all associated consequences. The prevailing high levels of vulnerability in Buikwe District puts the AGYW in risky situations, suffering significant physical, emotional, or mental harm that

may result in their human rights not being fulfilled and this emanate from underutilization of family planning services (Nuwasiima et al., 2019). Ugandan Government through Buikwe District Local Government has made some strides to reduce unwanted pregnancies such as quick access to family planning information, quality primary health care promotion, and the integration of reproductive health into national strategies and programmes by 2030 (United Nations, 2022). However, according to Baylor Uganda report (2023), an estimated 51.2% of young girls aged 15-24 still get unwanted pregnancies every year. It was from this background that this study pursued to establish Barriers and Facilitators for Contraceptive Utilization among Adolescent Girls and Young Women aged (15-24 Years) in Kiyindi Town Council, Buikwe District. The study's recommendations will help in improving implementation of programs focusing on reproductive health needs of AGYW in Buikwe and Uganda at large, which with better health, will increase their contribution to the development of this country.

#### **1.4 Purpose of the study**

To establish Barriers and Facilitators for Contraceptive Utilization among Adolescent Girls and Young Women Aged (15-24 Years) in Kiyindi Town Council, Buikwe District.

#### **1.5 Specific Objectives**

- i. To understand Adolescent Girls Young Women's perceptions of family planning access and utilization in Kiyindi Town Council, Buikwe district.
- ii. To explore barriers for family planning use among Adolescent Girls and Young women in Kiyindi Town Council, Buikwe district.

- iii. To understand facilitators for family planning use among Adolescent Girls and Young women in Kiyindi Town Council, Buikwe district.

### **1.6 Research Questions**

- i. What are the Adolescent Girls and Young Women aged 15-24 years perceptions on family planning services access and utilization in Kiyindi Town Council?
- ii. What are the barriers for family planning use among adolescent girls and young women aged 15-24 years in Kiyindi Town Council, Buikwe district?
- iii. What are the facilitators for family planning use among adolescent girls and young women aged 15-24 years in in Kiyindi Town Council, Buikwe district?

### **1.7 Justification of the study**

In Uganda, adolescent girls and young women, with those from Kiyindi Town Council Buikwe district inclusive face a problem of lack of enough support, information, resources and training on how to make healthy reproductive choices. This is compounded by the still existing socio-economic, cultural and religious barriers causing low contraceptive use among them. Having access to modern contraceptives is seen as one of the most important interventions to reduced unintended pregnancy and its associated negative effects and population management especially in this community of Kiyindi Town Council. This will continue to boost the community's development process because of acquiring planned pregnancies and having manageable family sizes.

Conducting this study, established Barriers and Facilitators for Contraceptive utilization among Adolescent Girls and Young Women Aged (15-24 Years) in Kiyindi Town Council, Buikwe District. This has created awareness on the existing impeding problems and

solutions have been suggested to improve the prevailing Family planning access and utilization situation in this area to realize its intended positive effects.

### **1.8 Significance of the study**

This study generated information that was deemed important to policy makers, health planners and end users of Kiyindi Town Council, Buikwe District that enhances progressive improvement of family planning services uptake and utilization.

The study's recommendations support efforts aimed at improving implementation of programs focusing on the reproductive health needs of AGYW in Kiyindi Town Council Buikwe District Uganda, which with better health, increases their contribution to the development of this country.

Findings from this research also informed policy makers in this area on the effective ways of supporting the adolescent girls and young women in their daily reproductive life in order to live a safe and meaningful sexual life.

This study also helped to fill that existing evidence gap in this community that applies elsewhere on barriers and facilitators of family planning utilization among AGYW thus contributing to literature on the same.

Students in Universities and other institutions of higher learning benefits from the information generated. The study formed a baseline for other scholars intending to carry out a similar or related study.

### **1.9 Scope of the study**

The study was conducted to establish Barriers and facilitators for contraceptive utilization among Adolescent Girls and Young Women Aged (15-24 Years) in Kiyindi Town Council, Buikwe District. It was carried out in the four selected villages of the Town Council and these are Kiyindi, Buzaama, Kakunyu and Zzinga from August 7<sup>th</sup> to August 20<sup>th</sup>, 2023 after securing approval to collect data.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter presents the review of literature on barriers and facilitators of family planning services. Literature was reviewed according to research objectives: understand AGYW perceptions of family planning access and Utilization, explore barriers for family planning use among adolescent girls and young women and understanding facilitators for family planning use among adolescent girls and young women in Kiyindi Town Council, Buikwe district. Literature was scanned from secondary sources, particularly Government publications, journals, magazines and newspapers.

The major factors identified in other studies that influence how adolescent girls and young women respond to birth control methods are majorly social, cultural and economic in nature. Demographic factors such as age, marital Status, and parity are equally largely associated and affects family planning utilization. Socio cultural factors include; Religion, attitudes and gender norms while economic factors include; income levels, occupation and cost of contraceptives.

Family planning users in general are motivated by the reduced or no cost on some contraceptives like condoms, pills and injectable which are often provided in some health centers for free. This therefore shows how the cost of certain contraceptives influence contraceptive uptake and usage.

## **2.2 Adolescent Girls Young Women's perceptions of family planning access and utilization**

Globally, among adolescent girls and young women in the U.S., UK and most developed countries, contraceptive pills, condoms, and long-acting reversible contraceptives (LARCs) are the most commonly used family planning methods. The preference for these methods reflects their effectiveness, convenience, and access, with a growing trend toward LARCs due to their long-term protection without the need for daily maintenance. According to Guttmacher Institute (2022), birth control pills remain one of the most commonly used methods among young women due to their effectiveness and ease of use. When taken correctly, they are 99% effective, though typical use drops this to around 91%. Pills remain a staple choice, though usage has decreased slightly in favor of more long-term methods like IUDs and implants.

The United Nations as adopted by 193 countries ensures universal access to sexual and reproductive health and reproductive rights for all women is Target 5.6 of the Sustainable Development Goals. To address women's, need for family planning, the provision of a wide range of safe, effective and affordable contraceptive methods is essential (Aventin et al., 2020). The mix of methods offered must cater to women's needs and preferences. It is also important to note that every contraceptive method has advantages and disadvantages (de Leon et al., 2019). Thus, it is essential that women are fully informed about them so they can make an informed decision on which method is more appropriate for their specific situation.

Ewerling et al. (2018) classifies modern contraceptive methods as technological products or medical procedures that affect natural reproduction. According to this definition, the following contraceptive methods were considered as modern: contraceptive pills, condoms (male and female), IUD, sterilization (male and female), injectable, diaphragms, spermicidal agents (foam/jelly), and emergency contraception. The modern contraceptive methods analyzed were also classified as: (1) short-acting reversible contraception (SARC), including contraceptive pills, injectable, condoms, diaphragms, spermicidal agents and emergency contraception; (2) long-acting reversible contraception (LARC), including solely IUD; and (3) permanent methods, comprised of male and female sterilization. Hormone implants (LARC) and patches are also considered modern methods but were recorded in the DHS questionnaire as other modern methods.

Use of modern contraceptives reduces maternal mortality, improves health outcomes of adolescent mothers and their children and reduces the costs associated with teenage pregnancy (Sserwanja, Musaba & Mukunya, 2021). Planned childbirths increase the likelihood of attaining higher educational levels, which results in financial independence (Dongarwar & Salihu, 2019). In France, the word “emergency contraception” is generally associated with modern “morning-after” pills. Interventions to avoid pregnancy after sexual intercourse already existed among women in precolonial such as the use of charms and herbal concoctions (Moroole et al., 2020).

In Vietnam, the highest abortion rate 83 per 1,000, abortion is used to prevent pregnancy by young women or else delaying sexual relations for years (Otang-Mbeng, 2020). Also, post-partum abstinence is used whereby a woman is not allowed to sleep

with her husband. Women relying on the calendar technique prevent pregnancy by noting ideal days to have sex. Withdrawal prevents pregnancy by preventing male sperms from entering the women. According to Moroole et al. (2020), the natural mechanism triggered by breastfeeding interrupts ovulation and the menstrual cycle, breastfeeding is associated with a significant reduction in fertility and blocks ovulation.

In Africa, countries such as Ghana and Nigeria encourage large families, however, they disrespect a woman whose children's birth is closely spaced. Such a woman is said to produce children like a chicken or rabbit, which is derogatory. She is expected to abstain from sexual intercourse after birth for some time. Therefore, a woman should practice traditional methods of family planning to ensure that children are properly spaced (Wulifan et al., 2019). Child (birth) spacing is clearly the most common practice of African indigenous contraception. Child or birth spacing refers to providing adequate birth spacing between two or more consecutive pregnancies (Aleni, Mbalinda & Muhindo, 2020). Long before the influx of Western ideas, understanding of the importance of child spacing to maternal and infant health was widespread and popular among African cultures.

Still in African indigenous contraception, Sexual relations between husband and wife are not forbidden, but the husband is expected to practice coitus interruptus until the child is weaned (Otang-Mbeng, 2020). It is said that if a woman becomes pregnant again while still weaning a child (which may take two or three years), the child at her breast will become foolish or sickly or suffer in some other way. A child thus affected is known as serathane, which is also derogatory. A major theme in African indigenous contraception is the nearly universal practice of post-partum abstinence among

traditional societies in tropical Africa. The importance of spacing is deeply ingrained into the value systems of these societies, as it enhances the survival of the last born. The actual period varies from as little as two to three months to well over three years, depending on the culture.

In South Africa, ash is mixed with water so that the woman can drink it immediately after sex to prevent her from getting pregnant. Whilst Zimbabwean women drink the powdered roots of *Flueggea virosa* before sexual intercourse, *Pouzolzia mixta* is however, taken the morning after sexual intercourse to prevent pregnancy. *Pouzolzia mixta* therefore has postcoital contraceptive properties (Morroole et al., 2019). Medicinal plants that have post-coital contraceptive effects can play a reproductive role in acting as contraceptive emergencies to prevent unwanted pregnancies.

Particularly important in Cameroon, the main purpose of practicing traditional contraception is to increase the birth interval for the health of the child, rather than for family planning reasons (Otang-Mbeng, 2020). The reason behind child spacing is that, even if the mistake can happen the next child will be born after the first one has two years and more, then the mother will be able to care for the new born child. Reasons for indigenous contraceptive use among women in Ghana were to prevent pregnancy; for child spacing; to reduce a family size; to be wealthier and to look healthier (in this review, child spacing is considered a practice, not a reason). The reason for postponing first birth is for young married women who are deemed physically not mature to carry the pregnancy to term and deliver it safely. The other reason for postponing first birth is for young boys and girls to finish school and seek formal sector employment (Sumankuuro et al., 2019).

There are indigenous techniques of contraception that are used for stopping the mother from further reproduction and these are performed when the woman is considered too old to produce children, and when her children are old enough themselves to have children. It appears, therefore that, women are motivated to practice contraception when they become grandmothers. In the past, this used to be a common practice in the society to avoid the embarrassment of “old” women competing with their daughters in child bearing, and to keep the respect of the younger generation (Rosenberg, 2020). The practice of stopping reproduction in Uganda, known as the “grandmother effect”, involves five methods: putting a child on the eaves of the house, hot foods, firstborn behind the house, son in law’s clothes and baby’s foot (Moroole et al., 2020).

In East Africa, family planning is through traditional healers whereby herbs are the remedies to manage fertility. These herbs are believed to have contraceptive properties and are used either to prevent pregnancy or to induce abortion. Some herbs are also used to regulate menstrual cycles or promote fertility after childbirth. For instance, in Tanzania, some of the herbs used include *Vernonia amygdalina* (bitter leaf), *Cucumis metuliferus* (African horned cucumber), and others that are thought to influence reproductive health (Makombe et al., 2023). However, the efficacy and safety of these herbs have not been extensively researched, and their use can be risky. In Kenya, extended breastfeeding is used as a natural contraceptive method. It is based on the principle that exclusive breastfeeding delays the return of fertility after childbirth (lactational amenorrhea). Women often rely on breastfeeding for up to two years or longer, during which time they may not menstruate, reducing the chance of pregnancy (Koronya, Olungah, & Odipo, 2022).

In some Ugandan communities, beliefs surrounding fertility and childbirth play a significant role in family planning. Some communities may believe in using spiritual or ritual practices to ensure fertility control such as seeking blessings from spiritual leaders, using charms or amulets or consulting local healers. The effectiveness of these methods is largely based on community beliefs and is not scientifically proven (Lubogo, 2022). According to Otti (2022), ethnic groups in Uganda such as Karamajong female circumcision (also referred to as female genital mutilation or FGM in some regions) has historically been practiced, though FGM is illegal in Uganda today. This practice was believed to reduce sexual desire and, in some cases, prevent pregnancy. There is no scientific evidence linking FGM to effective family planning, and such a practice is now widely regarded as harmful for women. FGM is illegal in Uganda and is condemned by World Health Organization.

### **2.3 Barriers to contraceptive access and use among Adolescent Girls and Young Women**

Under this theme, the main factors associated with use and non-use of family planning that were examined include age, parity of women, residence, marital status, religion, education level and the occupation of respondents. A closer look was put on how these factors affect contraceptive use. Different factors such as lack of trust in Western medicine, low socioeconomic status, proximity of family planning clinics, and lack of knowledge about modern contraceptives have all contributed to lower contraceptive utilization rates (Wai et al., 2019).

In European countries, evidence from the USA identified concerns that contraception is unnatural, foreign, and invasive, and worries about retention of blood or irregular bleeding when using hormones (D'Souza et al., 2022). Other concerns include weight gain or loss, headaches, nausea, vomiting, hair loss, dizziness, breast enlargement, acne, leg pain, varicose veins, bloating, low energy, depression, stress, and mood changes as well as concerns about future infertility and cancer. Young people in the UK were also concerned that hormonal contraception (including emergency contraception) is 'unnatural' and could be harmful and cause side effects (Gray, 2024). Women in the global south expressed similar concerns about side effects (menstrual disruption, fears concerning fertility and cancer and weight gain or loss) which deterred them from using contraception (Boyce, 2021).

Most evidence comes from the global north where barriers included poor understanding of the reproductive cycle, fertility, and 'safe' periods, sometimes over-estimating the effectiveness of withdrawal methods. Women had poor knowledge about how to access services and how to use contraception correctly, and poor capability to integrate knowledge into practice (Dasgupta, Wheldon, Kantorová & Ueffing, 2022). Approximately half of American women who had never been pregnant had incorrect knowledge about contraception use and side-effects, and most had not heard of intrauterine contraceptives (Wildeman & Lee, 2021).

Women in North America were influenced by friends not using birth control (Rahaman et al., 2022). Women in Ireland were discouraged from using contraception by worries about peers knowing they were sexually active, or using condoms or pills, due to the general unacceptability of pre-marital sex (Koops, 2023). Social networks play an

important role in attitudes towards contraceptives in Sub-Saharan Africa, particularly for men. In Ghana, encouragement towards contraceptive use from men's social networks positively influenced contraceptive uptake by their wives. In Ethiopia, support for contraceptive use in women's social networks was largely independent from men's social network support. There is a positive relationship between women's agency (decision-making, freedom of movement) and contraceptive use in the global south (Manu, 2023). Studies from Sub-Saharan Africa reported positive associations with self-efficacy, self-esteem, and equitable gender attitudes, whilst men who hold a strong influence over their wives often oppose the use of contraceptives (Deierlein, Litvak & Stein, 2022).

In Africa, especially in Malawi about contraceptive use among married women, it was found that the work status of women has also been linked to knowledge and use of contraceptives (Palamuleni, 2013). Women who work outside the home have higher rate of use than women who do not work outside home (housewives). It has also been hypothesized that there is a positive correlation between contraceptive use and level of education. Other things being equal, the higher the level of education the higher the contraceptive use is expected to be. Although both the wives' and husbands' education is important there appears to be a consensus that the former is more important than the latter. Those who earn cash incomes are assumed to have greater control over household decisions and increased awareness of the world outside home. Consequently, they have more control over reproductive decisions. Some studies also add that paid work also provides alternative satisfactions for women, which may compete with bearing and raising children and may promote contraceptive use.

In Nigeria as in many other countries, major factors associated with contraceptive use are women's age, education, and socioeconomic status. Ugandan women who are more educated and wealthier are more likely to use contraception compared with illiterate and less wealthy women (UBOS, 2011). Similarly, women who use contraceptives tend to have a better quality of life, higher social status, and greater autonomy. Contraceptive use has the power to reduce fertility considerably and ultimately to improve maternal and child health (Osemwenkha, 2004).

The findings from the Malawi DHS 2015, indicate that most of the social, economic and demographic characteristics are significant predictors of contraceptive use among adolescents and young women in Malawi. It was observed that women in the age bracket of 20-24 years were more likely to use contraceptives than their counterparts aged 15-19 years. This observation could partly explain the rise in Malawi's teenage childbearing from 26% in 2010 to 29% in 2016. It is assumed that women aged 20-24 years understand the consequences of engaging in unprotected sexual act or without contraceptive use compared to adolescents. Additionally, most adolescents and young women aged 15-19 years might be newly married, and may take marriage as an institution of producing children. Adolescents may also have problems in accessing Family Planning services because they may not know where to obtain contraception or cannot afford services. This concurs with the findings of previous studies in Ethiopia, Nepal and Uganda which also reported reduced contraceptive use among adolescents compared to women aged 20-24 years (Tamang et al, 2017).

Still in African countries, employability status is another important factor influencing maternal and child care service utilization in collaboration with contraceptive utilization and uptake. The employment status of women is highly linked to knowledge and use of contraception. Women young or old who work in the public domain have a higher rate of contraception use compared to women who are confined in the domestic sphere (mostly the unemployed). Paid work or self-employment provides an alternative to self-development for women, through provision of satisfaction in child bearing and nurturing. Women can be in position to take care of themselves and their children from the incomes obtained from their work (Sarah Nakirijja and Mark Ivan Kayiso, 2018).

In East Africa especially in urban Kenya, Partner communication, discordant fertility goals, and contraceptive use increases as number of living children increases (Tumlinsonl et al, 2013). This thus puts young women at a less advantage as many are newly married or have not produced a single child. As expected, approval of contraceptive by both partners and discussion about family planning among spouses affect contraceptive use of currently married women. At the same time women young or old who have never discussed family planning are 3.98 times less likely to use contraceptives than women who have discussed family planning issues with their spouses more than twice. Women who discuss family planning once or twice are 1.56 times less likely to use contraceptives than women who have discussed family planning with their spouses more than twice (Tumlinsonl et al, 2013).

Still in Kenya, age of women is also considered another important factor as seen according to (Tumlinsonl et al, 2013). He states that contraceptive use increases with

the age of women. The low contraceptive prevalence among women aged 15-19 years may be due to the fact that most of these are newly married, and marriage is looked upon as an institution of producing children. Young mothers may also have problems with accessing family planning services. The reduced contraceptive use among older women may be related to the fact that they have reduced their coital frequency and most of them rely on other methods like string tie and are afraid to talk about them in an interview. However, a good number of older women might be not sexually active.

In Uganda, Sarah Nakirijja and Mark Ivan Kayiso (2018) gender is a detriment of contraceptive uptake among women irrespective of age in Namasuba village. This is because society in Uganda is organized in a set of norms and beliefs that shape the way women and men perceive certain aspects in life. In Namasuba like many other parts of Uganda Kiyindi Town Council inclusive, these norms are normally socially or culturally constructed during the process of socialization, and mostly put females at a position of passiveness as compared to their male counterparts. The same study found out many power relations in terms of decision making in choices concerning contraceptive use. For example, women irrespective of age are socialized to be submissive to their husbands in matters concerning sexuality and they always report so many hindrances from the men in matters concerning child birth. This is because a woman's role in marriage is shaped around child birth without any birth controls.

It is important to note that in Uganda young age at marriage adds layers of vulnerability to women that leads to poor fertility control and fertility-related outcomes, and low maternal health care use. However, there is no significant association between both

age groups (young and old) and contraceptive use and this might be attributed to the fact that child bearing is expected regardless of the age at marriage as young women are expected to prove

#### **2.4 Facilitators of contraceptive use among adolescent girls and young women**

Western European countries, such as Sweden, the Netherlands, France, and the UK, tend to have higher levels of family planning services use among adolescent girls and young women (Boadu, 2022). These countries generally offer comprehensive sexual and reproductive health education, have easy access to a variety of contraceptive methods, and robust healthcare systems. Adolescent girls and young women in these countries often have access to contraceptives through public healthcare systems or subsidized programs (Sobotka & Berghammer, 2021). In countries like France and the UK, there are public health initiatives to offer free contraceptives, particularly targeting younger populations. In many Western European countries, comprehensive sex education is provided in schools, and young people are more likely to receive information about family planning methods, making them more likely to use contraception.

Southern European countries such as Italy, Spain, Greece, and Portugal tend to have moderate to lower rates of family planning services use compared to their northern counterparts. This can be attributed to stronger traditional cultural norms, where family and fertility are highly valued, and religious influences (especially Roman Catholicism) may affect attitudes toward contraception and reproductive health. Despite public healthcare systems, adolescent girls and young women may face challenges in accessing contraceptives due to social stigma or conservative societal

attitudes toward premarital sex and contraception (Brzozowska, Buber-Ennser & Riederer, 2021). Family planning usage is somewhat less commonly used compared to Northern Europe, although usage is increasing, especially in urban areas where access and awareness are higher.

In Africa, the use of modern contraception among adolescent girls and young women, especially those aged 15-24, is relatively low in many African countries. According to the 2020 UNFPA report, contraceptive prevalence among AGYW in Sub-Saharan Africa is around 20-30%, which is lower than that in other regions of the world. In some countries, contraceptive use among AGYW can be significantly higher (Ahinkorah, 2020). For instance, in countries like Kenya, Uganda, and South Africa, family planning programs have been relatively successful in reaching younger populations. In contrast, in countries like Chad, Somalia, and Niger, the use of contraception remains very low. The use of modern methods such as birth control pills, IUDs, and injectables is generally lower compared to traditional methods (like withdrawal or rhythm), though the trend is slowly shifting towards more modern forms of contraception in urban areas (Ahinkorah, Ameyaw & Seidu, 2020).

In East Africa, Countries like Kenya and Uganda have made notable progress in increasing contraceptive use among AGYW, primarily through intentional government policies, community-based programs, and youth-targeted health interventions (Moturi, 2022). The Kenya Vision 2030 and the National Family Planning Guidelines have been instrumental in promoting family planning across all age groups, including adolescent girls and young women. According to Kenya's Demographic and Health Survey (KDHS),

contraceptive prevalence among AGYW aged 15-24 has steadily risen, although challenges such as cultural barriers and lack of access in remote areas still persist (Katerere-Virima, 2023). Uganda has prioritized adolescent sexual and reproductive health, creating a conducive environment for AGYW to access family planning services. This has included the integration of youth-friendly services into health centers, with a focus on ensuring privacy, confidentiality, and non-judgmental care to all clients (Yahaya et al., 2023).

According to Nuwasiima et al (2019), family planning benefits cards were acceptable to the majority of female youth in urban slums in Kampala, Uganda. Women who refused to join the program gave reasons such as infrequent sex, lack of interest, fear of side effects of contraception, and desire to have a child. Most incentive-based family planning initiatives limit the choices of clients by designing method-specific family planning programs (Menotti & Farrell, 2016). According to Castle and Askew (2015) suggested that approximately 1 in 3 women who start a modern contraception change method within the first year. The main reasons for changing methods included discomfort and side effects while the main reasons for discontinuation included the desire to get pregnant, contraceptive failure, side effects, and infrequent sex/abstinence. Fear of side effects remains a strong barrier to both initiation and adherence to modern family planning methods as highlighted in prior studies (Barden-O'Fallon et al., 2018).

According to Dorothy Shaw (2010) on the ABCs of Family Planning, levels of utilization to family planning depends on the quality of care and medical services as key factors in the adoption of contraceptive use. Access helps determine whether the individual

makes contact with the family planning provider, while quality of care greatly affects the client's decision to accept a method and the motivation to continue using it. Medical barriers are scientifically unjustifiable policies or practices, based at least in part on a medical rationale, that inappropriately prevent clients from receiving the contraceptive method of their choice or impose unnecessary process barriers to access to family planning services. In the past, international family planning efforts have been criticized as placing too much emphasis on issues of access and the quantity of contraceptives distributed.

According to Ibrahim and Atteraya (2018), there is a positive significant association between a visit to a health facility and contraceptive utilization. It is believed that, women who visit health facilities have access or are exposed to sexual and reproductive health services information than those who do not visit such facilities. Besides, women who want to or are using contraceptives may also likely visit a health facility. This implies that the frequency of women visiting health Centres determines the utilization levels of family planning services.

The availability and utilization of contraceptive methods has significant number of teenagers come up against obstacles, leading to contraceptive discontinuation and failure (Tsui et al., 2017). Obstacles, such as unfavorable legal and social environment, limited contraceptive bargaining power; low knowledge of sexual and reproductive health (SRH) can result in risky sexual behaviors (Moghaddam et al., 2016). The majority of teenagers use unreliable sources for information on SRH; and out-of-school adolescents are more vulnerable and often make less informed choices (Munakampe,

Zulu & Michelo, 2018). Combining demand creation and the provision of information and user-friendly services can increase the uptake of contraceptives by removing the barrier of information lack (Mpunga et al., 2022)

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

This chapter presents the programme upon which the study objectives and research questions were evaluated. The chapter explains the research design, methodological approach, categories of respondents that were involved in the study, sample size, sampling techniques, data collection methods, tools and data analysis.

#### **3.2 Study design**

The study adopted a narrative research design which focuses on understanding how people construct and share their stories. The design uses interviews, storytelling, and personal accounts to gather data (Kim, J.-H. 2016). This study design aimed at understanding how AGYW make sense of their lives through narratives on barriers and facilitators of contraceptive use. The qualitative approach employed provided detailed information on barriers and facilitators of family planning among adolescent girls and young women aged 15-24 years from Kiyindi Town Council, Buikwe District.

#### **3.3 Methodological approach (Narrative research)**

Narrative research design is a qualitative research approach that focuses on understanding human experience through the stories people tell about their lives. It involves collecting, analyzing, and interpreting these stories to gain insights into individual experiences, perspectives, and the meanings people assign to them. Essentially, it's about understanding the "story" of a person's life as they tell it (Kim, J.-H. 2016)

In a narrative research design, subjects tell stories about their experiences. Researchers conduct in-depth interviews and user testimonials to gather data. Researchers document their views as the study progresses. They seek to understand how users think at each stage. Open-ended questions in this research design uncover people's attitudes and beliefs while immersed in a product. They identify themes and patterns across users to arrive at actionable conclusions (Jennifer & Vonzell, 2019).

A narrative research design in this study was effectively used to explore the complex experiences of adolescent girls and young women regarding contraceptive use in Kiyindi Town council, Buikwe district. This approach allowed the researcher to dig into individual AGYW stories, uncovering both the barriers and facilitators influencing their decisions about contraception. By focusing on personal narratives, the researcher gained a deeper understanding of the social, cultural, and personal factors at play, providing rich insights beyond quantitative data.

From the practical point of view employing the narrative research design in this study, the researcher was able to obtain valuable information for developing targeted interventions to address the barriers and promote the facilitators of contraceptive use in Kiyindi town council.

Additionally, employing a narrative research design in this study, the researcher was able to gain deeper understanding of the complex issues surrounding contraceptive use among adolescent girls and young women of Kiyindi town council Buikwe district, leading to more effective and targeted interventions as suggested in the recommendations.

### **3.4 Area of study**

The Study was carried out in Kiyindi Town Council, Buikwe District, Central Uganda. Kiyindi Town Council was formerly a parish and part of Najja Sub-County carved out in 2020 and became operational in 2021 after the general elections. Kiyindi Town Council is largely a rural setting partly borders and shares a section of Lake Victoria at a busy gazzeted Kiyindi Landing site whose setting is semi-urban. Kiyindi Town Council borders with Najja Sub-County in the North, Njeru Municipality in the West, and Buvuma district in Lake Victoria East and Southwards. Baganda, Banyarwanda, Basoga, Luo and Kenyan people predominately occupy the area whose most economic activity is fishing for both sale and home consumption. They also engage in crop farming of mainly cassava, bananas and coffee among others. Another segment of people in Kiyindi Town Council engage in booming small- and large-scale business of general merchandise, bars, lodging and transport facilitated by a strategic location at the lake shore of Lake Victoria on Kiyindi Landing site and is situated five (5) kilometers from River Nile that partly attracts tourists from all parts of the world to come and see the source of the Nile. Lake Victoria connects three East African Countries Uganda, Kenya and the Republic of Tanzania and so inhabits people from all these mentioned countries.

Kiyindi Town Council is largely served by Makonge H/CIII and Kingdom Life HCII all these two are private not for profit facilities (PNFPs). Others are largely private for-profit clinics and drug shops where people go to when in need of health services including family planning. A section of health workers from DHO's office and nine health facilities were included in the sample as key informants. Kiyindi Town Council was selected as a study area because of its ever-growing number of rural dwellers facilitated by massive

emigration from within the district itself, other neighboring districts, countries, islands and nearness to the lake shore plus its proximity to the source of the Nile and Tanzania border. This location is approximately 14 kilometers (8.7 miles), by road, southeast of Lugazi, the nearest large town. The coordinates of the district are: 00 21N, 33 02E.

### **3.6 Study population**

The population of Kiyindi Town council is projected at a total of **16,105** people that is **7,687** males and **8,418** Females (UBOS, 2014). The Study Population was characterized by mainly adolescent girls and young women falling under the age of 15-24 because many female adolescents begin sexual activity at this age and unintentionally get pregnant and suffer the related physical and psychological health effects. The study mainly focused on adolescent girls and young women in Kiyindi Town Council Buikwe District as the major category. Health workers from the health facilities of Makonge H/CIII, Kingdom Life H/CII, MAPP clinic, Sure medical centre, Olympus medical centre, Sanyu Medical centre, Star life medical clinic, Doctor's Clinic, Muzadde medical centre and the assistant district health officer (maternal child health) that serve this population were included as key informants.

### **3.7 Sample size determination**

According to Kothari (2003), the sample size for qualitative research depends on the saturation of data and can be between 20-30 respondents. The sample size was determined at a point of saturation where no new information was being obtained from respondents for further data collection (Saunders et al., 2018). The researcher was interviewing, at the same time monitoring the responses. This enabled the researcher

to know when no new information was produced. After realizing this, the researcher stopped data collection and considered the interviewed 40 adolescent girls and young women and 10 Key Informants as the sample size. The actual sample size of fifty (50) was determined after data saturation.

### **3.8 Sampling Techniques**

The sample was selected using three sampling methods and these are; purposive, convenience, and snow ball sampling.

#### **3.8.1 Purposive sampling**

The method of purposive sampling is used to select key populations with rich information (Palinkas et al., 2015). The researcher selected ten (10) health workers (Family Planning providers) in total for KI interview. One from DHO's office and 9 health facilities purposively based on in- depth information and knowledge of a phenomenon of interest. The Family planning providers interviewed include; 1 Assistant District health officer of Buikwe district, 2 medical officers, 3 clinical officers and 4 mid-wives from Private Not for Profit and private for profit health facilities. The sampled health facilities include Makonge Community HCIII, Kingdom Life HCII, Sure medical centre, MAPP clinic, Olympus medical centre, Sanyu Medical centre, Star life medical clinic, Doctor's Clinic and Muzadde medical centre. Key Informants are used in situations where participants are selected on a basis of their experience in relation to the research being carried out.

### **3.8.2 Snow ball sampling**

This method is applied when it is difficult to access subjects with the target characteristics. The snowball method not only takes little time but also provides the researcher with an opportunity to communicate better with the samples, as they are acquaintances of the first sample, and the first sample is linked to the researcher (Polit-O'Hara & Beck, 2006). This type of networking is particularly useful for finding people who are not willing to reveal their identities (Hejazi, 2006 for the purpose of obtaining a nonprobability sample or for constructing a frame from which to sample as suggested by Goodman, 1961.

In this study, the researcher identified the first 10 sample of FGD with the help of mentor mothers who are experienced, knowledgeable and have information on family planning in the community. For the remaining 30 AGYW, a few identified members of AGYW were asked to identify other fellow AGYW that have knowledge and experience or are using family planning methods and are in the same age category.

### **3.8.3 Convenience Sampling**

MacNealy (1999) defined a convenience sample as a sampling technique that requires the researchers to go to public locations and ask passersby to participate. According to Rahi (2017), convenience sampling describes the data collection process from a research population that is effortlessly reachable to the researcher. Since convenience sampling basically means that the researchers utilize a sample which is readily available and they have access to, it was applicable to this research. Therefore, this method was applied when some Key Informants declined from the study at the time of interview.

The researcher proceeded to the next available key informants that were willing to participate and provide information.

However, the term is exclusively employed if the availability of participants is the researchers' mere concern in choosing a sample and when they could not select from many various populations and research sites (Koerber & McMichael, 2008). In line with Alvi (2016), convenience provides a wealth of qualitative data and this technique provided a satisfactory sample in similar situations like my study despite its potential pitfalls.

### **3.9 Selection criteria (inclusion and exclusion)**

The Study involved adolescent girls and young women aged 15-24 years that are out of school. Those aged below 15 and those above 24 years were excluded from the study. The Adolescent Girls and Young Women that are critically ill and the mentally incapacitated at the time of interview were excluded from the study as well. Visiting AGYW in the research area at the time of data collection were excluded/not interviewed. Adolescent Girls and Young Women aged 15-24 years that consented/assented were involved in the study because the researcher thinks such a category of people are eligible for family planning use and would enrich the study.

### **3.10 Data collection methods**

Data collection methods refer to the techniques or strategies used to gather information or data for research or analysis. These methods are essential to obtaining reliable, valid, and relevant data to answer research questions, test hypotheses, or address the objectives of a study. These included face-to-face interviews for ten (10)

Key Informants and four (4) focused group discussion for AGYWs which are known and used for collecting qualitative data.

### **3.10.1. Interview Method**

This method of data collection was used by conducting structured face to face interviews using an interview guide. Interviews in this study helped to obtain more information on barriers and facilitators of family planning methods. This method helped the researcher to get responses from 9 health workers interfaced at Makonge HCIII, Kingdom Life HCII, Sure medical centre, MAPP clinic, Olympus medical centre, Sanyu Medical centre, Star life medical clinic, Doctor's Clinic, Muzadde medical centre, and at the DHO's office. This method was of advantage to the researcher because it offered him an opportunity to adapt and clarify the questions by using the appropriate language, clear doubts, establish a rapport and probe for more information as suggested by Serakan, (2004). The researcher had better chances of ensuring that the responses are understood by repeating and or rephrasing the questions and got more non-verbal expressions by observing participants body language. Also, an interview guide provided in depth data which may not be possible to obtain when using self-administered Questionnaires (Mugenda & Mugenda 1999). The interview was conducted using an interview guide and only key informants were interviewed.

### **3.10.2 Focus group discussion (FGDs)**

The study also administered focused group discussion guides where the researcher generated discussions about barriers and facilitator's for family planning services utilization in four (4) groups of 10 people (Dibb et al., 1994). Four FGDs guides were

administered separately on adolescent girls and young women in the villages of Kiyindi, Buzaama, Kakunyu and Zzinga. FGD is used to collect data from participants who have similar backgrounds or experiences while discussing a specific topic of interest and these discussions were tape recorded and notes taken after obtaining consent from the participants.

### **3.11 Data collection Tools**

#### **3.11.1. Interview guide**

An interview guide is a structured tool used by interviewers to direct and manage an interview process (Creswell, 2018). The goal of using an interview guide was to ensure that the interviewer stays on track, asks relevant questions, and collects the information necessary to meet the objectives of the interview. The interview guide helped standardize the questions asked across different key participants. This consistency ensured that all interviewees are assessed based on the same criteria or that research interviews gathered comparable data.

#### **3.11.2 Focus group discussion guide (FGDs)**

A Focus Group Discussion Guide is a structured tool used to facilitate a focus group discussion (FGD) (Kothari, 2003). It outlines the questions and topics the facilitator will cover during the session to ensure that the discussion stays on track, covers the intended areas of interest, and generates rich, relevant data. Focus group discussion guides were used to explore adolescent girls and young women's attitudes, perceptions, opinions, and experiences on family planning services utilization barriers and facilitators. The FGD guide ensured that all the necessary topics related to the research objectives are covered during the discussion. The facilitator ensured that the

conversation addresses key themes or questions, preventing important areas from being overlooked. This led to comprehensive and relevant data collection that aligns with the research goals.

### **3.12 Sources of Data**

#### **3.12.1 Primary source**

Primary data sources in this study included personal interviews. According to Mazhar et al., 2021 primary data is one which is collected for the first time by the researcher.

### **3.13 Data Collection Quality Control**

Data control was considered in terms of credibility, transferability, dependability, and confirmability as follows;

Data quality control was ensured so that data collected was of good quality. Qualitative data was collected by the candidate (researcher) after pretesting the data collection tool with (pilot participants) AGYW aged 15-24 years and are out of school in the neighboring Buikwe Town Council. After receiving feedback from the pilot participants, the tools were improved and made ready for data collection. The data collection tools and interviews were translated into local language (Luganda) and translated back into English for analysis to ensure that there is no loss of information on translation supported by the social scientist.

The researcher reviewed the qualitative data notes and listened to the audios recorded interviews daily before setting out to collect more data such that he detects if saturation had been achieved. The transcripts form of the qualitative interviews (FGD)

were transcribed verbatim in Luganda language and then translated into English for analysis.

### **3.14 Study procedure**

The study participants (AGYW) were identified with support from the health workers of Makonge community HCIII, Kingdom life HCII, mentor mothers and peer facilitators. The mentor mothers and peer facilitators usually engage with these AGYW that are out of school while they convene for HIV prevention and sexual reproductive services that are offered by Baylor Foundation Uganda. Mentors and peer facilitators assisted in mobilizing the AGYW in their respective meeting safe spaces (venues) in the villages of Zzinga, Kiyindi, Buzama and Kakunyu where FGDs were conducted. The interested AGYW were then introduced to the study, screened them for eligibility (age of 15-24) and are out of school. Consent was sought from their mentors and individually from Key informants. These were then enrolled into the study and data collection ensued.

### **3.15 Procedure of data collection**

The researcher submitted a proposal to the faculty of public health, nursing and midwifery Uganda Christian University where he got an introductory letter after clearance from Research Ethics Committee (REC) of Uganda Christian University to go to the field. Data collection tools were pre-tested in Buikwe Town Council for out of school AGYW to check if the tool is fit. Using the REC clearance letter, the researcher asked for permission to carry out research through an application form to the District Health Officer (DHO), Town Clerk and Health facility in-charges in Kiyindi Town Council, Buikwe District, Central Uganda.

Data was collected in a period of two weeks by the researcher at the ADHO (Maternal Child Health), 9 health facilities in Kiyindi town council at both private not for profit and private for profit as well in the villages of Buzaama, Zzinga, Kiyindi and Kakunyu. Data was collected in English for the key informants and Luganda for the AGYW. An audio recorder and a note taker were used throughout data collection. The tools for the AGYW (FGDs) were translated to Luganda since it is the one predominantly spoken in the study area. AGYW participants were able to respond in their native language, they felt comfortable and openly discussed family planning pertinent issues. The local Language used played a crucial role in building trust and rapport between the researcher and the participants. Participants expressed themselves in their own language, they engaged deeply in the conversation, interviews and focus group discussions leading to richer insights.

The researcher used interview guides for key informants (health workers) and FGD for the adolescent girls and young women. Data was collected using predetermined interview and focused group discussion guides. The two different sources of information augmented each other and all conversations were recorded while the interviews and discussion were ongoing.

### **3.16 Study exposure and outcome variables**

The independent (Exposure) variable are barriers and facilitators while the dependent (Outcome) variable is contraceptive utilization among AGYW.

### **3.17 Data analysis and management**

According to Leary as cited in Kakatura (2009), statistical analysis is used to describe an account for observed variability in the behavioral data that has been collected. Thus, the purpose of statistics is to summarize and answer questions about behavioral variability that were obtained in research. The Researcher ensured that Key Informant and Interview guide schedules were revisited and edited before leaving respondents. This was done to ensure completeness accuracy and consistency of data collected. Data was then compiled down, cleaned and stored safely on a daily basis until analysis was done.

The researcher used thematic analysis where the interview responses were transcribed, read several times, sorted and classified into themes, sub-themes, and analyzed using *NVivo software* to answer the pertinent research questions and address the objectives (Sarantakos, 1998). The detailed information on family planning barriers and facilitators on utilization among AGYW from the interview was scrutinized, analyzed, collated and presented in form of case studies paraphrased, quoted upon permission from the respondents. However, in most cases it was narrated and quoted verbatim.

### **3.18 Ethical approval**

The researcher got clearance and approval from the Research Ethics Committee of Uganda Christian University faculty of Public health, nursing and midwifery. An introductory letter was obtained and a data collection request was prepared by the researcher which was presented to the District Health Officer Buikwe, the In-charges Makonge Community HCIII, Kingdom life HCII and 7 other private clinics. The Town Clerk

Kiyindi Town Council was also approached for approval before collection of Data commenced. Informed consent was at all times sought from individual respondents and or their guardians that participated in the study. Every data collection tool had a consent form attached that was explained to respondents in the language well known to them.

Confidentiality was ensured throughout the process and respondent names were excluded from the recorded materials to avoid disclosure of the participants identity.

There were no anticipated health related risks and no direct benefits were expected just because one has participated in the study. This was explained and made clear to the participants before the interview begun.

### **3.19 Methodological constraints/study limitations**

During data collection, there was a challenge of language barrier. However, the tools were translated to Luganda since it is the one predominantly spoken in the study area. Participants were able to respond in their native language, they felt comfortable and openly discussed family planning pertinent issues. The local Language used played a crucial role in building trust and rapport between the researcher and the participants. Participants expressed themselves in their own language, they engaged deeply in the conversation, interviews and focus group discussions leading to richer insights.

Some key informants declined from participating in the study and were not ready to share their experience and contribute to the study findings. This was solved by

recruiting other participants that were willing to share the required information through convenient sampling.

The conducted study excluded women above 24 years of age from the sample yet they as well continue to get pregnant un-intentionally and equally suffer similar predicaments when it comes to access and utilization of family planning services and would therefore have been a source of information to enrich the conducted study.

Data and information about adolescent boys and young men of a similar age bracket such as spousal support and their opinion on Family planning was collected from their sisters or wives and not them directly. This as well left valuable information regarding their role thus requiring a study on these male counterparts specifically.

### **3.20 Dissemination of research findings**

The report findings will be shared to the DHO Buikwe District and Town Clerk Kiyindi Town Council. Other copies will be submitted to Uganda Christian University in partial fulfillment of the requirements for the award of a degree of master of Public Health. A manuscript will also be prepared and submitted to peer reviewed journals for publication.

## CHAPTER FOUR

### PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

#### 4.1 Introduction

This chapter presents the analysis and interpretations of the study findings arising from the data collected from the respondents using interview guides and focused group discussion guides. The first section presents the response rate and demographic characteristics followed by a presentation and analysis of the study findings in relation to specific objectives. The purpose of the study was to establish Barriers and Facilitators for Contraceptive Utilization among Adolescent Girls and Young Women Aged (15-24 Years) in Kiyindi Town Council, Buikwe District.

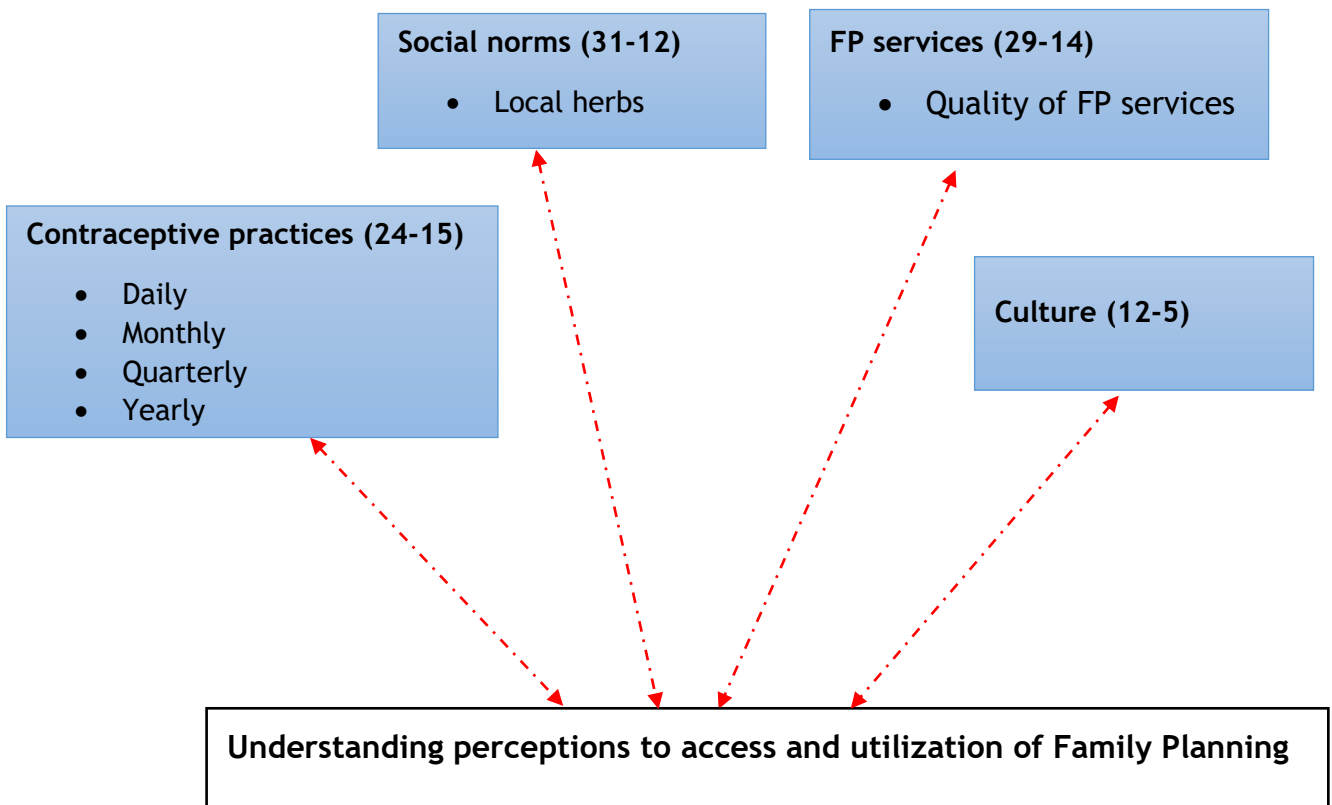
In this section, the researcher presents research findings followed by interpretation of study findings. The findings are supported by verbatim, quotations from the interviews with the participants. The findings are aligned and presented in themes that answer the research questions. Findings presented are based on interviews with AGYW aged 15-24 years, 1 District health officer of Buikwe district, 2 medical officers, 3 clinical officers and 4 mid-wives from PNFPs and private for-profit health facilities that were determined after data saturation. Findings are presented separately for each stakeholder to bring out more enriched narratives of barriers and facilitators of family planning services among adolescent girls and young women. This approach is intended to preserve the coherence of responses of each group and enable the whole picture of that group to be presented. Nevertheless, resultant viewpoints on barriers and

facilitators integrated and compared with a view to identifying similarities and dissimilarities.

The chapter is organized along four sections; Section 4.2 Understanding AGYW perceptions of Family Planning access and Utilization, Section 4.3 Barriers to access and utilization of family planning services, section 4.4 Facilitators of family planning services utilization while section.

#### **4.2 Understanding perceptions to access and utilization of family planning services by AGYW**

As part of AGYW understanding perceptions of contraceptive access and utilization, the study established personal and community-held opinions, views, and beliefs (both positive and negative) that influence AGYW decisions and behaviors regarding the access and utilization of contraceptive methods and services. It is noted that these perceptions are shaped by personal experiences, social networks, cultural norms, and religious beliefs. Findings from the analysis revealed that AGYW perceptions were shaped around contraceptive practices, social norms, quality of FP services, and culture as purported in the following verbatim;



**Figure 1: Understanding perceptions to access and utilization of Family Planning (Field data, 2023)**

**4.2.1 Sub-theme 1 Perceived Social Norms and Stigma:**

The study findings show that in Kiyindi Town Council AGYW decisions are heavily influenced by their beliefs about whether their partners, and community members approve of family planning. The fear of being perceived as promiscuous (especially for unmarried youth), unfaithful, was reported by the AGYW women, from accessing and utilizing FP services.

Key Respondent, Female aged 18 noted that;

*After producing my first child at 16 years, I wanted to space and produce another one at least after 4 years. I asked my husband and he kept quiet. I went ahead and started*

*getting the 3monthly injection. What brought me trouble is when my husband discovered I was taking longer days in my periods than usual. We quarreled and he slapped me heavily and warned me never to try it. He actually thought that it seems I am no longer faithful since I no longer want to produce for him.*

From this AGYW story, her perception towards FP use is positive but since the husband could approve of it, it became very difficult for her to continue despite her willingness to continue.

#### **4.2.2 Sub-theme 2 Perceived Access and Quality of Services:**

Regarding AGYW perception to access and utilization of FP services, it was noted that perception of access goes beyond the physical location of facilities; it includes views on the attitudes of healthcare providers, confidentiality, wait times, and the availability of preferred methods. Negative perceptions of provider bias or poor treatment act as significant barriers to utilization as seen in the following verbatim.

Key Interview respondent B pointed out that;

*I use implants which are inserted under the skin of the upper arm and I got it at one of the health facilities in Kiyindi. It was inserted for free. I wanted a method that can protect me from getting pregnancy for a relatively longer period. I was told Implants provide continuous contraceptive protection for several years and are highly effective. This method plus other methods are available and the health workers take time to explain. However, I stayed almost the whole day waiting because the line was long and the health worker was very busy.*

From this narration, one can conclude that the quality of health services is relatively fair. The method is available, health worker's attitude is ok apart from long waiting times before a client is served.

#### **4.2.3 Sub-theme 3 Culture:**

The study also revealed that strong cultural norms, and religious beliefs do exist in Kiyindi Town Council and do negatively influence contraceptive access and utilization as seen in the following verbatim;

According to Key respondent aged 20 asserts that;

*In my culture, it is not good to use family planning because ancestors always get offended. This is because large families are valued, and the use of contraception is viewed as contrary to these norms.*

Another Key respondent aged 22 states that;

*In my religion, men are allowed to marry many women for as long as they can look after them. The wives to this one-man sort of compete to produce and any woman who decides to use family planning is seen as one who does not understand her primary responsibility and actually this annoys the men. Because men are the decision makers and the beliefs are to obey, the women have no choice and most do not bother to try using family planning.*

From these two responses, it is noted that strong cultural norms and religious faiths heavily and negatively influences contraceptive use. Thus, the perception to contraceptive use is negative.

#### 4.2.4 Sub-theme 4: Contraceptive Practices-Daily

The daily utilization of family planning services among young people aged 15-24 can vary significantly based on factors such as access to services, awareness, cultural factors, and individual preferences as per the following quotations;

*“I use herbs daily for family planning, I got them from my grandmother, I cook them and keep them in a 5-litre Jerrycan which I drink one cup per day. I have spent 2 years using them and I have never seen any sign of pregnancy” (Female aged 23 years).*

This AGYW perception towards modern contraceptive use is negative and this may be attributed to information lack hence regarding to using local herbs that do not provide effective protection against pregnancy.

Key Respondent Female aged 38 noted that;

*I always take my pills daily for 21 days followed by a 7-day break during which a menstrual period occurs. The pills work for me well though sometimes I bleed which is unpleasant.*

According to Key Informant **Health worker male aged 47** it is noted that;

*Individuals using contraceptive methods that require daily administration, such as birth control pills, tasks them to swallow the pill every day at the same time. Consistent daily use is crucial for the effectiveness of oral contraceptives and other daily methods. In some cases, it could involve daily or regular reassessment of family planning goals, methods, and needs, including considering changes in life circumstances or preferences.*

This implies that daily utilization of family planning services among young women aged 15-24 is influenced by a complex interplay of factors. Efforts to improve access, awareness, affordability, and cultural acceptance are essential to ensuring that AGYW can make informed choices about their reproductive health and access to the services they need.

#### **4.2.5 Sub-theme 4 Contraceptive practices- Monthly**

The monthly utilization of family planning methods among individuals aged 15-24 involves considering various factors that influence their choices and access to services.

This was reflected in the following verbatim:

*At the health centre, there is monthly injectable contraceptive known as Norigynon. Though, this is given to some of us who know doctors personally since it is rare and expensive, I am injected every month whenever I feel I don't want pregnancy.*

This implies that some AGYW perception to access and utilization is positive however, monitoring the monthly level utilization of family planning methods among young people involves collecting data on the number and types of services accessed over time. This information helps inform strategies to improve access, address barriers, and tailor services to meet the needs of AGYW effectively.

#### **4.2.6 Sub-theme 4 Contraceptive practices- Quarterly**

The quarterly utilization of family planning among individuals aged 15-24 involves assessing trends and factors that influence their access to and use of contraceptive

services over a three-month period. Here are key considerations for understanding this demographic's utilization patterns:

Key respondent A noted that;

*I always contact my personal doctor for Depo-Provera every 3 months. It is exactly 2 months since I visited the facility and it requires a quarterly visit to a healthcare provider. Sometimes, I get side effects like headache and extended menstrual period but I still go ahead and use the method because it is the one I can afford and manage.*

Similarly, the perception to access and utilization from this respondent is positive however it requires more information regarding managing the method related side effects and other possible options incase this one does not work out. Tracking quarterly utilization involves gathering data on the number of visits, types of services utilized, and demographic characteristics. This information guides efforts to improve service delivery, address barriers, and tailor interventions to meet the specific needs of AGYW aged 15-24 in accessing family planning services effectively.

#### **4.2.7 Sub-theme 4 Contraceptive Practices-Yearly**

The yearly utilization of family planning among individuals aged 15-24 involves examining trends and factors that influence their access to and use of contraceptive services over a longer timeframe. Here are key considerations for understanding yearly utilization pattern;

According to Key Respondent, Female aged 24 noted that;

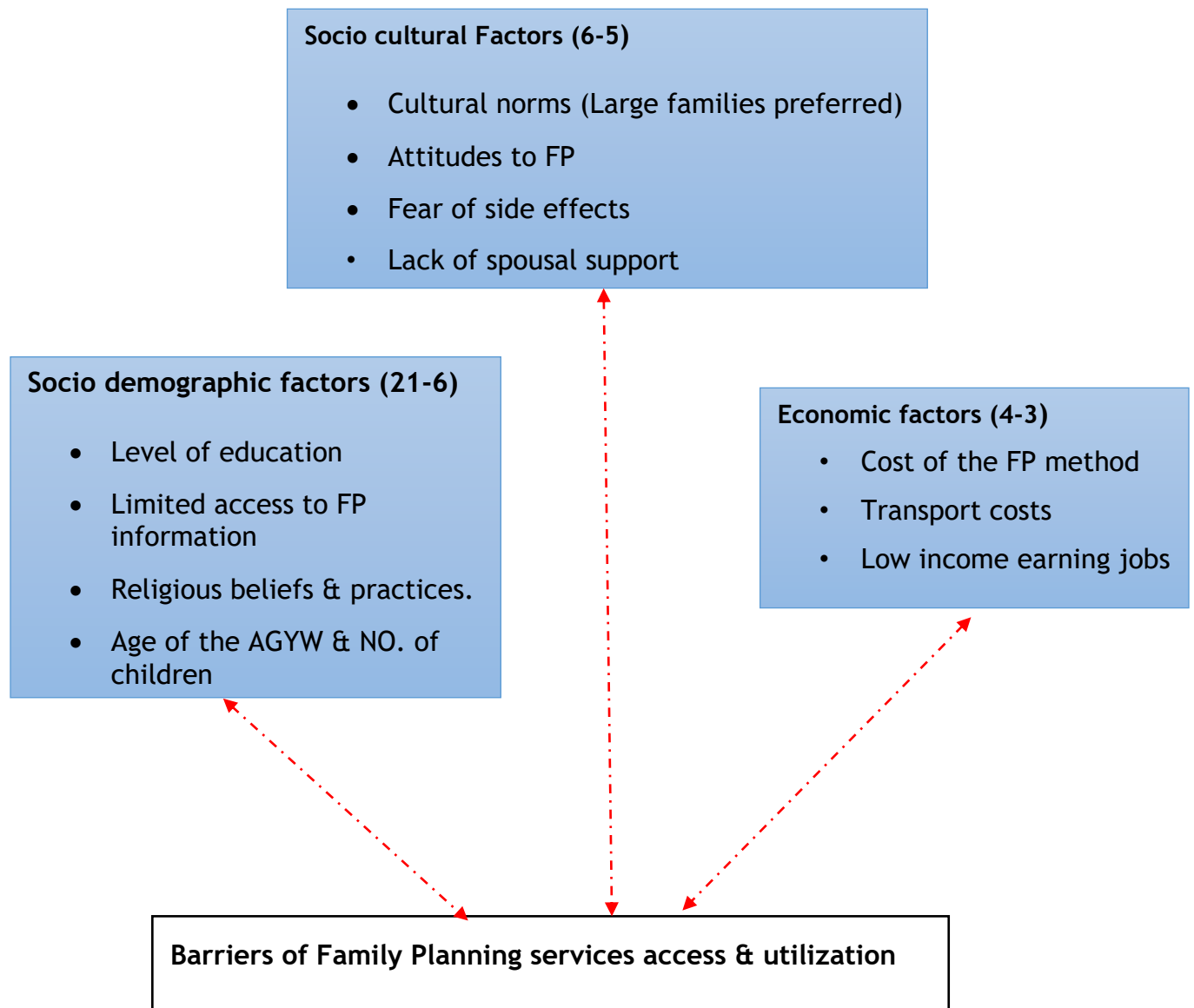
*I always use implants that are inserted under the skin and this provides*

*contraception for 3 to 5 years. This method has been effective and convenient for me since I do not experience serious side effects. I wanted to give birth and I contacted my doctor to remove the implant before the end of its effective period, I used an alternative contraceptive method until fertility returned.*

Therefore, yearly utilization involves collecting data on the number of visits, types of services utilized, demographic characteristics, and changes in utilization patterns over time. This information guides efforts to improve service delivery, address barriers, and tailor interventions to meet the specific needs of young people aged 15-24 in accessing family planning services effectively throughout the year.

#### **4.3 Barriers of family planning services access and utilization among AGYW**

The study set out to determine the barriers of family planning services among adolescent girls and young women aged 15-24 years in Kiyindi Town Council, Buikwe district. The findings from the analysis revealed that socio demographic, socio cultural and economic factors influenced Family planning use.



**Figure 2: Barriers to family planning services access and utilization (Field data. 2023).**

#### **4.3.1 Sub-theme 1: Social demographic factors**

Social demographic factors influencing utilization of family planning among adolescent girls and young women aged 15-24 in Kiyindi town council involves considering various aspects of their backgrounds, beliefs, practices and circumstances. Here are key social demographic factors that can impact utilization:

According to Health worker female aged 38 noted that;

*Girls in this town council are not educated enough to have awareness and understanding of family planning options since higher levels of education often correlate with better understanding of contraceptive methods and their benefits. Still most of the young women do not attend trainings regarding access to sexual and reproductive health services to acquire enough information.*

Key Informant Interviewed aged 24 years noted that;

*In my religion, we have some religious groups that have teachings that influence attitudes towards family planning use. For instance, in my religious group, we oppose contraceptive methods and promote large families as a religious duty. The views of religious leaders/ group impact our attitudes.*

This implies that social demographic factors are essential for developing targeted interventions, policies, and programs that address barriers and promote equitable access to family planning services among adolescent girls and young women aged 15-24 in Kiyindi town council. Tailored approaches that consider these factors can enhance utilization rates and improve reproductive health outcomes in the community.

#### **4.3.2 Sub-theme 2: Social cultural factors**

Social and cultural factors play a significant role in the utilization of family planning services among young women aged 15-24 in Kiyindi town council;

According to Key respondent aged 20 asserts that;

*In my culture, it is not good to use family planning because ancestors always get offended. This is because large families are valued, and the use of contraception is viewed as contrary to these norms.*

Key Informant female aged 31 noted that;

*I am a musoga and my cultural practices related to marriage, childbirth, and family life can influence attitudes towards family planning. We always celebrate large families and place high value on childbirth and so this can impact contraceptive use. So, balancing traditional values with modern family planning practices is challenging at times. Community-driven approaches that respect cultural values while promoting reproductive health can be effective.*

This implies that these social and cultural factors require a multi-faceted approach. Efforts should focus on improving access to affordable family planning services, enhancing education and awareness about contraception, and addressing cultural and social barriers. Tailored interventions that consider the specific needs and challenges of young people in Kiyindi town council are essential to promote equitable utilization of family planning services and improve reproductive health outcomes in the community.

#### **4.3.3 Sub-theme 3: Economic factors**

Economic factors play a crucial role in the utilization of family planning services among adolescent girls and young women aged 15-24 in Kiyindi town council. Here's how these economic factors can influence family planning utilization:

According to Health worker Female aged 38 noted that;

*Adolescent Girls and Young women especially from lower-income families face barriers to accessing family planning services due to costs such as transport and the cost for the service itself especially in the private clinics. These Young*

*people are employed in bars and hotels whereby they don't earn enough resources to enable them afford and access these services.*

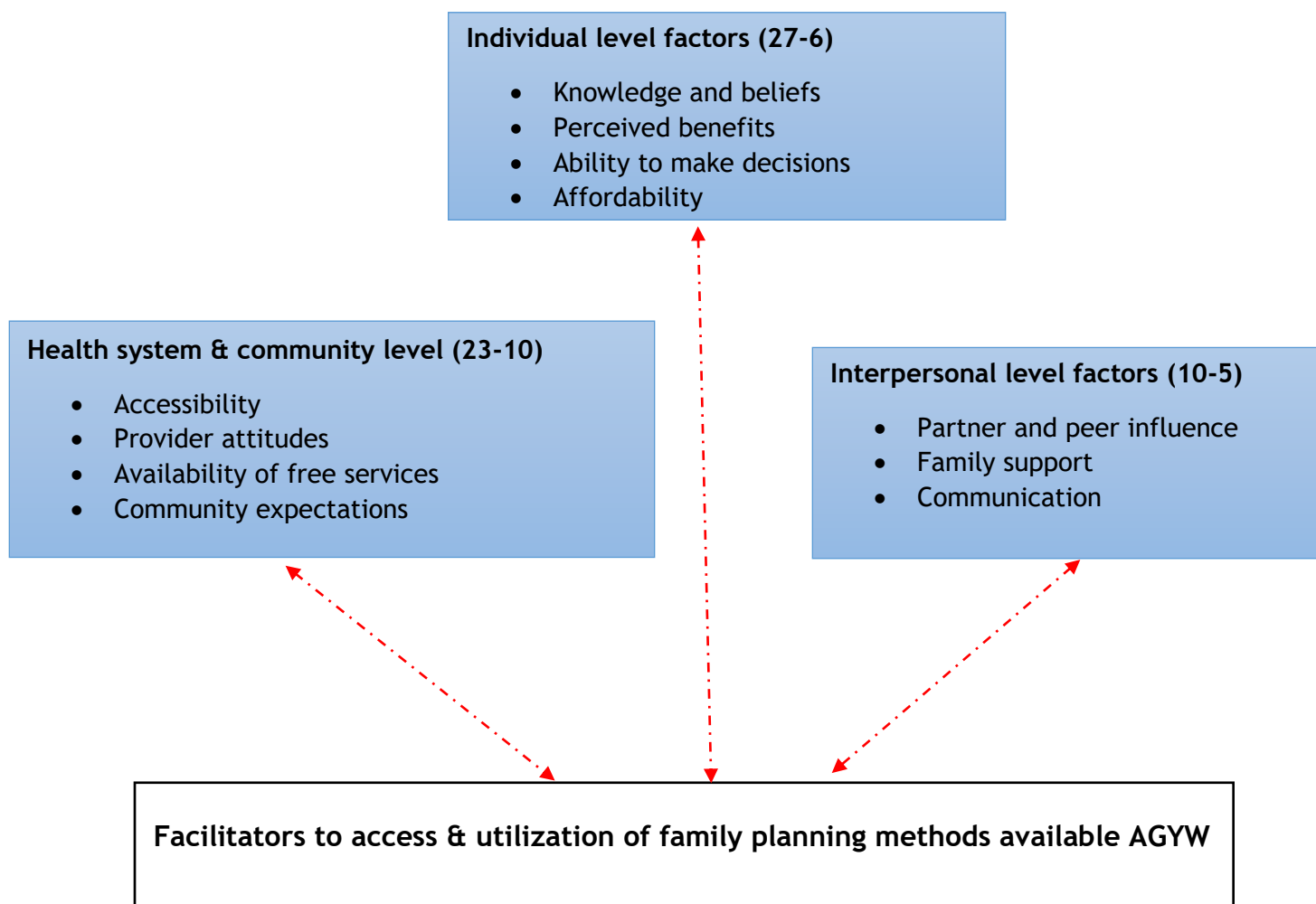
Health worker Female aged 41 noted that;

*Economic challenges can exacerbate social and cultural norms towards family planning use. This might reinforce traditional attitudes that discourage the use of contraceptives. The economic factors influence the allocation of funds to family planning programs since it's essential for implementing effective programs and providing services to young people.*

These economic factors require targeted interventions to improve access and utilization of family planning services for adolescent girls and young women in Kiyindi town council. Strategies may include subsidizing prices of contraceptive methods, expanding youth-friendly healthcare services, providing comprehensive sex education, and advocating for policies that support reproductive health rights and economic empowerment. By addressing economic barriers, communities can promote equitable access to family planning services and improve reproductive health outcomes among adolescent girls and young women inclusive.

#### 4.4 Facilitators to access and utilization of family planning methods by the AGYW

The study set out to identify the Facilitators to access and utilization family planning services by the adolescent girls and young women aged 15-24 years in Kiyindi Town Council, Buikwe district and the following section presents and interprets the opinion of the respondents. As far as family planning services access and utilization is concerned, findings from the analysis revealed that facilitators for contraceptive uptake among AGYW include individual factors like knowledge and perceived benefits, interpersonal factors such as partner/peer approval, and health system factors like accessibility and provider attitudes. Other key facilitators are community expectations, family support, and the ability to afford services as shown in the following verbatims:



**Figure 3: Facilitators to access and utilization of family planning methods available by the adolescent girls and young women (Field data, 2023).**

#### **4.4.1 Sub-theme 1: Individual level factors**

In Kiyindi Town Council, Buikwe district, facilitators to contraceptive access and use identified among the AGYW aged 15-24 years include knowledge about the available FP methods and the perceived benefits. These typically include;

According to Key Interview B note that;

*Young women use condoms as part of its contraception, when provided by their male counterparts (Male condoms) especially those working in bars and lodges. However, very few females come out voluntarily to demand for the male condoms. The female condoms are not popularly used in this community.*

Key Interview G respondent pointed out that;

*I use condoms for safer sex because they block the exchange of body fluids during any form of sexual contact and also prevents me from acquiring sexual transmitted infections (STIs). We use a new condom each time I have any sexual contact and when switching between different types of sex.*

These methods are preferred and used by young women for their ease of access, use, effectiveness when used correctly, and in some cases, affordability and accessibility. It's important to note that the choice of contraceptive method can vary based on individual preferences related to perceived benefits, access to healthcare services, commodity availability at the health facility, cultural factors, and availability of information and education regarding family planning options.

#### 4.4.2 Sub-theme 2: Health system & community level factors

In Kiyindi Town Council, Buikwe district, other factors identified that facilitate utilization of FP services used by adolescent girls and young women aged 15-24 years especially the long-term contraceptive methods include their availability at the nearest health facility, they are freely provided and health workers share information on their use freely.

Key Interview B pointed out that;

*I use implants which are inserted under the skin of the upper arm and I got it at one of the health facilities in Kiyindi. It was inserted for free. I wanted a method that protect me from getting pregnancy for a relatively longer period. I was told Implants provide continuous contraceptive protection for several years (typically 3-5 years, depending on the type) and are highly effective.*

Key Interview F respondent noted that;

*Both hormonal and non-hormonal IUDs are used by the adolescent girls and young women in Kiyindi Town Council for various reasons. Some of the clients we receive prefer an IUD because once inserted it frees-up the user and does not worry them of getting pregnant since it is effective. All this information is provided to our clients and it is them to make a choice. Hormonal IUDs release progestin and can last for 3-5 years while non-hormonal copper IUDs can provide protection for up to 10-12 years. IUDs are inserted into the uterus by a highly trained healthcare provider.*

Key informant, Female 28 years pointed out that;

*At the facility where I work, we have long-acting Reversible Contraceptives such as Implanon and intrauterine devices (IUDs) that are highly effective and can provide contraception for several years without the need for daily or frequent intervention for instance contraceptive pills, contraceptive patches, and contraceptive injections. On agreed appointments, Marriestoppes supports us with an outreach where also provide both and male and female sterilization. This is however not popular among AGYW.*

The utilized long-term contraceptive methods are preferred by adolescent girls and young women for their high effectiveness, convenience (once inserted, they require minimal maintenance), and do not interfere with sexual pleasure. They offer reliable pregnancy prevention without the need for daily or frequent administration, making them suitable for young women who prefer a set-it-and-forget-it approach to contraception. Though, the choice of contraceptive method can be influenced by factors such as accessibility of healthcare services, counseling provided by healthcare providers, personal preferences, and cultural considerations. It's essential for AGYW to have access to comprehensive information about all available contraceptive options to make informed choices that best suit their reproductive health needs and preferences.

#### **4.4.3 Sub-theme 3: Interpersonal level factors**

Among other contraceptive access and use facilitators identified among AGYW are Partner and peer influence. Approval and support from a sexual partner or recommendations from friends and siblings are significant motivators, also noted is the open communication and discussing contraception with partners, peers, and family

members.

Permanent contraceptive methods, such as sterilization, are typically not common among adolescent girls and young women aged 15-24 years in Kiyindi Town Council due to their irreversible nature and the fact that they are usually chosen by individuals who have acquired their desired family size or do not wish to have children in future. However, it's important to note that in many settings including Kiyindi Town Council, interpersonal factors such as partner/peer approval still do influence contraceptive choices thus heavily impacting their utilization.

Key Health worker C noted that;

*Permanent methods like sterilization involve surgical procedures that are intended to be irreversible. This means that once the procedure is done, the ability to conceive naturally is permanently removed. Adolescent girls and young women are still in the early stages of their reproductive years, may not yet be certain about their long-term family planning goals making them unfit for the choice on this method.*

Key Health worker A asserts that;

*Many adolescent girls and young women may not have yet decided on their ideal family size or may change their minds about having children in the future. Permanent methods are usually chosen by individuals who have already completed their desired family size or who are certain they do not wish to have children at all anymore. Even when the discussion about how many children the*

*to be born by the family will have been discussed the AGYW find it difficult to choose the permanent methods.*

In summary, while permanent contraceptive methods like sterilization are not typically chosen by AGYW aged 15-24 years, they have access to a variety of other effective and reversible contraceptive options that allow them to manage their reproductive health needs according to their current life circumstances and future plans.

#### **4.5 Summary of the study findings**

##### **4.5.1 Understanding perceptions to family planning services access and utilization among AGYW aged 15-24 years**

The findings show that regarding AGYW perceptions, there are established personal and community-held opinions, views, and beliefs (both positive and negative) that influence AGYW decisions and behaviors regarding the access and utilization of contraceptive methods and services. It is noted that these perceptions are shaped by personal experiences, social networks, cultural norms, and religious beliefs. Findings from the analysis revealed that AGYW perceptions were shaped around contraceptive practices, social norms, quality of Family Planning services, and culture.

##### **4.5.2 Barriers to access and utilization of family planning services among AGYW aged 15-24 years**

The study revealed that culture influences the usage of family planning because large families are still valued, and the use of contraception is viewed as contrary to the existing norms in the study area. Still, AGYW especially from lower-income families face barriers to accessing family planning services due to costs attached such as transport and cost for the method. In Kiyindi Town council, most AGYW are employed

in bars and hotels whereby they do not earn much to enable them afford and access the needed family planning services. Economic factors influence the allocation of funds to family planning programs since it's essential for implementing effective programs and providing free services to adolescent girls and young women such as those of Kiyindi Town Council.

#### **4.5.3 Facilitators to family planning access and utilization among adolescent girls and young women aged 15-24 years**

The study revealed that facilitators for contraceptive uptake in Kiyindi Town council among AGYW include individual factors like knowledge and perceived benefits, interpersonal factors such as partner/peer approval, and health system factors like accessibility and provider attitudes. Other key facilitators are community expectations, family support, and the ability to afford services. Ensuring that all people have access to their preferred contraceptive methods and the ability to determine if, when and how often to reproduce is paramount. Health workers also routinely provided information on the availability of permanent methods like sterilization that involve surgical procedures. This method has however not been utilized on a large scale by adolescent girls and young women.

## CHAPTER FIVE

### DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

In this chapter, discussion, conclusions and recommendations were written basing on the findings from chapter four. The discussion, conclusions and recommendations were done according to major study themes in relation to the study objectives.

#### 5.2 Discussion of the study findings

##### 5.2.1 Perceptions of AGYW on family planning services access and utilization

The findings show that some adolescent girls and young women in Kiyindi Town Council use herbs daily for family planning provided by their grandmothers as opposed to modern contraceptives as seen in the following verbatim;

*“I use herbs daily for family planning, I got them from my grandmother, I cook them and keep them in a 5-litre Jerrycan which I drink one cup per day. I have spent 2 years using them and I have never seen any sign of pregnancy” (Female aged 23 years).*

This AGYW perception towards modern contraceptive use is negative and this may be attributed to information lack hence resorting to using local herbs that do not provide effective protection against pregnancy.

This method has no scientific proof and may be putting the users at risk of getting unwanted pregnancies. These findings agree with the study conducted by Makombe et al., 2023 In East Africa, family planning is through traditional healers whereby herbs are the remedies to manage fertility. These herbs are believed to have contraceptive

properties and are used either to prevent pregnancy or to induce abortion. Some herbs are also used to regulate menstrual cycles or promote fertility after childbirth. For instance, in Tanzania, some of the herbs used include *Vernonia amygdalina* (bitter leaf), *Cucumis metuliferus* (African horned cucumber), and others that are thought to influence reproductive health (Makombe et al., 2023). However, the efficacy and safety of these herbs have not been extensively researched, and their use can be risky. Much as these studies reveal the use of local herbs, as far as perceptions to access and utilization of family planning is concerned this is contrary to the current ideal trends where modern contraceptives are being encouraged to be adopted by every-one.

The study findings show that in Kiyindi Town Council AGYW decisions are heavily influenced by their beliefs about whether their partners, and community members approve of family planning. The fear of being perceived as promiscuous (especially for unmarried youth), unfaithful, was reported by the AGYW and this prevents some from accessing and utilizing Family Planning services.

**Key Respondent, Female aged 18 noted that;**

*After producing my first child at 16 years, I wanted to space and produce another one at least after 4 years. I asked my husband and he kept quiet. I went ahead and started getting the 3monthly injection. What brought me trouble is when my husband discovered I was taking longer days in my periods than usual. We quarreled and he slapped me heavily and warned me never to try it. He actually thought that it seems I am no longer faithful since I no longer want to produce for him.*

These study findings agree with the one conducted by Tumlinsonl et al, 2013. He notes that teen or young age puts young women at a less advantage as many are newly married or have not produced a single child. As expected, approval of contraceptive by both partners and discussion about family planning among spouses affect contraceptive use of currently married women. At the same time women young or old who have never discussed family planning are 3.98 times less likely to use contraceptives than women who have discussed family planning issues with their spouses more than twice. Women who discuss family planning once or twice are 1.56 times less likely to use contraceptives than women who have discussed family planning with their spouses more than twice.

From this AGYW story, her perception towards FP use is positive but since the husband did not approve of it, it became very difficult for her to continue despite her willingness to use family planning.

In addition, regarding AGYW perception to access and utilization of FP services, it was noted that perception of access goes beyond the physical location of facilities; it includes views on the attitudes of healthcare providers, confidentiality, wait times, and the availability of preferred methods. Negative perceptions of poor treatment as a result of long waiting time can act as significant barriers to utilization as seen in the following verbatim.

**Key Interview respondent B pointed out that;**

*I use implants which are inserted under the skin of the upper arm and I got it at one of the health facilities in Kiyindi. It was inserted for free. I wanted a method that will protect me from getting pregnancy for a relatively longer period. I was*

*told Implants provide continuous contraceptive protection for several years (typically 3-5 years, depending on the type) and are highly effective. This method plus other methods are available and the health workers take time to explain. However, I stayed almost the whole day waiting because the line was long and the health worker was very busy.*

From this narration, one can conclude that the quality of health services is relatively fair. The method is available, health worker's attitude is ok apart from long waiting times before a client is served which may deter many from utilizing if they cannot wait.

The study also revealed that strong cultural norms, and religious beliefs do exist in Kiyindi Town Council and do negatively influence contraceptive access and utilization as seen in the following verbatim;

**According to Key respondent aged 20 asserts that;**

*In my culture, it is not good to use family planning because ancestors always get offended. This is because large families are valued, and the use of contraception is viewed as contrary to these norms.*

**Another Key respondent aged 22 states that;**

*In my religion, men are allowed to marry many women for as long as they can look after them. The wives to this one-man sort of compete to produce and any woman who decides to use family planning is seen as one who does not understand her primary responsibility and actually this annoys the men. Because men are the decision makers*

*and the beliefs are to obey, the women have no choice and most do not bother to try using family planning.*

This agrees with the Uganda's study findings as according to Sarah Nakirijja and Mark Ivan Kayiso (2018) gender is a detriment of contraceptive uptake among women irrespective of age in Namasuba village. This is because society in Uganda is organized in a set of norms and beliefs that shape the way women and men perceive certain aspects in life. In Namasuba like many other parts of Uganda Kiyindi Town Council inclusive, these norms are normally socially or culturally constructed during the process of socialization, and mostly put females at a position of passiveness as compared to their male counterparts. From these two responses, it is noted that strong cultural norms and religious faiths heavily and negatively influences contraceptive use. Thus, the perception to contraceptive use is negative.

The study findings also reveal that in regard to AGYW perceptions to access and utilization of FP services, contraceptive practices such as daily, monthly quarterly or yearly are highly dependent on the method availability, affordability and individual preferences.

**Key Respondent Female aged 38 noted that;**

*I always take my pills daily for 21 days followed by a 7-day break during which a menstrual period occurs. The pills work for me well though sometimes I bleed which is unpleasant.*

According to Key Informant **Health worker male aged 47** it is noted that;

*Individuals using contraceptive methods that require daily administration, such*

*as birth control pills, tasks them to swallow the pill every day at the same time. Consistent daily use is crucial for the effectiveness of oral contraceptives and other daily methods. In some cases, it could involve daily or regular reassessment of family planning goals, methods, and needs, including considering changes in life circumstances or preferences.*

This implies that daily utilization of family planning services among young women aged 15-24 is influenced by a complex interplay of factors. Efforts to improve access, awareness, affordability, and cultural acceptance are essential to ensuring that AGYW can make informed choices about their reproductive health and access to the services they need.

The monthly utilization of family planning methods among individuals aged 15-24 involves considering various factors that influence their choices and access to services.

This was reflected in the following verbatim:

*At the health centre, there is monthly injectable contraceptive known as Norigynon. Though, this is given to some of us who know doctors personally since it is rare and expensive, I am injected every month whenever I feel I don't want pregnancy.*

This implies that some AGYW perception to access and utilization is positive however, monitoring the monthly level utilization of family planning methods among young people involves collecting data on the number and types of services accessed over time. This information helps inform strategies to improve access, address barriers, and tailor services to meet the needs of AGYW effectively.

The quarterly utilization of family planning among individuals aged 15-24 involves assessing trends and factors that influence their access to and use of contraceptive services over a three-month period. Here are key considerations for understanding this demographic's utilization patterns:

Key respondent A noted that;

*I always contact my personal doctor for Depo-Provera every 3 months. It is exactly 2 months since I visited the facility and it requires a quarterly visit to a healthcare provider. Sometimes, I get side effects like headache and extended menstrual period but I still go ahead and use the method because it is the one I can afford and manage.*

The results on contraceptive practices also agree with Castle and Askew (2015) who stated that approximately 1 in 3 women who start a modern contraception change a method within the first year. The main reasons for changing methods included discomfort and side effects while the main reasons for discontinuation included the desire to get pregnant, contraceptive failure, side effects, and infrequent sex/abstinence. Similarly, the perception to access and utilization of FP from this respondent is positive however it requires more information regarding managing the method related side effects and other possible options in case this one does not work out. Tracking quarterly utilization involves gathering data on the number of visits, types of services utilized, and demographic characteristics. This information guides efforts to improve service delivery, address barriers, and tailor interventions to meet the specific needs of AGYW aged 15-24 in accessing family planning services effectively.

The yearly utilization of family planning among individuals aged 15-24 involves examining trends and factors that influence their access to and use of contraceptive services over a longer timeframe. Here are key considerations for understanding yearly utilization pattern;

According to Key Respondent, Female aged 24 noted that;

*I always use implants that are inserted under the skin and this provides contraception for 3 to 5 years. This method has been effective and convenient for me since I do not experience serious side effects. I wanted to give birth and I contacted my doctor to remove the implant before the end of its effective period, I stopped using contraceptives until fertility returned.*

Therefore, the perception is positive however, yearly utilization involves collecting data on the number of visits, types of services utilized, demographic characteristics, and changes in utilization patterns over time. This information guides efforts to improve service delivery, address barriers, and tailor interventions to meet the specific needs of young people aged 15-24 in accessing family planning services effectively throughout the year.

The study results about contraceptive practices in regard to AGYW perceptions agree with the one conducted by Guttmacher Institute 2022 which notes that globally, among adolescent girls and young women in the U.S., UK and most developed countries, contraceptive pills, condoms, and long-acting reversible contraceptives (LARCs) are the most commonly used family planning methods. The preference for these methods

reflects their effectiveness, convenience, and access, with a growing trend toward LARCs due to their long-term protection without the need for daily maintenance.

According to Guttmacher Institute (2022), birth control pills remain one of the most commonly used methods among young women due to their effectiveness and ease of use. When taken correctly, they are 99% effective, though typical use drops this to around 91%. Pills remain a staple choice, though usage has decreased slightly in favor of more long-term methods like IUDs and implants.

The results are not in agreement with Otang-Mbeng (2020) who noted that the main purpose of practicing traditional contraception is to increase the birth interval for the health of the child, rather than for family planning reasons. The reason behind child spacing is that, even if the mistake can happen and the woman conceives, the next child will be born after the first one has two years and more, then the mother will be able to care for the new born child. Reasons for indigenous contraceptive use among women in Ghana were to prevent pregnancy; for child spacing; to reduce a family size; to be wealthier and to look healthier (in this review, child spacing is considered a practice, not a reason). The reason for postponing first birth is for young married women who are deemed physically not mature to carry a pregnancy to term and deliver it safely. The other reason for postponing first birth is for young boys and girls to finish school and seek formal sector employment (Sumankuuro et al., 2019).

Child or birth spacing means to provide adequate birth spacing between two or more consecutive pregnancies. Long before the influx of Western ideas, understanding the importance of child spacing to maternal and infant health was widespread and popular

among African cultures. Much as Most cultures in Africa, such as Ghana encourage large families, they disrespect a woman whose children's birth is closely spaced. Such a woman is said to produce children like a chicken, or Rabbit which is derogatory. She is expected to abstain from sexual intercourse after birth for some time to avoid conception. Therefore, a woman is encouraged to practice traditional methods of family planning to ensure that children are properly spaced (Wulifan et al., 2019).

### **5.2.2 Barriers to family planning services access and utilization among adolescent girls and young women aged 15-24 years**

The study revealed that culture influences usage of family planning Kiyindi Town council Buikwe district as quoted by Key respondent aged 20;

*In my culture, it is not good to use family planning because ancestors always get offended. This is because large families are valued, and the use of contraception is viewed as contrary to these norms.*

This agrees with the Uganda's study findings as according to Sarah Nakirijja and Mark Ivan Kayiso (2018) gender is a detriment of contraceptive uptake among women irrespective of age in Namasuba village. This is because society in Uganda is organized in a set of norms and beliefs that shape the way women and men perceive certain aspects in life. In Namasuba like many other parts of Uganda Kiyindi Town Council inclusive, these norms are normally socially or culturally constructed during the process of socialization, and mostly put females at a position of passiveness as compared to their male counterparts.

Additionally, AGYW in Kiyindi Town Council from especially lower-income families face barriers to accessing family planning services due to costs such as transport and for the method itself. This is because most of these AGYW in Kiyindi town council are majorly employed in bars and hotels whereby they don't earn much to enable them afford the cost involved to utilize these family planning services. Owing to the fact that the available health facilities are PNFPs and private for profit, most of these services are accessed at cost that may not obviously be afforded by every AGYW. The study findings concur with the one conducted by Tamang et al, 2017 who notes that, adolescents may have problems in accessing Family Planning services because they may not know where to obtain contraception or cannot afford services.

The study also revealed that some AGYW even when they would wish to use contraceptives they decide otherwise for fear of method related side effects especially prolonged bleeding and others like headaches, leg pains among others. Fear of side effects remains a strong barrier to both initiation and adherence to modern family planning methods as highlighted in prior studies (Barden-O'Fallon et al., 2018). The results also agree with Castle and Askew (2015) who suggested that approximately 1 in 3 women who start a modern contraception change a method within the first year. The main reasons for changing methods included discomfort and side effects while the main reasons for discontinuation included the desire to get pregnant, contraceptive failure, side effects, and infrequent sex/abstinence.

The results obtained from the study are also in agreement with Munakampe, Zulu & Michelo (2018) who noted that the majority of teenagers use unreliable sources for

information on Sexual Reproductive Health (SRH); and out-of-school adolescents are more vulnerable and often make less informed choices. The results agree with Mpunga et al. (2022) who noted that combining demand creation and the provision of reproductive health information and user-friendly services can increase the uptake of contraceptives by removing the barrier of information lack.

The study results also agree with Ewerling et al. (2018) who classifies modern contraceptive methods as technological products or medical procedures that affect natural reproduction. The results are also in agreement with Sserwanja, Musaba and Mukunya (2021), which notes that use of modern contraceptives reduces maternal mortality, improves health outcomes of adolescent mothers plus their children and reduces the costs associated with teenage pregnancy. The results agree with Dongarwar and Salihu (2019) who noted that planned childbirths increase the likelihood of attaining higher educational levels, which results in financial independence.

The results from the study agree with Otang-Mbeng (2020) who noted that terminal abstinence is used to prevent pregnancy by young women delaying sexual relations for years. During post-partum abstinence, a woman is not allowed to sleep with her husband. Women relying on the calendar technique prevent pregnancy by noting ideal days to have sex. Withdrawal prevents pregnancy by preventing sperms from entering the women.

These results also do agree with Moroole et al. (2020) who noted that natural mechanism triggered by breastfeeding interrupts ovulation and the menstrual cycle, breastfeeding is associated with a significant reduction in fertility and blocks ovulation.

In addition, the results agree with Aleni, Mbalinda & Muhindo (2020) who noted that child (birth) spacing is clearly the most common practice of African indigenous contraception.

### **5.2.3 Facilitators of family planning services utilization among AGYW aged 15-24 years**

The study revealed that the identified facilitators for contraceptive uptake among adolescent girls and young women in Kiyindi Town Council include individual factors such as knowledge and perceived benefits, interpersonal factors such as partner approval, and health system factors like accessibility and provider attitudes. Other identified key facilitators are community expectations, family support, and the ability to afford services.

In Kiyindi Town Council, Buikwe district, facilitators to contraceptive access and use identified among the AGYW aged 15-24 years include knowledge about the available FP methods and the perceived benefits. The methods commonly utilized including pills, injection Depo-Provera, implants and the male condom are preferred and used by young women for their ease of access, use, effectiveness when used correctly, and in some cases, affordability and accessibility. It's important to note that the choice of contraceptive method can vary based on individual preferences related to perceived benefits, access to healthcare services, commodity availability at the health facility, cultural factors, and availability of information and education regarding family planning options.

The study also reveals that In Kiyindi Town Council, Buikwe district, other factors identified that facilitate utilization of FP services by adolescent girls and young women aged 15-24 years especially the long-term contraceptive methods include their availability at the nearest health facility, they are freely provided and health workers share information on their use freely.

All the above identified findings agree with a study conducted by Boadu (2022). He notes that Western European countries, such as Sweden, the Netherlands, France, and the UK, tend to have higher levels of family planning services use among adolescent girls and young women. These countries generally offer comprehensive sexual and reproductive health education, have easy access to a variety of contraceptive methods, and robust healthcare systems. Adolescent girls and young women in these countries often have access to contraceptives through public healthcare systems or subsidized programs (Sobotka & Berghammer, 2021). In countries like France and the UK, there are public health initiatives to offer free contraceptives, particularly targeting younger populations. In many Western European countries, comprehensive sex education is provided in schools, and young people are more likely to receive information about family planning methods, making them more likely to use contraception.

The results are also in agreement with Dorothy Shaw (2010) on the ABCs of Family Planning. Utilization to family planning depends on the quality of care and medical services as key factors in the adoption of contraceptive use. Access helps determine whether the individual makes contact with the family planning provider, while quality of care greatly affects the client's decision to accept a method and the motivation to

continue using it. Medical barriers are scientifically unjustifiable policies or practices, based at least in part on a medical rationale, that inappropriately prevent clients from receiving the contraceptive method of their choice or impose unnecessary process barriers to access to family planning services. In the past, international family planning efforts have been criticized as placing too much emphasis on issues of access and the quantity of contraceptives distributed rather than quality that answers the question of client satisfaction.

The results obtained in this study agree with Ibrahim and Atteraya (2018). He states that there is a positive significant association between a visit to a health facility and contraceptive utilization. It is believed that, young women who visit health facilities have access or are exposed to sexual and reproductive health services including information than those who do not visit such facilities. Besides, women who want to or are using contraceptives may also likely visit a health facility. This implies that the frequency of women visiting health Centres determines the utilization levels of family planning.

Among other contraceptive access and use facilitators identified among AGYW are Partner and peer influence. Approval and support from a sexual partner or recommendations from friends and siblings are significant motivators, also noted is the open communication and discussing contraception with partners, peers, and family members. Permanent contraceptive methods, such as sterilization, are typically not common among adolescent girls and young women aged 15-24 years in Kiyindi Town Council due to their irreversible nature and the fact that they are usually chosen by

individuals who have acquired their desired family size or do not wish to have children in future. However, it's important to note that in many settings including Kiyindi Town Council, interpersonal factors such as partner/peer approval still do influence contraceptive choices thus heavily impacting their utilization.

These study findings agree with the one conducted by Tumlinsonl et al, 2013. He notes that teen or young age puts young women at a less advantage as many are newly married or have not produced a single child. As expected, approval of contraceptive by both partners and discussion about family planning among spouses affect contraceptive use of currently married women. At the same time women young or old who have never discussed family planning are 3.98 times less likely to use contraceptives than women who have discussed family planning issues with their spouses more than twice. Women who discuss family planning once or twice are 1.56 times less likely to use contraceptives than women who have discussed family planning with their spouses more than twice.

### **5.3 Conclusion**

Adolescent Girls and Young Women of Kiyindi Town council Buikwe district generally demonstrated a positive perception and attitude plus good knowledge of contraception, with injection Depo-Provera, implants, oral pills and male condoms being the most widely known and used methods. It was however found that barriers to contraceptive use among AGYW such as strong cultural norms, religious opposition, fear of side effects, concerns about partner disapproval and cost still exist and are a major

hinderance. The study revealed that facilitators for contraceptive uptake in Kiyindi Town council among AGYW include individual factors like knowledge and perceived benefits, interpersonal factors such as partner approval, health system factors like accessibility and provider attitudes, community expectations, family support, and the ability to afford services.

Understanding barriers and facilitators to contraceptive access and uptake among Adolescent Girls and young women aged 15-24 is very important for improving reproductive health outcomes in Kiyindi Town council, Buikwe district. It should also be noted that individual, interpersonal, community, and health systems factors all play a major role in influencing contraceptive use. Therefore, refining access to family planning information and services by providing accurate, comprehensive information through healthcare providers, social media platforms and educational materials is key.

## **5.4 Recommendations**

### **5.4.1 Perceptions/understanding of family planning services among adolescent girls and young women**

The study recommends that health workers in Kiyindi town council should enhance implementing comprehensive educational programs in schools and communities about family planning methods and the associated benefits, towards reproductive health. The study also recommends use of all available social media and digital platforms to reach adolescent girls and young women with accurate and engaging information about family planning options. Furthermore, there should be peer education to train peer facilitators

to provide information and support to their peers in a relatable and non-judgmental manner.

The study recommends that health workers in Kiyindi town council should ensure family planning services are available at all convenient locations even if through outreaches and at a free cost, including rural and underserved areas to consider mobile clinics and community-based distribution points.

The authorities of Kiyindi town council in conjunction with the district health office should advocate for skilling programs for these vulnerable adolescent girls and young women who are out of school. This empowers them with knowledge and skills that enables them to seek for better livelihood alternatives other than bars that puts most of them at risk of exposure to acquisition of STIs and unwanted pregnancies. Better livelihood options also give the AGYW capacity to afford the cost involved in accessing and utilizing family planning services other than relying on their male counterparts.

#### **5.4.2 Barriers and facilitators of contraceptive utilization among the adolescent girls and young women**

The study recommends that health workers in Kiyindi town council should promote and popularize the use of both male and female condoms as they offer dual protection against both unintended pregnancies and sexually transmitted infections (STIs). Ensure they are freely available at health centers, pharmacies, and community outlets. Integrating family planning with other health services is also recommended to provide enough opportunities to the AGYW to access them as much as possible. Offering contraception alongside HIV testing and treatment, antenatal care, and other relevant services is equally important.

## 5.5 Areas for further research

- i. Examine the role of Family/community in the uptake of modern contraceptives.
- ii. Impact of social norms on Family Planning access and utilization in the community.

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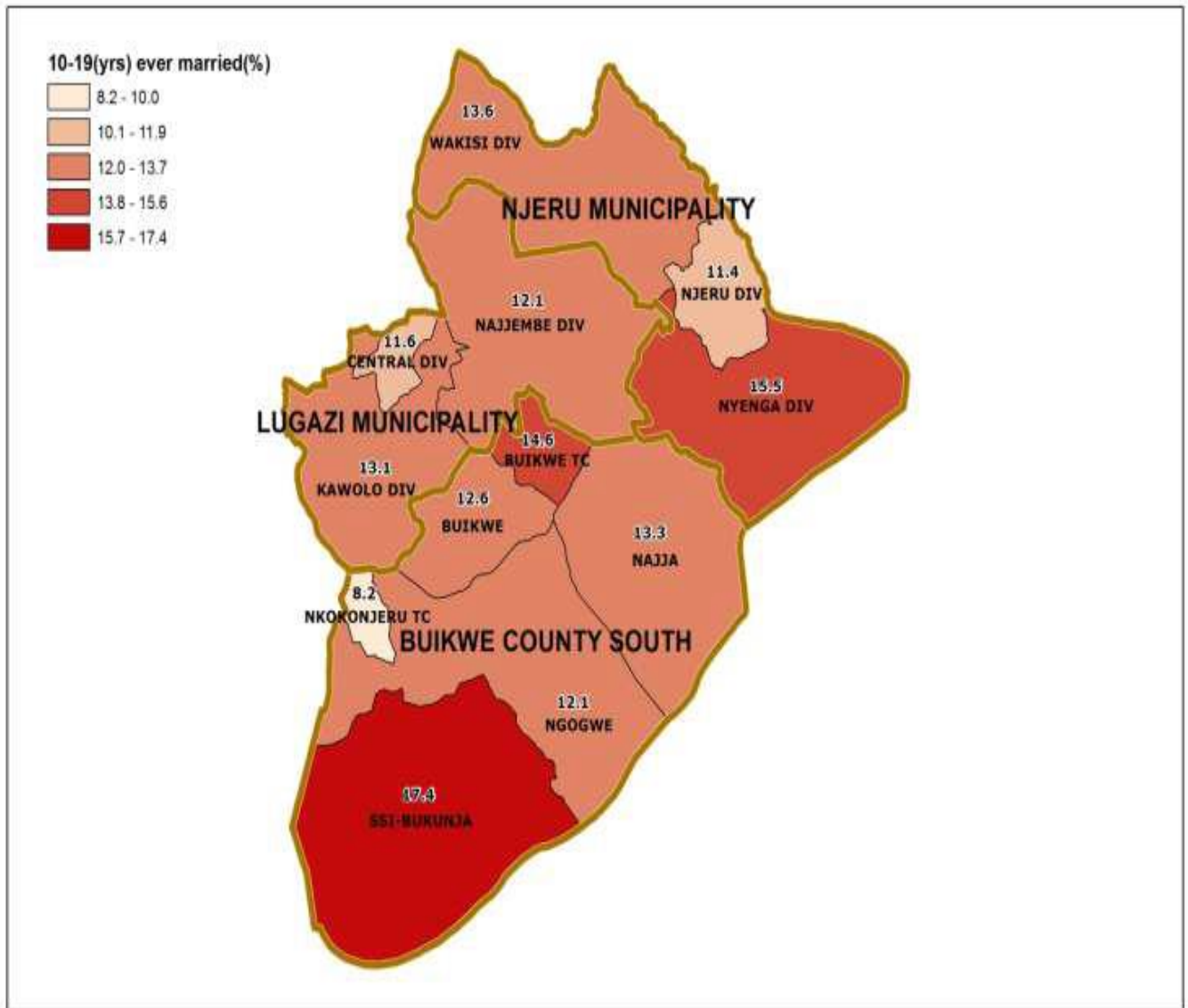
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## APPENDICES

### Appendix1: Percentage Distribution of Population aged 10-19 Years, Ever Married; Buikwe District, 2014



## **Appendix 2: Interview Guide for health workers, NGO representatives**

My name is **Alex Bahima** a student of Uganda Christian University. In partial fulfillment of the requirements for the Master's degree in public health, I am required to conduct a research in an area of my interest. My interest in this study is barriers and facilitators of family planning services utilization among adolescent girls and young women aged (15-24 years) in Kiyindi town council, Buikwe district. The information obtained from you will be kept highly confidential. You are also requested not to write your name on this Interview guide. Should you have any queries please do not hesitate to request for clarification.

### **Questions**

- i. What is your opinion in regard to access and use of family planning?
- ii. What are the reasons for the use and none use of family planning services by young women in this area?
- iii. How do health partners support your facilities in providing family planning services to young women?
- iv. What are the cultural values influencing utilization of family planning services in this area?
- v. How does religion influence utilization of family planning services in this area?
- vi. What are the family planning methods used by most women in Kiyindi town council?
- vii. What are the challenges faced in providing family planning services to young women in Kiyindi town council?
- viii. What are some of the lessons learnt while providing family planning services to young women in Kiyindi Town Council?
- ix. What are the strategies being taken to increase utilization of family planning methods?
- x. What suggestions do you propose to be taken by the policy makers to increase utilization of family planning methods among young women in this area?

**Thank you for your Participation**

### **Appendix 3: Focused group discussion guide for young women**

My name is **Alex Bahima** a student of Uganda Christian University. In partial fulfillment of the requirements for the Master's degree in public health, I am required to conduct a research in an area of my interest. My interest in this study is barriers and facilitators of family planning services utilization among adolescent girls and young women aged (15-24 years) in Kiyindi town council, Buikwe district. The information obtained from you will be kept highly confidential. Should you have any queries please do not hesitate to request for clarification.

#### **Questions**

- i. What are your opinions in regard to access and use of family planning?
- ii. Where do you usually go when in need of family planning services?
- iii. What are the types of family planning methods provided in this area?
- iv. What are the reasons for the use of family planning services and the choice of your preferred method?
- v. How does your spouse support you in utilization of family planning services?
- vi. What are the cultural values influencing the usage/nonuse of family planning services?
- vii. How does religion influence you in the usage of family planning services?
- viii. What are the challenges faced while accessing and utilizing family planning services?
- ix. What are some of the lessons learnt while using family planning services?
- x. What suggestions do you propose to be taken by service providers to increase utilization of family planning methods in this area?

**Thank you for your Participation**

#### **Appendix 4: Ekitabo ky'okukubaganya ebirowoozo mu bibinja ebitunuuliddwa eri abawala na abakyala abato**

Amannya gange nze Alex Bahima omuyizi mu Uganda Christian University. Mu kutuukiriza ekitundu ku bisaanyizo by'okufuna diguli ya Master mu by'obulamu bw'abantu, nteekwa okukola okunoonyereza mu kitundu kye njagala. Ekintu kye njagala mu kunoonyereza kuno kwe kufuna n'okukozesa empeereza y'okuteekateeka amaka mu bakyala abato ab'emyaka (emyaka 15-24) mu tawuni kanso y'e Kiyindi, mu disitulikiti y'e Buikwe. Amawulire agafunibwa okuva gy'oli gajja kukuumbwa nga ga kyama nnyo.

##### **Ebibuuzo**

- i. Mu ndowoza yo nnyonnyola ekifuga enkozesa ye enteekateeka y'amaka.
- ii. Wa otera okugenda nga weetaaga obuweereza bw'okuteekateeka amaka?
- lii. Bika ki eby'enkola z'okuteekateeka amaka eziweereddwa mu kitundu kino?
- iv. Ensonga ki ezikuvirako okukozesa empeereza y'okuteekateeka amaka n'okulonda enkola gy'oyagala?
- v. Munno mu bufumbo akuwagira atya mu kuzesa empeereza y'okuteekateeka amaka?
- vi. Empisa ki ez'obuwangwa ezifuga enkozesa/obutakozesa empeereza z'okuteekateeka amaka?
- vii. Eddiini ekwata etya mu nkozesa y'obuweereza bw'okuteekateeka amaka?
- viii. Ebiki ebisomooza nga ofuna n'okukozesa empeereza y'okuteekateeka amaka?
- ix. Ebiki ebimu ku by'oyize nga okozesa obuweereza bw'okuteekateeka amaka?
- x. Ebiki by'oteesa okutwalibwa abagaba obuweereza okwongera okukozesa enkola z'okuteekateeka amaka mu kitundu kino?

Mwebale Okwetaba kwo

## **Appendix 5: Consent Form**

**Consent form on barriers and facilitators of family planning services utilization among adolescent girls and young women aged (15-24years) in Kiyindi town council, Buikwe district**

### **Purpose**

Dear respondent, you have been identified as a participant in this study to determine contraceptive practices, barriers and ways of improving access and utilization of family planning services. The study targets young women aged 15-24 years in Kiyindi Town Council. Information given will help in improving family planning services access and utilization as well as enable the researcher complete his studies.

### **Procedure**

The researcher will ask you questions to determine contraceptive practices, barriers and ways of improving access and utilization of family planning services. The interview will take about 30 minutes.

### **Confidentiality**

Your identity will not be revealed as names shall not be recorded on the interview guide. All the information given will be kept confidential.

### **Risks and discomforts**

You have a right to decline from participating at any stage of the interview if you feel uncomfortable. There is however no anticipated risk anticipated or involved.

### **Benefits**

There are no direct benefits to those participating in the study. The information given will help in improving family planning services access and utilization in Kiyindi Town Council Buikwe District.

Respondent's initials.....Date.....

Signature of person obtaining consent.....Date.....

## **Appendix 6: Consent Form for guardian/Parent**

**Consent form on barriers and facilitators of family planning services utilization among adolescent girls and young women aged (15-24years) in Kiyindi town council, Buikwe district**

Dear respondent, you have been identified as a guardian/parent of your child/children to participate in this study to determine contraceptive practices, barriers and ways of improving access and utilization of family planning services. The study targets adolescent girls and young women aged 15-24 years in Kiyindi Town Council. Information given will help in improving family planning services access and utilization as well as enable the researcher complete his studies.

### **Procedure**

The researcher will ask your child/children questions to determine contraceptive practices, barriers and ways of improving access and utilization of family planning services. The interview will take about 30 minutes.

### **Confidentiality**

Your identity will not be revealed as names shall not be recorded on the interview guide. All the information given will be kept confidential.

### **Risks and discomforts**

Your child or children has/have a right to decline from participating at any stage of the interview if she/they feel uncomfortable. There is however no anticipated risk anticipated or involved.

**Benefits:** There are no direct benefits to those participating in the study. The information given will help in improving family planning services access and utilization in Kiyindi Town Council Buikwe District as well as academic purposes.

Respondent's initials.....Date.....

Signature of person obtaining consent.....Date.....

**Ekyongerezeddwako 6:**

Ffoomu y’okukkiriza ku ffoomu ya Guardian/ParentConsent ku kutuuka n’okukozesa obuweereza bw’okuteekateeka amaka mu bawala n’abawala abato ab’emyaka 15-24) mu Kiyingi Town Council, Buikwe District Deding respondent

Omwana/abaana eri abeetabye mu kunoonyereza kuno okuzuula enkola z’okuziyiza okuzaala, ebiziyiza n’engeri y’okutumbula okufuna n’okukozesa empeereza y’okuteekateeka amaka. Okunoonyereza kuno kutunuulidde abavubuka n’abawala abato ab’emyaka 15-24 mu Kiyindi Town Council.

Amawulire agaweereddwa gajja kuyamba mu kulongoosa empeereza y’okuteekateeka amaka n’okukozesa wamu n’okusobozesa omunoonyereza okumaliriza emisomo gye.Enkola Omunoonyereza ajja kubuuzza ebibuuzo by’omwana/abaana wo okuzuula enkola z’okuziyiza okuzaala, ebiziyiza n’engeri y’okulongoosa okufuna n’okukozesa empeereza y’okuteekateeka amaka. Yintaviyu ejja kutwala eddakiika nga 30.

**Confidentiality**

Yowo endagamuntu yo tegenda kubikkulwa kuba amannya tegajja kuwandiikibwa ku ndagiriro ya yintaviyu.

Amawulire gonna agaweereddwa gajja kukuumbwa nga ga kyama.risks era obutabeera bulungi omwana oba abaana wo alina/alina eddembe okugaana okwetaba mu mutendera gwonna ogw’okubuuzza singa awulira nga tateredde.

Wabula tewali bulabe busuubirwa oba obukwatibwako.Emigaso Tewali migaso butereevu eri abo abeetabye mu kunoonyereza. Amawulire agaweereddwa gajja kuyamba mu kulongoosa obuweereza bw’okuteekateeka amaka okutuuka n’okukozesa mu disitulikiti y’e Kiyingi Town Council Buikwe nga kwotadde n’ebigendererwa by’okusoma.

Ebiwandiiko by’okuddamu.....  
olunaku.....omukono gw’omuntu okufuna okukkiriza  
.....

## Appendix 7: Uganda Christian University Research Ethics Committee Approval



**UGANDA CHRISTIAN  
UNIVERSITY**

A Centre of Excellence in the Heart of Africa

03/07/2023

To: ALEX BAHIMA

Uganda  
+256752396210

**Type:** Initial Review

**Re: UCUREC-2023-519: ACCESS AND UTILIZATION OF FAMILY PLANNING SERVICES AMONG YOUNG WOMEN AGED (15-24 YEARS) IN KIYINDI TOWN COUNCIL, BUIKWE DISTRICT**

I am pleased to inform you that the Uganda Christian University REC, through expedited review held on **15/06/2023** approved the above referenced study.

Approval of the research is for the period of **03/07/2023** to **03/07/2024**.


As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **03/07/2024** in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by Uganda Christian University REC:

No.	Document Title	Language	Version Number	Version Date
1	Admission Letter	English	Admission Letter	2020-02-03
2	Data collection tools	English	Data collection tools	2023-05-15
3	Protocol	English	Protocol seeking for approval	2023-05-15

Yours Sincerely



Peter Waiswa

For: Uganda Christian University REC

## Appendix 8: Data collection Approval

*Recommended to be conducted with the District staff, please accord the necessary support.*  
*Recommended to carry out data collection. 1st of 2023*

20<sup>th</sup> July, 2023

The District Health Officer Buikwe;  
The Town Clerk Kiyindi Town Council;  
Health Facility In-charge Makonge HCIII and Kingdom life HCII;

**RE APPLICATION TO CONDUCT A RESEARCH STUDY IN KIYINDI TOWN COUNCIL**

*You are welcome  
and we shall  
assist you  
15/8/23*

*Kingdom Life Medical Centre  
P.O. Box 309, LUGAZI*

My name is Alex Bahima a student of Uganda Christian University. In partial fulfillment of the requirements for the Master's degree in public health, I am required to conduct a research in an area of my interest. My interest in this study is access and utilization of family planning services among young women aged (15-24 years) in Kiyindi town council, Buikwe district.

Through report sharing, this study will generate information that is deemed important to policy makers, health planners and end users of Kiyindi Town Council, Buikwe District that in the end help to improve family planning services uptake and utilization.

The study's recommendations will also help in improving implementation of programs focusing on the reproductive health needs of young women in Kiyindi Town Council Buikwe District Uganda, which with better health, will increase their contribution to the development of the country.

This is therefore to request for permission to have the above-named study conducted.

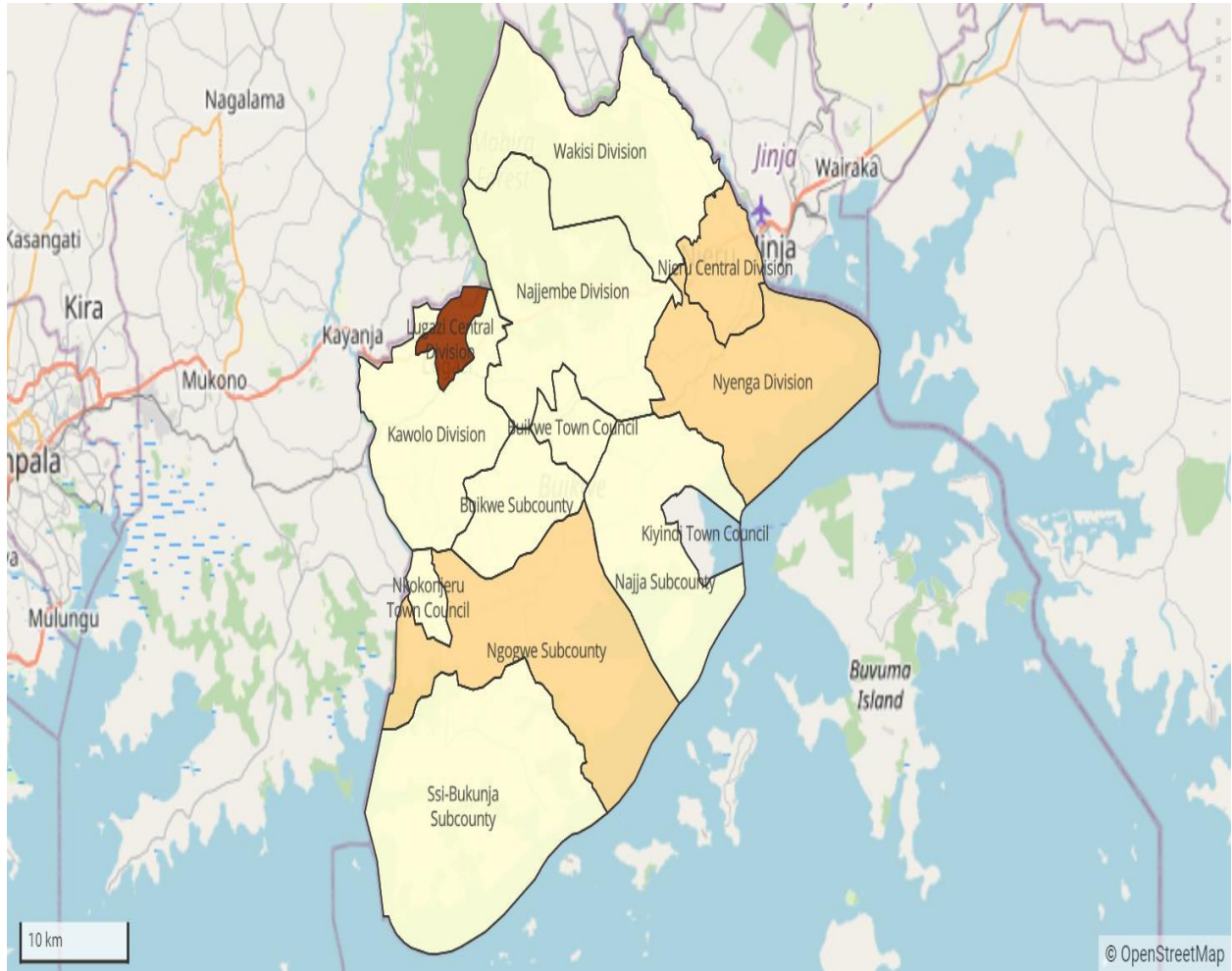
Sincerely yours;

*Alex Bahima*

Bahima Alex

*DISTRICT HEALTH OFFICER  
Date: 15/8/23  
KIYINDI TOWN COUNCIL  
BUIKWE DISTRICT*

**Appendix 9: Map of Buikwe District showing the Study area (Kiyindi Town Council)**





**UGANDA CHRISTIAN UNIVERSITY**  
**School for Research and Postgraduate Studies**

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*"A Centre of Excellence in the Heart of Africa"*

**REGULAR SUPERVISION REPORT**

Supervisor's Name: Dr. Ogwang Isaac Robinson

Student's Name: Bahima K. Alex Reg No: RJ20M21/049

Date of Submission of Work to Supervisor 7<sup>th</sup> December, 2025

Date of Meeting that Discussed the Work 9<sup>th</sup> December, 2025

**SUPERVISORS COMMENTS ON STUDENT'S WORK AND RECOMMENDATION FOR ACTION**

Alex has over time progressed on his research project. He has invested time and has been consultative at every stage. We have physically and virtually engaged to have him supported to enable him reach this very completion stage. I congratulate him for passing the VIVA VOCE.

He only needs to align his results, discussions and recommendations to the research objectives and submit to the department.

We have agreed that at a later stage, he needs to have his work published.

Wishing him the very best.

**STUDENT'S SIGNATURE**

**SUPERVISOR'S SIGNATURE**

Cc Head of Department

Cc Co-supervisor (if there is one)