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IAA Journal of Applied Sciences 10(1):1-19, 2023.
©IAAJOURNALS
https://doi.org/10.59298/IAAJAS/2023/1.1.1000

www.iaajournals.org
ISSN: 2636-7246

Unraveling the Intersection of Socio-Economic Dynamics and Family Planning Accessibility: Insights from Women of Reproductive Age in Kween District, Eastern Uganda

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ABSTRACT

The provision and utilization of Family Planning (FP) services play a pivotal role in not only safeguarding women's health but also significantly enhancing the overall well-being of their partners, children, and the wider societal fabric. Studies have estimated that optimizing FP services could potentially save 32% of maternal lives and 10% of child lives. In light of these critical implications, this research delves into the multifaceted factors hindering women's access to Family Planning Services within the precincts of the Kween district. Employing a cross-sectional descriptive study design, this investigation focuses on women aged between 18-49 years. Data collection involved survey questionnaires administered to a strategically sampled group of 40 women. The quantitative data underwent meticulous analysis utilizing SPSS version 20, while qualitative data was subjected to content and thematic analysis, presenting findings in a verbatim format. The study revealed that while 47.5% of women were utilizing modern FP methods, encompassing pills, implants, and injectables, there existed a notable unmet contraceptive need of 25%, coupled with a 22.5% contraceptive discontinuation rate. The primary deterrent to accessing modern FP methods stemmed from acceptability issues entrenched in prevailing myths, notably the erroneous beliefs associating Family Planning with infertility and the culturally unfavorable birth of twins. Moreover, the discontinuation of modern FP methods predominantly stemmed from reported side effects such as excessive bleeding, backaches, and headaches. Additionally, the research underscored a correlation between the utilization of modern FP methods, women's educational attainment, and demographic factors like the number of living male children and participation in polygamous marriages. Intriguingly, religious affiliations had a limited impact on FP method utilization, as women demonstrated a tendency to contravene religious doctrines to access FP services despite religious opposition. This study illuminates critical barriers obstructing women's access to and sustained use of modern FP methods in the Kween district, emphasizing the urgency for tailored interventions addressing socio-cultural misconceptions, side-effect management, and demographic sensitivities to foster more inclusive and effective FP service delivery in similar contexts.

Keywords: Family Planning, Contraceptives, Injectables, Implants.

INTRODUCTION

Globally, family planning (FP) is widely acknowledged as an important intervention towards achieving Sustainable Development Goals (SDGs) as it has been proven to reduce maternal and child mortality and entrench human rights for women and girls [1]. FP covers a wide range of services concerning women, children, and their families including access to birth control, contraceptives, sexual education, and other health resources. Access to FP services can be a major source of knowledge for birth spacing and can help to make known the benefits of birth spacing. Infant mortality can be reduced by such knowledge as it

plays a critical role. In addition, maternal mortality, unwanted pregnancies, and births, as well as improving the overall health of the mother, child, and ultimately the welfare of the family unit are key benefits of family planning [2, 3]. Family planning is well known to be crucial in the deterrence of unwanted pregnancies and unsafe abortions as well as the spread of sexually transmitted infections (STIs) including the much-threaded HIV/AIDS [4-6]. As a consequence of the actual and perceived positive impacts of FP, many countries around the globe especially those in Sub-Saharan Africa and Asia where birth rates are still unacceptably high, have embraced FP as one of the means to lessen the rate of infant mortality, improving women and children's health and even reducing the rate of population growth [7]. Many countries in Sub-Saharan Africa including Uganda have over the last half a century, made substantial progress not only in promoting FP but also in making FP services available and accessible to their citizens [7].

In Uganda, the government through financial and technical support from donor agencies and development partners has made useful progress in rolling out FP services in the country. Such efforts aim to enhance access to and utilization of FP, especially by poor people in rural areas and urban slums. This is done against the hope that FP would make very useful contributions to poverty alleviation, improving maternal and child health, and fostering development [7]. The unmet need for family planning refers to women capable of reproducing who are not using contraception but wish to postpone their next birth or stop childbearing altogether [8]. Meeting the unmet need for family planning and maternal and newborn health care in sub-Saharan Africa is estimated to result in a 69 percent reduction in maternal deaths and a 57 percent drop in newborn deaths [10]. Women in developing nations are disproportionately affected by an unmet need for family planning, with the highest need in sub-Saharan Africa. Uganda, one of the fastest growing countries in the world is especially in need of increased family planning services. Fertility rates are high at 6.2 children per woman overall and 6.8 children per woman in rural areas [8] and in 2010 the country's annual population growth rate was 3.2%, the 5th highest globally. Among married women, 34.3% have an unmet need for family planning, with a higher unmet need in rural compared to urban areas (37% and 23%, respectively) [8]. In 2011, only 30% of currently married women were using contraceptives [8] compared to a global average of 63% [10]. In Uganda, rural women face a problem of lack of enough support, information, resources, and training on how to make healthy reproductive choices, coupled with the negative stereotyping of women as mothers, which leads to questioning of their parenting abilities in terms of family planning and child spacing. The high fertility rate results in a high birth rate, bringing about large family sizes with a negative impact on the family, the community, and the nation at large as a result of economic overload in covering the additional demand of the persistent population growth as well as increased maternal and infant morbidity and mortality. Access to modern contraceptives encompasses the most important intervention in population management, thus boosting the nation's development process. Limited research has been put in place to address the socioeconomic factors or barriers to contraceptive use among rural women in Uganda. These factors may vary from one society to another due to the gender norms that exist in different societies as far as the use of contraception is concerned [11]. This research will help to bridge the efforts and reality of contraceptive use among rural women in Uganda by identifying the possible factors negating or enabling women's adoption of contraceptive use. The study also will go ahead to find out why rural women don't access and utilize contraceptives, despite making them available to relevant stakeholders and this will be done by identifying the major challenges to CU. Hence, the study aims to understand the access and utilization of contraceptives use among rural women in Uganda, Kween District.

METHODOLOGY

Area of Study

Kween district is a district in eastern Uganda bordering Kapchorwa district to the west, Bukwo district to the east, and Nakapirpirit district to the north. It covers an area of 851.4 square kilometres and an estimated population of 103,000 people with the annual growth rate being 4.5 percent.

Research design.

The study employed a cross-sectional descriptive research design using both quantitative and qualitative approaches. Concurrent triangulation was used to triangulate qualitative and quantitative findings. The study described the factors that hinder women's access to and utilization of FP services as well as the socio-cultural and socio-economic factors that hinder women in Kween from accessing FP.

Target Population and Unit of Analysis.

The target population for the study comprised all women aged between 18 and 49 years living in Kween. Women in this age bracket were chosen because they constitute a large majority of potential and actual consumers of FP services and therefore are well-positioned to provide the required information to answer the questions posed in this research.

Sample size and sampling procedure.

To estimate the true proportion of women with unmet need for family planning services within ± 5 % points with 95% confidence, with p = 0.39(UDHS [8]), (q=1-p), d=0.05, α =0.05 and *Z=1.96;*
Given that:

$n = Z2.\ Pq$ (Leslie Kish [12])

then,

$$n = \frac{(1.96 \times 1.96) \times (0.39 \times 0.61)}{d^2} = 365.56$$

n = 0.05x0.05

Thus, the sample size was 366 mothers of reproductive age.

p= Prevalence (unmet need for family planning) = 39% (UDHS [8])

q = 100% - 39% =61%

d = maximum error the PI was willing to allow, between the estimated prevalence of the outcome P and the true prevalence in the population = 5%.

A convenient sampling procedure was adopted to recruit women who responded to the study questionnaires.

Data collection

The main method for primary data collection was structured interviews using a questionnaire. The questionnaire was constructed to contain structured open and closed-ended questions and was used to gather both qualitative and quantitative data. These were administered by the researcher through face-to-face interviews and collected data in three sections including; socio-demographic characteristics, factors that hinder women's access to FP services, and factors that constrain women's utilization of FP services.

Data Processing and Analysis

At the end of each interview, the filled questionnaires were checked for completeness and any missing entries. The quantitative data obtained from the questionnaires was entered, cleaned, and analysed using the Statistical Package for Social Sciences (SPSS). Descriptive statistics such as frequency and percentages were used to present quantitative findings using tables and charts. Qualitative data from KIIs and secondary sources was subjected to content and thematic analysis where the responses were transcribed and themes developed with these themes presented together with verbatim. Emerging patterns and themes were compared against the survey data and the study objectives and were used to complete and supplement quantitative data.

Ethical Considerations

The researcher upheld all the ethical principles of the study as a whole. The researcher considered the following in ensuring all the ethics were upheld during and after the study: The researcher obtained approval from Kampala International University IREC, ensured a proper introduction and explanation about

the research to the participants, and collected data after the respondents had given their informed consent. The respondents were given an assurance that the information collected would be kept and treated with strict confidentiality and for academic purposes only. Respondents' names and any other personal identifiers were not collected which ensured the anonymity of respondents. Interviews with respondents were conducted in a secluded environment which ensured the privacy of the respondents. Collected data has been used for this research's purpose only and individuals concerned consented in writing to its inclusion beforehand at the end of the research.

RESULTS

Socio-demographic characteristics of respondents

Three-quarters of the respondents were aged below 35 years while nearly a third were monogamously married. However, polygamous marriage was also prevalent with 3 in every 10 respondents being in a polygamous union. Over half (55%) of the respondents had attained a primary level of education and below with only 2 respondents having not had any formal education. Over a third of the respondents were Protestants while 27.5% were Catholics, there was only 1 Muslim woman among the respondents. Over a third of the respondents were engaged in small businesses while 32.5% were housewives. Among the respondents with quantifiable income (except housewives), over half earned below Uganda shillings (UGX). 300,000 per month while a paltry 10% earned above Uganda shillings (UGX). 300,000.

Table 1: Socio-demographic characteristics of respondents. (Number, n=40)

Characteristics	Category	Frequency	Percentage (%)
Age	18-24	6	15.0
	25-34	20	50.0
	35-44	12	30.0
	>=45	2	5.0
Marital status	Polygamous.	12	30.0
	Monogamous.	13	32.5
	Single (never married)	8	20.0
	Separated/widowed/divorced	7	17.5
Educational level	University/ college	5	12.5
	Secondary	13	32.5
	Primary and below	22	55.0
Occupation	Farmer	6	15.0
	Housewife	13	32.5
	Business lady	15	37.5
	Employed	6	15.0
Religion	Catholic	11	27.5
	Protestant	14	35.0
	Moslem	1	2.5
	Pagan	5	12.5
	Others	9	22.5
Monthly income (UGX)	0	13	32.5
	<300,000	23	57.5
	300,000-500,000	2	5.0
	>500,000	2	5.0

Socio-demographic characteristics of spouses

Nearly half (44%) of respondents' spouses were aged above 45 years with over half (57.5%) having attained primary education. Over a third of the respondents were married to Protestant spouses (36%) who were mostly (48%) engaged in business activities. The majority (60%) of respondents' spouses were also earning less than UGX 300,000 per month.

Table 2: Socio-demographic characteristics of spouses. Number, n=25

Characteristics	Category	Frequency	Percentage (%)
Age	25-34	6	24.0
	35-44	8	32.0
	>=45	11	44.0
Educational level	University/ college	5	20.0
	Secondary	5	20.0
	Primary and below	15	60.0
Occupation	Farmer	5	20.0
	Business man	12	48.0
	Employed	8	32.0
Religion	Catholic	8	32.0
	Protestant	9	36.0
	Moslem	1	4.0
	Pagan	4	16.0
	Others	3	12.0
Monthly income (UGX)	0	15	60.0
	<300,000	5	20.0
	300,000-500,000	2	8.0
	>500,000	3	12.0

Planned Parenthood

The respondents had between 0 and 9 living children but on average the respondents had 4 living children including 2 boys and 2 girls. There was however wide variation in the number of boys as compared to several girls alive.

Table 3: Number of living children

	Minimum	**Maximum**	**Mean**	**Standard deviation**
Number of living boy children	0	6	2	2
Number of living children girls	0	5	2	1
Total number of living children	0	9	4	2

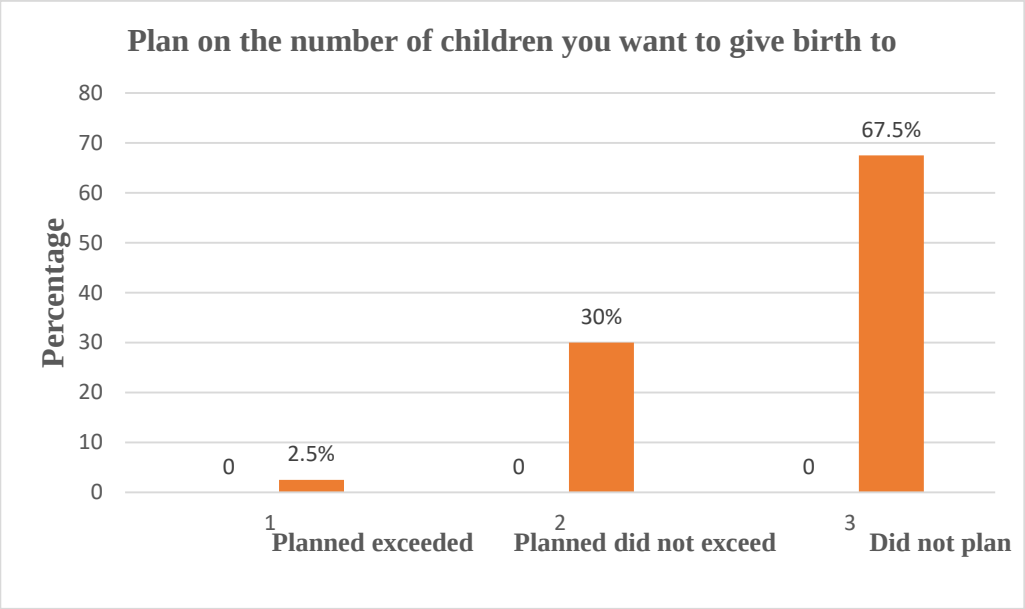

Figure 1: Planning on the number of children to give birth to

Contraceptive use

Previous use of modern FP methods

Nearly a third (30%) of the respondents had never used a modern FP method while 70% had previously used a modern FP method. Among the respondents who had never used a modern FP method, only 5% were willing to use a modern FP method in the future. Among the 70% who had previously used a modern FP method, over half (37.5%) had used injectables, 32.5% had used implants, and 2.5% used sterilization. This indicated that most of the respondents had used more than one FP method previously. However, the non-willingness of the respondents to use modern FP methods was blamed on religious objections, fear of side effects, and husband's disapproval as well as the desire to have more children.

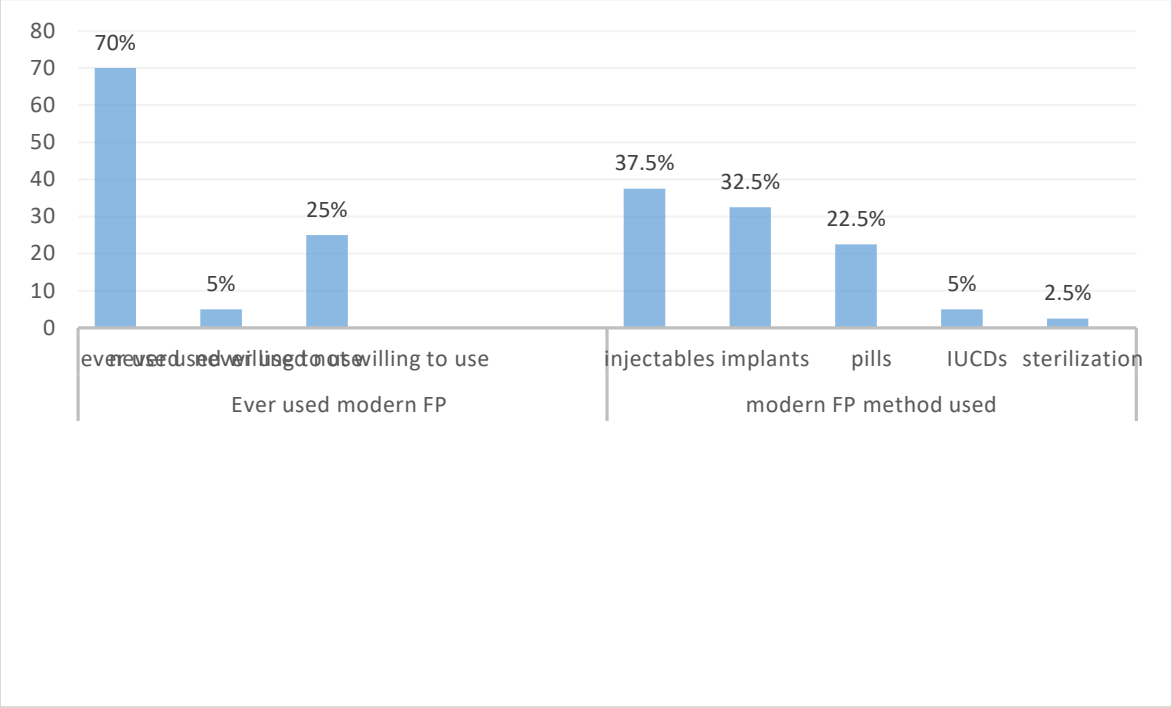

Figure 2: Previous use of modern FP methods

Current use of modern FP methods

Only 47.5% of the respondents were using a modern FP method while 62.5% were not using any modern FP method. This indicated that 22.5% had dropped from using modern FP methods as70% had indicated they had previously used modern FP methods. Among the 22.5% who abandoned using modern FP methods, less than half had dropped using FP methods since they wanted to have another child while the remainder 12.5% abandoned using modern FP methods due to other reasons. In general, a quarter of the respondents did not like to have a child (or another child) shortly. This means that the unmet contraceptive use was 25%.

Table 4: current use of FP methods

	Response	Would like to have children in the near future	Frequency	Percentage
Currently using FP methods	Yes	Yes	5	12.5%
		No	14	35.0%
	No	Yes	10	25.0%
		No	11	27.5%

Among the 47.5% of the respondents using FP methods, 17.5% were using pills, 12.5% were using implants while the injectables were the third most common (10%) FP method used. Sterilization (tube ligation) was the least common (2.5%) type of modern FP method used. No respondent reported the use of barrier methods of contraception (female condoms).

Factors Hindering Access to FP Services

Physical Accessibility of FP Services Centers

Among the 47.5% of the respondents using FP methods, 42.5% sourced the FP method from health centers or dispensaries while 12.5% sourced from pharmacists/shops and 7.5% sourced from friends or relatives. This indicated that women sourced modern FP methods from more than one source.

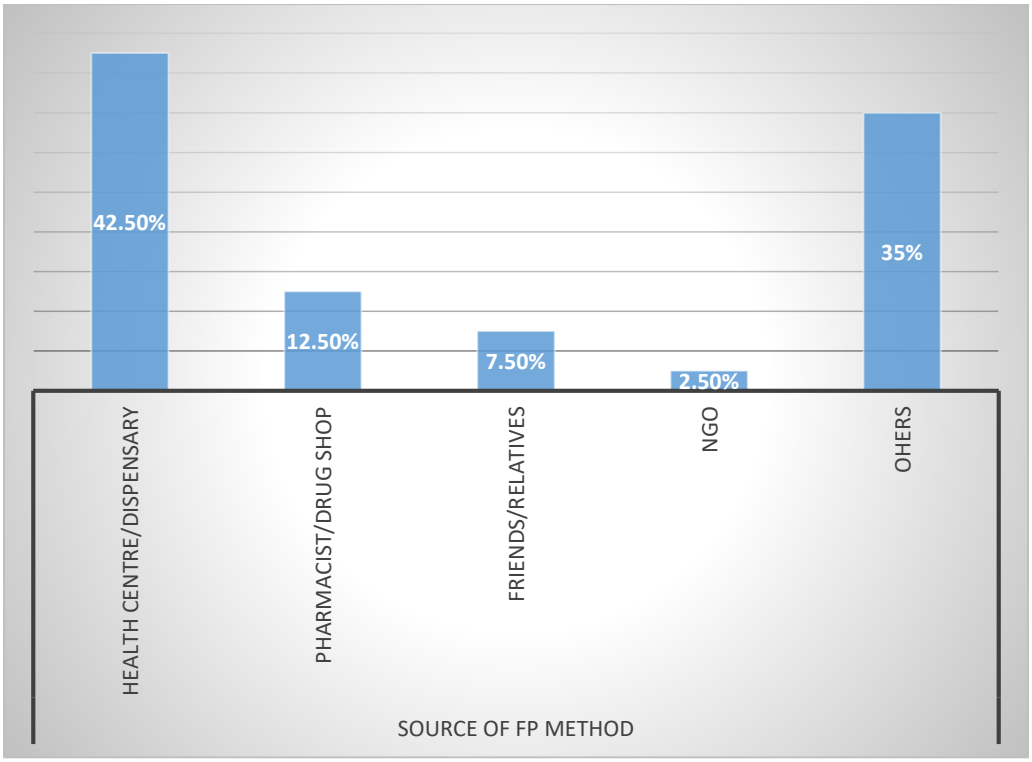

Figure 3: current source of FP method.

Among the 47.5% of the respondents using FP methods, over half (30%) of respondents currently using modern FP methods considered the place where they sourced the FP method not to be far and 32% thought that the cost implications in traveling to and fro the source of modern FP were affordable. This shows that physical access was not a critical hindrance to modern FP method use.

Table 5: physical accessibility of FP services. Number n=19 (47.7%)

		Frequency	Percentage
Affordable	Far	1	2.5%
	Near	12	30.0%
Not affordable	Far	6	15.0%
Total		**19**	**47.5%**

Availability of FP Services

Among the 47.5% of the respondents using FP methods, 25% were of the opinion that the method they were using was not always available while the other 20% always got their chosen FP method. Similar observations were made in an interview with a nurse at a local health facility who observed that at times the health facility ran out of FP supplies.

Table 6: Availability of FP services. n=19

	Response	Frequency	Percentage
Availability	Always available	8	20.0%
	Not always available	11	25.0%

Availability of FP services within the hospital was also hampered by a shortage of personnel which led to limiting the time of delivering FP services as revealed by an interview with a nurse:"One nurse serves FP, Antenatal Clinics, and Child Immunization which leads to a lot of workload. We are forced to stop FP service delivery at 1 o'clock."

Affordability of FP Services

Among the 47.5% of the respondents using FP methods, 42.5% thought that the costs they incurred in purchasing FP methods were affordable while the reminder 5% thought that purchasing FP methods was not affordable. The affordability of modern FP methods was linked to the fact that they were offered free of charge in public health facilities. All current users of modern FP methods who reported not affording FP methods sourced these methods from Pharmacists/drug shops. This shows that the affordability of FP services was not a major determinant in the use of modern FP methods.

Acceptability of FP Services

There were widespread myths regarding the effects of modern FP methods especially with regard to its side effects. Some of the mythical effects included changes in body size, reduction in libido and fertility, abnormal births, and that FP causes diseases such as vaginal wall prolapses, fibroids, high blood pressure, and cancer. Some of the respondents perceived the modern FP methods to be ineffective in preventing pregnancies as illustrated by the following statements *"*Many People complain that they still get pregnant even after use"

In agreement with a nurse informant, other respondents also feared that using modern FP services would result in giving birth to twins which is culturally unacceptable as it is perceived to lead to the death of either the husband or the wife as illustrated by the following statement: "FP use leads to twin pregnancies. Yet firstborn twins are not acceptable in society as it will lead to the death of either the husband or the wife." In addition to perceived resultant infertility, subsequent births after using modern FP methods were also riddled with myths. According to an interview with a nurse, there were some community members who believed that a child born after using FP would have disabilities. Among the 47.5% of the respondents using FP methods, 22.5% had experienced side effects due to the use of modern FP methods while 17.5% of those who were not currently using FP methods had also experienced side effects previously. 30% of the respondents were not included since they had never used FP services. This shows that side effects were equally experienced by current users and current non-users of modern FP methods hence the experience of FP side effects was widespread. Some of the side effects experienced by the respondents included excessive bleeding, general body weakness, and backaches as illustrated by the following except where one woman noted; *"*Personally I bled for a long time and it culminated to a divorce as I could not offer conjugal rights to my husband".

Table 7: Experience of FP side effects

	Experienced side effects	Percentage
Currently using FP services	Yes	22.5%
	No	25.0%
Currently not using FP services	Yes	17.5%
	No	5.0%

Factors Hindering Utilization of FP Services

Spousal Communication

In total, over half (55%) of the respondents had talked with their sexual partners about the use of modern FP methods. Among the 47.5% of the respondents using FP methods, 30% had communicated with their sexual partners about the use of modern FP methods. However spousal communication about FP was found to be similar across different education levels. There were cases in which sexual partners blatantly did not want to discuss issues regarding FP as illustrated by the following sentiments: *"*He just does not like discussing such matters"

Spousal Attitudes

Among the 55% of the respondents who had talked with their sexual partners about the use of modern FP methods, half (27.5%) had spouses who did not approve use of modern FP methods. The sexual partners cited mostly the fear of the modern FP method's side effects including perceived infertility and changes in body sizes as the reasons behind their modern FP method's disapproval. Spousal approval played a critical role in enhancing the uptake of modern FP methods since among the 30% of the respondents who had communicated with their spouses about modern FP methods and were using modern FP methods, 25% reported that the spouses approved of its use. Despite disapproval from the spouses, some respondents (5%) reported using modern FP methods without their knowledge. Only 2.5% were not using modern FP methods despite spousal approval. An interview with a nurse indicated that spouses had negative attitudes and misconceptions about modern FP methods: "They believe that Jadelle can move from the site of insertion to the heart". Spousal approval was critical to the survival of marriage unions as illustrated by an FGD discussant who observed that when the husband disapproves of modern FP use. When a disapproving partner finds the wives using it, the wives are subjected to humiliation or worse gender-based violence and even divorce as illustrated by the following excerpt. "I was chased away to go back to my parents by my mother-in-law after my husband reported to her that I was using FP."

Table 8: Spousal approval and modern FP usage

	Partner approves	Partner does not approve
Currently using FP services	25.0%	5.0%
Currently not using FP services	2.5%	22.5%

Number of Living Children

The results indicated that current users of modern FP services had an equal number of living children. However, the number of living children was different by gender, the number of boys was higher among current users of FP services as compared to girls and vice versa. This indicates that the gender of living children was an important determinant of using modern FP methods. This could be attributed to the value of the boy child in society with the desire of

women with fewer male children to have more male children hence avoiding the use of modern FP methods.

Table 9: Number of living children and modern FP use

	Currently using any modern FP services	
	Yes	**No**
	Mean	**Mean**
Number of boys living children	3	1
Number of girls living with children	1	3
Total number of living children	4	4

Education Level

As shown in the table below, the prevalence of the use of modern FP methods increased with an increase in women's highest education level. In addition, women with spouses who had College or university education had the highest prevalence of contraceptive use. This therefore indicates that higher education was associated with more use of modern FP methods.

Table 10: Education level and modern FP methods use

		Currently using any FP services			
		Yes		**No**	
		Frequency	**%**	**Frequency**	**%**
Education level	College/university	4	80.0	1	20.0
	Secondary level	7	53.8	6	46.2
	Primary and below	8	36.4	14	63.6
Education level of spouse	College/university	7	70.0	3	30.0
	Secondary level	1	14.3	6	85.7
	Primary and below	11	47.8	12	52.2

Religious Influence

Modern FP methods use was highest among respondents who thought that their religion supported their use while lowest among respondents who were not sure of whether their religion allowed the use of modern FP methods. However, half of the respondents whose religion did not support the use of modern FP methods defied their religious doctrine and used modern FP methods. This shows that religion was not a significant determinant of modern FP methods use.

Table 11: Religious influence and modern FP methods use

		Currently using any modern FP services			
		Yes		No	
		Frequency	%	frequency	%
Does your religion support the use of these FP services	Yes	7	63.6	4	36.4
	No	5	50.0	5	50.0
	Not sure	7	36.8	12	63.2

Polygamy

As shown in Table 12 below, modern FP methods had low prevalence among respondents in polygamous marriage while respondents who were never married had the highest prevalence of using modern FP methods. In comparison, however, respondents in monogamous marriages reported higher use of modern FP methods compared to respondents in polygamous marriages. This in general shows that polygamous marriage discouraged and hindered the use of modern FP methods.

Table 12: Marital status and modern FP methods use

		Currently using any modern FP services			
		Yes		**No**	
		Frequency	**%**	**Frequency**	**%**
Marital status	Monogamously married	7	53.8	6	46.2
	Polygamous married	4	33.3	8	66.7
	Single/ never married	5	62.5	3	37.5
	Separated/widowed/divorced	3	42.9	4	57.1

DISCUSSION

Contraceptive Use

Modern FP method with over half (37.5%) having used injectables, 32.5% having used implants, and 2.5% using sterilization. According to this study, it was found that 47.5% of women were currently using modern FP methods with 17.5% using pills, 12.5% using implants and 10% using injectables. The current contraceptive prevalence was found to be higher than the national average of 39% [8]. Also, this study found that pills were the most commonly used modern FP method contrary to the national average where injectables and implants are the most widely used as compared to pills. Similar to a study by Tsui et al. [13] this study observed that one in four women had an unmet need for contraceptives. The study also found that 22.5% discontinued the modern FP method they previously used mostly due to perceived or real side effects. A small portion had discontinued FP since they wanted to have another child. The discontinuation rate was however lower compared to a study among Kenyan women aged between 18 to 24 years which found a discontinuation rate of 42.4% [14]. This study found that the discontinuation rate was high among those using injectables and implants while those using pills had the lowest discontinuation rate. This was contrary to a study in Nairobi Slums that found that women previously using pills had the highest discontinuation rate [15].

Factors Hindering Access to FP services

Physical Accessibility of FP Services Centres

Women in the Kween district sourced modern FP methods from more than one source mostly including health centers or

dispensaries followed by chemists and relatives or friends. Despite sourcing from public health facilities there were some cases in which women were not counseled before being given these methods, however, health workers remained the key source of information on contraceptives. This meant that the women who were not counseled then sourced information from their social networks which could be attributed to widespread misconceptions about contraceptives. Nearness to a health facility reduces the costs and time needed to travel to these health facilities hence increasing the likelihood of access and utilization of FP services. This study found that the majority of women sourced their modern FP methods from facilities nearby and hence did not spend much time and money traveling to and fro these facilities. Given that the modern FP prevalence was higher than the national average it was therefore inferred that their closeness to the source of modern FP methods enhanced the uptake of these methods in Kween.

Availability of FP Services

Consistent availability of FP supplies in health facilities increases the probability of flexible choices and reduces the need for repeated visits to health facilities hence reducing costs that would have burdened women who need FP services. The findings in this study however revealed that FP supplies were not always available therefore forcing women to have repeated facility visits or forced women to seek FP services from private chemists. The availability of FP services was further hampered by a shortage of health workers which limited the provision of these services.

Affordability of FP Services

Although modern FP methods in public health facilities were offered free of charge, tests required in assessing eligibility for an FP method were not covered by cost subsidies. However, all these services according to the respondents were affordable hence affordability of FP services did not hamper the use of modern FP methods. Due to a persistent shortage of FP supplies, some women were forced to seek FP services from private facilities which most of them considered to be unaffordable. Generally, findings depicted that modern FP methods were affordable across all socio-economic statuses of women and hence did not determine the use of modern FP methods. Contrary findings were made in Uganda [16] and Zambia [17] which found that women in poorer households had a lower likelihood of using modern FP methods in comparison to women from wealthier households.

Acceptance of FP Services

In this study, perceived and actual side effects of contraceptive methods emerged as a primary barrier to use. Modern FP methods were believed to cause temporary infertility or reduce one's childbearing capacity, limiting the number of children they were able to conceive in their lifetime. It was also believed that modern FP methods predisposed women to give birth to twins who were considered culturally unacceptable. Similar to a study by Sharan et al. [18], this study therefore infers that acceptance of FP was traditionally low coupled with high cultural resistance to FP.

Factors Hindering Utilization FP Services

Spousal Communication

Spousal communication is critical in eliciting support from the spouses which goes a long way in enhancing compliance to FP methods. The findings indicated that women who had communication regarding FP issues were more likely to use modern FP methods. However only a portion of women discussed with their spouses these issues for they feared that they might be opposed to FP methods. Similar findings were made in Western Kenya [9] and Uganda [19] which found that FP use was associated with partner discussion. This study also found that issues to do with contraceptive use were at times viewed as a women's issue. Similar findings were made in a study in Tanzania which found that some men believed that discussing FP issues with their partners was not that important [20]. This was also noted in a study in Nigeria which reported the lack of interest in men as they viewed that it is the

role of women to determine when to get pregnant [21].

Spousal Attitudes

In this study, it was found that the decision to start or discontinue modern FP methods was not entirely decided by women but was significantly influenced by the spouses and extended family views. In this study, women who had approval and support from their spouses about the use of FP methods were more likely to use modern FP methods. The women who deviated from their husband's views on contraceptives and proceeded to use contraceptives were deemed to have hidden agendas and thus linked to promiscuity. Spouses in this study who were opposed to using modern FP methods feared it might have side effects on their wives, reduce their sexual urges or even result in difficulties in giving birth or when the wife conceives it was feared that she might give birth to a child with disabilities. These findings were similarly recorded in a study in Nigeria which found that women using contraceptives without their husband's consent were brandished promiscuous [21].

Number of Living Children

In typical African society, people are socialized to attach more value to a higher number of children, especially the boy child. In this study, most users of modern FP methods were found to have a higher number of boys and vice versa. This was attributed to the desire for those with fewer boy children to seek more children (boys) and hence avoid using modern FP methods. There was also a misconception regarding the reduction in ability to conceive after using modern FP methods hence women with fewer children tended to avoid using modern FP methods. This specifically discouraged the use of FP since social status in the community was viewed in the number of children a man has in his family. Similar findings were found in India which found that contraceptive use decreased with an increase in the number of living male children and decreased with an increase in the number of living female children [22]. Similar findings were also reported in Ghana [23] and Burkina Faso [24] which found that contraceptive use increased with the number of living male children.

Education Level

Education enhances access to information on FP which helps in demystifying the myths and misconceptions about contraceptives. In this study, the prevalence of the use of modern FP methods increased with an increase in women's highest education level. The study further found that women with higher education tended to be married to spouses with higher education who happened to have higher approvals for modern FP methods. Higher education level enables women to mitigate the effects of spousal locus of control hence increasing their ability to use contraceptives despite opposition from the spouse as they will be able to purchase FP methods without having to rely on the spouse to provide. More educated women are also likely to keep women with higher education levels in their social networks who are likely to have utilized FP methods which further increases the likelihood of using modern FP methods. This finding concurs with several other local studies that have documented that women with lower education levels tend to have low knowledge about the benefits of FP, are less likely to approve of FP, and therefore less likely to use modern FP methods [9, 25].

Religious Influence

According to the functional theory of religion, religion has a strong social and personal influence and control over the believers as it not only determines people's identity but also guides their social and other forms of behavior. According to this study although the prevalence of modern FP methods was higher among women whose religion supported FP, half of those whose religion opposed FP went against their religious views and used FP. This showed that religion had minimal effect on the use of modern FP methods in the Kween district. Findings of this nature were reported in Western Kenya which found that religious affiliation was not a significant predictor of FP approval among women [9].

Polygamy

In this study, women in monogamous marriages reported higher use of modern FP methods compared to women in polygamous marriages. This could be attributed to the notion that women in polygamous marriages tend to have less education and a wider spousal age gap which limits their probability of having spousal communication in FP resulting in a wide difference in FP approval. Women in polygamous households often feel a need to have more children than their counterparts to attain influence. On the other hand, women in polygamous marriages often resort to clandestine use of contraception due to spousal disapproval. Similar findings were made in Ndhiwa District [1], Gambia [26], and Ethiopia [27] which found that polygamous marriage discouraged and hindered the use of modern FP methods.

Contraceptive Use

The majority (70%) of women in the Kween district had previously used a modern FP method however currently 47.5% of women are using modern FP methods mostly involving pills, implants, and injectables. A quarter of women did not like to have a child (or another child) in the near future but were not currently using any contraceptive method.

Factors Hindering Access to FP services

Given that most women sourced their modern FP methods from public health facilities, access to these supplies was sometimes hindered by erratic supplies which forced some women to seek these services from private chemists hence induced considerable costs. Primarily access to FP services was hindered by the acceptability of modern FP methods. These methods were riddled with myths and misconceptions. The modern FP methods were believed to cause temporary infertility or reduce one's childbearing capacity, limiting the number of children they were able to conceive in their lifetime and predisposing them to give birth to twins which were considered culturally unacceptable [28]-[33]. These myths were spread through women's social networks and further driven by a shortage of health workers to provide adequate counseling services during administration. There were women who had genuinely experienced side effects including excessive bleeding, backaches, and headaches as a result of FP which resulted in total discontinuation of these services.

Factors Hindering Utilization FP Services

Although just over half (55%) of women had discussed FP with their spouses, women who had communication regarding FP issues were more likely to use modern FP methods. In addition, despite low spousal approval of modern FP methods, women who had approval and support from their spouses about the use of FP methods were more likely to use modern FP methods. Due to the value of male children in society, most users of modern FP methods were found to have a higher number of boys as compared to girls and vice versa. Also, the use of modern FP methods increased with the increase in women's highest education level but women's religious affiliation did not hinder the utilization of modern FP methods as most women went against their religious doctrines when it was opposed to FP. Furthermore, women in polygamous marriages had a low prevalence of modern FP methods as compared to women in monogamous marriages as the former sought to attain influence in having a higher number of children.

CONCLUSION

Results from the research indicated that 47.5% of women were using modern FP methods mostly involving pills, implants, and injectables, however, unmet contraceptive use stood at 25% while the contraceptive discontinuation rate was 22.5%. Primarily access to modern FP methods was hindered by acceptability since they were riddled with myths including beliefs that Family planning caused infertility and predispose to giving birth to twins, who were considered culturally unacceptable. Discontinuation of modern FP methods was predominantly blamed on experienced side effects including excessive bleeding, backaches, and headaches. Also, the study found that the use of modern FP methods increased

with an increase in women's highest education level and it decreased with a decrease in several living male children and polygamous marriages. Other factors like religion had minimal effect on the use of modern FP methods as women went against their religious doctrines and used FP methods despite opposition from their religions.

Recommendations

Due to widespread misconceptions and myths about modern FP methods, there is a need for the Government and other health stakeholders to create public sensitization about modern FP methods. In these sensitization forums men should adequately be involved as their approval of FP methods would drive the uptake of modern FP methods. The Government should ensure an adequate number of health workers in health facilities and other community settings to ensure that women are adequately counseled and examinations done before being administered modern FP methods. This will help in psychologically preparing them for the contraindications of modern FP methods.

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CITE AS: **Chemutai Meshak (2023). Unraveling the Intersection of Socio-Economic Dynamics and Family Planning Accessibility: Insights from Women of Reproductive Age in Kween District, Eastern Uganda. IAA Journal of Applied Sciences 10(1):1-19. https://doi.org/10.59298/IAAJAS/2023/1.1.1000**