

FACTORS INFLUENCING THE UPTAKE OF FAMILY PLANNING METHODS AMONG FEMALES AGED (15-49) AT MARIESTOPES CENTRE MAKERERE- KAVULE, KAMPALA DISTRICT. A DESCRIPTIVE CROSS-SECTIONAL STUDY.

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Abstract

Introduction:

According to WHO, family planning is the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births.

Objectives of the study:

The main objective of the study was to determine the factors influencing the uptake of family planning services among females aged 15-49 years at Marie Stopes Centre, Makerere-Kavule, Kampala District.

Methodology:

A descriptive cross-sectional one in which a quantitative method of data collection was used. The researcher utilized simple random sampling on 80 respondents from December 2022 to January 2023 at Marie Stopes Centre Makerere-Kavule. The data collection process was based on the use of self-administered questionnaires which were filled, cleaned, and later analyzed using tables, graphs, and pie charts.

Results:

Out of the 80 respondents in the study, the majority (46.25%) of the respondents were between (20-30) years old, graduates 36(45%), and 45(56%) were marrieds. The study revealed that the leading factors influencing the uptake of family planning at Marie Stopes Centre Kavule included; the cost of family planning services (90%), the age of first sexual intercourse (70%), and accessibility (78%)

Conclusion:

According to the results, factors influencing the uptake of family planning methods included socio-economic factors [i.e. employment status, cost of family planning, level of education], demographic factors [i.e. marital status, age of first sexual intercourse], and health-related factors [i.e. accessibility, age of service providers]. People prefer receiving their family planning services from the private sector compared to the public sector, they also prefer receiving family planning services from service providers who are elderly and experienced, rather than young service providers.

Recommendations :

The researcher recommends that the cost of family planning methods be reduced and service providers be of mixed ages. This will build up trust among family planning utilizers.

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1. Background.

According to the U.S. Government and International Family Planning & Reproductive Health Efforts | KFF, Family Planning is the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births (Gonie et al, 2018)

Factors that contribute to the use of family planning methods are socioeconomic factors, health-related factors, demographic factors, and Knowledge and attitude of persons towards the use of Family planning. Socio-economic factors (i.e. employment, partner support), health-related factors like confidentiality, accessibility, attitude of the health workers, privacy situations, and demographic factors such as age, level of education, marital status, race).

Among the 1.9 billion women of reproductive age group (15-49) years worldwide in 2019, 1.1 billion (57.9%) need family planning; of these, 842 million (7.65%) are using contraceptive methods, and 270million have an unmet need for contraception (WHO, 2020)

Overall, there were significant wealth-related disparities in the Department of Family and Protective Services (DFPS) in West Africa only (17.8 percentage points (pp)) among married AGYW. The disparities were significant in 5 out of 10 countries in Eastern, 2 out of 6 in Central, and 7 out of 12 in West among married AGYW and in 2 out of 6 in Central and 2 out of 9 in West Africa among unmarried AGYW (Mutua et al, 2021). Overall, DFPS among married AGYW increased over time in both the poorest and richest households (AARC = 1.6%), and 1.4%) respectively, and among unmarried AGYW from the poorest households (AARC = 0.8%)(Mutua et al., 2021). However, DPFS has increased over time among married and unmarried AGYW from the poorest households in Eastern (AARC = 2.4%, $p < 0.001$) and Southern sub-regions (AARC = 2.1%, $p = 0.030$) respectively (Mutua et al, 2021). Rwanda and Liberia have the largest increases in

DFPS among married AGYW from the poorest and richest households (AARC = 5.2%,5.3%,) respectively. There have been decreasing DFPS trends among both married (AARC = -1.7%, $p < 0.001$) and unmarried (AARC = -4.7%, $p < 0.001$) AGYW from poorest households in Mozambique (Mutua et al., 2021)

From the study made, most respondents have a primary educational level, with the highest proportion in the Northern region (67.1%). Also, the Northern region (49.8%) unlike other regions had the highest proportion of women in the poorest wealth index. Across regions, more than half of the respondents reside in rural areas [Otim, 2020]

Additionally, the results also reveal that several respondents across regions married before their 18 birthdays; with the majority of respondents in the Northern region (51%), followed by the Eastern region (48%), and lowest in the Central region (37.9%). In addition, results depict that over 50% of the respondents across all regions perceived no problem with distance to health facilities. Besides, the majority of the respondents were unemployed, with the highest proportion in the Northern region (80.7%) [J Otim, 2020]

According to Bright Opoku's study among the cross-sectional surveys of 29 countries, the individual-level factors are noted as being the following elicited; among women aged 25-29 (38.2%), those who are married 32.2%. Religiously, Christians 33.9%, those working 29.7%, those who had their first sex at ages 15-19, 31.1%. Also, women who have attained higher levels of education 41.8%, and women with exposure to the newspaper ,41.8%, those who have accessed radio for knowledge, 32.7%, television 33% [Bright Opoku et al, 2021]

However, in terms of contextual-level factors, the highest prevalence of modern contraceptive use was found among women living in urban areas (32.4%), those in the richest areas (36.5%), women in communities with medium community literacy levels,35.9%, and socio-economic status (36.0%), those in communities with low knowledge of modern contraceptives (30.9%)(Ahinkorah et al., 2021)

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1.1. General Objective.

To determine the factors influencing the uptake of family planning services among females aged 15-49 years at Marie Stopes Centre, Makerere-Kavule, Kampala District.

1.2. Specific Objectives.

1. To determine the socio-economic factors influencing the uptake of family planning methods among females aged 15-49 years at Marie Stopes Centre, Makerere-Kavule, and Kampala District in Uganda.

2. To determine the demographic factors influencing the uptake of family planning methods among females aged 15-49 years at Marie Stopes Centre, Makerere-Kavule, and Kampala District in Uganda.

3. To determine the health-care system factors influencing the uptake of family planning methods among females aged 15-49 years at Marie Stopes Centre, Makerere-Kavule, Kampala District in Uganda.

2. METHODOLOGY.

2.1. Study design.

A cross-sectional study design, which involved both qualitative and quantitative data collection methods and analysis, was employed in the study. This was major because fitted into the schedule, and the topic involved both the dependent and independent variables.

2.2. Study area .

The study was conducted at Marie Stopes Centre, Makerere-Kavule, and Kampala. The location lies approximately 6.5 kilometers by road, east of the central business district of Kampala. The hospital has outpatient services.

2.3. Study population .

The population was the female beings who received their family planning services from Marie Stopes Centre, Makerere- Kavule, and Kampala district from December 2022 to January 2023.

2.4. Sample size estimation.

The sample size was determined using Kish Leslie's (1965) formula

$$N = \frac{z^2 p q}{e^2}; \text{ where } q=(100-p)$$

$$N = \frac{Za^2 P (1-P)}{e^2}$$

Where:

N= required sample size

Za = Reliability coefficient at 95% CI,

P = Family Planning prevalence for Uganda (40%)

e = Minimum likely error which will be taken to be 0.05

$$N = \frac{1.96^2 \times 0.4 (1-0.4)}{0.05^2}$$

$$= 368.7836$$

The sample size will be 369.

NB: However, because of financial constraints, a sample size of 80 was used.

2.5. Sampling procedure.

The research study employed a simple random sampling method while selecting the respondents who participated in the study. The researcher selected this sampling method because it allowed the selection of respondents based on certain factors and can be categorically descriptive among the study population particulars.

2.6. Data collection.

2.7. Data collection for the method.

The participants were assessed using an interviewer-administered questionnaire. The questionnaire was translated and back-translated to ensure that the information was obtained from respondents who don't speak English.

In this method, information regarding whether one is using family planning services, the knowledge about family planning that females of reproductive ages have, and the demographics of these clients such as age, occupation, estimated income, and religious affiliation.

Therefore, questions targeting these fields were conveyed in the questionnaire.

2.8. Data collection tools.

The only data collection tool that was used in this study was the questionnaire. These were printed in English since the majority of the target population was literate and also to ease the work but it will be translated and back-translated to get clear information from the respondents. Respondents are expected to answer questions from the interviewer as information will be captured accordingly. Envelopes will be used for storage of the questionnaire forms before and after the study.

2.9. Data collection procedures.

Questionnaires were used. Participants were given these instruments to fill. Since the questionnaire was in English, it was translated and back-translated to ensure that information can be collected from the respondents who did not speak English. Completed questionnaires were collected for analysis.

Oral consent was obtained from the participant.

The participants were recruited after fulfilling the exclusive and inclusion criteria that are contained in an eligibility form.

Questionnaires were used to collect information and each respondent was allocated a single questionnaire with printed questions to gather systematic information.

2.10. Study variables.

2.10.1. Dependent variable.

Utilization of family planning methods among females aged 15-49 years. This variable focused on females within the above age bracket who utilize family planning methods at Marie Stopes Centre, Kavule.

2.10.2. Independent variable.

The independent variable in this study was; factors contributing to, including; socio-economic factors, demographic factors, and healthcare system factors. These factors can exist on their own, however, the utilization of family planning in Uganda depends on them.

2.11. Inclusion criteria.

The study included;

1. Females 15-49 years who receive family planning services from Marie Stopes Centre in the time frame.
2. Only those people who consent to participate in the study were considered from Dec 2022 to Jan 2023.
3. The study also included service providers

2.12. Exclusion criteria.

- Women who come for post-abortion care will not be included
- Women who come for treatment over medical conditions like PUD

2.13. Quality control.

The quality of the study was guaranteed by taking into consideration the following. Pre-visits to the study area for the exercise with authorities to be conducted before the study. The researcher with one assistant collected the data. The research assistant was trained on how to collect data and the goals and objectives of the research topic. Research instruments like questionnaires were checked for errors of omission to ensure consistency, completeness, and accuracy in filling out the questionnaires.

2.13.1. Piloting the study.

A pilot study was carried out a week before the start of actual data collection and it was done among females who came for family planning services at Marie Stopes Centre, Kavule. Questionnaires were administered for pre-testing to check the efficiency of the questionnaires and rectify any errors before the actual data collection started.

2.14. Data analysis and presentation.

The data collected was summarized on paper, tailed, and analyzed using the Microsoft Excel program. Results shall be presented in the form of a frequency table, percentage, pie chart, and graph.

2.15. Data management.

Codes were assigned to every respondent to attain a high level of privacy. The already answered questionnaires were filed and kept safely in a drawer locked up such that only the researcher can gain access to them.

2.16. Ethical consideration.

The researcher obtained an introductory letter from the Principal, Medicare Health Professional's College of Clinical Medicine addressed to the Centre Manager to approve the research proposal.

Confidentiality, dignity, and respect of all participants were observed throughout the study. Participants were assured that there was no form of harm if they did not wish to participate in the study. Proper consent in writing was obtained from the study participants before questionnaires were issued.

3. DATA PRESENTATION.

From the above table, respondents of age group(20-30) were the majority 37(46.25%), followed by age group of (15-19), 24(30%), then age group of (31-40),16(20%) then the age group of the minority (41-49), 3(3.75%).

According to the religion of the respondents, the majority were the Protestants 33(41.25%), then Catholics 24(30%), then Born again 14(17.5%) and the Muslim as the minor group of 09(11.25%).

In regards to the tribe of the respondents, the Baganda turned up most 45(56.25%), followed by Banyankole 15(18.75%), then the Batooro 8(10%) and the least group was that of the Basoga 12(15%)

Basing on the marital status of the respondents, the married were the majority 45(56%) and the unmarried were the minority with a frequency of 35(44%).

Considering the level of education, there was no respondent with a primary qualification, however, 5(6.25%) had acquired a post graduate, 17(21.25%) had acquired a secondary certificate, 22(27.5%) had tertiary qualification and 36(45%) had acquired graduate qualification.

3.1. Socioeconomic factors influencing the uptake of family planning methods among females aged (15-49)

All the respondents, 80 (99%) were using family planning

Of these, only 62(77.5%) were aware about their friends using FP, only 6(7.5%) were aware that their friends were not using FP, and 12(15%) did not know about their friends involvement with FP.

However, there were no cultural beliefs listed that could affect the use of family planning.

31 (38.75%) persons did not report about any myths and misconceptions, 23(28.75%) reported that implants get lost in the body, 16(20%) reported abnormal bleeding and 10(12.5%) reported that IUD causes cervical cancer.

None of the respondents reported that FP methods were cheap 0%. 72,(90%) reported that FP methods were expensive and 8,(10%) reported that FP methods were **very** expensive.

Majority of the respondents were employed 42(53%) and 38(47%) were unemployed.

3.2. Demographic factors influencing the uptake of family planning services among females aged 5-49 years.

24(30%) people used FP in the age of (15-19) years, 37(46.25%) people used FP in the age (20-30) years, 16(20%) people used FP in the age (31-40) years, 3(3.75%) people used FP in the age (41-49) years.

Figure 6 represents the married and unmarried who used FP. 45(56%) were married whereas 35(44%) were unmarried.

Figure 7 represents the percentage of FP users whose decisions were made either by their partners or by themselves. Those whose decisions were made by their partners were 27(34%) and those whose decisions were made by themselves were 53(66%).

15 (18%) people first utilized FP between ages (15-19), 56 (70%) people first utilized FP between ages (20-30) years, 9(11.2%) people first utilized FP between ages (31-40) years.

Table 1: distribution table showing the frequency and percentage of the demographic data of the respondents (n=80)

PATTERN	FREQUENCY	PERCENTAGE (%)
AGE		
15-19	24	30
20-30	37	46.25
31-40	16	20
41-49	3	3.75
RELIGION		
Muslim	09	11.25
Protestant	33	41.25
Catholic	24	30
Born again	14	17.5
TRIBE		
Baganda	45	56.25
Banyankole	15	18.75
Batooro	08	10
Basoga	12	15
MARITAL STATUS		
Married	45	56
Unmarried	35	44
LEVEL OF EDUCATION		
Primary	0	0
Secondary	17	21.25
Tertiary	22	27.5
Graduate	36	45
Post Graduate	5	6.25

Table 2: A distribution table showing the number of respondents aware about the use of FP among their friends(n=80)

FEATURE	FREQUENCY	PERCENTAGE
Those aware about friend use of FP	62	77.5%
Those who do not know	12	15%
Those who were aware that friends do not use FP	6	7.5%

Table 3: istribution of respondents according to religious acceptance (n=80)

RELIGION	ACCEPTANCE
MUSLIM	NO
PROTESTANT	YES
CATHOLIC	NO
BORN AGAIN	NO

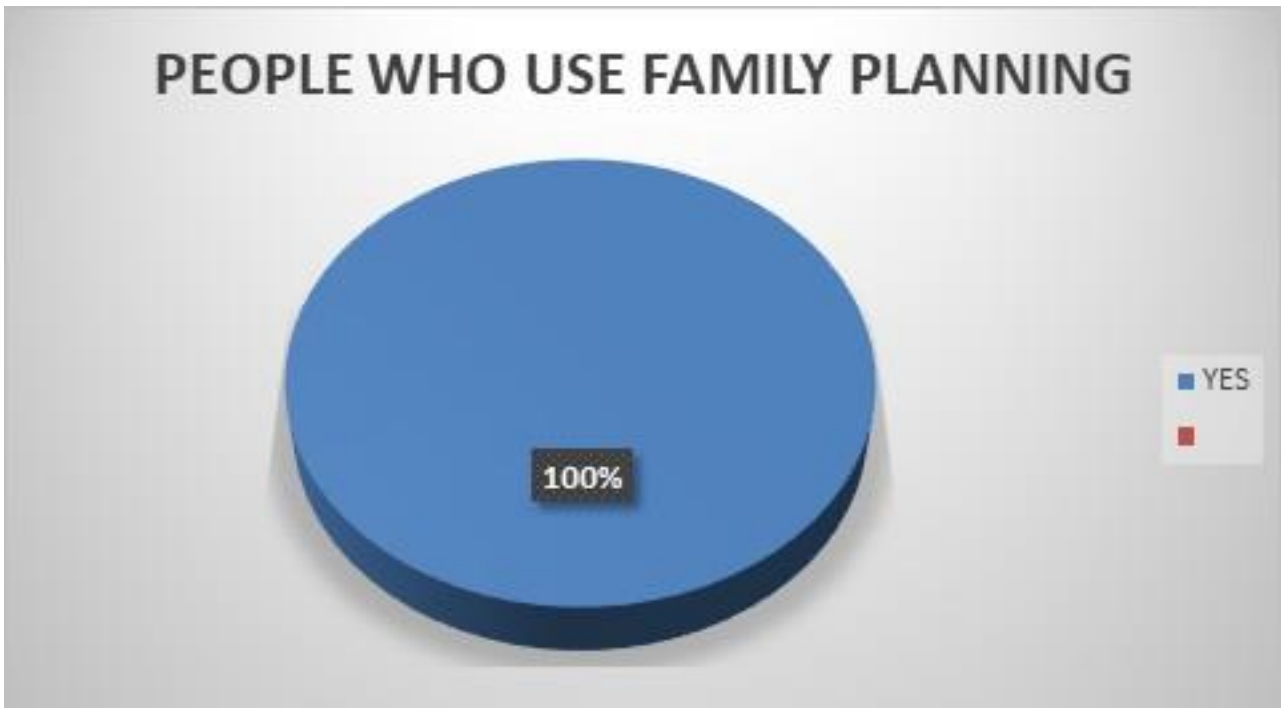


Figure 1: Distribution of respondents according to whether they used any family planning methods (n=80)

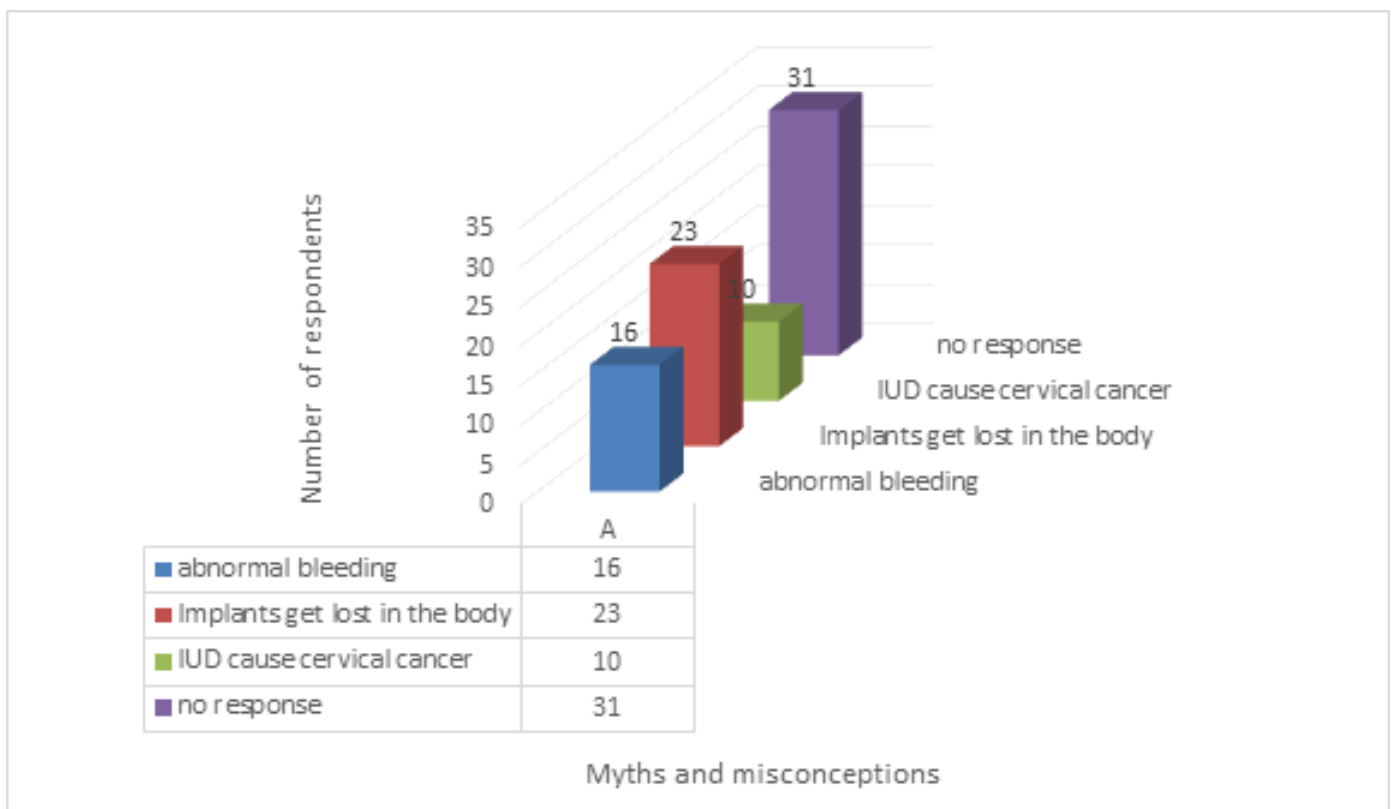


Figure 2: Distribution of respondents according to myths and misconceptions about family planning. (n=80)

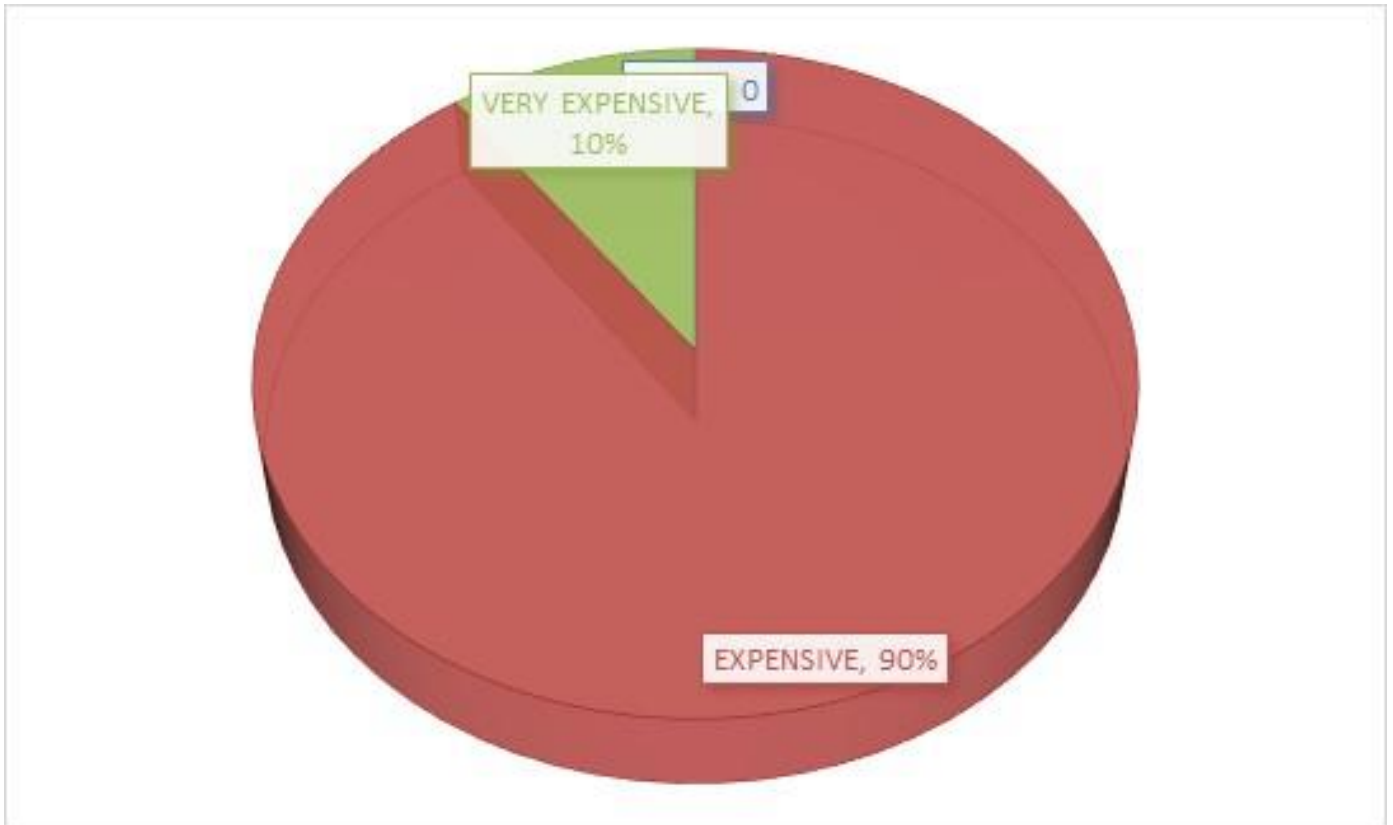


Figure 3: Distribution of respondents according to the cost of family planning.(n=80)

3.3. Healthcare system factors influencing the uptake of family planning services among females aged 15-49 years

62 (78%) persons reported that private not for profit were nearer to them while 18 (22 %) persons reported to have government facilities nearer to them.

Among these, 47(58.8%) persons preferred using public health facility, while 33(41.25%) preferred private not for profit.

Those who preferred receiving FP from public health facility, reported that services were cheap, accessible and privacy.

Whereas, those who preferred receiving FP from private not for profit, reported that there was good hygiene, they were accessible, good attitude of health workers towards them, good physical infrastructure and readily available services.

The above chart shows how FP services were rated. 40(50%) reported good, 35(43.75%) reported very good, 5 (6.25%) reported excellent. The factor that mostly influenced them to receive

family planning services were unwanted pregnancy and child spacing for better development of their children.

Majority of the respondents 45(56%) reported that they had ever had a stock out of family planning services,35(44%) respondents reported that they had never had a stock out for family planning services at the public health facility.

100% of the respondents reported that they had never experienced a stock out of modern family planning methods at the private health facility.

4. DISCUSSION OF RESULTS.

4.1. Respondents' Bio-data.

The majority (46.25%) of the respondents were of the age group of 20 to 30 years. This is probably so because the study area was in the same geographical location as Makerere University indicating that most of the clients seeking Family Planning from Marie Stopes- Kavule Centre are youths who came from the university.

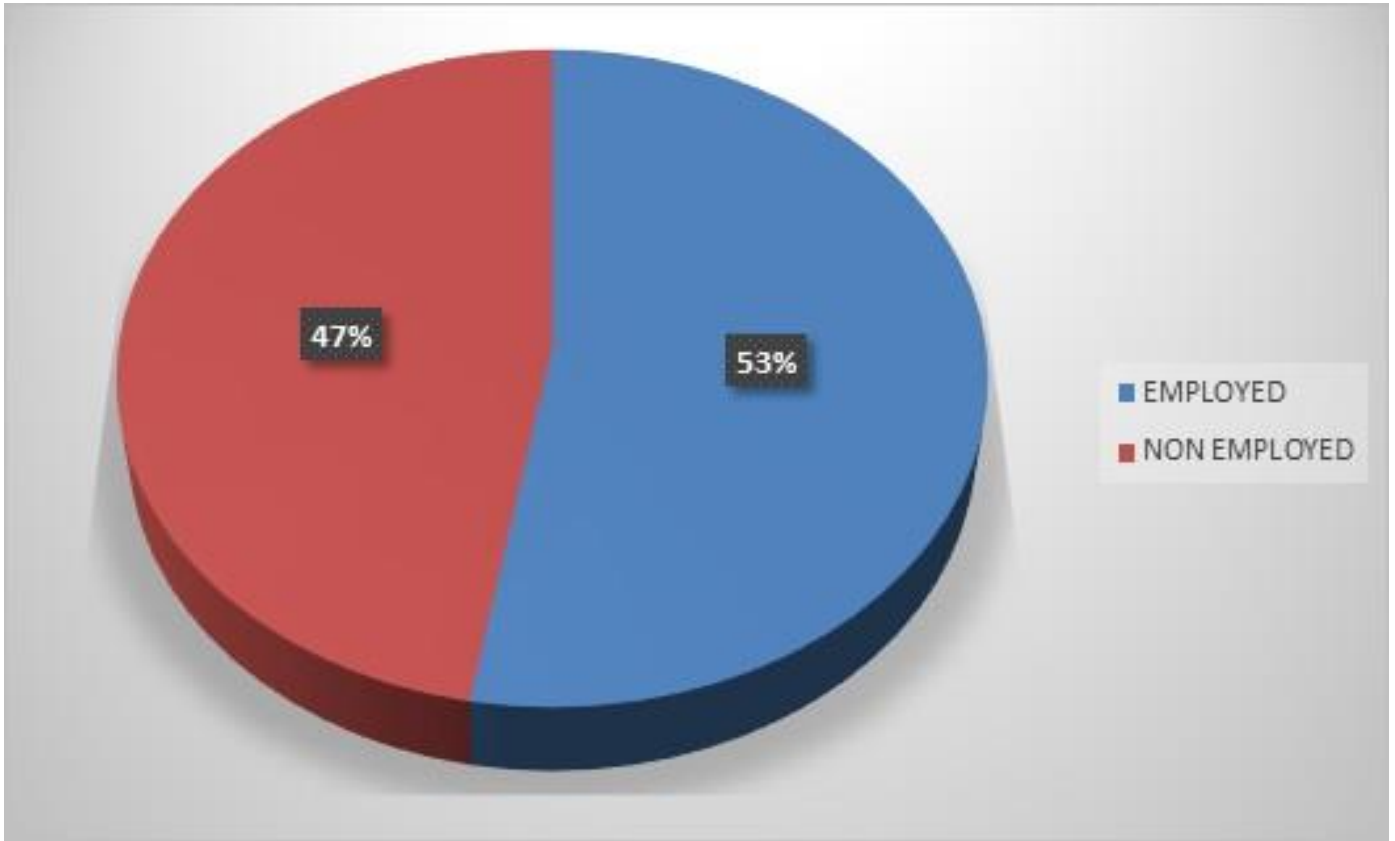


Figure 4: Distribution of respondents according to the employment status(n=80)

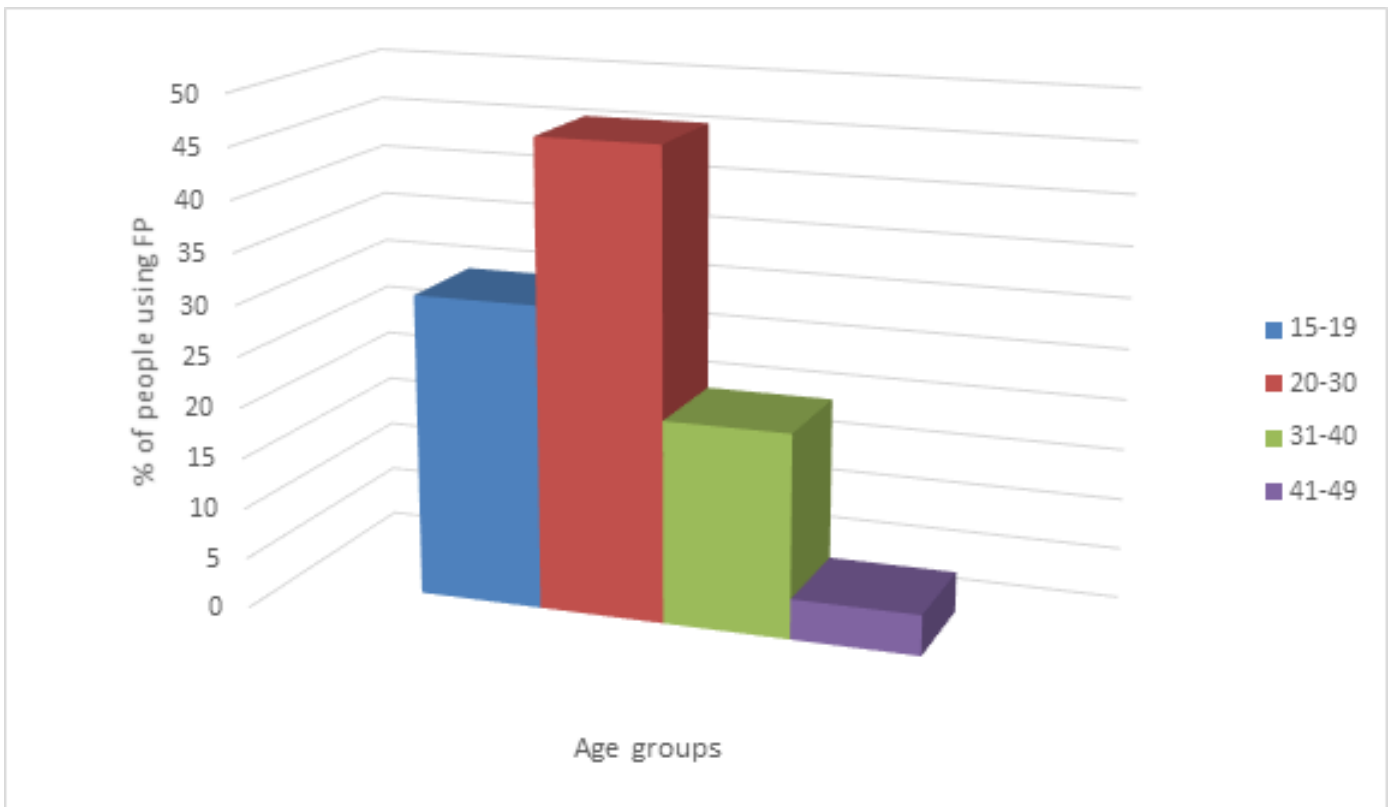


Figure 5: Distribution of respondents utilizing family planning according to age group. (n=80)

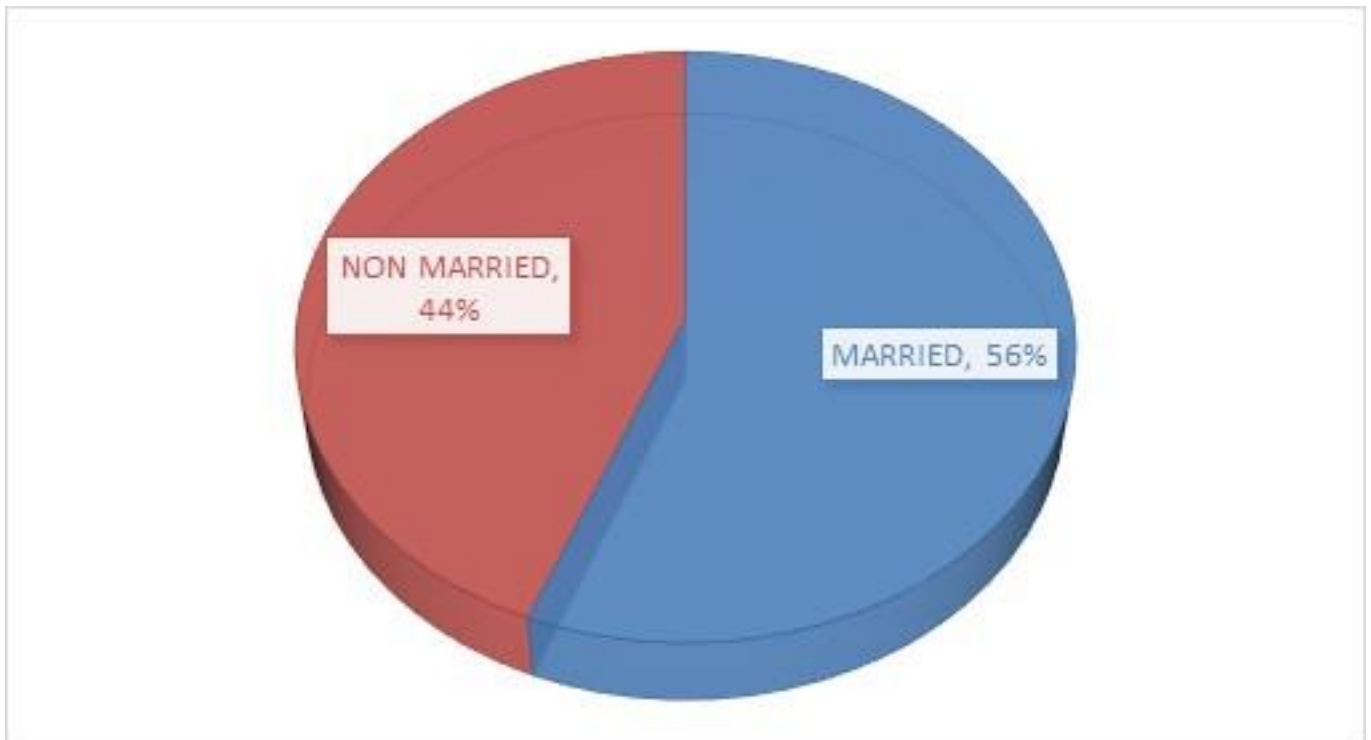


Figure 6: Distribution of respondents according to marital status. (n=80)

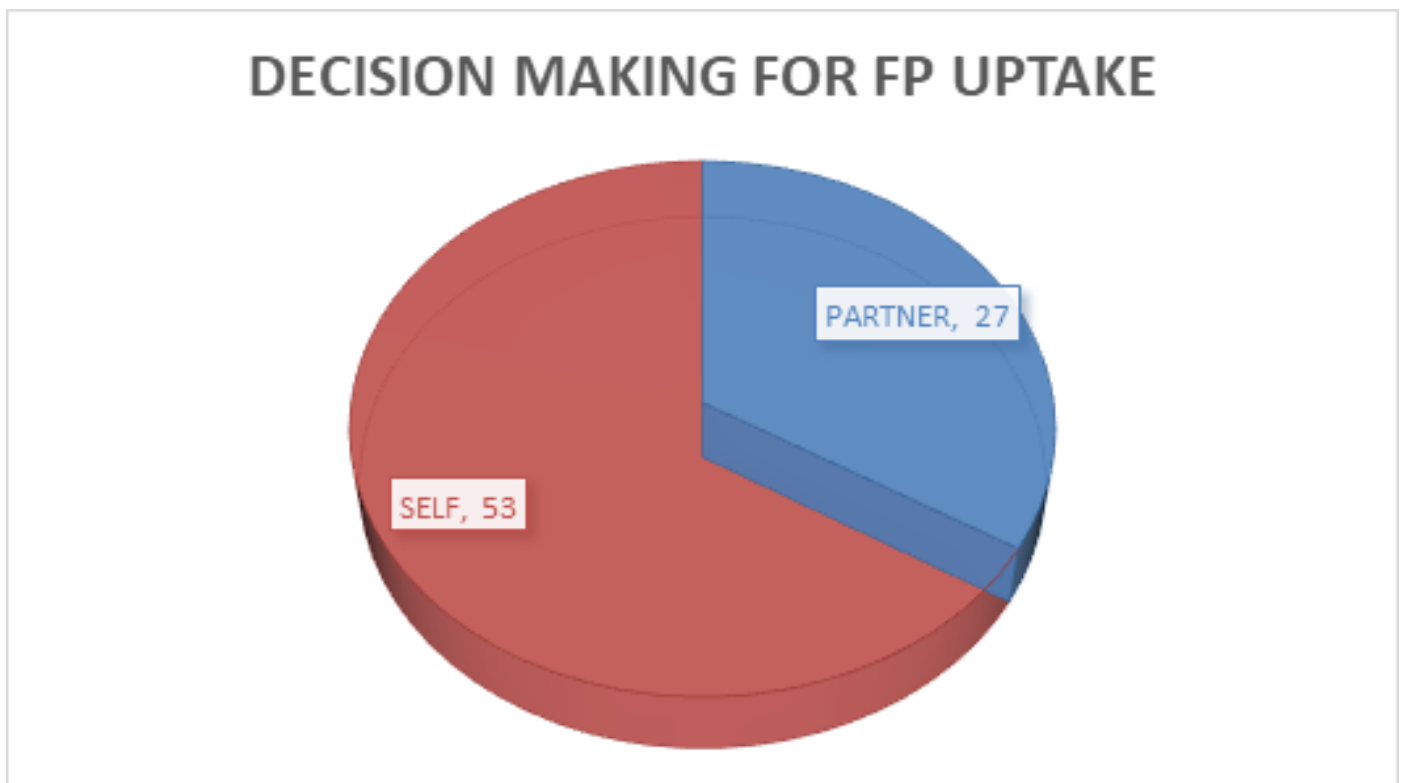


Figure 7: Distribution of respondents according to decision making for FP uptake.

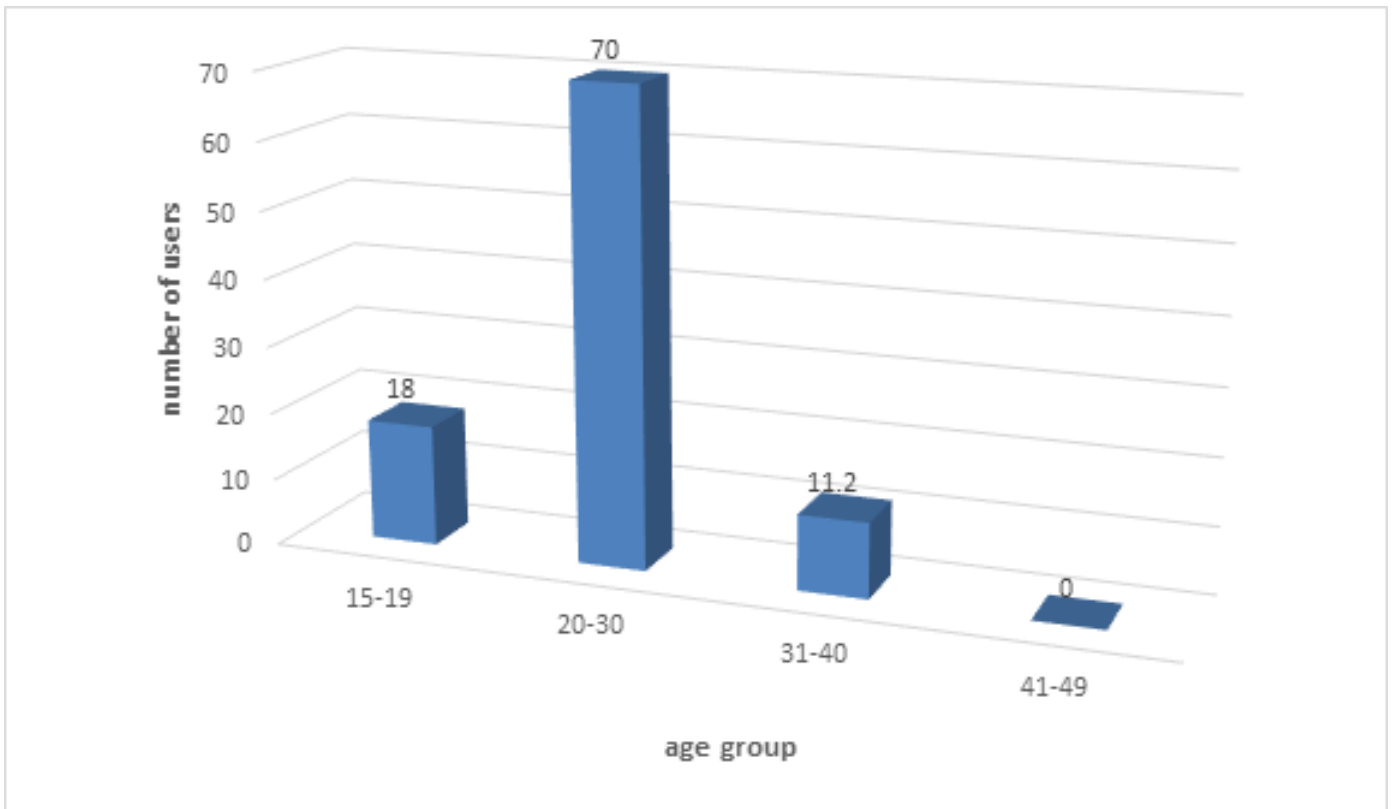


Figure 8: Distribution of respondents according to the age of first utilization of FP (n=80)

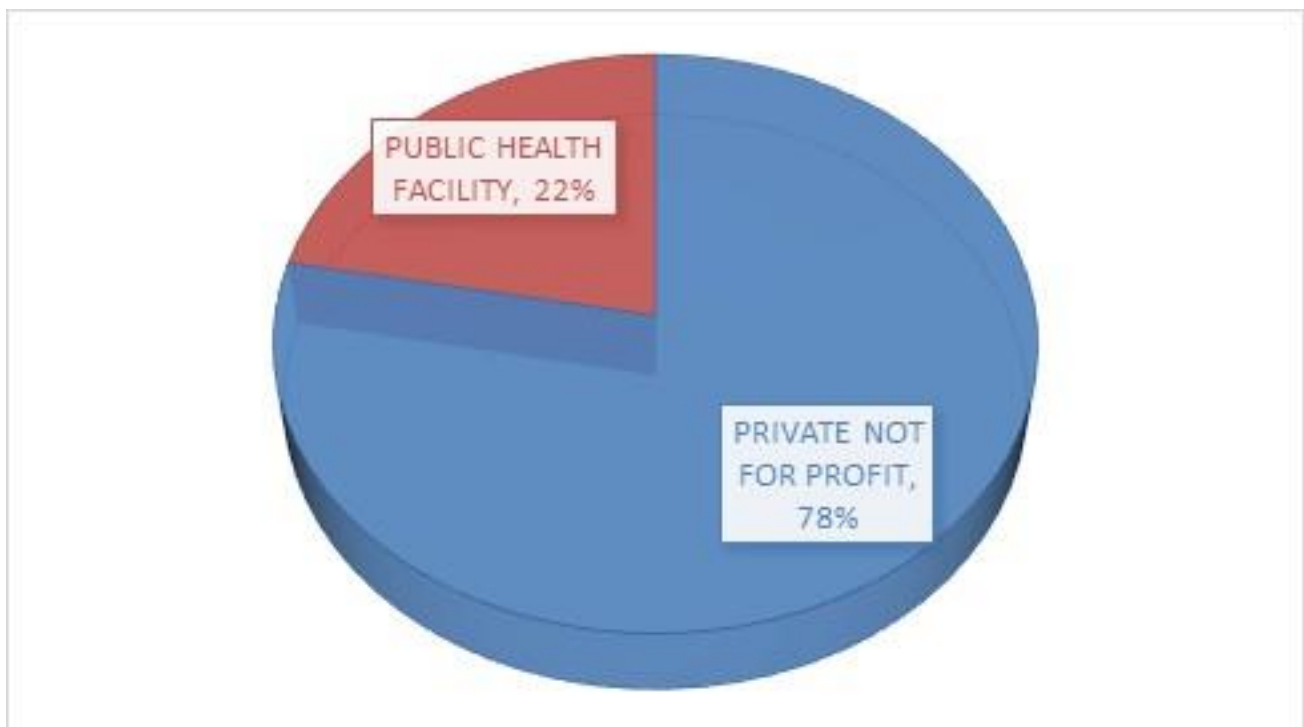


Figure 9: Distribution of health facilities near the respondents (n=80)

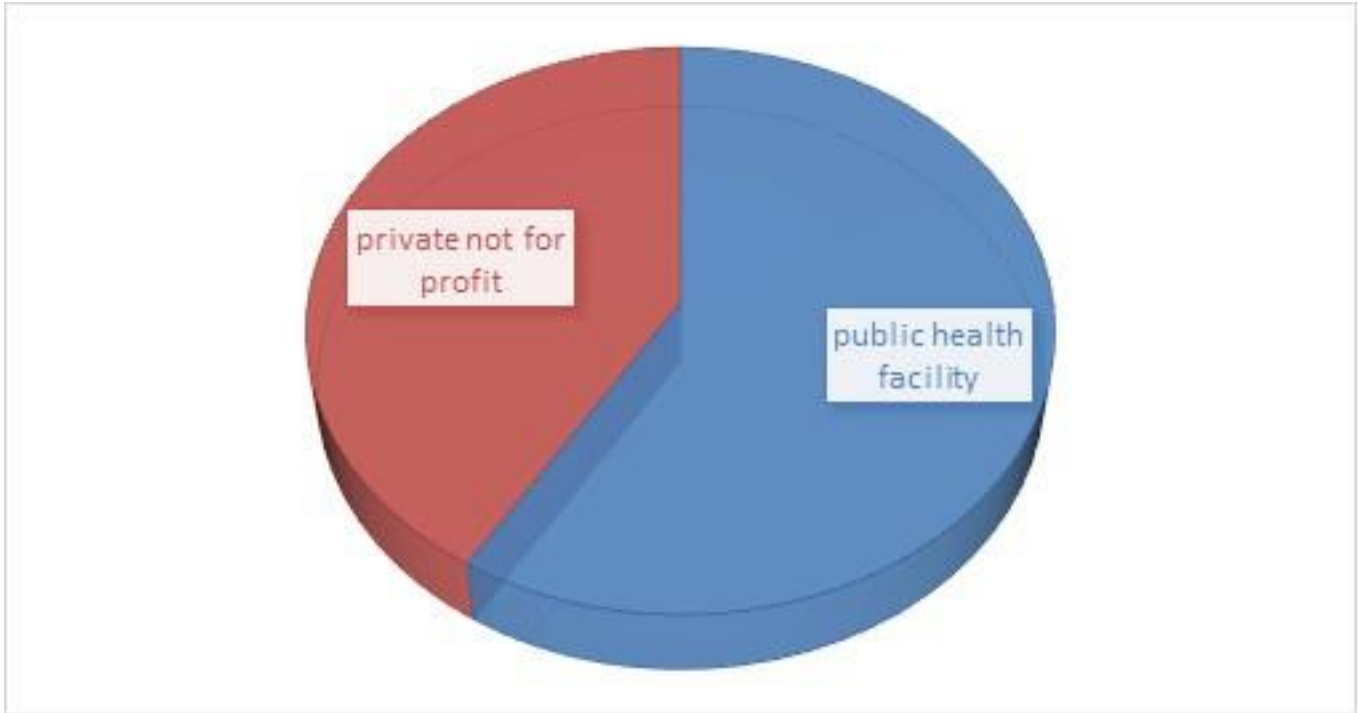


Figure 10: **Distribution of health facilities according to the preference of the respondents (n=80)**

Table 4: **Distribution table showing factors reported by clients influenced them to use a particular health facility. (n=80)**

PRIVATE NOT FOR PROFIT	PUBLIC HEALTH FACILITY
Good hygiene	cheap
Accessibility	accessible
Good attitude of health workers towards them	privacy
Good infrastructure	
Readily available services	

The least age group utilizing family planning services was 41 to 49 years 3 (3.75%), probably because the national population statistics showed that the women in that age group are fewer compared to those aged below 41 years. More so, there is a possibility that some of the women in the age group 41 to 49 years have hit menopause and do not need to use a family planning method.

In addition, the majority of the respondents at Marie-Stopes Centre, Kavule were Protestants 33 (41.25%). They reported that their religion could not allow them to use family planning because of God's law of procreation. They further explained that they had to use FP methods to control themselves from unplanned pregnancies especially at a

time like this when the country is experiencing an economic fluctuation.

Furthermore, the majority of the respondents were Baganda 45 (56.25%). This was probably because the study was held within the central region of Buganda Kingdom where Baganda people mostly reside whilst respondents from other tribes came probably because of tribal-inter-marriages and business relations.

Accordingly, the majority of the respondents were married and accounted for 45 (56.25%). Some of the married reported that they wanted to provide adequate parental love and proper care to their developing children, others reported that they were preventing themselves from the face of

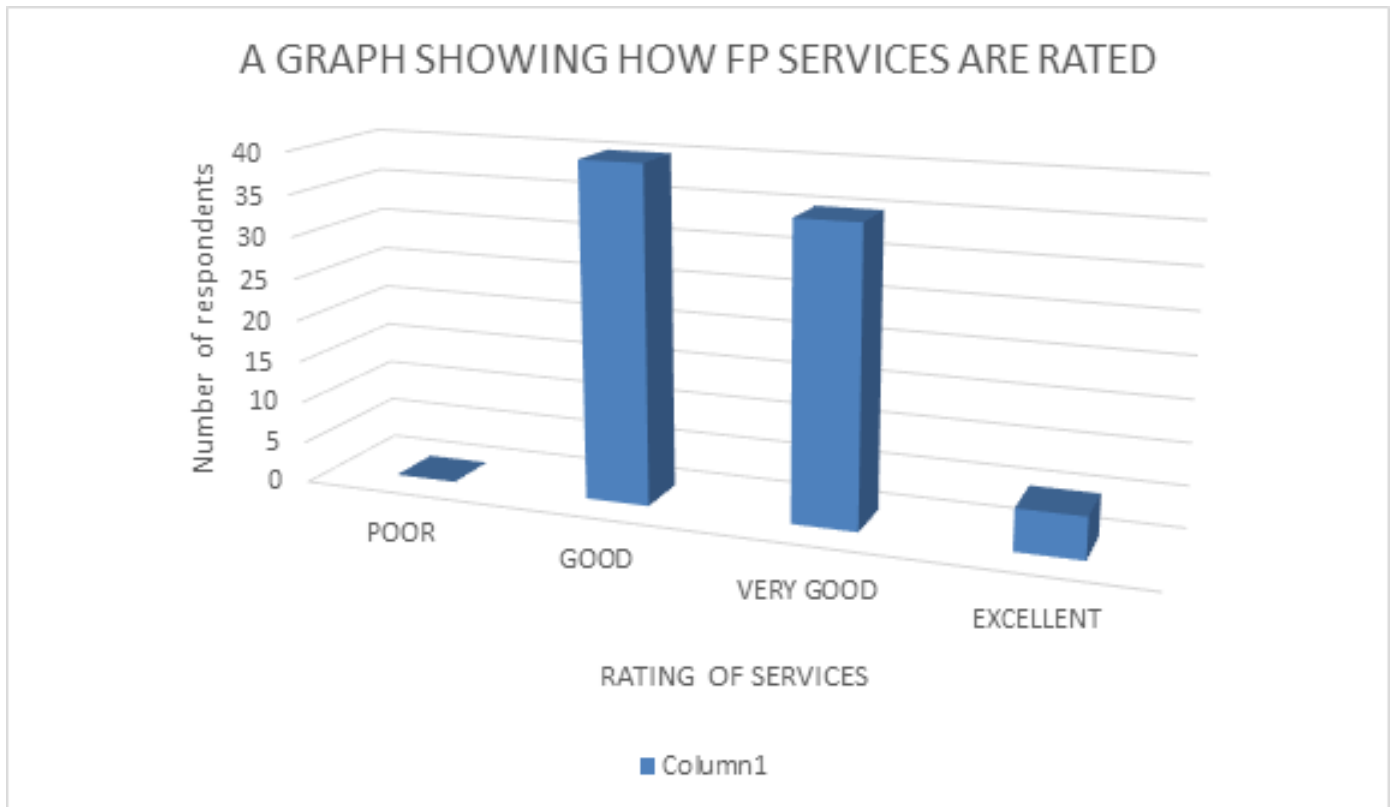


Figure 11: Distribution of respondents according to how family planning services are rated (n=80)

society in case they got pregnant since they were having long-distance marriages.

Considering the level of education, the majority of the respondents were graduates 36(45%). This showed that most females who engaged in the use of FP were educated, aware of, and had acquired adequate knowledge about the use of FP.

4.2. Socio-economic factors influencing the uptake of family planning services among females aged (15-49) years.

The study revealed that all 80(100%) of the people were using FP. This shows that there is a high met need for contraception to prevent unintended pregnancy. The study findings were about the study carried out by Metcalfe et al .2016 who noted that socioeconomic factors influenced both choice and use of contraception, the rate of unintended pregnancy, and the decision to continue or terminate an unintended pregnancy.

Furthermore, the study revealed that the majority 42(53%) of the respondents were employed. This possibly means that many employed females

live in a high socio-position status because they are earning, and therefore can afford FP methods cost levels thus a high met need for contraception. The study is in line with that of Dingeta,2018 in Ethiopia who noted that unmet need for contraception declined with women's social position marked by decision-making capacity.

In addition, 38 (47%) of the respondents were unemployed. This probably means that they had a low socio-position status since they were not earning. Due to a lack of money, they are most likely to have an unmet need for contraception.

The study finding is in line with that made by UNFPA, 2022, which noted that lack of money and access to appropriate information to enable women, to make informed choices were important barriers to contraceptive utilization among many adolescents. Therefore, there was a direct association of low contraceptive utilization with poverty.

The majority 72(90%) of the respondents reported that FP methods were expensive. This probably could lead to low contraceptive utilization, especially among unemployed females.

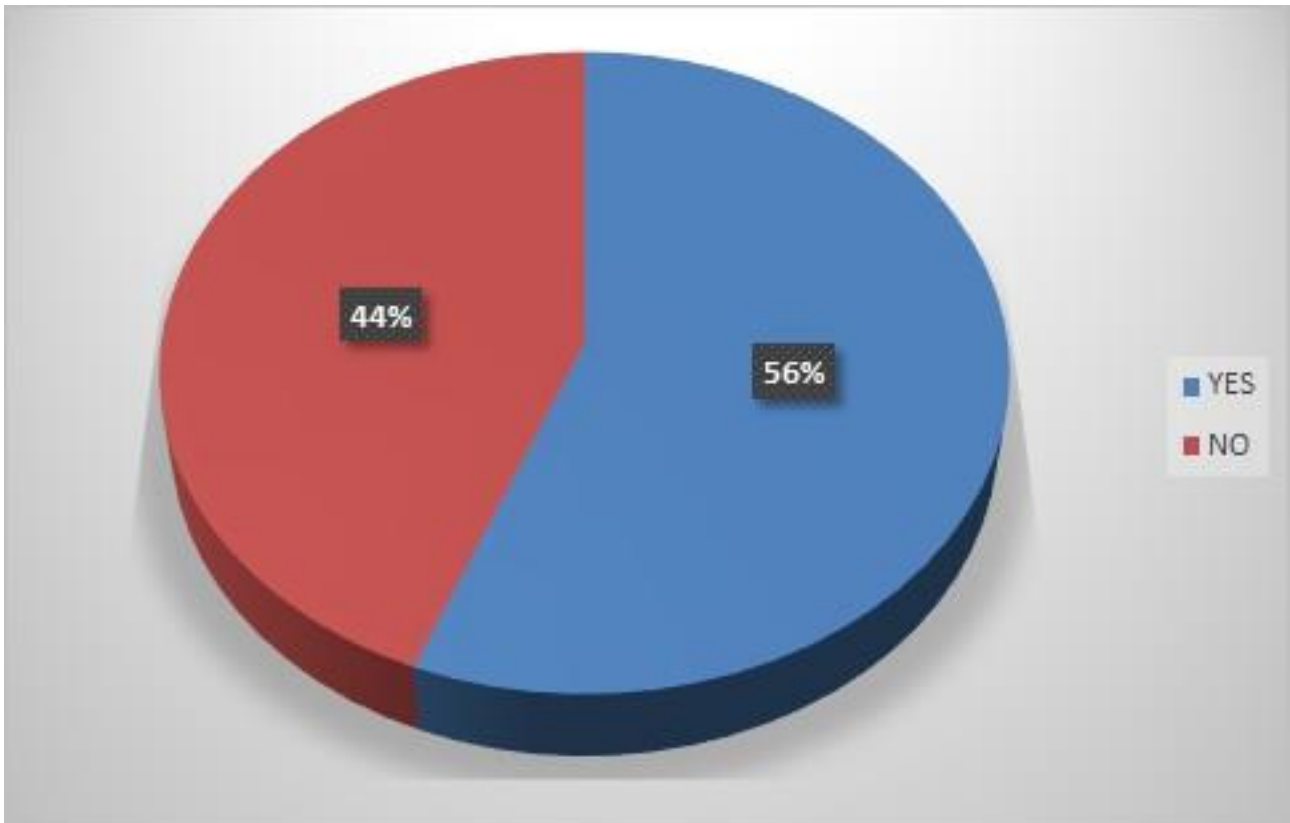


Figure 12: **Distribution of stock out of modern Family Planning methods at the public health facility near to the respondent.**

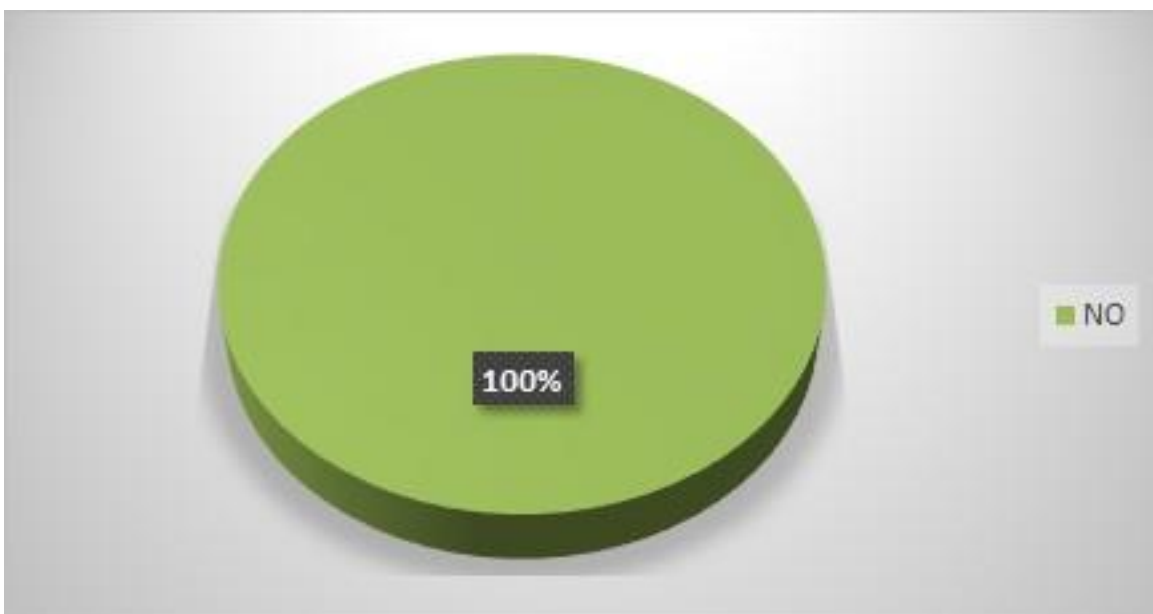


Figure 13: **Distribution of stock out of modern family planning methods at the private health facility.**

The study also revealed that the majority 36 (45%) of the respondents were graduates. This possibly means that the females who are utilizing family planning have attained knowledge and awareness about family planning methods. It also stresses the possible fact that education has enabled females to get employed therefore making them able to easily access and incur costs of FP at Marie-Stopes Centre, Kavule.

In conclusion to the socio-economic factors, the uptake of family planning at Marie-Stopes Centre Kavule is influenced by the high social position status, employment status, level of education attained, cost of family planning services, and the clients' need of taking on family planning services. Despite the influencing factors, there is a high met need for the uptake of family planning services.

Demographic factors influencing the uptake of family planning methods among women aged 15 to 49 years.

The study revealed that the majority 45 (56%) of the respondents were married. The married reported that they used family planning methods to enable child spacing in fear of economic fluctuations. The study findings are in support with the findings of Kassim, M 2022 who documented that women generally believed that having many children could impair their economies and make them fail to take care of their families.

The study revealed that the age at which most females first utilized FP was 20 to 30 years at a percentage of 56(70%). The age at which females first utilized FP is probably assumed that it is the age they first indulged in sexual intercourse. This, therefore, indicates the level of FP uptake over the years. However, there is no prior evidence to compare the study findings with the findings made by Otim J, 2022 in the Western region that stated that age at first marriage predicted contraceptive nonuse in only the Western region. This is because Otim, J correlated FP uptake with age at first marriage, whereas this study correlated FP uptake with age at first sexual intercourse.

The majority 53(66%) of the respondents reported that they decided for themselves whether to use family planning or not. This indicates that family planning decisions are taken on by females,

most probably because of domestic violence, and cultural beliefs. This could lead to a decreased uptake of FP as females are supposed to be submissive to men by nature therefore the opinion made by the man in a family weighs the most.

In conclusion of demographic factors, the uptake of family planning is influenced by marital status, the age of first sexual intercourse, partner involvement, and religion. Despite the above-elicited factors, there is still an unmet need for contraception as the results are inconclusive.

4.3. Health-related factors influencing the uptake of family planning methods among females aged 15-49 years.

The majority of the respondents 62(78%) reported that private not for profit were nearer to them compared to public health facilities. This indicates that the private not-for-profit is more accessible than the public health facility thus a high uptake of family planning services. These findings are in line with those of Fikru Tafese, 2019 who reported that client satisfaction was greater for private than publicly owned health facilities. It was also associated with the geographic location of health facilities. Therefore, the findings have evidenced that people can easily go to FP services if the health facilities are extended nearer to them, hence an increased uptake of FP.

The majority of the respondents 47(58.8%) preferred using public health facilities. This indicates that respondents are aware that public health facilities also provide these services, however, they also reported that they preferred public health facilities because they are cheap and less free though they had to always incur transport costs to these facilities hence limited access to family planning services. These study findings agree with those documented by Sserwanja, Denis ML et al, 2017 who noted that the poor are more likely to have limited access to modern contraceptives due to the out-of-pocket expenditures to purchase the contraceptives or transport expenditures to free public health facilities.

However, the respondents who preferred receiving FP from the public health facility, reported that services were cheap, accessible, and private.

Whereas those who preferred receiving FP from private not for profit, reported that there was good hygiene, they were accessible, good attitude of health workers towards them, good physical infrastructure, and readily available services. The study findings are in line with those by Birhanu B, 2019 in South West Ethiopia which noted that welcoming or greeting clients in the first contact at service delivery points enhances the interaction as it had emotional contents of exchange between provider and clients.

The majority of the respondents 45(56%) reported that they had ever had a stock out of family planning services at the public health facilities nearer to them. This probably indicates that at public health facilities, services are not readily available, therefore persons have to move to private health facilities to acquire FP services thus decreasing access and uptake of FP methods. The study is in line with the findings made by Fikru Tafese, 2019 who reported that the availability of resources including materials and skilled personnel affects the process of FP service delivery, which consequently predicts the service quality and utilization.

Furthermore, some respondents, 16(20%) reported that they were at times biased toward the young service providers. This indicates that clients are not satisfied with FP services among clients. This is probably because they assume that the young FP service providers are immature and inexperienced and so may not work on them properly as an older physician would. This however would bridge a gap of un-satisfaction and decrease in FP uptake. The findings of this study agree with the study findings of Fikru Tafese, 2019 which stated that clients were less satisfied with family planning services provided by young physicians than services provided by older physicians.

In conclusion to the health-related factors, the uptake of family planning methods is influenced by accessibility, the expense of the FP methods, the attitude of the service providers, readily available services, and the level of education and experience of the service providers.

5. Conclusion.

The study sought to determine the factors influencing the uptake of Family Planning services among females aged 15 to 49 years at Marie Stopes Centre, Kavule Kampala district. Factors influencing the uptake of family planning methods at Marie-Stopes Centre, Kavule are both positive and negative.

The factors include socio-economic factors, demographic factors, and health-related factors. Socio-economic factors namely. Employment status 42 (53%), cost of family planning services 72 (90%), level of education attained 36 (45%) in consideration of the reason for the clients' need of taking on family planning services and socio-position status.

Demographic factors namely marital status 45 (56.25%), the age of first sexual intercourse 56 (70%), and partner 53 (66%). Health-related factors namely accessibility 62 (78%), the expense of the FP methods, the attitude of the service providers, readily available services, and the level of education and experience of the service providers 16 (20%).

Given the above findings, there is a remarkable increase in the uptake of family planning at Marie Stopes Centre, Kavule in comparison to January to December. However, there is still an unmet need for contraception.

6. Study limitation.

Due to the time scope of the study, timeliness, and resource of the study, the following limitations impacted negatively the validity and reliability of the findings of the study.

Non-compliance by some of the respondents.

Data and records about family planning among females of reproductive ages were hard to access, though family planning is expected to capture data from parents' charts and files.

7. Recommendations.

The researcher recommends that Marie Stopes Centre, Kavule lessen the costs of family planning

services such that even the unemployed/poor easily meet their need of family planning.

The researcher recommends that Marie Stopes Centre, Kavule embarks on massive sensitization campaigns on the benefits of uptaking family planning services through outreaches inside and outside the university.

The researcher recommends that Marie Stopes Centre, Kavule mixes up service providers based on experience, age, and level of education during recruitment such that all ages of females who come for family planning services are satisfied and trust the services provided to them.

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9. Abbreviations/Acronyms.

AGYW Adolescent Girls and Young Woman
CHWs Community-Based Health Workers
DFPS Demand for Family Planning Services
DHMT District Health Management Team
DMPA Depot-Medroxyprogesterone Acetate
FGDs Family Group Discussions
FP Family Planning
LARC Long-acting reversible contraceptives

SAC Short Acting Contraceptives
SDG Sustainable Development Goals
UDHS Uganda Demographic and Health Services
VHTs Village Health Teams
WHO World Health Organization

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