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Factors Associated with the Utilisation of Family Planning Services among Women of Reproductive Age (15-49 Years) Attending Hoima Regional Referral Hospital

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ABSTRACT

Family planning is defined as the ability for individuals and couples to attain their desired number of children and plan the spacing and timing of their births through the use of contraceptive methods. Promoting family is one of the main targets to reach the SDGs, and timely achievement of family planning targets is expected to accelerate achievement across the 5 SDG themes of people, planet, prosperity, peace, and partnership. Despite the enormous benefits of family planning services, the uptake of the service remains low Uganda. This has resulted in high rates of unwanted pregnancies, unplanned deliveries, unsafe abortions, and maternal mortalities in Uganda. Several factors play an important role in the use of contraceptives among women of childbearing age. The identification of these factors is crucial to the planning and implementation of a suitable family planning programme. The study was designed to determine the factors associated with the utilisation of family planning among women of reproductive age (15–49) attending Hoima Regional Referral Hospital, Western Uganda. This was a hospital-based cross-sectional study. Quantitative and qualitative methods of data collection were utilised to collect data from 251 participants. From the results of the study majority, 182(72.5%) had never used family planning services and 68 (27.5%) had ever used family planning services. Therefore, the level of utilizing family planning services was found to be 27.5%. Thus, the level of utilisation of family planning services among women of reproductive age (15–49) attending Hoima Regional Referral Hospital, Western Uganda, was low, which is significantly associated with the education level and perceived skills of health workers. There is a need to promote and effectively implement policies in support of girls' education to increase FP service utilisation.

Keywords: Family Planning, Women, SDGs, Contraceptives, HIV/AIDS

INTRODUCTION

Family planning is defined as the ability for individuals and couples to attain their desired number of children and plan the spacing and timing of their births through the use of contraceptive methods [1]. Promoting family is one of the main targets to reach the SDGs, and timely achievement of family planning targets is expected to accelerate achievement across the 5 SDG themes of people, planet, prosperity, peace, and partnership [2]. Family planning can prevent unwanted pregnancies and unsafe abortions. Some family planning methods, such as condom usage, can protect individuals from sexually transmitted infections (STIs), including HIV/AIDS [3-5]. Family planning (FP) allows individuals and couples to achieve their desired number, spacing, and timing of births using contraceptive methods [3]. Globally, 63% of married or in-union women of childbearing age were using some form of contraception in 2017. The prevalence of contraceptives is 63%, and the unmet need for family planning is 11% [6]. However, contraceptive use was above 70% in Europe, Latin America, the Caribbean, and Northern America; below 25% in Middle and Western Africa [7]. In 2018, more than one-third of women in the United States who were not using a contraceptive method when they had an unintended pregnancy said it was because they did not think they could get pregnant [8]. The benefits of family planning have become increasingly recognised worldwide, including improved health, economic, and social outcomes for

women and families, as well as public health, economic, and environmental benefits at the population level. At the individual level, the health benefits for women and infants include the prevention of pregnancy-related health risks and deaths in women, reductions in infant mortality and the rate of unsafe abortions, the prevention of the transmission of HIV/AIDS from mother to child (PMTCT), and the prevention of sexual transmission of HIV and sexually transmitted infections (STI) between partners [9-11]. Enabling women to act on their pregnancy preferences has become a high priority on the global development agenda. Not long ago, strategies called for improving the unmet need for modern contraception, which arises when women want to avoid a pregnancy but are using no method or a traditional one. The most prominent of these initiatives is Family Planning 2020, a global partnership launched in 2012 that aims to add 120 million new users of modern contraceptives in the world's 69 poorest countries by 2020 [12]. In sub-Saharan Africa, population growth increases dramatically, which adversely affects the socio-economic development of the country. As a result, countries are forced to develop population policies to limit population growth [13]. Sub-Saharan Africa is known for its low literacy rate, poor access to information, poor health care, and other infrastructure services. All these factors have a strong correlation with the family planning programme [14]. Although efforts to control fertility in sub-Saharan Africa are being vigorously pursued, few results have been recorded. This could be attributed to the fact that the economy in the region continues to be agricultural-based, with most of the population being predominantly rural [15]. Modern contraceptive use has steadily increased over the past 15 years in Ethiopia. The contraceptive level rate in 2000 was only 6.3%, which accelerated to 35% in 2016. However, the utilisation of long-acting family planning methods (LAFPM) is still low compared to injectable contraceptives [16]. As of the year 2015, in South Sudan, however, only 6.8% of women of reproductive age use family planning, 2.5% are using modern methods of family planning, and 4.1% are using traditional methods of family planning [2]. The coverage of contraceptives in eastern Africa stands at 40% and is expected to grow to 55% by 2030 [2]. In Kenya, the national contraceptive level rate has stagnated at 39%, and many women have limited access to FP during the immediate postpartum period [17]. Uganda's total fertility rate (TFR) of 6.2 has resulted in a population growth rate of 3.2%, the fastest in Africa and the third highest in the world. The contraceptive level rate (CPR) among married women, which has recently improved from 24% to 30% [18], is still unfortunately low. Uganda also has a high unmet need for FP services of 41% [19]. Since rates of contraception use have an inverse relationship with fertility rates, greater utilization of modern family planning (FP) methods decreases the rate of maternal morbidity and mortality. Conversely, insufficient uptake of FP contributes to morbidity and mortality in women and girls of reproductive age. Higher parity increases the probability that pregnancy will be the cause of death, as well as the risk of complications such as haemorrhage, foetal malposition, and multiple gestations [20]. Uganda's maternal mortality rate (MMR) has consistently been one of the highest in the world, with 440 deaths per 100,000 live births, according to UNICEF's latest data. In Uganda, one woman out of every 49 will die of a maternal complication related to pregnancy or delivery. Despite the enormous benefits of family planning services, the uptake of the service remains low in Sub-Saharan Africa [3]. This has resulted in high rates of unwanted pregnancies, unplanned deliveries, unsafe abortions, and maternal mortalities in sub-Saharan Africa, of which Uganda is no exception. Family planning (FP) could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space birth, avoid unintended pregnancies and abortions, and stop childbearing when they reach their desired family size [17]. Nonetheless, the low percentage of individuals using family planning services suggests that either some women are not planning their pregnancies deliberately or they are experiencing problems accessing this type of service. Despite women's increased awareness and knowledge and the obvious unmet need for FP, there exist economic, cultural, cognitive, and administrative barriers to FP service utilisation. Several factors play an important role in the use of contraceptives among women of childbearing age. The identification of these factors is crucial to the planning and implementation of a suitable family planning programme. The study was designed to determine the factors associated with the utilisation of family planning among women of reproductive age (15–49) attending Hoima Regional Referral Hospital, Western Uganda.

METHODOLOGY

Study Design

This was a hospital-based cross-sectional study. Quantitative and qualitative methods of data collection were utilised to collect data that was used to describe the study population and establish associations between the dependent variable,

intervening variables, and the independent variables. The principal investigator used a cross-sectional study research design because the method enables the data collection from a relatively large number of different categories of respondents at a particular time, with the exposure and outcome being measured at the same time, and there is no need to follow up with the study participants.

Area of Study

The study was conducted at Hoima Regional Referral Hospital, which is located in Hoima district. Hoima District is bordered by Bulisa District to the north, Masindi District to the northeast, Kyankwanzi District to the east, Kibaale District to the south, Ntoroko District to the southwest, and the Democratic Republic of the Congo across Lake Albert to the west. Hoima, the location of the district headquarters, is approximately 230 kilometres (140 mi) by road, northwest of Kampala, the capital of Uganda and the largest city in that country. The coordinates of the district are: 01 24N, 31 18E. With an annual population growth rate of 2.8%. In 2012, the mid-year district population was estimated at 548,800. The major economic activity is fishing on Lake Albert, which employs several hundred people. The recent discovery of petroleum in the district is increasingly attracting people from the district to the many activities that the industry entails.

Study population

All the women of reproductive age (15–49) are attending the Hoima regional referral hospital.

Target population

The study targeted women of reproductive age (15–49) living in Hoima district and areas neighbouring Hoima Regional Referral Hospital.

Sampling Technique

For the proposed study, the techniques selected were based on probability sampling. The main method that was employed in selecting samples from the population was the systemic sampling technique.

Systemic Sampling

Systematic sampling is a type of probability sampling method in which members of a larger population are selected according to a random starting point but with a fixed, periodic interval. This interval called the sampling interval, is calculated by dividing the population size by the desired sample size. The chief advantage of this method is that it gives results like those of simple random sampling, and it is easy to do.

Sample size determination

The sample size was determined using Fishers *et al.'s* [21] formula. The formula was used to estimate the smallest possible sample size for the study.

$$n = \frac{z^2pq}{d^2}$$

Where

n = minimum sample size

d = margin of error

z=standard normal deviation, corresponding to 1.96

p = level, 20.6% from a study conducted among women of reproductive age in rural Kenya ([22]).

q=1-p

Therefore, taking

p = 20.6/100 = 0.206

z = 1.96

q = 1 minus 0.206 = 0.794

d = 5% or 0.05

$$n = \frac{1.96^2 X 0.206 X 0.794}{0.05^2}$$

= 251

Therefore, data from 251 participants was used in the study.

Inclusion criteria

All women aged 15 to 49 who attended Hoima Regional Referral Hospital during the study period and who consented to take part in the study were included.

Exclusion criteria

i. Women who were below 15 years of age or above 49 years of age.
ii. Women who were not willing to answer questions about family planning.
iii. Women who were severely ill and unable to answer the questions.

Independent variables

The various factors influencing the utilisation of family planning services among married women (15–49 years old) were the independent variables.

Dependent Variables

Utilisation of family planning services among women of reproductive age (15–49 years) was the dependent variable.

Study procedure

The principal investigator and research assistants moved from ward to ward and clinic to clinic to identify women of reproductive age (15–49). Participation in the study was proposed to all the women of reproductive age (15–49) who were attending Hoima Regional Referral Hospital. Participants were informed about the purpose of the study. Participants who finally signed a consent form were enrolled. Participants were interviewed by a trained investigator for about 15 to 25 minutes. Interviews were conducted in English or the local language at the convenience of the participant and the investigator. After consent from eligible women, a face-to-face interview using a pre-tested, pre-coded structured questionnaire was conducted by the principal investigator and the research assistants in the clinics or in the wards on respective days during the study period. Every woman of reproductive age

(15–49) was requested to participate only once during the entire four months of data collection.

Data Collection Instruments

This provided a guide for the researcher to collect adequate data that helps in answering the research questions to achieve the study objectives. A data collection instrument is a tool that is used in data collection, such as a questionnaire. In this study, a questionnaire was the data collection instrument that was used. A questionnaire is the best instrument because it gives the respondents time to fill it out without being intimidated by the researcher's presence. The questionnaire was designed according to information obtained from the literature review. The questions in the questionnaire were closed-ended questions for ticking yes or no, and some questions had multiple choices that required the participants to choose the correct answer. For women of reproductive age who were unable to read and write, the research assistants who were conversant with the local language were the ones to fill out the questionnaires after getting responses from such women. Using the questionnaire, data regarding the utilization of family planning services, socio-demographic variables, and health facility variables were collected.

Validity of Instruments

The data collection instruments were first examined by colleagues conducting a similar study as the researchers. They were then scrutinised by the supervisor to ensure that the terms used in the questionnaire and interview were precisely defined and properly understood. The content validity index was calculated based on judgment by at least two experts in the field of study. When the result was 0.7 or above, the instrument was deemed valid for use.

Reliability of the Data Collection Tool

Before data collection, a pretest of the questionnaire was employed among 5% of the study sample in a nearby health facility. During the pretest, the sequence of the question and time of data collection were taken accordingly. Data obtained from a predetermined questionnaire were used to determine the Cronbach's alpha. An index of more than 0.8 was considered to indicate that the items in the questionnaire are reproducible and consistent.

Quality assurance and quality control

The data compilation system and data completeness were checked and strictly controlled by the principal investigator and supervisors. A test was conducted on 5% of the sample. Based on the pre-test, modifications were made to the questionnaire. Data collected from the pretest was not included in the final data analysis. Double data entry and random checking will be done to ensure the validity of the study. Data was collected by using paper questionnaires and was safely stored in lockable file cabinets to prevent unauthorised persons from accessing the filled questionnaires and to avoid alteration of information captured in the questionnaires.

Data Management

The principal investigator reviewed all the data collected on a particular day before data entry into the research database and upon entry before analysis. The data collection and entry process was designed in such a way that all data collection sheets completed in a day were reviewed and entered on the same day. Editing involved checking the questionnaire. Incomplete and improperly filled questionnaires were sorted. Completely filled-out questionnaires were kept in the cupboard for safety and confidentiality and later taken for analysis. Coding: All questions in questionnaires were coded for easy analysis and also further helped to reduce the data into manageable proportions.

Data analysis

Data was entered on the computer using Microsoft Excel, and statistical analysis was done using STATA version 14.0. Descriptive statistics were analysed in terms of frequency and percentage with a 95% confidence interval, and information was summarised in the form of tables, pie charts, and narrations. Continuous variables were described in the median (inter-quartile range, IQR), and categorical variables were described in percentages. Continuous variables were compared using the Mann-Whitney test, and categorical variables were compared using the Chi-square test or Fischer's exact test as appropriate. The dependent variable was the utilisation of family planning services by women of reproductive age (15–49). Univariate associations between various factors and utilisation of family planning services adjusting for the woman's age were identified, and multiple logistic regression was used to construct the model to examine the independent association of various factors with utilisation of family planning services while simultaneously controlling for potential confounders. The statistical tests that were used were binary logistic regression, and the level of significance was set at $p < 0.05$. The odds ratio (OR) and 95% confidence interval (CI) were calculated as a measurement of the association between an independent variable and the outcome. All variables associated with the utilization of family planning services in the univariate analysis were included in the initial multivariate model. Variables were excluded from the final logistic model if they were not associated with the dependent variable and if their removal from the model did not materially affect the association of other variables in the model.

RESULTS

Socio-demographic data

Table 1: Socio-demographic findings

Variable	Frequency (n)	Percent (%)
Age		
<24 years	**110**	**43.8**
25-34 years	107	42.6
≥ 35 years	34	13.6
Marital status		
Married	**106**	**42.3**
Single	64	25.4
Widow	51	20.4
Divorced	30	11.9
Level of education		
Primary	46	18.3
Secondary	**108**	**43.1**
Tertiary	49	19.5
Uneducated	48	19.1
Place of residence		
Rural	**166**	**66.1**
Urban	85	33.9
Religion		
Catholic	**72**	**28.7**
Pentecostal	50	19.9
Anglican	68	27.1
Muslim	61	24.3
Income		
100,000 +	37	14.9
<100,000	213	**85.1**
Number of children		
≤5	156	**62.3**
6+	95	37.7
Type of marriage		
Monogamy	**231**	**92.0**
Polygamy	20	8.0
Decision making		
Husband	158	**62.8**
Wife	34	13.5
Both	59	23.7

Table 1 shows that the majority (110, 43.8%) were aged less than 24 years, the majority (106, 42.3%) of the participants were married, many (108, 43.1%) were of secondary level of education, those who lived in rural areas were 166 (66.1%), and 72 (28.7%) were Catholics by religion. Many 85.10% (213/251) had a monthly income of less than $100,000, and the majority (231/92%) were from monogamous families. The majority of participants (62.30%; 156/251) had a family size of 5 or fewer members, with the husband being the one with authority for decision-making in the family (62.8%) (158/251).

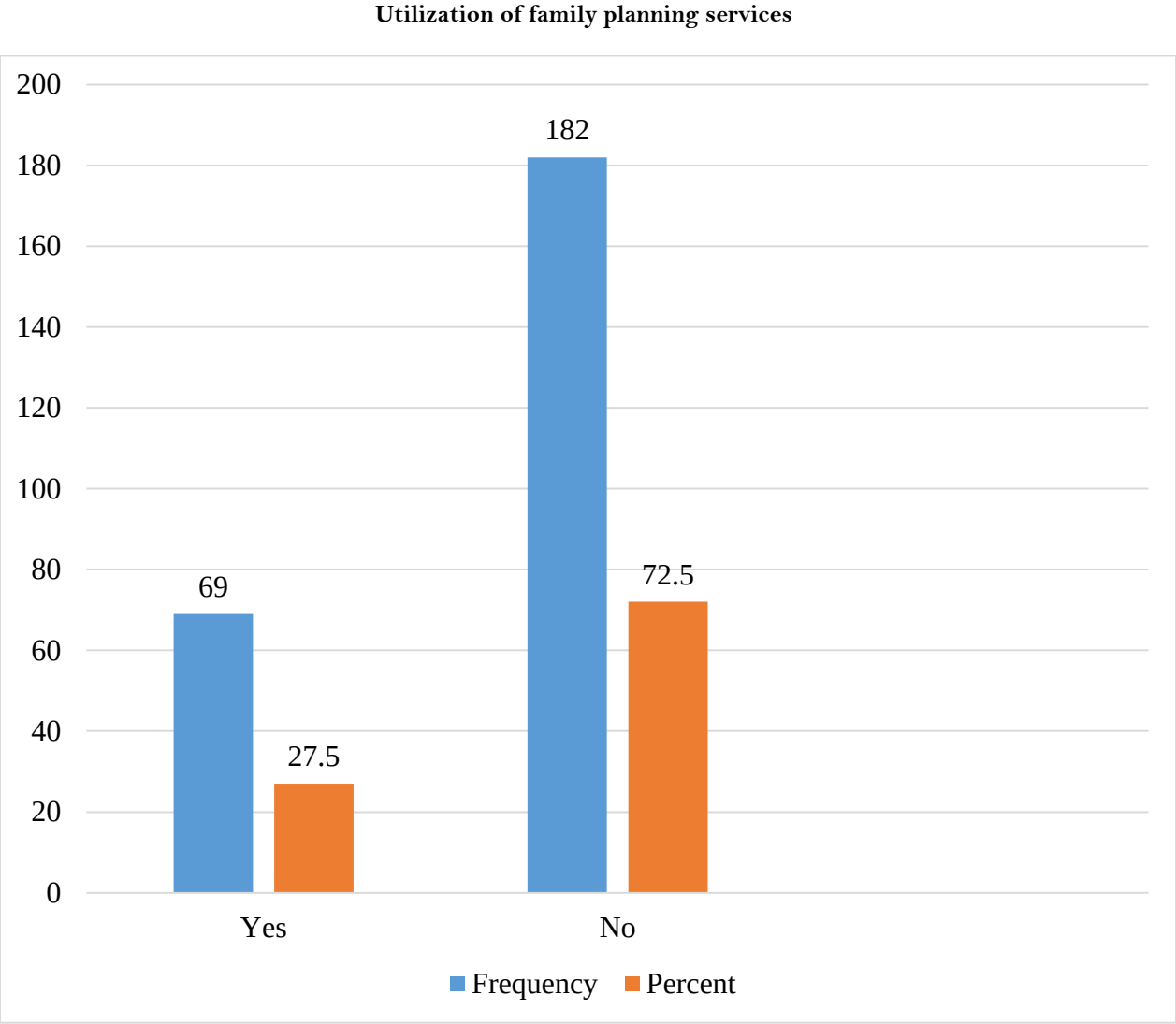

Figure 1: Shows Utilization of family planning services

From the above majority, 182(72.5%) had never used family planning services and 68 (27.5%) had ever used family planning services. Therefore, the level of utilizing family planning services was found to be 27.5%.

Socio-demographic factors influencing utilization of antenatal care services in Jinja Regional Referral Hospital.

Table 2: bivariate logistic regression of socio-demographic factors associated with utilization of family planning services among women of reproductive age (15-49) attending HRRH.

Variables	e you ever used FP		RR	95% CI	P-Value
	Yes				
Age					
<24 years	27	83	Reference		
25-34 years	27	80	1.0	0.32-3.23	0.969
≥ 35 years	15	19	1.7	0.40-7.24	0.478
Residence					
Urban	7	78	Reference		
Rural	62	104	1.8	0.23-14.49	0.572
Religion					
Christians	38	152	Reference		
Muslims	31	30	1.1	0.36-3.62	0.829
Marital status					
Married/Cohabiting	55	90	Reference		
Single/divorced/widow	14	92	0.5	0.07-4.38	0.572
Education					
Secondary +	22	72	Reference		
<Secondary	**47**	**110**	***3.5***	**0.97-12.95**	***0.055***
Family type					
Polygamy	4	16	Reference		
Monogamy	65	166	1.5	0.18-11.80	0.717
Income					
100,000 +	12	25	Reference		
<100,000	57	156	2.6	0.33-20.24	0.371
Number of children					
≤5	40	126	Reference		
6+	29	66	0.8	0.29-2.48	0.719
Decision making					
Husband	44	114	Reference		
Wife	12	22	1.3	0.34-4.99	0.702
Both	13	46	0.2	0.03-1.79	0.259

P value = significant value, cRR= Crude Relative Risk, CI Confidence interval.

Shown in Table 2 above is the result of the bivariate logistic regression which was run to determine socio-demographics associated with utilization of family planning services among women of reproductive age (15-49) attending Hoima Regional Referral Hospital, Western Uganda. Results of the analysis revealed that education had p-values less than 0.2. Thus, education proceeded to the next stage (multivariate stage)

Health facility factors associated with utilization of family planning services among women of reproductive age (15-49) attending Hoima Regional Referral Hospital, Western Uganda.

Table 3: Bivariate logistic regression to establish health facility factors associated with utilization of family planning services among women of reproductive age (15-49) attending HRRH

Variables	Have you ever used FP		cRR	95% CI	P-Value
	Yes				
Time spent waiting for FP services					
< 1 hours	51	133	Reference		
≥ 1 hour	**18**	**49**	**0.5**	**0.10-2.17**	**0.137**
Distance to the nearby health facility					
<5 km	33	50	Reference		
≥ 5 km	**36**	**132**	**0.4**	**0.13-1.11**	**0.078**
Knowing where to find FP services					
Yes	43	121	Reference		
No	26	61	1.9	0.66-5.74	0.277
FP services are always available					
Yes	25	79	Reference		
No and don't know	44	103	0.8	0.25-2.70	0.746
Attitude of health workers					
Good, welcoming and friendly	45	165	Reference		
Bad, harsh, and rude	24	17	18.4	5.12-66.04	0.218
Perceived skills of health workers					
Qualified or experienced	38	153	Reference		
Unqualified or inexperienced	**31**	**29**	**2.1**	**0.64-7.19**	**0.001**

P value = significant value, cRR= Crude Relative Risk, CI Confidence interval.

Shown in Table 2 above is the result of the bivariate logistic regression which was run to determine socio-demographics associated with the utilization of family planning services among women of reproductive age (15-49) attending Hoima Regional Referral Hospital, Western Uganda. Results of the analysis revealed that education had p-values less than 0.2. Thus, education proceeded to the next stage (multivariate stage).

Health facility factors associated with utilization of family planning services among women of reproductive age (15-49) attending Hoima Regional Referral Hospital, Western Uganda

Table 4: Bivariate logistic regression to establish health facility factors associated with utilization of family planning services among women of reproductive age (15-49) attending HRRH

Variables	Have you ever used FP		CRR	95% CI	P-Value
	Yes				
Time spent waiting for FP services					
< 1 hours	51	133	Reference		
≥ 1 hour	**18**	**49**	**0.5**	**0.10-2.17**	**0.137**
Distance to the nearby health facility					
<5 km	33	50	Reference		
≥ 5 km	**36**	**132**	**0.4**	**0.13-1.11**	**0.078**
Knowing where to find FP services					
Yes	43	121	Reference		
No	26	61	1.9	0.66-5.74	0.277
FP services are always available					
Yes	25	79	Reference		
No and don't know	44	103	0.8	0.25-2.70	0.746
Attitude of health workers					
Good, welcoming and friendly	45	165	Reference		
Bad, harsh, and rude	24	17	18.4	5.12-66.04	0.218
Perceived skills of health workers					
Qualified or experienced	38	153	Reference		
Unqualified or inexperienced	**31**	**29**	**2.1**	**0.64-7.19**	**0.001**

P value = significant value, cRR= Crude Relative Risk, CI= Confidence interval

Shown in Table 4 above is the result of a bivariate logistic regression done to health facility factors associated with the utilization of family planning services among study participants. It can be observed from Table 4 that distance to the nearby health facility, attitude of health workers, and perceived skills of health workers had p-values less than 0.2. Thus, were proceeded for the multivariate stage.

Multivariate logistic regression to factors associated with utilization of family planning services among women of reproductive age (15-49) attending HRRH

Table 5: Multivariate logistic regression to establish factors associated with utilization of family planning services among women of reproductive age (15-49) attending HRRH

Variables	aRR	95% CI	P-Value
Education			
Secondary +	Reference		
<Secondary	**4.4**	**1.25-15.35**	**0.021**
Time spent waiting for FP services			
< 1 hours	Reference		
≥ 1 hour	6.5	0.71-59.67	0.097
Distance to the nearby health facility			
<5 km	Reference		
≥5 km	0.4	0.09-1.40	0.065
Perceived skills of health workers			
Qualified or experienced	Reference		
Unqualified or inexperienced	**5.3**	**2.58-49.46**	**0.001**

P value = significant value, aRR= Adjusted Relative Risk, CI= Confidence interval.

Table 5 shows a multivariate logistic regression analysis of factors associated with the utilisation of family planning services among women of reproductive age (15–49) attending HRRH. Factors with a p-value less than 0.2 with the use of FP services in bivariate logistic regression analysis were considered for multivariate analysis. It was found that participants with a lower secondary level of education increased the odds of not using FP by 4.4 (aRR 4.4, 95% CI 1.25–15.35, P = 0.02). On the other hand, study participants who considered the skills of health workers as unqualified or inexperienced were 5.3 times more likely not to use FP services than participants who considered the skills of health workers as qualified or experienced (aRR 5.3, 95%CI 2.58–49.46, P = 0.001).

DISCUSSION

Level of utilisation of family planning services among women of reproductive age (15–49)

In this study, the level of utilisation of family planning services was found to be 27.5%. This is consistent with the results of a cross-sectional study done by Tesfa and Gedamu [13] among women of reproductive age (15–49) attending Bahir Dar health facilities, which found that 26.4% of participants were utilising family planning methods. It was also consistent with 28% of Kaduna, Nigeria, respondents who used contraception, according to a cross-sectional study done by Ayodeji et al. [23]. The reason for consistency could be due to similar study designs. The study finding is high: 12.3% of respondents used contraceptives in a study done in Kebribeyah town, Somali region, Eastern Ethiopia [24]. It was also higher; 18% of respondents had used family planning services, according to a descriptive cross-sectional study conducted in Talensi district in the Upper East Region of Ghana by Apanga and Adam [3]. This higher level might be due to the accessibility of health facilities, increased awareness of the community due to health extension workers, and the study design. However, it was low when compared to the 39% of respondents who used contraception in Lagos, Nigeria [23]. Another study conducted to determine the factors influencing family planning method use among women of reproductive age in urban communities in Imo State, Nigeria, found the level of ever use and current use of family planning was 54.1% and 35.1%, respectively [25].

Socio-demographic factors

In this study, only education level was significantly associated with the use of FP services, and it was established that less than a secondary level of education increased the odds of not using FP by 4.4. In addition, a study done to establish factors influencing the uptake of family planning services in the Talensi District, Ghana, revealed that the educational level of respondents was positively associated with the usage of family planning services (P<0.05) [3]. Another study conducted in two cities

in Nigeria revealed that the age of respondents was significantly associated with contraceptive use, with a p-value less than 0.05 both in Kaduna and Lagos ($\chi 2 = 89.0$, $p<0.001$) in Kaduna and ($\chi 2 = 13.1$, $p<0.05$) in Lagos. Respondents' educational level also has a significant relationship with contraceptive use [23]. Therefore, having illiterate women or having women who have attained little formal school education increases the odds of not using FP services.

Health facility factors associated with utilisation of family planning services among women of reproductive age (15–49)

In this study, only perceived skills of health workers were significantly associated with the use of FP services, and it was established that participants who considered skills of health workers as unqualified or inexperienced were 5.3 times more likely not to use FP services than participants who considered skills of health workers as qualified or experienced. This is consistent with the results of a study done by Zimmerman et al. [26] which showed that nomadic health practices and healthcare services are the main influencing factors affecting the utilisation of maternal healthcare services. A study done by Ontiri et al. [22] in rural Kenya also showed that a lack of adequate skills in the provision of services was identified as a key barrier to the uptake of contraception services among women of reproductive age. Thus, the perceived skills of health workers have a great impact on the use of FP services, and experience, together with the qualifications of health workers, leads to trust in health care or FP services, which in turn increases the use of FP services.

CONCLUSION

The level of utilisation of family planning services among women of reproductive age (15–49) attending Hoima Regional Referral Hospital, Western Uganda, was low, which is significantly associated with the education level and perceived skills of health workers.

Recommendation

- Informal channels such as seminars and media platforms should be expanded to influence and motivate women about their reproductive rights and choices.
- There is a need to promote and effectively implement policies in support of girls education to increase FP service utilisation.
- There is a need for health workers to review the representation and image they show patients that reflect their experience and qualifications. If necessary, they go for further studies, seminars, and short courses.
- More research related to the study topic should be done.

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