

Factors Influencing the Utilisation of Family Planning Services among Post-Partum Women at Kitagata General Hospital in Sheema District Uganda

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ABSTRACT

This study looks into the variables that affect postpartum women at Kitagata General Hospital in Sheema District, Uganda, using family planning services. For the sake of both mother and child health, postpartum women must use family planning services, but little is known about the factors influencing this group's adoption of these services. To collect thorough data, a mixed-methods approach was used, including quantitative surveys and qualitative interviews. Structured surveys were given to a sample of postpartum women who were patients at Kitagata General Hospital as part of the quantitative phase. Qualitative interviews were carried out with healthcare practitioners to obtain an understanding of the obstacles and enablers related to the provision of family planning services. The results show that a wide range of factors, such as sociocultural attitudes, service accessibility, knowledge, and perceptions of family planning methods, influence postpartum women's use of family planning services. Designing focused interventions to increase postpartum women's use of family planning services and enhance mother and child health outcomes in Uganda's Sheema District requires an understanding of these aspects.

Keywords: Family Planning, Maternal mortality, Women, Postpartum

INTRODUCTION

Maternal mortality remains a significant public health concern in Uganda [1, 2]. It is estimated that if all women in need of contraceptives in Uganda were using them, the number of maternal deaths would be reduced by 40% [3]. Family planning is very important to the control of population growth, reducing pressure on the environment, and economic development [3, 4]. Moreover, population control is among the most effective measures for protecting the environment. If, through female education, women's rights, maternal-child health, and family planning, the United Nations' low population projection existed in the year 2050 as opposed to the medium projection (2.2 billion higher), 4.4 million square kilometres of land would be saved and there would be 9.3 billion tonnes less in carbon dioxide emissions per year [5]. However, contraceptive use in Uganda is low, and the unmet need for family planning is among the highest in the world [6]. The unmet need for family planning refers to women capable of reproducing who are not using contraception but wish to postpone their next birth for 2 or more years or to stop childbearing together [7]. According to the 2012 Demographic and Health Survey (DHS) data, among currently married rural women, 37% have an unmet need for family planning, and only 27% report currently using effective contraceptives [8]. Furthermore, 44% of pregnancies are unplanned [9], and the spacing between pregnancies is poor, which is associated with an increased risk of infant mortality, childhood malnutrition, and complications during pregnancy [10]. One important step in addressing the unmet need for family planning in Uganda is to explore factors that influence women wanting to delay their next pregnancy to use contraceptives. Prior research in developing countries has identified an array of multi-level determinants of contraceptive uptake. Examples of determinants identified at the individual level include age, education, income, relationship status, and religion [11], and psychosocial factors encompassed by theories of behaviour change, such as one's knowledge of contraceptive methods [12], beliefs towards contraceptive efficacy and safety [11, 13, 13] and self-efficacy towards contraceptive use [14]. At the interpersonal level, evidence from some studies supports the influence of the male partner on women's reproductive health and decision-making, especially in resource-limited settings. Gender norms and unequal power in relationships may manifest in several ways that influence a woman's ability to use contraceptives, such as gendered sexual decision-making [15], norms prohibiting communication about sexual health [16], and intimate partner violence [12]. Additionally, there is increasing support for the importance of contextual determinants of family planning in resource-limited settings [17]. Health system factors associated with access to care include access to trained staff, follow-up care, cost, and the environment of health facilities (e.g., wait time, and space) [18]. While a sizable body of research exists on determinants of family planning uptake among the general

population, little is known about what factors influence women's use of contraception postpartum [7]. The postpartum period is considered an ideal time to deliver family planning as women more regularly visit healthcare facilities during this time [19] and may be more motivated for health behaviour change after having recently given birth [20]. Given national trends of short intervals between births [21], the provision of postpartum family planning should be prioritised in Uganda, as there may only be a brief window of time to link many postpartum women to family planning services before their next pregnancy [7]. Despite the need for increased postpartum family planning in Uganda, few studies are exploring contraceptive use that specifically targets women postpartum ([22], and different factors may influence family planning service uptake and contraceptive use during this period [23]. Therefore, the purpose of this study is to explore factors influencing family planning and the utilisation of family planning services among post-partum women at Kitagata General Hospital in Sheema District, Uganda.

The United Nations Millennium Development Goal aims at reducing maternal mortality by three-quarters between 1990 and 2015. An important intervention towards achieving this target is the promotion of modern family planning among women in sub-Saharan Africa. Despite the need for increased postpartum family planning in Uganda, few studies are exploring contraceptive use that specifically targets women postpartum. Moreover, very little is known about how pregnant women in sub-Saharan Africa arrive at their postpartum family planning decisions, even though this information is critical to the design of strategies to increase the uptake of postpartum family planning. The purpose of this study, therefore, is to explore factors influencing the utilisation of family planning services among postpartum women at Kitagata General Hospital in Sheema District, Uganda. The study was designed to determine the factors influencing the utilisation of family planning services among postpartum women at Kitagata General Hospital in Sheema District, Uganda.

METHODOLOGY

This chapter presents an evaluation of the research methodology for the proposed study, which includes the study design, study site and setting, study population, sample size determination, sampling technique, eligibility criteria, data management, and ethical considerations.

Study Design

A quantitative cross-sectional study approach will be conducted to determine the factors influencing the utilisation of family planning services among postpartum women at Kitagata General Hospital in Sheema District, Uganda.

Area of Study

The study will be conducted at the ANC clinic at Kitagata General Hospital. The hospital is located in the central business district of the town of Kitagata, in Sheema District, in the Ankole sub-region, in Western Uganda, about 62 kilometres southwest of Mbarara Regional Referral Hospital. This is about 111 kilometres north of Kabale Regional Referral Hospital. The coordinates of Kitagata General Hospital are 0°40'21.0"S, 30°09'04.0" E (latitude: -0.672503; longitude: 30.151111).

Study population

The study will be conducted among post-partum women at Kitagata General Hospital in Sheema District, Uganda.

Inclusion criteria

It will include postpartum women at Kitagata General Hospital in Sheema District, Uganda who fit the eligibility criteria for family planning.

Exclusion criteria

- i. Those not in the postpartum period.
- ii. Those that don't fit the eligibility criteria for family planning.

Sample size determination

The sample size will be determined using Kish Leslie's formula [24].

$$n = \frac{(Za/2)^2 p(1-p)}{e^2}$$

Where n is the required sample size, p is the approximate number of postpartum women at Kitagata General Hospital in Sheema District, Uganda, and e is the permissible error in the estimate.

Sampling Procedure

Consecutive random sampling techniques will be used to choose respondents to participate in the study, from whom data will be collected.

Dependent variables

Utilisation of family planning services among post-partum women

Independent variable

The independent variables include socio-demographic factors, knowledge, awareness, perception, and attitude regarding family planning services.

Data collection method and tools

Data was collected using an interviewer-administered questionnaire adopted from Tafa & Worku [25] and adjusted to fit this study. The researcher will meet with the targeted respondents who will take part in the study

after obtaining permission for data collection from the respondents. Each participant will be required to give informed consent before enrolling in the study. The researcher will assist the respondents in filling out the questionnaires by explaining to them for clarification. The properly filled questionnaires will then be collected, and then data will be taken for analysis. The researcher will use a structured questionnaire, and participants will be asked similar questions, and from the options, they will pick the best alternative. A pen and paper will be used to record the necessary information.

Data entry and cleaning

The data in the questionnaire will be checked for completeness, cleaned, and sorted to eliminate obvious inaccuracies and omissions. The data will then be coded and entered into a computer.

Data Analysis

The qualitative data collected will be statistically analysed and documented using Microsoft Excel and Word version 2019, which will then be analysed using SPSS v.16. The analysed data will then be presented in the form of tables and graphs, which will be the basis for discussion and conclusions, among others.

Measurement of Variables

The variable ‘Utilisation of family planning services’ is the dependent variable and will be measured on the number of women that will receive postpartum family planning. The independent variables are the socio-demographic factors—attitudes, knowledge, and practices—and will be measured in percentage. Specific statistical tests will be done to determine the relationship between different factors and the utilisation of family planning services among postpartum women.

Quality Control

To ensure quality control, the researcher will conduct a pre-test using eight questionnaires in the target population, and data will be collected before the actual study to help in the reconstruction of the questionnaire where necessary.

Ethical Considerations

Participants will be given information regarding the research to seek consent. Each participant’s choice to participate or not will be respected, and the data collected from participants will be kept confidential. The participants’ names will not be included while filling out the questionnaire to maintain privacy. It will be communicated that the information obtained from the participants will be kept under lock and key to only be used for research purposes.

RESULTS

Table 1: Shows the Demographic data of the sample population

| Variable | Category | Frequency | Percentage |
|--------------------|----------------|-----------|------------|
| Age | ≤20 | 9 | 6 |
| | 21-30 | 79 | 53 |
| | 31-40 | 50 | 33 |
| | >40 | 12 | 8 |
| Religion | Catholic | 57 | 38 |
| | Protestant | 71 | 47 |
| | Muslim | 13 | 9 |
| | Other | 9 | 6 |
| Educational status | None | 35 | 23 |
| | Primary | 52 | 35 |
| | Secondary | 34 | 22 |
| | Tertiary | 29 | 20 |
| Occupation | Civil servant | 46 | 31 |
| | House wife | 69 | 46 |
| | Business woman | 20 | 13 |
| | Student | 9 | 6 |
| | other | 7 | 5 |
| Place of residence | Urban | 87 | 58 |
| | Rural | 63 | 42 |

A total of 150 study participants were involved in the study. The mean age of the study participants was 29.8. The majority of the study participants (47%) were protestant by religion, while 38% were Catholic. One-hundred-fifteen (77%) of the respondents attended formal education, while 23% didn't. Nearly half of the study participants were housewives (46%). Regarding the place of residence, 87 (58%) lived in urban places. Concerning obstetric history, 44% of the study participants had four or more children, and 76% had a history of family planning utilization. The implant was the most frequently used family planning (FP) method (39%). Regarding maternal health services, 77% had ANC follow-up, 62% of them delivered their baby in a health institution, and 53% received postnatal care.

Table 2: Shows the Knowledge and Utilization of Postpartum Family Planning Among Women

| Knowledge Questions | Frequency | Percentage |
|--|-----------|------------|
| Which method of modern FP do you know (more than one answer was possible) | | |
| Pills | 21 | 14 |
| Implant | 30 | 20 |
| Injectable | 32 | 21 |
| IUD (intrauterine device) | 5 | 3 |
| More than one method | 36 | 24 |
| Where do you get information Reason? | | |
| Mass media | 32 | 21 |
| Health professionals | 66 | 44 |
| Family | 38 | 25 |
| Friends | 17 | 11 |
| Reason women use Modern FP | | |
| Prevention of unwanted pregnancy | 39 | 26 |
| Child spacing | 60 | 40 |
| To limit family size | 36 | 24 |
| Prevention of STI/HIV | 6 | 4 |
| Other | 9 | 6 |
| Discussed about FP with your husband | | |
| Yes | 116 | 77 |
| No | 35 | 23 |
| Your husband supported you in using FP | | |
| Yes | 107 | 71 |
| No | 44 | 29 |
| Current PPFM used | | |
| Pills | 27 | 18 |
| Implant | 71 | 47 |
| Injectable | 47 | 31 |
| IUDs | 9 | 6 |
| Reason for not utilizing PPFM | | |
| To get more children | 38 | 25 |
| Family disapproval | 27 | 18 |
| Religious reasons | 20 | 13 |
| Fear of side effects | 35 | 23 |
| Inaccessibility | 23 | 15 |
| Others | 5 | 3 |
| Is PPFM culturally acceptable in your context | | |
| Yes | 101 | 67 |
| No | 50 | 33 |

All of the respondents had heard about postpartum family planning at least once. About 70% of the respondents had good knowledge of postpartum family planning. Regarding utilisation, 41% used postpartum family planning. The most commonly mentioned modern family planning was injectables (21%), and implants (20%). The main source of information was health professionals (44%), and 40% knew that family planning enables women to control birth spacing. Most of the study participants (77%) discussed family planning with their husbands, and 71% stated that their husbands supported them in using family planning. Of those women who utilised postpartum family planning, 47% of them used an implant. Among the women who did not utilise postpartum family planning, the main reason for not utilising PFP was to get more children and fear of side effects (25% and 23%), respectively.

Table 3: Shows Utilization of postpartum family planning Among Women

| Variables | Utilization of postpartum family planning (%) | |
|---------------------------------|---|----|
| | Yes | No |
| Age group | | |
| ≤20 | 36 | 64 |
| 21-30 | 37 | 64 |
| 31-40 | 48 | 52 |
| >40 | 39 | 61 |
| Number of alive children | | |
| One | 32 | 68 |
| Two-Three | 38 | 62 |
| Four+ | 47 | 53 |
| PNC Utilization | | |
| Yes | 53 | 47 |
| No | 27 | 73 |
| Educational status | | |
| None | 34 | 66 |
| Primary | 55 | 45 |
| Secondary | 79 | 21 |
| Tertiary | 88 | 12 |

The study defined postpartum contraceptive or post-partum family planning (PPFP) as a woman’s use of any modern method of contraception during the 12 months following her most recent childbirth.

DISCUSSION

The research participants' average PFP knowledge was found to be 75%, which was lower than that observed in comparable studies from Nepal, central Ethiopia, and Nigeria [13, 14]. However, it outperformed a research from Axum, Ethiopia (46%).[26]. The variation may result from variations in study locations and sociodemographic traits. In addition, this study discovered that 41% of the individuals use PFP. This number was consistent with the majority of investigations carried out in Sub-Saharan African nations. Between 40% and 49% of participants in these studies used PFP [27]. But the lower figure was reported in Somalia Region, Uganda (28%) and Ethiopia (12%) [21]. It's possible that this discrepancy results from the different sociodemographic traits and study sites. Sub-national differences at the state, regional, and district levels were discovered in all three countries in a research to evaluate the patterns and trends of postpartum family planning in Ethiopia and Nigeria[28]. The observed discrepancies are more indicative of differences in options for accessing and providing the service, or in social and cultural norms of behavior. The variances in the use of contemporary contraception during the postpartum period may have been significantly influenced by the socioeconomic differences in the women's education, place of residence, and wealth quintile. In general, access to information and services is better in cities and among the wealthiest women [28]. The significant unmet need for FP in Uganda is attributable to a lack of access to quality services, women's lack of understanding about side effects and the availability of techniques [5], cultural influences such as husbands, and religious prohibitions on contraception [29]. These distinctions imply that context-specific interventions are needed to improve contraceptive use during the postpartum period. In areas with low rates of maternity and child

care utilization, community-based initiatives may need to be prioritized. While integrating family planning services into mother and child routine care may be a desirable strategy in areas with high institutional delivery rates, it is not a universal method. Women with a greater level of education were more likely to be aware of PPFp. This finding was consistent with other studies that found that women with a higher educational background have a better understanding of PPFp [11]. Furthermore, women who have used modern FP were shown to be knowledgeable about modern FP. This could be owing to the counseling and health education provided during the distribution of contraceptive techniques. Similarly, having an ANC follow-up has been linked to understanding of PPFp in research [30]. Other studies in Uganda and Tanzania found that health practitioners were the primary source of information during ANC [31-36]. The use of PPFp was also linked to an increase in the number of live children. It was congruent with the findings of a study conducted in Burundi and Rwanda, which found that "the likelihood of utilizing PPFp increased by approximately 30% for a woman with an extra living child" [31]. This study also found a link between PNC service consumption and PPFp utilization. This was consistent with prior research conducted in Nigeria, Uganda, and Ethiopia [30]. For example, a study done in southern Ethiopia discovered that women who used PNC services were nearly twice as likely to use PPFp [32]. This could be attributable to the provision of contraceptive counselling and promotion during normal PNC visits [33]. This could mean that women who utilize maternity and newborn health services (PNC, institutional birth, child immunization) are more likely to use postpartum family planning services, or that by visiting these services, they have greater chances to be convinced to use them and given a technique. However, due to a lack of capacity and integration of family planning services with maternal health services, opportunities to enhance the use of PPFp are lost. The most often reported reasons for using PPFp were to avoid undesired pregnancy, restrict family size, and space children. The reasons for not using PPFp included a desire to have more children, apprehension about the adverse effects of modern FP, family disapproval, inaccessibility, and cultural and religious considerations. Religious and cultural variables also influence postpartum contraceptive acceptance and utilization [34]. One-third of the women in this survey claimed that PPFp is not culturally acceptable, which is one of the key hurdles to increasing PPFp adoption in Uganda. Cultural norms that favour childbearing and religious prohibitions on contraception for postpartum mothers have also been noted in other studies [35]. This suggests that to overcome cultural barriers to PPFp usage, personalizing discussions during antenatal care and teaching the community about the benefits of birth spacing via community-based initiatives are required. In Uganda, Local Health Centres and VHTs are in charge of providing community-level reproductive health services, such as counselling and the provision of some contraceptive methods, as well as referrals for others [36]. Male involvement has also been linked to increased maternal health treatment utilization, particularly FP, in underdeveloped countries [34].

CONCLUSION

The majority of survey participants expressed good attitudes toward PPFp. However, PPFp was not used by more than half of postpartum women. PPFp utilization was connected with educational status, understanding of PPFp, the number of children, and PNC service. The most often reported reasons for using PPFp were to avoid undesired pregnancy, restrict family size, and space children. The reasons for not using PPFp included a desire to have more children, apprehension about the adverse effects of modern FP, family disapproval, inaccessibility, and cultural and religious considerations.

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