

Enhancing Contraceptive Utilization among Women of Reproductive Age (15-49 Years) in Hoima Regional Referral Hospital: A Comprehensive Analysis

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ABSTRACT

According to the 2015 WHO Family Planning report, approximately 225 million women in developing countries express a desire to delay or cease childbearing but do not utilize any contraceptive methods. This study aimed to identify the factors influencing contraceptive utilization among women aged 15-49 accessing healthcare services at the Maternal and Child Health (MCH) outpatient department of Hoima Regional Referral Hospital (HRRH) in the Bunyoro Region. The research adopted a hospital-based cross-sectional design, enrolling mothers attending antenatal, immunization, and family planning clinics at HRRH from April 2021 to May 2021. A total of 113 participants were selected via simple random sampling. Data collection involved both open and closed-ended questionnaires administered through face-to-face interviews, covering topics such as knowledge, socio-demographic characteristics, and utilized family planning methods. Statistical analysis was conducted using SPSS version 16. The median age group was 20-24 years (33.7%), followed by 25-29 years (24.8%), with the lowest representation in the 40-44 age group (2%). The majority of participants had completed primary education (56%), followed by secondary education (19%), while only 10% had no formal education. Overall, participants exhibited satisfactory knowledge regarding family planning. Injectable contraceptives were the most commonly used method (45.5%), followed by implants (6.9%) and pills (5.0%), with intrauterine devices (IUDs) being the least utilized (2.0%). Women aged 20-29 years demonstrated a higher likelihood of contraceptive usage compared to those aged 45-49 years. Education emerged as a significant determinant of contraceptive utilization.

Keywords: Family Planning, Contraception, Childbearing, Women, Unintended pregnancy.

INTRODUCTION

Contraception is a birth control measure that prevents pregnancy by interfering with the normal process of ovulation, fertilization, and implantation [1, 2]. Some of the contraceptive methods as defined by the World Health Organization include intra-uterine devices, male condoms, female condoms, sterilization, implants, injectables, vasectomy, spermicides, and diaphragms and pills [3]. The traditional methods include withdrawal method, natural rhythm, breastfeeding, and abstinence. Family planning has been practiced for centuries [4]. Early methods were not always safe and effective. For example, centuries ago Chinese women drank Lead and mercury to reduce fertility, which sometimes led to sterility and death [5]. Current reports on the global contraceptive prevalence rates and unmet needs for family planning indicate overall gains across countries [6, 7]. Despite the overall gains, indicators of slow progress in contraceptive uptake and reduction in unmet needs or family planning

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are evident in some sub-Saharan African countries [1, 8]. The situation of family planning uptake and unmet needs for family planning in conflicted afflicted areas in the Sub-Saharan African countries presents a picture of serious overlook [9, 10] by the humanitarian actors. In these settings, available evidence indicates low prevalence rates ranging from 4% to 16% and calls for more investment in family planning services for both national and donor-country action plans [11, 12]. Women who use contraceptives tend to have a better quality of life, higher social status and greater autonomy. This association has been highlighted in a study in Nigeria by Osemwenkha, who emphasized that contraceptive use has the power to reduce fertility considerably and ultimately improve maternal and child health [13]. An estimated 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception [9]. The worldwide rate of unintended pregnancy in 2012 was 53 per 1,000 women aged 15-44 with the highest regional rate in Africa [14]. Avoiding barriers to the use of contraceptive methods could avert 54 million unintended pregnancies, 79,000 maternal deaths, and one million infant deaths each year. The drivers of family planning uptake are a set of multiple factors that may be complex and difficult to address in real-world settings, specifically in under developed countries where things happen in an emergency [15]. These factors range from individual and social factors, cultural factors, availability, and access factors to factors related to the attributes of the contraceptive methods such as fear of side effects [16]. There is insufficient evidence to explain how these factors interplay to influence contraceptive use in sub-Saharan Africa, such as Uganda. According to the Uganda Bureau of Statistics (UBOS), family planning services were introduced in the country in the 1950s with the establishment of the Family Planning Association of Uganda. In the 2011 Uganda Demographic Health Survey (UDHS) the country's contraceptive uptake (any method) was estimated at 30 %, [17]. The country's contraceptive prevalence rate is lower than figures among neighboring countries namely Kenya (46%), Tanzania (34%) and Rwanda (52%), [17]. With regards to the modern use of contraceptive methods, the country lags in comparison with global estimates and those among the neighbouring countries. Contraceptive utilization has multiple benefits to women who are using it and to the community in advance. Contraceptives prevent unintended pregnancies, reduce the number of abortions, and lower the incidences of death and disability related to complications of pregnancy and childbirth. In Uganda, as in many other countries, major factors associated with contraceptive use are women's age, education, and socioeconomic status. Ugandan women who are more educated and wealthier are more likely to use contraception compared with illiterate and less wealthy women, [1, 17]. Unintended pregnancy occurs primarily among couples who use contraception incorrectly or inconsistently or do not use any contraception, [18]. Globally, an estimated 40% of women report unintended pregnancies [19]. In Africa, research evidence consistently reports the low prevalence of the use of modern contraception, which translates to the high incidence of unintended pregnancies, unsafe abortions, and maternal death [20-22]. In Ghana, researchers found a prevalence of contraceptive use at 17% in public and private health facilities in a peri-urban community, which is lower than the national target of 23.3%. Several decades after the introduction of modern family planning methods, Kenya's population is still growing and it's projected to exceed 60 million by 2025 [23, 24]. Uganda has one of the highest maternal mortality rates in the East African region, at 343 maternal deaths per 100,000 live births in 2015, [25], yet one of the lowest contraceptive use prevalence rates within this region [26]. In western Uganda, the research that was done shows also low utilization of contraceptives. The findings suggested that the region is in the early stages of fertility transition –when fertility is high and contraceptive prevalence is low [27]. A recent study conducted among very young adolescents in southwestern Uganda revealed that 7.6% had ever had sex yet 90% of the adolescents were not using any form of protection from HIV and pregnancy [28]. Despite serious campaign programs to sensitize women of reproductive age to take up contraception, there is still a rise in population and other problems such as a rise in the number of street children, maternal morbidity, and mortality which negatively impact the economy and available resources. Therefore, this study will aim to find local data about factors influencing contraceptive use among women of reproductive age from the Hoima district in western Uganda.

METHODOLOGY

Study design

The study employed a mixed design where both quantitative and qualitative research methods were used at the same time with the help of questionnaires and interview guides to collect data. This helped to obtain information on variables in different contexts but at the same time.

Area of Study

The study was conducted in family planning, antenatal care and immunization units of Hoima Hospital. Other services provided include; OPD where patients are examined and treated, and a laboratory unit that conducts several laboratory investigations. The OPD also provides HIV/AIDS-ART and EMTCT services, among others.

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Study population

The study population included women of reproductive age 15 to 49 years attending MCH outpatient clinics at Hoima Regional Referral Hospital, Bunyoro Region. These respondents included the estimated 113 women in the study area. Key informant interviews were held with midwives and heads of antenatal, family planning, and immunization services.

Inclusion criteria

Women of reproductive age 15-49 attending MCH outpatient department health services from Hoima Hospital

Exclusion criteria

Women below 15 or above 49 years, Women of reproductive age 15-49 years but had not consented, Women in the hospital wards and the communities.

Sample size determination

According to the current HMIS report, the prevalence of contraceptive use in HRRH was at 8% (HMIS report March 2018).

Determination of the sample size was calculated using Kish Leslie [29] formula

$$n = \frac{z^2 p (1-p)}{E^2}$$

Where;

n = Estimated minimum sample size

z = 1.96 for 95% confidence interval

p = proportion of characteristic sample, 8%

E = margin of error (E = 5%)

So,

$$n = \frac{(1.96)^2 \times 0.08(1-0.08)}{(0.05)^2}$$

n = 113 respondents

Therefore, 113 women were recruited in the study.

Sampling procedure

Simple random sampling was used to obtain the participants of the study. Small papers some written on 'yes' and others written on 'no' were distributed to the mothers. Whosoever picked the paper written on 'yes' was considered in the sample.

Data collection and management

Both qualitative and quantitative data were collected using questionnaires and interview guides containing both open and closed-ended questions. This tool was selected because the study involved mixed groups including those who are illiterate and unable to read, write, and understand English and those who are literate. The researcher also verbally translated the interview guide into Runyoro which is the most common local language which improved efficiency during data collection. Qualitative data was collected using interview guides. Questions specific to factors that influence contraceptive use were asked to ensure that the themes of the study were well-defined and understood. Data collection was also by use of interview guides which enabled the respondents to exhaust each question asked. The researcher sampled 20 respondents per day for 7 days.

Data analysis

Questionnaires were checked for errors and completeness at the end of each day of the interview and corrected by re-interviewing. Statistical analysis was done using a statistical package for social scientists (SPSS) version 16.0.

Quality control

Consent of the participants was sought and those who wanted to withdraw some information already given and noted were allowed to do so. Participants were also allowed to withdraw completely from the study if they wished to do so and the information already recorded from them was discarded.

Ethical consideration

An introductory letter was obtained from KIU after approval by the research and ethics committee of the Department of Health Studies KIU-TH. Permission was also sought from the relevant authorities at Hoima Hospital. Meetings with the charge of family planning, and antenatal and immunization units were held to discuss the purpose of my research. Informed consent was obtained from the respondents after explaining the nature and purpose of the study and it emphasized that participation was to be voluntary.

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RESULTS

Table 1: Social Demographic Characteristics of Respondents

Socio-Demographics	Variables	Frequency	Percentage (%)
Age	15-19	12	11.9
	20-24	34	33.7
	25-29	25	24.8
	30-34	19	18.8
	35-39	8	7.9
	40-44	2	2.0
Religion	catholic	39	38.6
	Anglican	45	44.6
	Muslim	5	5.0
	Adventist	4	4.0
	Pentecostals	7	6.9
Marital Status	Married	98	97.0
	Divorced	2	2.0
Occupation	Peasant	83	83
	civil servant	15	15
	Student	2	2
Tribe	Munro	88	87.1
	mukiga	6	5.9
	mu Kinyarwanda	5	5.0
	others	1	1.0
Number of Children	None	42	41.6
	1-4	42	41.6
	5-10	16	15.8
Level of Education	Informal	10	9.9
	Primary	56	55.4
	Secondary	19	18.8
	Tertiary	15	14.9
Desired Number of Children	2	5	5
	3	15	14.9
	≥4	80	79.2

I enrolled a total of 100 participants who were categorized into six age groups; 11.9% were between 15 – 19 years, 33.7% were between 20 – 24 years, 24.8% were between 25-29, 18.8% were between 30-34, 7.9% between 35-39 and 2.0% between 40-44 years. There were slightly more women from the age of 20-24 years at 33.7% and more Christians belonging to the Protestant faith 44.6% and Catholics 38.6%, Pentecostals 6.9%, Muslims 5% and Adventists 4%. The highest levels of education for the study participants were 55.4% in primary school, 18.8% had gone up to secondary education 14.9% had tertiary as their highest level of education and 9.9% had no education (never been to school). This was very important as it had an impact on the understanding and utilization of the various contraceptive methods. The 98(98%) participants were married; 2(2%) were divorced or separated. 83% of the participants were peasant farmers, 15% were civil servants and 2% were students. 87.1% of the participants were Banyoro, 5.9% were Bakiga, 5% were Banyarwanda and 1% were others. 41.6% of the participants had not yet had any child, 41.6% had between 1-4 children, and 15.8% of the participants had had 5-10 children. In the study, I discovered that 79.2% of the participants wished to have >4 children whereas 14.9% wished to have at least 3 children and the remaining 5% wished to have 2 children. The constantly mentioned reason for the number of children was the ability to manage them as well as social security by the children when fully grown up.

Table 2: Knowledge about Contraceptive Use

Knowledge	Variables	Frequency	Percentage
Ever Heard About Family Planning	yes	99	99.0
	no	1	1.0
Ever Used Any Family Planning Method	Yes	59	58.4
	No	41	40.6
Methods Known	Pills	11	10.9
	injectable	45	44.6
	IUDs	1	1.0
	Implants	7	6.9
	all the above	36	35.6
Contraceptive Methods Used	pills	5	5.0
	injectable	46	45.5
	IUDs	2	2.0
	Implants	7	6.9
Reasons For Using the above method	most available	22	21.8
	easy to use	25	24.8
	fewer side effects	9	8.9
	more privacy	4	4.0
Time of Use of the Method	less than one year	28	27.7
	more than one year	32	31.7
Benefits of the Method	delays pregnancy	16	15.8
	child spacing	60	59.4
	reduces family expenditure	13	12.9
	all the above	11	11.9
If no Method Used why?	per vaginal bleeding	7	6.9
	weight gain	2	2.0
	generalized body weakness	8	7.9
	no child yet	24	23.8
Partner awareness About the Method	yes	79	78.2
	no	15	14.9
If not why?	Doesn't want	10	9.9
	comes irregularly	5	5.0

The majority of the respondents had heard about family planning (99%) whereas a small number of participants had not heard about family planning (1%). 58.4 % of the participants had ever used some contraceptive method of the 99% who had heard about contraceptive methods and 40.6% had never used any of the methods with their reasons as indicated in the next findings. The injectable method was well known to them as the commonest family planning method and the most used family planning method by the participants as their method of choice with 45.5%, meanwhile, pills, implants and IUDs remain the least used methods of family planning in the population of my study(2.0%) 23.8% of the respondents had not used any method because they had no child yet while 7.9% and 6.9% of the participants feared side effects associated with contraception which are general body weakness and pervaginal bleeding respectively. Most of the respondents knew family planning with child spacing being the highly known factor with 59.4% compared to other benefits of using family planning.

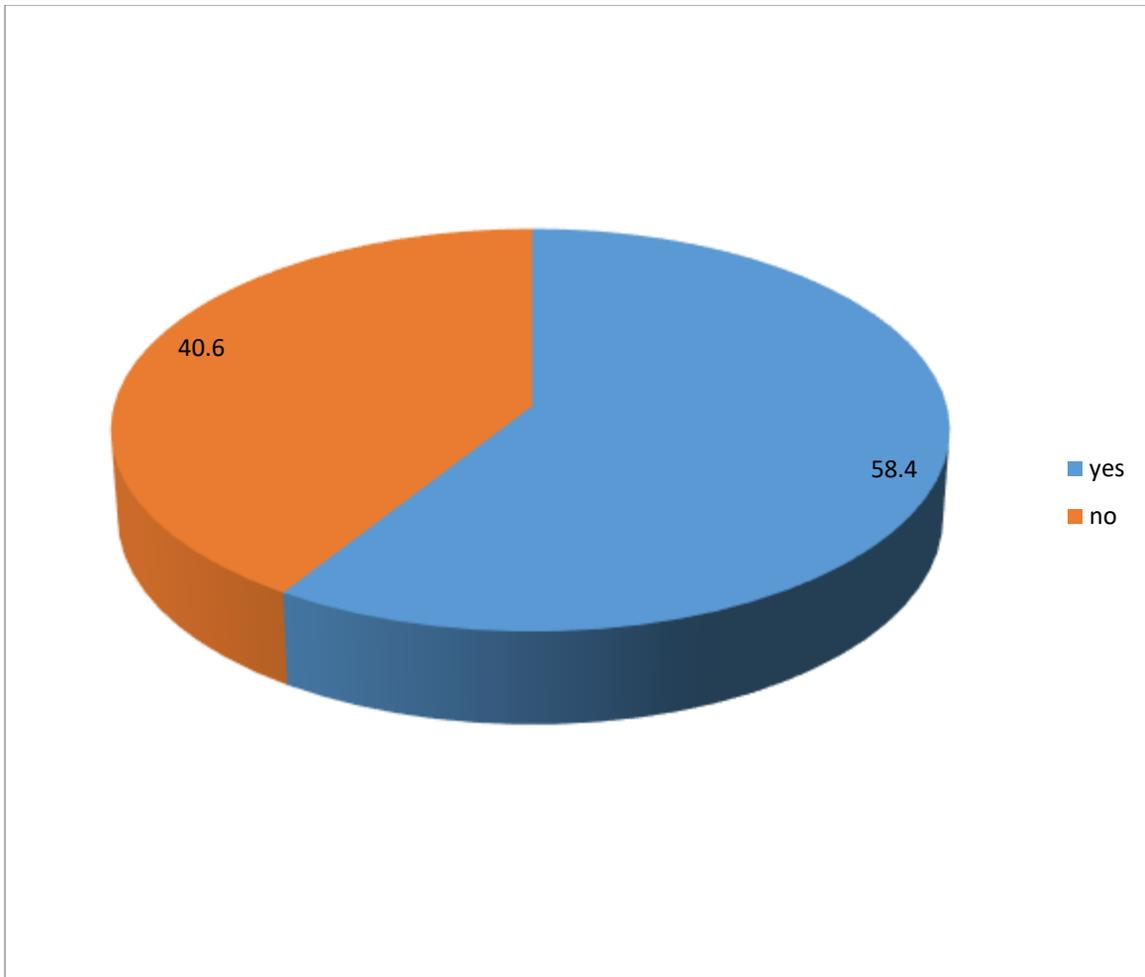


Figure 1: A Pie Chart Showing the Proportion of the Respondents Who Ever Used Any of the Family Planning Methods

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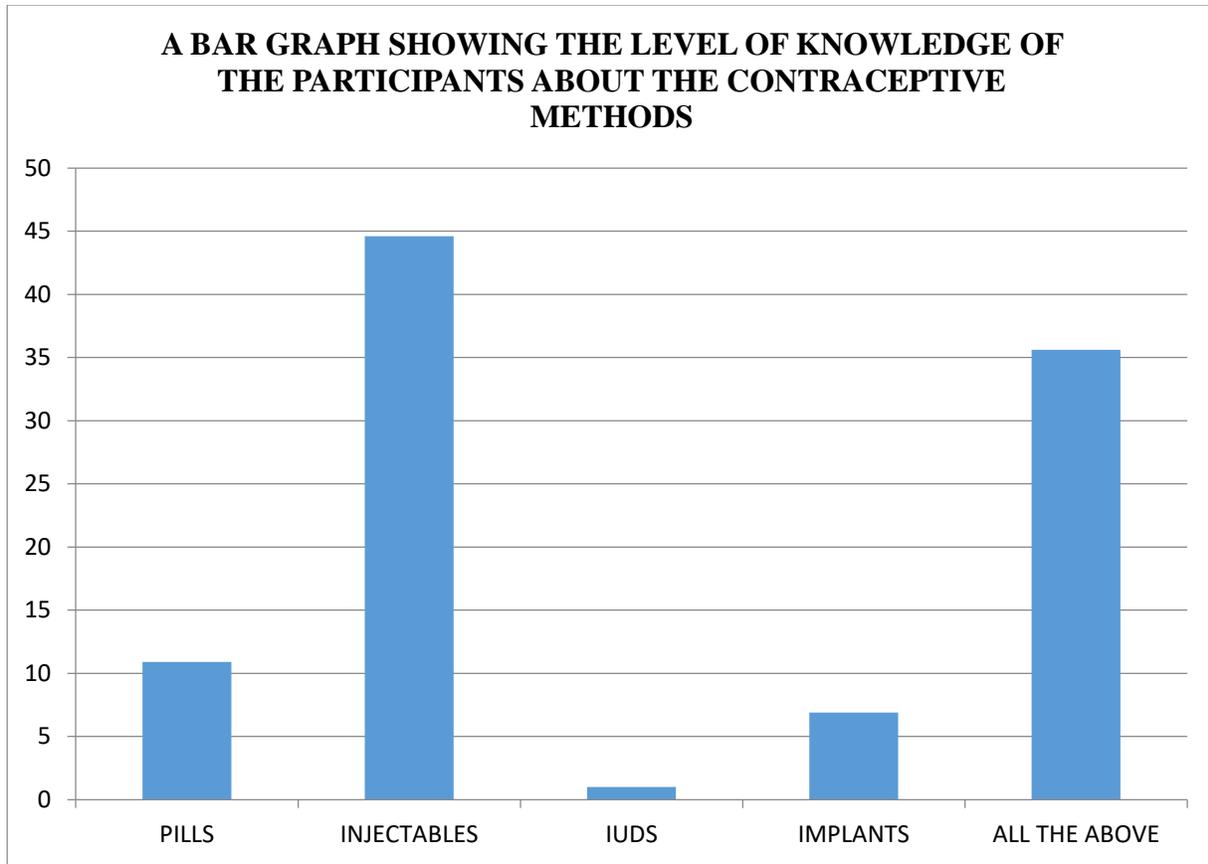


Figure 2: A Bar Graph Showing the Level of Knowledge of The Participants About the Contraceptive Methods

The above graphical representation shows the level of knowledge the participants had in terms of various family planning methods. Most of the participants knew injectables (44.6%) as opposed to 1% of the participants who knew about an IUD yet it's one of the long-acting family planning methods. However, 35.6% of the participants had some knowledge of all the methods of interest by the researcher.

DISCUSSION

The median age group was 20-24 (33.7%) followed by 25-29 (24.8%) and the least age group was 40-44 with 2%. This was largely attributed to most of the women in that age group (20-24) being sexually active and yet they had no need of having children yet and thus seeking family planning methods. Also, 11.9% of the population aged between 15-19 seeking family planning was largely due to school dropouts, early marriages and teenage pregnancies. This was in line with UDHS reports in 2017, which indicated a 17% school dropout rate in Hoima district. The ages 40-44 which had the least (2%) were linked with separation and probably were having external sexual affairs thus seeking family planning. Also physiologically, as they are tending to menopause, there is decreased libido (sexual desires) and thus are less likely to seek family planning methods. Fourteen per cent of the currently married women aged 15-19 are said to use any method which eventually increases to 38% among 35-44 years then declines between ages 45-49 to 21 % hence clearly showing that younger women are more likely to use contraceptives than their counterparts, hence indicating a negative attitude among older women to accept contraceptives [30]. On the contrary, some research has it that the use of contraceptives is high among older women since they at times reached their ideal family sizes [31]. However, this wasn't the case with the findings of my study. Women aged 20-24 years and those in 25-29 years are more likely to use contraceptives than those 45-49 years which was in line with my findings. Anglicans had the highest percentage (44.6%) followed by Catholics (38.6%) and the least being Adventists and Muslims 4% and 5% respectively. These results indicated that there is a steady improvement in family planning-seeking behaviors among the Catholics who had previously been discouraged by religious leaders. The number of Anglicans remains high and such barriers have not been in place

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to interfere with their utilization of family planning. The Moslems didn't support family planning methods and thus could be the reason for their low percentage. On the other hand, Adventists and Pentecostals had a low percentage possibly due to distribution by number in the study area. In Uganda, research indicated that one's religion has a strong influence on family planning. Ugandans identified as both Catholics and Muslims cite their religions as a major reason for not using contraceptives. They desire a large family [32].

Most of the participants were married (98%) and only 2% had separated/ divorced. Even when married, participants felt that there was a need to space their children to have productive families thus seeking family planning methods. The 2% of separated women were having sexual affairs but never wanted to bear children a reason for family planning. This is because these women are sexually active and engage in sexual activity, therefore they are likely to use contraceptives to overcome pregnancy [21].

Employment is an important aspect that determines contraceptive use. Research proved that most women who have to do work away from their homestead have a higher rate of using contraceptives than those who stay home or are housewives [33]. However, the majority of the participants I had were peasants (83%), followed by civil servants (15%) and 2% were students. This was large because the health facility where I conducted the study was government-founded and so attracted more peasant-based participants as opposed to civil servants who probably due to their social class prefer not to use government-healthy facilities but opt for other private centres. Students registered a small percentage probably due to the fear of seeking family planning services from public health facilities where they might be seen by the same village members and thus could choose to go to private centres as opposed to my facility where the study was conducted.

Banyoro tribe had the highest percentage (87.1%) followed by Bakyiga (5.9%) and the least was Banyarwanda (5%). This is because Hoima my area of study is dominantly occupied by Banyoro and these other tribes (Bakyiga and Banyarwanda) are due to intermarriages and from the neighbouring districts.

Participants who had more than four children registered the highest participation number at 80% whereas those who had two children and below had the least (5%). This was largely because mothers with 4 children and above were believed to have acquired their desired family size yet they are still sexually active thus requiring family planning to prevent conception. On the other hand, those who had less than two children because they still needed to attain their desired family size and thus needed not to use family planning.

Education is a very significant factor that determines contraceptive use. Studies show that most women with at least any level of education are more likely to use contraception than those with no education level at all [34]. According to research done in Uganda, it was discovered that women with primary education use contraceptives compared to those with no education level [35].

Results of the study show that most of the participants had stopped in the primary with a percentage of 56% followed by secondary with 19%. The least number of participants had not attained any level of education (10%). This is largely due to the high school dropout rate reported in variable one above thus resorting to early marriages. The same reason can justify the small numbers at the tertiary level since these tertiary institutions depend on the output from primary and secondary.

The majority of the participants (99%) had heard about family planning before. Only 1% of the participants admitted not knowing family planning. About 59% of the participants reported having used at least one of the family planning methods while 41% reported having never used any family planning. According to the 2011 Uganda Demographic Health Survey (UDHS), the country's contraceptive uptake (any method) is estimated at 30% [17]. This therefore means that the prevalence of utilization of family planning methods in my area of study is 59% which is relatively high. As per the above findings, it noted that of the 41 participants who didn't use contraceptives, 24 participants which constituted 58.5% had not yet had any child and therefore needed to conceive thus restraining themselves from any method.

Injectable contraceptives had the highest number of users (45.5%) followed by implants (6.9%), and pills (5.0%) with the least used being intrauterine devices (IUDs) 2.0%. IUDs had the lowest percentage of users because the participants I interviewed had a belief that they affect the sexual activity of their partner. Whereas Injectable contraceptives were preferred because of easy accessibility and their ease of use. 31.7% of those who were using any of the family planning methods, had used it for more than one year which probably was due to the efficiency of the method and minimal or no side effects while 27.7% of those who used the method for less than one year was due to their desire to conceive.

The agreed benefits of family planning methods were as follows; child spacing (59.4%), delayed pregnancy (15.8%), reducing family expenditure (12.9%) and 11.9% knew all the benefits above.

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Among the major benefits of Contraceptive use are woman's ability to space and limit pregnancies which has a direct impact on their health and well-being as well as the outcome of pregnancies [36, 37]. This was in line with the agreed benefits from my respondents. However, those who denied use of family planning had their reasons but the most common was having no child yet and some had not yet attained their desired family size.

78.2% of the participants said that their partners were aware of the methods under use, and 14.9% said that their partners were unaware. Of those whose husbands were unaware of the method, it was because the husbands never wanted their spouses to go for family planning whereas some of the husbands could come irregularly since they were working very far from home. Injectable contraceptives should be readily available by the government since the highest percentage of people prefer their use compared to other methods. The government should make more efforts to sensitize people about family planning through radio. More nurses and midwives should be recruited in health care by the government to enhance the rapid delivery of family planning services.

CONCLUSION

Women aged 20-24 years and those in 25-29 years were found more likely to use contraceptives than those in the age group 45-49 years. Injectable contraceptives had the highest number of users compared to other contraceptive methods. Education was a very significant factor that determined contraceptive use. Studies showed that most women with at least any level of education were more likely to use contraception than those with no education level at all.

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