

Full-Length Research Paper

The Influence of Social-cultural Characteristics on the Utilization of Modern Contraceptives in Namutumba District, Uganda

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ABSTRACT: Namutumba district lays in the rural areas of East-Central Uganda, where a large majority of women have unmet need for family planning and or child-spacing resulting into unwanted pregnancy which is a leading factor for high maternal morbidity and mortality. This study seeks to document the influence of social-cultural characteristics on the utilization of modern contraceptives in Namutumba District. A cross-sectional study on modern contraceptive utilization was conducted on 308 women of child bearing age in the community and 8 service providers in 4 health facilities. Data was collected using Semi-structured and in-depth interviews by the research assistants through standardized pre-coded questionnaires at the residence or workplace of the study participant. Socio-cultural factors significantly associated with modern contraceptive utilization were: place of residence and desire for more children, [(OR= 0.58, P= 0.004, 95% CI 0.003-0.910) (OR=1.5, P= 0.029, 95% CI 0.015-0.625)] respectively. Religion and husband/partners support were 2 times more likely to influence modern contraceptive utilization compared to other social cultural characteristics [(OR=2.012, 95%CI 0.731-5.539) and (OR= 1.794, 95% CI 0.659-4.888)]. Conclusively, socio-cultural factors like husband/partner support and religion were also crucial in influencing the use of modern contraceptive methods. The main recommendation is that District Health department should improve modern contraceptive utilization among women of reproductive age by strengthening IEC, at all levels through support supervisions, mentorships and continuous medical education to improve access to information on Family planning, owing to the fact that community members access health information from government health centres.

Keywords: Socio-cultural characteristics, utilization, modern contraceptive

INTRODUCTION

According to the United Nations Population Fund (UNPF), family planning services are defined as the right of all couples and individual to decide freely and responsibly the number and spacing of their children and to have the information and means to do so (Martine, 2017). Indeed, family planning services are regarded as a basic human right to attain the highest standard of sexual and reproductive health, free of discrimination, coercion and violence (Kanem, 2018). Globally, family planning services are an essential element of reproductive health care and have saved the lives and protected the health of millions of women and children (Ilene et al., 2018). The widespread adoption of family planning represents

one of the most dramatic changes of the 20th century (Ikhiya and Olochomeru, 2015). It started early in the 1930s but a drastic change occurred in the late 1950s following the introduction of IUDs and hormonal contraceptives. The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has tremendous lifesaving benefits (Markos and Ayele, 2019). Yet despite the impressive gains, contraceptive use is still low and the need for contraception high in some of the world's poorest, most populous and rural areas where the majority of the populations live. Various studies and programs have been carried out with the aim of

increasing modern contraceptive use in rural areas but they have not been commendably successful (Markos and Ayele, 2019).

Contraceptive utilization is a major component of Family Planning, where a couple or individual use a contraceptive method to prevent pregnancy. Contraceptive use is fundamental in health care services; it benefits the health and wellbeing of women, men, children, families, and their communities. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (Williams, 2013).

Namutumba district is located in Eastern Uganda, has one county, one Town council and six sub-counties, 36 parishes and 348 villages as administrative units within the district.

Agriculture is the main livelihood activity. The district is bordered by Palisa district to the north, Kibuku district to the northeast, Butaleja district to the southeast, Bugiri district to the south, Iganga district to the southwest and Kaliro district to the northwest. The district headquarters at Namutumba are located approximately 90 kilometers (56 miles), by road, northeast of Jinja, the largest city in the sub-region.

The coordinates of the district are: (00°21'N 33°03'E). It has a land area of 814.3 km² (314.4 sq. mi). At a district annual population growth rate of 2.7%, the projected population of Namutumba in 2012 was approximately 230,105 and 3684 households (UBOS, 2012 projections), and a population density of 268.8/km² (696/sq. mi).

Within Namutumba district there are 33 government health service delivery points, including one health Centre IV six Health Centre IIIs and 26 Health Centre IIs. A unique difficulty of accessibility to contraceptive services in the district exists, owing to the large unevenly distributed rural population. The types of modern contraceptives available in the district include oral contraceptives (the pill), Depo-Provera injections and male condoms among others.

The supply of such contraceptives is unreliable in the study area and no systematic stock system is in place, this is compounded by the fact that 97% of the facilities in the district get drugs through the PUSH system from NMS.

Thus, supply shortages are not uncommon. Implants, IUD, diaphragms/ cervical caps, foam/jelly and female condoms are not readily available and technical proficiency for their provision is lacking in over 90% of the facilities.

Aim of the study

This study was set to establish the influence of social-cultural characteristics on the utilization of modern contraceptives in Namutumba District.

Literature review

It is known that no country in the world can claim to achieve sustainable development without demographic planning. For instance, in the developed countries, the total fertility rate is low and the contraceptive prevalence rate high. In North America (e.g. USA) the CPR is 79% and Japan is 77% (UNFPA, 2011).

In 1994, 179 nations came together in Cairo at the International Conference on Population and Development (ICPD) to address issues of population growth and sustainable development (UN, 2004). These nations emphasized the importance of social and economic development and individual and family well-being of achieving reproductive health for all. During the conference a *Programme of Action* was developed to set out a series of recommended actions targeting population growth and development (UNFPA, 2011). Included in this *Programme of Action* was a pledge from all 179 nations to transform and fund reproductive health services around the world including the assurance that everyone who wanted to limit or space their children could do so with appropriate access to relevant services (UNFPA, 2011).

Six years after the conference in Cairo, the Global Health Council set out to measure progress made toward achieving the ICPD goals that were set in 1994. This report, entitled *Promise to Keep; The Toll of Unintended Pregnancies on Women's Lives in the Developing World*, supports the idea that unmet needs for contraception lead to unintended pregnancies (Daulaire et al., 2002). According to this report, between 1994 and 2000, 1.3 billion women globally experienced a total of 1.2 billion pregnancies with more than 300 million of them being unintended (Martine, 2017).

The report further specified that, over 700,000 women died from unintended and unwanted pregnancies due to problems with pregnancy, labor and delivery. Of the 700,000 deaths, more than 400,000 were ascribed to botched abortions during that period (Martine, 2017).

Unwanted pregnancies happen for many reasons and about 75 million pregnancies worldwide are unplanned/unwanted (WHO, 2020). One of them could be rape; Some people who engage in coitus simply do not know about contraception, or they are unable to get contraceptives, or they are young, cannot discuss on using contraceptives with their partners, or the contraceptives they use do not work as many of them fear technologies and thus, use traditional methods instead of modern contraceptives (Alves and Lidia, 2013). Most of these unintended pregnancies are not carried to full term, but aborted often in unhygienic condition leading to serious consequences and it is estimated that worldwide about 46 million pregnancies (22% of total pregnancies and 61% of unintended pregnancies) are aborted (Darroch et al., 2016).

A study done from TASO Jinja, At least 61 (11.7%) reported that the decisions to use contraceptives was made by the female partner, 54 (10.4%) both partners and 28 (5.4%) by the male partner. However, a third party was also reported that included: health workers, counsellor and in-laws (Okoboi and Barbara, 2019).

Another study in Tanzania, almost 65 % of the users reported that traditional and cultural beliefs did not influence the use of contraceptive methods while 75.8% of non-users of contraceptive methods reported that traditional and cultural beliefs influenced the use of contraceptive methods. About 89% of the users of contraceptive methods indicated characteristics use of contraceptive method total (%) P-value (Massoumeh, Masoud, Mohammad, and Targari, 2017).

In the same study, Users of contraceptive methods (30.7%) reported that refusal by husband/partner as one of the factors that hinder the use of contraceptive methods while 69.3% of non-users reported it was because of refusal by husband or partner. Non availability of contraceptive methods for users (93%) was also reported as a factor that will hinder the use of contraceptives.

As for non-users 78% reported that religious beliefs will hinder their use of contraceptive methods. There was a significant association between availability, religious beliefs and refusals by husband and partner and contraceptive methods use ($p < 0.001$) (Massoumeh, et al., 2017).

Of the 316 respondents, 187(59.2 %) were encouraged to use family planning services by their parents compared with 37(11.7%) who were encouraged by their religious leaders. However, only 5.6 % (18/316) of respondents had sought family planning services in their lifetime. Females were more likely than males to report contraceptive use (55. 6% vs. 44.4%). Out of 18 respondents, 8 (44.4 %) reported that they sought family planning services whenever they planned to have sex. Of the 18 respondents, 8(44.4 %) seek family planning services in the past month, 6 (33.3 %) in the past one year and, 4(22.3 %) in the past 5 years respectively. The most common contraceptive used by males was the condom (100%), while among females it was the injection (30%) (Massoumeh, et al., 2017).

The long-standing forms of African social organization including the high value attached to the perpetuation of the lineage, the importance of children as a means of gaining access to resources (particularly land), the use of kinship networks to share the costs and benefits of children (primarily through child fostering) and the weak nature of conjugal bonds clearly inhibit contraceptive adoption and fertility decline. In the empirical examination of the factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels (Kahama, 2018).

In traditional societies of Africa children mean the reproduction of the lineage. The ancestors determine the maintenance of the tradition by as many descendants as possible. Families with few children refuse themselves the right of the fore bearers in the continuation of the line of descent (Nabugoomu and SSeruwagi, 2020). The long-standing forms of African social organization including the high value attached to the perpetuation of the lineage, the importance of children as a means of gaining access to resources (particularly land), the use of kinship networks to share the costs and benefits of children (primarily through child fostering) and the weak nature of conjugal bonds clearly inhibit contraceptive adoption and fertility decline (Nabugoomu and SSeruwagi, 2020).

Religious influence

Due to limited social diversity and less external social influences, there are strong religious values are held in rural areas. In areas where the predominant religion discourages modern contraceptive use, the majority of the population is likely not use modern contraceptives, which is the case in Latin America, Asia and Africa (Kost et al., 2017).

For the case of Uganda, Religious beliefs have a direct influence on family planning acceptance. For example, the Catholic region does not subscribe all artificial family planning methods. For Muslims the Koran provides the infallible rules of conduct fundamental to their way of life. Previously conservative religious leaders represented a force opposing changes in the traditional status of women and large family norms in Egypt. It is further emphasized that religious beliefs may discourage women and their spouses/partners from using contraceptive methods (Kost, et al., 2017).

In reference to Islam for instance, in Egypt, the Grand Mufti openly expressed his support for responsible parenthood and family planning in an interview where he said that family planning is compatible with the trading of the Koran and there is no problem in promoting family planning. Among Islamic countries, Egypt is one of the few countries where family planning has been well accepted (Kost, et al., 2017). The total fertility rate would not have dropped to 3.9 in Egypt without the strong support for family planning by the Grand Mufti. Religious leaders, medical doctors, and mass media specialists recognized that the Koran's teachings harmonized with family planning; therefore, the promotion of family planning has been successful. Men should definitely participate in family planning since family planning fits in with the Koran (Kost, et al., 2017).

Bernhart, and Mosleh (2018) interviewed husbands whose wives had reported them to be opposed to family planning on the basis of their religious beliefs (14.6% of

the sampled women said their husbands had religious-based opposition to family planning). Surprisingly, 26% of these supposed opposers reported that the couple was currently using contraception (their wives had reported no use).

In addition, 57.5% of the "opposers" interviewed approved of family planning for child spacing and 50% approved of use for limiting family size. The authors propose that the high incidence of false reporting could be due to women's reluctance to tell their true reasons for not practicing family planning. Blaming their husbands' religious beliefs may offer them a socially acceptable scapegoat. The real truth is that couples rarely communicate with each other regarding family planning and taking joint decisions on the same.

Moreover, the need for contraceptive use is generally high in societies where poverty, illiteracy, and gender inequality are high. In such societies, unintended and repeated pregnancies make it difficult for women to participate in economic development and self-development.

Studies in Sudan, an Islamic country in the developing world, very few women reported that the use of contraceptive methods was against religion or cultural beliefs (Ibnouf et al., 2007). Other factors include urban-rural residence, woman's work status, woman's status relative to men, religion, culture and taboos, household standard of living (or economic status of the household), exposure to mass media, and community development (Kiran, Dana, and Jill, 2020).

Another study conducted in Tanzania about Contraceptive methods found that information provided was seldom sufficiently adapted to local beliefs and characteristics (Massoumeh et al., 2017). Cultural barriers were especially noticeable when service providers were from a dominant or relatively successful ethnic group or social class, and clients from a relatively impoverished one.

In highly stratified societies, there is a tendency to underestimate the ability of lower class women to think for themselves, and thus to use family planning information to make informed decisions themselves. In addition, communication difficulties sometimes arise because of different languages or belief systems between providers and clients (Massoumeh et al., 2017).

Influence of spouse on modern contraceptive utilization

In a study carried out in Eastern Uganda by Aleni, et al., (2020) on the pattern of birth intervals it was noted that an outstanding reason for non-use of contraception among women who knew about contraception was because husbands did not approve of it. Other studies too have shown that opposition from husbands, spousal

communication had influence in the use of contraceptive methods (Meremikwu, Anne, and John, 2016).

However, Ernest, Ojofeitimi, and Olanrewaju (2017) noted that men's opposition to family planning was not as wide spread as it was popularly believed. Men have a major role in the decision to use of family planning methods and in determining the number of children a couple should have although they do not encourage women to participate in decision making about family size and share responsibility in women's health. The problem appeared to be lack of communication between couples/partners which if it was available, men's consent for family planning use would be favorable. Male knowledge of various family planning methods was as high as was approval and ever use of family planning and they are an important factor to prevent frequent and unwanted pregnancies or limit family size for financial reasons (Ernest et al., 2017).

Other studies elsewhere also support the idea. In Baltimore, during the study on men and family planning, most women reported that their husbands approve of family planning. Only 5.7 % of wives nationwide believed that their husbands did not approve, and another 7.8 % said that they did not know their husbands' opinions. But, the vast majority of men, 78.4 %, whose wives thought they do not approve of family planning (Mwangeni and Ankoma, 2016). In Egypt, 87% of men approved of the use of family planning with the level of approval not varying much among men of different age groups or education levels, or between rural and urban residence. 18% of married men surveyed reported having used a male method of contraception in the past, and 60% of the surveyed men indicated desiring to have no more children (UNICEF, 2019).

While approximately 73% of African men approved of family planning, only 22% couples use either a modern or traditional method. There are clearly many checks at the individual, community, institutional, and policy levels to increase both the level of active male involvement in Family Planning and acceptance use of appropriate methods (Meremikwu et al., 2016). More than 69% of the men believed that a man's/woman's quality of life is reduced by having a large family; more than 70% thought that Uganda had too many people, while 66.4% agreed that family planning helped to improve a woman's health. However, a good proportion of men (43%) also thought that the side effects associated with family planning outweighed any benefits resulting from its use. More than 30% indicated that their peers would lose respect for them if they decided to have a small family. Nearly 65% believed that most people in their community wanted to have five or more children (Okoboi and Barbara, 2019).

The Nigerian study concluded that determinants of reproductive health service use, rest on the individual, household, service and community levels (Massoumeh et al., 2017). Therefore, when considering those influential

determinants of use of reproductive health services, the household and community in which the individual lives as well as the characteristics of the health services available in the community must be taken into consideration (Massoumeh et al., 2017). Providers should note that women do live in a context where they are not making unilateral decisions about their reproductive health. It is also significant to note that husbands' approval was also rated high as determinant of contraceptive use and this is consistent with literature that men are usually dominant decision makers when birth or fertility control issues are to be determined found the Tanzanian study. One of the frequent reasons women gives for not beginning or continuing to use contraception is their partner's opinions (Massoumeh et al., 2017). Social and cultural norms, gender roles, social networks, religion, and local beliefs influence people's choices including choice of whether to use a modern contraceptive or not (Huber et al., 2008). Due to limited social diversity and less external social influences, strong cultural and religious values are held in rural areas. The situation in Uganda is not any different. During the Uganda Family Health Project baseline survey, 82% of the respondents in rural areas were not using modern contraceptives, and 27% of them gave reasons related to cultural influences (Massoumeh et al., 2017). Therefore, it is evident from different studies that use of contraceptive methods and uptake of contraception is a multifactor. Socio-economic status, cultural beliefs and value attached to children; educational level of a mother plays an important role. Perceptions of risks and benefits attached to contraceptive use have influence in the use of methods. Furthermore, the studies have shown that spousal acceptance and communication contributes to acceptance of contraception. Accessibility and availability of contraception methods are the factors that have been mentioned.

METHODOLOGY

Study area

The study was carried out in Namutumba District found in the East-central Region of Uganda. The Basoga are the main inhabitants of this District and the dominant local language is Lusoga. There are 324 villages which make up the six sub-counties of the district. There is a total population of 230,105 and 3684 households (UBOS, 2012 projections). The Main economic activity is subsistence agriculture carried out by 85% of the rural population, while petty trading and formal employment occupies the remaining minor section.

Study design

This was a cross-sectional study using both quantitative

and qualitative research methods. The design was suitable for this study as it was intended to establish the extent of utilization of modern contraceptives and factors associated with it at a point in time without follow up in Namutumba District.

Study population and sample size

The study target population was women of child bearing age, currently residing or working in Namutumba District. The sample included: Women of reproductive age (15-49years) willing to participate in the study and able to give informed consent; in the communities of Namutumba District during the study. Health care workers providing reproductive health services, including family planning participated in the Key informant interviews. The sample size was determined using Fisher Exact formula. According to UDHS 2011, the prevalence of modern contraceptive utilization among women of reproductive age in Uganda was found to be 24 %. The district target population (N), was 55,317 which is 24.04% of the total population 230,105 (women of reproductive age). The sample size was determined using the formula recommended by fisher et al. (1998)

$$[n = z^2pq / d^2]$$

Where:

z = (Z score corresponding to 95% confidence interval).

p = the estimated prevalence of use of contraceptive methods (this was set at 0.24 according to UDHS, 2011.)

q = $1 - p = (1 - 0.24) = 0.76$

d = 0.05 (Sampling error /the margin of error (5%) that can be accepted in this study).

$$n = \frac{1.96^2 \times 0.24 \times 0.76}{0.05^2}$$

N = 52,624 (Target population),
280

10% of the calculated figure was added to the calculated sample size for nonresponse i.e. $(10/100 \times 280) = 28$
So, $280 + 28 = 308$.

The sample size for in-depth interview was 8 healthcare workers

Sampling technique

A multistage random sampling technique was used to select the study sample. It was done in three stages as follows:

Stage 1

The District was first divided into six strata, which are the six sub counties that make up Namutumba District. These are; Ivukula, Kibaale, Nsinze, Magada, Bulange and Namutumba. Cluster sampling was used to obtain three sub counties out of the six in Namutumba district. Each name of the six sub counties was written on a piece of paper and three names were picked randomly.

Stage 2

Nine villages were randomly selected from three sub counties. Each name of the villages in semi urban and rural areas were written on pieces of papers. Three villages from urban, three from semi urban and three from rural area were randomly picked. Pieces of papers written "Yes" and "No" were used for picking eligible respondents. Whoever picked yes was then interviewed.

Stage 3

To get the sample for in-depth interviews, two staff were picked randomly from each facility out of 3 to 4 who were on duty on the day of interview. Three health facilities were randomly selected out of the six Health facilities in the district. All health facilities in the district were listed on pieces of papers and three facilities picked randomly. The only Health Centre IV in the district was purposively picked, giving a total of 8 health workers.

Research Instruments

Primary data was collected using pre-coded questionnaires. Data was collected by the research assistants through standardized pre-coded questionnaire guided interview at the residence or workplace of the study participant. It would have been ideal to have the questionnaire self-administered in order to limit responses that reflect desired responses rather than true responses but because of the high levels of illiteracy, the respondents were interviewed by research assistants and the responses filled in the questionnaire. Respondents were interviewed after signing or thumb printing a consent form. Secondary data was used in this study mainly for reviewing literature.

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Data analysis and presentation (management)

The completed questionnaires were checked manually for completeness and un-coded data was coded before entry and analyzed by STATA and was analyzed and presented using the following: Univariate analysis in form of frequency tables, bar graphs, pie charts and proportions and bivariate analysis using cross tabulations and calculating chi-square and p-values. It was analyzed with the help of STATA and excel spreadsheet software.

RESULTS AND DISCUSSION

Social cultural characteristics influencing modern contraceptive use;

Majority of the respondents 159(52.30%) agreed upon partner support for contraceptive use, 74(24.34%) disagreed upon having partner support on contraceptive use and only 9(2.96%) claimed they had no partners. Most respondents 132(43.14%) said they had no hindrance from traditional culture towards contraceptive uptake and only 78(25.49%) agreed upon hindrance from traditional culture as a factor affecting their contraceptive use (Table 1).

Majority 115(37.70%) of respondents unanimously agreed decision making as regards child bearing was done by both partners ,101(33.11%) said decision making was done by only the husband/male partner and only 62(20.33%) of the respondents confessed it was only the wife or female partner who made decisions as regards child bearing. In terms of willingness to bear more children, 228(76.25%) of the respondents agreed upon the intention of having more children and only 71(23.75%) disagreed and when it came to partners' willingness to have children, 210(70.47%) women responded saying their male partners agreed to this assentation and only 34(11.41%) were negative towards having more children.

Most of the respondents 179(63.25%) said decision on number of children was mainly made by their husbands/ male partners, 67(23.67%) claimed they made decisions on number of children by themselves, 28(9.89%) agreed on family members/close friends' decisions towards number of children and only 9(3.18%) said parents made

Table 1: Social cultural characteristics

Characteristics	Variable	Frequency	Percentage
Partner support for FP	Yes	159	(52.3)
	No	74	(24.34)
	I don't know	62	(20.39)
	I have no partner	9	(2.96)
	Total	304	(100)
Hindering factors	Refusal by husband/partner	78	25.74
	Religious beliefs	65	21.45
	Non availability of FP methods	53	17.49
	Inadequate financial support	33	10.89
	Still at school	74	24.42
	Total	303	100
Hindrance from traditional culture	Yes	78	25.49
	No	132	43.14
	I don't know	96	31.37
	Total	306	100
Decision maker	Husband/male partner	101	33.11
	Wife/female partner	62	20.33
	Both partners come to consensus	115	37.7
	Not applicable	27	8.85
	Total	305	100
Willingness to bear more children	Yes	228	76.25
	No	71	23.75
	Total	299	100
Willingness of partner to bear more children	Yes	210	70.47
	No	34	11.41
	Not sure/don't know	22	7.38
	Have no partner	32	10.74
	Total	298	100
Decision on number of children	Husband/partner	179	63.25
	Myself	67	23.67
	Family members/close friends	28	9.89
	Parents	9	3.18
	Total	283	100
Decision on contraceptive use	Husband	76	28.68
	Wife	72	27.17
	Husband and wife jointly	117	44.15
	Total	265	100

Source; primary data

decisions on number of children (Table 1).

Table 2 shows a bivariate relationship between social cultural factors and contraceptive use and the variation in contraceptive use caused by the social cultural variables. The significant level was taken at $p < 0.05$. Partner support and contraceptive use did not show statistically significant associations $p > 0.05$, however a moderately high

proportion 46(63.89%) of respondents who had partner support for contraceptive utilization were actively using contraceptives and only 3(4.17%) using contraceptives had no partners but were 2.4 times more likely to use contraceptives than the rest of users with partner support. Moreover, respondents with no partner were 2.4 more at odds of using contraceptives than respondents without

Table 2: Bivariate analysis of social cultural characteristics by use

Characteristics	Variable	Contraceptive use		COR	P-value	95% CI
		Yes[n(%)]	No[n(%)]			
Partner support for FP	Yes	46(63.89)	37(63.79)	1		
	No	16(22.22)	11(18.97)	0.17	0.727	0.485-2.824
	I don't know	7(9.72)	9(15.52)	0.626	0.394	0.213-1.839
	I have no partner	3(4.17)	1(1.72)	2.413	0.454	0.241-24.169
Hindering factors	Refusal by husband/partner	17(23.94)	19(32.76)	1		
	Religious beliefs	18(25.35)	10(17.24)	2.012	0.176	0.731-5.539
	Non availability of FP methods	14(19.72)	7(12.07)	2.235	0.159	0.730-6.841
	Inadequate financial support	6(8.45)	6(10.34)	1.118	0.868	0.302-4.130
	Still at school	16(22.54)	16(27.59)	1.118	0.819	0.431-2.899
Hindrances from traditional culture	Yes	19(26.39)	11(18.97)	1		
	No	35(48.61)	28(48.28)	0.724	0.478	0.296-1.768
	I don't know	18(25.00)	19(32.76)	0.548	0.231	0.205-1.466
Decision maker on child bearing	Husband/male partner	18(25.00)	21(36.21)	1		
	Wife/female partner	13(18.06)	12(20.69)	1.264	0.648	0.462-3.456
	Both partners come to consensus	33(45.83)	24(41.38)	1.604	0.259	0.706-3.643
	Not applicable	8(11.11)	1(1.72)	9.333	0.044	1.063-81.915
Willingness to bear more children	Yes	51(71.83)	46(79.31)	1		
	No	20(28.17)	12(20.69)	1.503	0.029	0.015-0.625
Willingness of partner to bear more children	Yes	46(65.71)	48(82.76)	1		
	No	12(17.14)	5(8.62)	2.504	0.108	0.818-7.667
	Not sure/don't know	5(7.14)	4(6.90)	1.304	0.705	0.330-5.162
	Have no partner	7(10.00)	1(1.72)	7.304	0.049	0.028-0.989
Decision on number of children	Husband/partner	45(66.18)	42(73.68)	1	1	
	Myself	15(22.06)	11(19.30)	1.273	0.593	0.526-3.082
	Family members/close friends	7(10.29)	2(3.51)	3.267	0.154	0.642-16.619
	Parents	1(1.47)	2(3.51)	0.467	0.54	0.041-5.338
Decision on contraceptive	Husband	15(23.08)	17(32.08)	1		
	Wife	19(29.23)	12(22.64)	1.794	0.253	0.659-4.888
	Husband and wife jointly	3(47.69)	24(45.28)	1.464	0.393	0.610-3.513
Disclosure on contraceptive use	Yes	47(70.15)	38(70.37)	1		
	No	20(29.85)	16(29.63)	1.011	0.979	0.461-2.214

Source; primary data

partners' support. [OR=2.413, 95% CI 0.241-24.169].

Majority of the non-users 46(79.31%) were willing to bear more children whereas only 12(20.69%) did not have the intention to bear more children and this was significant at $P=0.029 < 0.05$ predicting that respondents not willing to bear more children were 1.5 more at odds of using contraceptives compared to those willing to bear more children [OR=1.503, 95% CI 0.015-0.625].

Majority of respondents 48(82.76%) agreed on the willingness of their partners to bear more children, those whose partners were not willing to bear more children were 2.5 more at odds of using contraceptives and only 1(1.72%) agreed that she did not use contraceptives due to no partner. This resulted into a statistically significant outcome ($p=0.049, < 0.05$) meaning that respondents with no partners were 7.3 more at odds of using

contraceptives than those whose partners were willing to bear more children.

Conclusion

The prevalence of modern contraceptive utilization for women of reproductive age in Namutumba district is generally low compared to the national average for rural women of the same age group in Uganda as indicated by UDHS. Socio-demographic characteristics like education level, place of residence and parity were found to influence the utilization of contraceptive methods among women of reproductive age. Socio-cultural characteristics like husband/partner support were crucial in influencing the use of contraceptive methods. Access to information

and services was a major health system factor influencing the utilization of modern contraceptives. A large portion of those who were not using modern contraceptives were mainly peasants residing in the rural areas. This is an indication of unmet need of modern contraceptives in the district since they form the largest part of the district population.

Recommendations

District Health department should strengthen Information, Education, communication capacities at all government health facilities through support supervisions, mentorships and continuous medical education at all facilities to improve access of information on Family planning. This is because most of the community members access health information from government health Centres. This will help to improve the prevalence of modern contraceptive utilization among women of reproductive age. Training of health workers on the provision of long-term contraceptive method and ensuring the availability of both such skills and the methods at all health facilities in the district should be implemented. Inter-sectoral corroboration between the district Education department and other departments should take course to help improve the level of Uganda primary education enrolment. This is because, with formal education it is easier to make informed choices because of wide understanding of issues, including health as compared to one without formal education, and it is easy to put information delivered by health workers in the right context. Programs to promote male involvement should be developed to curb the tendency of discouragement of contraceptive utilization by husbands, as the findings of this study clearly indicates about 20% of nonuser being discouraged by husbands. Since this study did not involve men, further studies are needed to determine the extent of use of contraceptive methods among men and associated factors. The district health office should pick interest, follow up and therefore take action on the findings that there exists out of pocket payment for contraceptive services at health facilities following the result that 67% of non-users and 54% of users were paying for modern contraceptive services.

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