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Factors Influencing Contraceptive Use among Women and Adolescents: A Study at Entebbe Grade B Hospital, Uganda

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ABSTRACT

This study investigates the multifaceted factors influencing contraceptive use among women and adolescents attending Entebbe Grade B Hospital in Uganda. Utilizing a mixed-methods approach, both quantitative and qualitative data were collected to comprehensively evaluate the socioeconomic, cultural, educational, and individual factors affecting contraceptive uptake. The study involved 150 participants, focusing on demographics, contraceptive use patterns, and correlations between various factors and contraceptive practices. Findings indicate a moderate level of contraceptive utilization, with education level, occupation, and parity significantly associated with contraceptive use. However, limited awareness of the broader benefits of family planning suggests the need for enhanced education and awareness campaigns. While the study provides valuable insights, further research incorporating rural populations and qualitative methodologies is recommended to better understand cultural influences and societal perceptions surrounding contraception.

Keywords: Access; Awareness; Education; Socioeconomic status; Cultural norms

INTRODUCTION

Family planning services are instructive, broad medical or social activities which enable individuals to determine freely the number and spacing and timing of their children, and to select the means by which this may be achieved, furthermore, a woman's ability to space and limit her pregnancies has a direct impact on her health and wellbeing as well as on the outcome of each pregnancy [1, 2]. Contraceptives are drugs, methods or objects used for preventing a woman from getting pregnant. Contraceptives are grouped into two types that is modern and traditional methods. Modern contraceptives include female sterilization, contraceptive pills, intrauterine devices (IUDs), injectables, implants, male condoms, female condoms, lactational amenorrhea (LAM), and emergency ("morning after") contraception. The traditional contraceptive methods include the rhythm method (periodic), breast feeding and withdrawal. Reproductive health requires careful attention because it constitutes a sensitive component of public health. It is estimated that each one-million-dollar shortfall in support for reproductive health supplies means 360,000 unplanned pregnancies, 150,000 additional induced abortions, 11,000 infant deaths and 14,000 deaths of children under five years [3]. This is a clear indication that contraceptive use plays an important role in reproductive health. In Uganda for instance, 41% of women have no access to family planning methods and maternal mortality ratio (MMR) stands at 336 deaths per 100,000 live births, yet less than 10 percent of the national budget is allocated to health according to the National census of Uganda, the population of the country increased five times during the second half of the 20th century, from 5.0 million people in 1948 to 24.3 million in 2002. Significant population growth rate was recorded in one decade, at 3.2 percent per annum between 1991 and 2002. In 2007, Uganda's population was estimated to be 30 million and at the current growth rate, the country's projected population will be 55 million in 2025 and 130 million in 2050. Many factors may play a role in contributing to such an exploding population but keen attention should be paid to the persistently high total fertility rate of 4.7 children per woman as of 2020 [4, 5]. This can be attributed to the rate of contraceptive use, with the current contraceptive prevalence rate being as low as 35%. Globally, contraception use has risen from 54% in 1990 to 57.35% in 2015, the proportion of women aged 15–49 reporting use of a modern contraceptive method has been minimal between 2008 and 2015 while in Africa it increased from 23.6% to 28.5%, where as it has remained stable in Latin America and the Caribbean at 66.7% [2, 6]. According to [2] a number of contraceptive methods are available to prevent unwanted pregnancy. There are a range of contraceptive methods, each with particular advantages and disadvantages. Behavioral methods to avoid pregnancy that involve vaginal intercourse include the withdrawal and calendar-based methods, which have little upfront cost and are readily available, but are much less effective in typical use than most other methods. Long-acting reversible contraceptive methods, such as intrauterine device (IUD) and implant are highly effective and

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convenient, requiring little user action. When cost of failure is included, IUDs and vasectomy are much less costly than other methods.

The use of contraceptives is one of the most cost-effective strategies to address many sexual and reproductive health (SRH) challenges, including unintended pregnancies, early marriages, and sexually transmitted infections. Despite a high burden of SRH challenges, uptake and unmet needs of modern contraceptives remain low in Uganda, especially among adolescents and young adults [7, 8]. In Uganda, the level of awareness and knowledge of contraceptive use is high in many areas with 97% of all women (aged 15-49) having heard of at least one method of family planning [9]. However, the adoption of family planning practices seems to be poor with the country despite the increase in Contraceptive Prevalence Rate (mCPR) from 18% in 2006, to 35% in 2016 [3, 10]. Wakiso District is one of the districts with a high fertility rate at 4.7% higher than the Kampala region of 3.5% [11], but one of the most populated districts though attributed to migration. In such a geographical area where awareness levels are highest, this fertility rate is very high since contraceptive use is as well expected to be high. Consequently, with such high rates of fertility as opposed to the low levels of contraceptive use among women, much is needed to be done to improve the adoption of family planning practices in Uganda and Wakiso in Particular with the prime target being the young mothers and generally women in the reproductive age bracket. There could be a number of factors responsible for this fertility rate which corresponds with the country's low contraceptive uptake and this study seeks to address this gap. The main objective of this study is to investigate the factors influencing contraceptives uptake among the women and adolescents visiting Entebbe Grade B Hospital in Uganda.

METHODOLOGY

The research employed a quantitative cross-sectional study design to investigate the factors influencing contraceptive use among women and adolescents visiting Entebbe Grade B Hospital in Uganda. This design facilitated the collection of data at a single point in time, allowing for the assessment of various factors and their correlations with contraceptive practices among the study population.

Study Design

A quantitative cross section study approach was used in order to determine the factors influencing malnutrition among women of reproductive age attending Kampala International University Teaching Hospital.

Area of Study

The study was conducted in Entebbe Grade B hospital in Entebbe Municipality, Wakiso District. The total population of Entebbe is 69,958, and majority of the people around depended on fishing, tourism and other forms of business. The hospital was located in the central business of the town of Entebbe, in Wakiso District, approximately 44 kilometres (27 mi), by road, southwest of Mulago National Referral Hospital, the largest hospital in the country, located in Kampala, Uganda's capital and largest city. The coordinates of the hospital are 0°03'50.0"N, 32°28'18.0"E (Latitude:0.063874, Longitude:32.471655).

Study Population

The study was conducted among clients seeking family planning services from Entebbe Grade B hospital within the age range of 15-50 years.

Inclusion Criteria

All Women seeking for family planning services were allowed to take part in the study. Married women and singles were included in the study within the age bracket of 15 to 50 years.

Exclusion Criteria

Women in the above age category but who did not consent to participate in the study as well as very ill clients who couldn't talk and those who are mentally unstable were excluded from this study.

Sample Size Determination

The sample size was obtained using Krejcie and Morgan table [12] for determining sample size for Finite Population, as illustrated below basing on the known value of the total number of clients seeking family planning services in a month at Entebbe Grade B hospital. The estimated average value of the total number of clients who attend seek for family planning sevices at Entebbe Grade B hospital is 450 and therefore using Morgan tables, a total number of 196 participants which may vary according to circumstances.

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Table 1: Krejcie and Morgan

Required Sample Size†

Population Size	Confidence = 95% Margin of Error				Confidence = 99% Margin of Error			
	5.0%	3.5%	2.5%	1.0%	5.0%	3.5%	2.5%	1.0%
10	10	10	10	10	10	10	10	10
20	19	20	20	20	19	20	20	20
30	28	29	29	30	29	29	30	30
50	44	47	48	50	47	48	49	50
75	63	69	72	74	67	71	73	75
100	80	89	94	99	87	93	96	99
150	108	126	137	148	122	135	142	149
200	132	160	177	196	154	174	186	198
250	152	190	215	244	182	211	229	246
300	169	217	251	291	207	246	270	295
400	196	265	318	384	250	309	348	391
500	217	306	377	475	285	365	421	485
600	234	340	432	565	315	416	490	579
700	248	370	481	653	341	462	554	672
800	260	396	526	739	363	503	615	763
1,000	278	440	606	906	399	575	727	943
1,200	291	474	674	1067	427	636	827	1119
1,500	306	515	759	1297	460	712	959	1376
2,000	322	563	869	1655	498	808	1141	1785
2,500	333	597	952	1984	524	879	1288	2173
3,500	346	641	1068	2565	558	977	1510	2890
5,000	357	678	1176	3288	586	1066	1734	3842
7,500	365	710	1275	4211	610	1147	1960	5165
10,000	370	727	1332	4899	622	1193	2098	6239
25,000	378	760	1448	6939	646	1285	2399	9972
50,000	381	772	1491	8056	655	1318	2520	12455
75,000	382	776	1506	8514	658	1330	2563	13583
100,000	383	778	1513	8762	659	1336	2585	14227
250,000	384	782	1527	9248	662	1347	2626	15555
500,000	384	783	1532	9423	663	1350	2640	16055
1,000,000	384	783	1534	9512	663	1352	2647	16317
2,500,000	384	784	1536	9567	663	1353	2651	16478
10,000,000	384	784	1536	9594	663	1354	2653	16560
100,000,000	384	784	1537	9603	663	1354	2654	16584
300,000,000	384	784	1537	9603	663	1354	2654	16586

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Sampling Procedure

Simple random sampling procedure was used in selecting participants. In this case each individual was chosen entirely by chance and each member of the population had an equal chance of being selected. As with all probability sampling methods, simple random sampling allows the sampling error to be calculated and reduces selection bias. A specific advantage is that it is the most straightforward method of probability sampling.

Data Collection Method

Interviewer-administered questionnaires were used. The researcher used a structured questionnaire and participants were asked similar questions and from options, they picked the best alternative. A pen and paper were used to record the necessary information. Both open and closed questions were used in the questionnaire. Translations will be done to those respondents who may not understand the language being used.

Data Analysis

Data was entered into the Microsoft Excel and SPSS programs for analysis. Descriptive tests were done to determine the percentages, frequencies (proportions) of the different variables. The analysis generated descriptive and inferential statistics. Descriptive statistics were in form of frequency tabulations and percentages to present background information of the respondents and to determine their opinions and responses on the set questions. In inferential statistics, Pearson's correlation was used to establish the strength and direction of the relationship between the independent variables and dependent variable as well as testing the hypotheses between the independent variables and dependent variable.

Ethical Considerations

Ethical approval was obtained from the School of Medicine and Surgery, KIU-WC and a letter of introduction was obtained from the faculty Dean. Permission to carry out the research was also sought from the administration at Kampala International University Teaching Hospital to gain access to the study site. Participants were given information regarding the research to seek consent. Each participant's choice to participate or not was respected and data collected from participants was kept confidential. The participants' names were not included while filling out the questionnaire to maintain privacy. It was clearly communicated that the information obtained from the participants would be kept under lock and key to only be used for research purposes

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RESULTS

Table 2: Distribution of the participants by sociodemographic variables

Variable	Frequency	Percentage
Age		
18–24	36	24
25–34	79	53
35–44	32	21
45+	4	2
Marital status		
Married	109	72
Single	32	22
Divorced	8	5
Cohabiting	1	1
Religion		
Catholics	71	47
Anglicans	69	46
Muslim	9	6
Others	1	1
Education level		
No formal education	15	10
Primary education	35	23
Secondary school level	49	33
Professional certificate	17	11
Diploma or degree	35	23
Occupation of respondents		
Small retail business	20	13
Petty trader	19	13
Civil servant	33	22
Paid wage	24	16
Unemployed	55	37
Parity		
1 to 2 children	57	38
3–5 children	43	28
More than 5 children	19	12
No child	32	21

The research included 150 women in total. Fifty-three percent of the participants were between the ages of 25 and 34, with a mean age of 29. The majority of participants (47% were Catholics, 46% were protestants, and 72% were married). Thirty-three percent of participants had completed secondary school, however only 37% of the women were unemployed. Table 2 contains information on participant characteristics.

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Contraceptive Use

According to this survey, just 43% of study participants had ever used family planning methods. Furthermore, it was shown that 36% of respondents utilized contraceptive techniques in the previous three months.

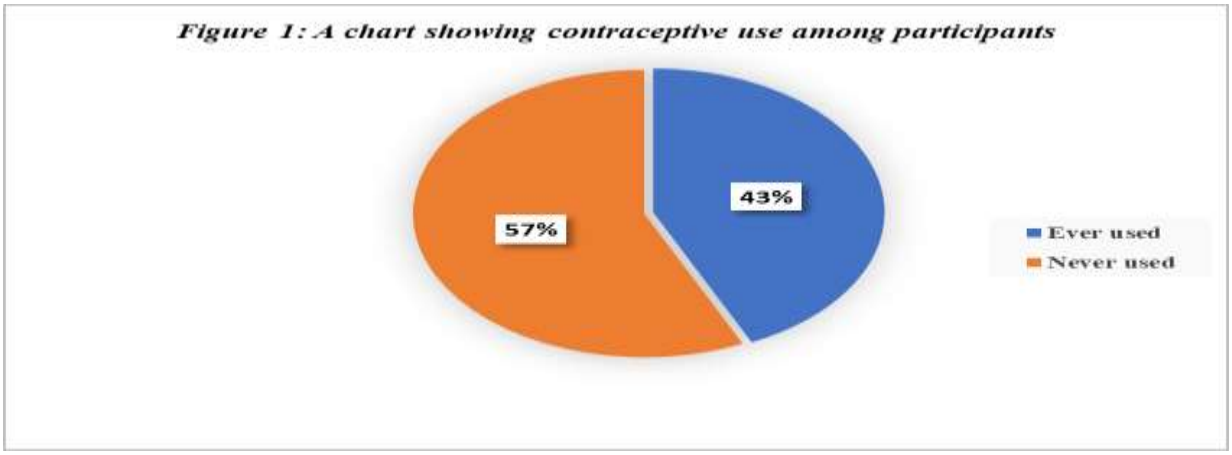

Table 3: Pearson's correlation analysis to predict relationship between contraceptives use with independent variables (sample *N* = 150)

	Variables	2	3	4	5	6	7	8	9
1	Age	-0.251	-0.024	0.272	0.214	0.081	0.134	0.006	0.006
2	Marital status		0.082	0.093	0.047	0.363	-0.04	0.019	0.018
3	Religion			-0.06	-0.08	0.009	-0.04	0.056	-0.06
4	Education				0.162	0.029	0.398	-0.118	-1.16
5	Occupation					-0.116	0.02	0.115	0.113
6	Parity						0.02	0.154	0.148
7	Knowledge							0.213	0.205
8	Ever used contraception								0.044
9	Use of contraceptives in the last 3 months								0.984

Lifetime contraceptive usage was favorably connected with education level (r = 0.118, P<0.05) and positively correlated with profession (r = 0.115, P<0.05). The researchers also discovered a link between lifetime contraceptive usage and responder parity (r = 0.154, P<0.001). Level of contraceptive awareness only had a weak significant positive connection with lifetime contraceptive use (r = 0.213, P<0.01). The researchers also discovered a link between lifetime contraceptive usage and responder parity (r = 0.148, P<0.001). Only a small significant positive connection between contraceptive awareness and lifetime contraceptive use was found (r= 0.205, P<0.01). Contraceptive usage in the previous three months was positively connected with education level (r = 0.116, p<0.05) and profession (r = 0.113, p<0.05) [Table 3]. Regression analysis found that in the examined population, parity (AOR = 1.242, 95% CI 1.000-1.544) was a greater predictor of lifelong contraceptive usage (see Table 4)

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Table 4: Binary logistic regression of independent variables with contraceptives use

Variables	COR	AOR	95% CI		p value
			Lower	Upper	
Age	1.003	1.003	0.964	1.043	0.897
Marital status	0.730	0.730	0.482	1.105	0.137
Education	0.973	0.973	0.791	1.196	0.792
Occupation	1.104	1.104	0.943	1.293	0.218
Parity	1.242	1.242	1.000	1.544	0.050
Knowledge	1.054	1.054	0.910	1.222	0.483

Table 5: Binary logistic regression of independent variables with contraceptives use in the last three months

Variables	COR	AOR	95% CI		p value
			Lower	Upper	
Age	1.009	1.009	0.97	1.049	0.663
Marital status	0.752	0.752	0.498	1.135	0.175
Education	0.974	0.974	0.792	1.196	0.799
Occupation	1.108	1.108	0.947	1.297	0.201
Parity	1.222	1.222	0.984	1.517	0.07
Knowledge	1.044	1.044	0.901	1.21	0.563

DISCUSSION

The purpose of this study was to look at the factors that influence contraceptive use among women and adolescents visiting Entebbe Grade B Hospital in Uganda. Overall, this study demonstrates adequate contraceptive technique use in the studied area. Furthermore, my findings contribute to a better knowledge of the variables related with the use of family planning in Uganda. In this study, 43% of survey participants reported having used contraception at some point in their lives. This is slightly higher than the 31% previously recorded among Ugandan postpartum mothers [13]. This data, however, indicates a greater rate of family planning uptake than the 6.8% previously reported in South Sudan [14, 15], but it is consistent with the prevalence rate reported for eastern Africa (UN, 2015). This percentage can be explained by the fact that the data was only collected in metropolitan areas. The low-income position of Ugandans makes it difficult for government organizations to acquire accurate statistics on contraceptive prevalence rates. Other research in the study settings reveal that the long-held belief that families must be larger and males must make contraceptive decisions is diminishing [7, 9, 16]. Furthermore, young women are increasingly making the decision to utilize family planning methods on their own, either explicitly or discreetly [17, 18]. Because this study was only done in metropolitan areas of the nation with strong exposure to family planning promotion efforts and easy access to family planning services, the findings may not be generalizable to the entire country, as the majority of the population lives in rural areas. Future research may provide additional light on the reasons that have led to the shifting patterns in family planning prevalence in rural areas. The conclusion that the respondent's level of education was positively connected with contraceptive usage in the previous three months complements previous findings from other research indicating a direct association between education level and use of family planning techniques [19, 20]. Furthermore, the findings paint a clear picture of the study's context, namely, metropolitan settings with two-thirds of participants having a secondary level of education. The link between contraceptive usage and parity seen in this study has been observed elsewhere [9, 21–23]. Although not investigated in this study, this finding may imply that there are unmet family planning needs among women of childbearing age. Efforts to increase uptake should also focus on increasing awareness of the broader benefits of family planning approaches and emphasizing child spacing. Future family planning policy orientations should focus on disseminating information about the broader advantages of contraception to both urban and rural populations. Because of the cross-sectional character of our study, establishing a causal association is difficult, and interpretation of our findings should be done with caution. Because male engagement in reproductive health services is being

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highlighted and men have impact on their wives' usage of family planning methods, the outcomes of this study may alter if males were also included. Furthermore, qualitative methodologies that were not used in this study might have expanded the findings by revealing the involvement of additional factors such as political, socioeconomic, and broader obstacles to contraceptive usage.

CONCLUSION

According to the findings of this study, women in Uganda's Entebbe Grade B Hospital are well-versed in family planning methods and make good use of them. Aside from utilizing family planning strategies to prevent childbirth, women have limited comprehension of the broader benefits of family planning. Parity, age, level of education, and views all have a substantial impact on the usage of family planning methods in the studied region. The impact of cultural elements may require additional investigation because it was not clearly evident in our study.

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