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Original article

FACTORS INFLUENCING UPTAKE OF POST-PARTUM FAMILY PLANNING AMONG MOTHERS 0- 6 WEEKS POSTPARTUM AT KIRYANDONGO HOSPITAL. A CROSS-SECTIONAL STUDY.

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Abstract

Background:

Postpartum period is a critical time to address the unmet family planning needs and reduce the risk of too-soon pregnancies, maternal and child morbidity, and mortality. The study was conducted to determine the factors influencing the uptake of postpartum family planning among postpartum mothers 0 to 6 weeks postpartum

Method:

The study was a cross-sectional study that employed quantitative methods for data collection. 56 postpartum mothers present at the study area at the time of data collection were counseled and interviewed using a semi-structured questionnaire.

Result:

There is a significant association between age and uptake of PPFP where mothers at a younger age are more likely to use PPFP within 6 weeks after delivery [x2(1) =6.222a; p<0.045], between religion and uptake of PPFP [x2(1) =6.257a; p<0.044]. Also, a significant association between attitude and uptake of PPFP where mothers who perceived PPFP to be both very good and good are more likely to use PPFP [x2(1) =7.840a; p<0.020]. In the same way, challenges such as inadequate counseling, long waiting time, inadequate staffing, and uncooperative health workers may affect the use of PPFP within 6 weeks after delivery [x2(1) =10.114a; p<0.039].

Conclusion:

commonly identified socio-demographic factors including age groups, religion, and attitude were significantly associated with the utilization of PPFP within 0-6 weeks. These socio-demographic factors are made worst by some health facility factors such as inadequate counseling of mothers, uncooperative health workers, and often few skilled service providers leading to over waiting by the clients.

Recommendation:

Strengthening the health facility's ability to adequately disseminate accurate information to mothers and the community at large concerning IPPFP. Healthcare providers should build the capacity of community health workers to promote effective community awareness about PPFP and its advantages to families and society at large.

Keywords: Postpartum family planning, postpartum period (06 weeks), Family planning,
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1. Background of the study

Postpartum family planning is the initiation and use of family services within the first 12 months postpartum to prevent unintended and too-soon pregnancies. (WHO, 2013)

The post-partum period is a critical time to address the unmet family planning needs and reduce the risk of too-soon pregnancies, maternal and child morbidity, and mortality

The Global population was estimated to be 7.5 billion in 2018, at an estimated population growth rate of 1.12% yearly. Sub-Saharan Africa fertility rates showed a gradual decline from 5.42 (2007) to 4.92 (2015) and 4.78 (2017)

Globally an estimated 808 women die every day due to preventable pregnancy and labor-related causes. A high incidence of 86% maternal mortality persisted mainly among the low-income community of sub-Saharan Africa and southern Asia and hundreds of thousands of deaths occurred during pregnancy or childbirth in 2017(United Nations Population Fund, 2020).

Uganda still has a high fertility rate of 5.4%, rural areas account for 5.9% and 4.0% in urban areas. This was attributed to high cases of unwanted pregnancy of about 61% among reproductive-age women (UDHS, 2016). Making Uganda is ranked 32nd position among countries with the highest population growth rate and it accounts for 0.57% of the world's population. The total population of Uganda is currently estimated to be 42,729,036 with a population growth rate of 3.61 (world population review, 2019).

Post-partum information and family planning services are a lifesaving strategy for both mothers and their babies and can reduce maternal and child morbidity and mortality in low-income countries where there are still unmet needs despite the existing services in postnatal and family planning clinics. (Nguyen Toan Tran et al, 2018).

The use of preventive measures such as Family planning counseling and the provision of family planning methods during the postpartum period prevent risks associated with too-soon pregnancies, and postpartum hemorrhage as well as promote maternal and child health during subsequent pregnancy. WHO Department of reproductive health emphasizes the utilization of postpartum family planning for both women and their partners to prevent unintended pregnancy within 12 months following delivery. Report however shows that 95% of women intend to delay subsequent pregnancy, though 70% still have an unmet need for modern contraception methods. (world health organization, 2018).

WHO recommends the utilization of immediate postpartum family planning methods such as PPIUD, condoms, progesterone-only pills, implants, and bilateral tube ligation right after placental delivery to reduce the risk associated with having unplanned subsequent or unwanted pregnancy before the recommended period of two years or more. This was to cater to mothers who resume their menstrual cycle soon following childbirth and also for couples or mothers who wish to spice up their children well after delivery or to prevent the burden of going back to fertility a week after discharge. (Nakiwunga.N., 2022)

IUD among the different methods is cost-effective, highly effective with immediate onset of action, less or no discomfort following insertion, and may not require any additional facility visit.

According to (Rogers Twesigye, 2016) the immediate PPFP use within 48 hours in South Ethiopia accounted for only 21.6% out of the 38% who showed interest, this was attributed to maternal access to counseling about postpartum family planning during the antenatal clinic. However, the low uptake of PPFP was ascribed to poor attendance at ANC and inadequate knowledge about PPFP.

A similar finding from research done in south Ethiopia showed that - the low acceptance of the PPFP were associated with religious beliefs, uncooperative husbands, fear of side effects, low level of education, low attendance, and inadequate counseling during antenatal care (Alemayehu Gonie, 2018). Rwanda had approximately 1% of PPFP uptake within 48 hours of delivery in 2016;

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the low utilization was attributed to unskilled health professionals, inadequate knowledge about the available family planning option, and reduced male involvement in the decision-making.

WHO reproductive health (2013), report showed that - The socio-cultural, gender rule, few trained health service providers, misconceptions, and inadequate knowledge are some of the mentioned attributes of low uptake of PPFP in some countries.

WHO (2016), recommends the utilization of immediate PPFP to any mother at risk of too soon pregnancy or couples who wish to have an effective way to prevent unwanted pregnancy. However, in Ugandan, the uptake of post-partum family planning methods is still very low below the targeted 50%, with an unmet need of 28% (UDHS, 2016) and according to a study done in Northern Uganda found that the IPPFP use among postnatal women was only 4.3%(Obua & Okori, 2021). In Kiryandongo the uptake of PPFP remains very low among the postpartum mothers. Therefore, this study assessed the factors influencing the uptake of postpartum family planning at 0 to 6 weeks among postpartum mothers at Kiryandongo Hospital

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2. METHODOLOGY

2.1. Study design

The study used a cross-sectional study design and employed a quantitative method of data collection. This method was chosen because the researcher was to collect data at one point in time and the data was used to describe the relationships among the variables.

2.2. Study Area

The researcher conducted the study in the postnatal ward, young child clinic, and family planning clinic at Kiryandongo general hospital from the 8th of November 2022 to the 26th of November 2022. This is the only general hospital in the kiryandongo district located at the heart of the district serving a big population with different cultural beliefs due to immigrants from different parts of the country and refugees from other parts of the world, especially South Sudan. Kiryandongo district is located along Gulu / Kampala highway 123 Kilometers from Kampala. It's bordered by the river Nile from the east and north, the Masindi district from the west, and Nakasongola from the south. The study area was chosen because of high maternal and infant mortality rates among women, too many mothers with too soon pregnancies, an increase in malnutrition cases among children less than 2 years in the nutrition ward, and low uptake of family planning.

Services offered at the facility include all forms of family planning services, MCH (Mother Child health) services, HIV/AIDs and TB care services, cancer screening, inpatient and outpatient services, operations (cesarean section), and other minor operations, psychiatry clinic, outreaches. The Hospital has a total of 173 staff as follows 1 pediatric specialist, 1 principal medical officer, 5 medical officers 5 senior medical officers, 8 medical clinical officers, 18 enrolled midwives and 8 registered midwives, 12 registered nurses, and 20 enrolled nurses among other staff. The hospital registers approximately 380 antenatal attendance and approximately 140 or more deliveries in a month

2.3. Study population

The researcher interviewed postpartum mothers, married or unmarried, with one or more number of children within 0-6 weeks postpartum, irrespective of their educational and occupational status.

2.4. Sample size determination

Yamane (1967) was used, because it provided a simplified formula to determine sample size (Glenn 2003)

n = Sample size

N = Population size for postpartum mothers= 65

e = Level of precision = 0.05

Calculation of sample size: for postpartum mothers

n= 65/1+ (0.0025*65) =56

2.5. Sampling Technique

All mothers 0 – 6 weeks postpartum who were present at the study site during the period of the study and gave consent participated in the study. This was because the mothers within the period stipulated were few and to reach the stipulated number there was no need to sample considering the inclusion criteria.

2.6. Sampling procedure

The mothers who were within the period of 0 to 6 weeks postpartum were selected from among mothers at the postnatal ward and young child clinic and then requested their consent to participate in the study. This included only mothers who were in good health and with the capacity to answer the question. Those critically ill or with mental incapacitation within the period of 0 to 6 weeks postpartum were not included.

2.7. Data collection method

After obtaining informed consent from the study participants, the researcher and research assistants collected data from the respondents by giving a self-administered structured questionnaire written in English to those who can read and write, but those who can't read and write were asked questions translated in the language

they understood and responses where be written exactly the way they said it.

2.8. Data management and analysis

The filled questionnaire was reviewed by the researcher to ensure consistency and quality of the collected information. The raw data were coded and entered into the computer for analysis, after entering all the questionnaire was burnt by the researcher to maintain confidentiality of the collected information from the facility. The data were analyzed based on the study objectives using Statistical Package for Social Scientists (SPSS) Version 20.0. The processed information was summarized and presented in the form of narrative text, frequency distribution tables, percentages, and graphs.

2.9. Study variables

The main outcome variable was the uptake of immediate postpartum family planning. The independent variables include; socio-demographic variables such as religion, marital status, education level, employment status, and partner age difference. Reproductive health variables such as parity, live children, age of the last born, desired number of children, desired birth interval, mode of delivery, and place of last delivery were also explored. Information on challenges regarding postpartum family planning use was also sought from the study participants using open-ended questions. These open-ended questions were later on coded and quantified into the different themes that emerged.

2.9.1. Data Quality Control

Data quality control refers to efforts and procedures a researcher puts in place to ensure the quality and accuracy of data being collected using the chosen methodologies for a particular study (Lavrakas, 2008). This was achieved by ensuring Validity, Reliability.

2.9.2. Reliability

Reliability refers to the consistency with which the research instrument measures the target attributes (Polit and Beck 2012). This was done by pre-testing the questionnaires on 10 postnatal mothers in Lira Regional Referral Hospital with similar characteristics to the study area. The gaps identified with the questions were addressed before the actual data collection exercise. The questions were made simple, and precise and the participants were exposed to the questionnaire only once.

2.9.3. Validity

According to Polit and Beck (2012), validity is the extent to which an instrument measures what it is intended to measure. In this study, the questionnaire was designed with all the information needed to gather data that met the objectives of the study. The questionnaire was also designed under the guidance of the research supervisor that ensured that all the necessary information was included.

2.10. Ethical considerations

Authorization to conduct the study was sought from the Research Ethics Committee (REC) at Jerusalem Institute of Health Science, the District health officer Kiryandongo District, the Medical Superintendent of Kiryandongo Hospital, and finally from the ward in charge respectively.

Participation in the study was voluntary and participants were given detailed explanations about the study and they made verbal or written informed consent before taking part in the study. The participant was given the right to decline participation in the study without being intimidated by the researcher or the research assistant. Data confidentiality was maintained by keeping the collected information under lock and key and concealing the participant's identity.

3. Results

The parameters used for social demographic characteristics in this study included; age brackets of the respondents, religion, marital status, tribes, educational level, occupation, the actual number of children, and the desired number of children. These are presented in the table below.

Table 1: Distribution of respondents according to socio demographic data.

VARIABLE	FREQUENCY	PERCENT
AGE GROUP		
15-24	**21**	**37.5**
25-34	**21**	**37.5**
35-45	**14**	**25**
RELIGION		
Catholic	**29**	**51.8**
Anglican	**26**	**46.4**
Others	**1**	**1,8**
MARITAL STATUS		
Married	**37**	**66.1**
Single	**19**	**33.1**
TRIBE		
Munyoro	**22**	**29.3**
Acholi	**29**	**51.8**
Others	**5**	**8.9**
OCCUPATION		
Farmer	**34**	**60.7**
Student	**1**	**1.8**
Civil servant	**9**	**16.1**
Shop vender	**1**	**1.8**
Others	**11**	**19.6**
NUMBER OF CHILDREN		
1-3	**37**	**66.1**
4-6	**16**	**26.8**
More than 6	**4**	**7.1**
NUMBER OF DESIRED CHILDREN		
1-4	**34**	**60.7**
More than 4	**22**	**39.3**
EDUCATION LEVEL		
None	**8**	**14.3**
Primary	**29**	**51.8**
Secondary	**7**	**12.5**
Tertiary	**12**	**21.4**

3.1.

3.1.1. Age brackets

It was observed that of 56 respondents, a bigger number of respondents i.e. 37.5% (21/56) belonged to 15-24 years of age similarly 37.5% (21/56) belonged to 25-34 years of age and only 25% (14/56) belonged to age group of 35-44 years.

3.1.2. Religion

Majority of the respondents 51.8% (29/56) were catholic, 46.4% (26/56) of the respondents were Anglican and only 1.8% (1/56) of the respondent pray in other church.

3.1.3. Marital status

It's observed that of the 56 respondent's majority 66.1% (37/56) were married and only 33.9%

(19/56) of the respondent were single.

3.1.4. Tribes

Majority of the respondent 51.8 % (29/56) were the Luo and only 8.9% (5/56) of the respondent belong to other tribes other than Luo and Bunyoro

3.1.5. Occupation

Majority 60.7% (34/56) of the respondents were farmers, 17.9% (10/56) of the respondents were housewife, 16.1% (9/56) of the respondent were civil servants and only (1/56) was a student.

3.1.6. Actual number of life children

Majority of the respondents 30.4% (17/56) had only 1 child, 25% (14/56) of the respondents had 2 children and only 5.4% (3/56) of the respondent had 5 live children, the rest of the respondent 7.1% (4/56) had 7 living children.

3.1.7. Desired number of children

Of the total number of the respondent, majority 41.1 % (23/56) desired to have 4 children during their reproductive age, 17.9% (10/56) desired to have 3 children and similar percent desired to have 6 children while only 1.8% (1/56) of the respondent wished to have only 1 child.

3.1.8. Educational level

hows that of the 56 respondents, about 8(14.3%) never attended school, Majority 29(51.8%) stopped in primary level of education, 7(12.5%) stopped at secondary level and a moderate number12 (21.4%) completed the tertiary level of education. PPFP uptake was greatest 3(5.4%) among respondents who stopped in primary level, followed by 2(3.6%) of respondents who never attended school. The rest never used PPFP.

3.2. Information about PPFP

When the respondents were assessed for mothers who were informed about post-partum family planning within 6 weeks after birth, 67.9% of the respondents had ever heard about PP family planning services and 50% heard it from the hospital, 10% heard from their spouse, 7.9% from their friends and 31.6% did not specify where they heard it from.

3.3. Uptake of PPFP within 6 weeks after birth.

Out of 56 respondents, only 10.7% (6) has ever used PPFP within 6 weeks after birth, 33.3% (2) of them used it within 2 weeks and 66.7% used the methods between 4 weeks to 6 weeks after birth. 89.3% of the respondents did not use the PPFP and the reasons for not using were, 24% of the participants mention that their religion is against it, 12% was due to culture not supporting it, 20% were not informed, 34% were fearing the side effects and 10% were still waiting for their period to resume.

Of the 56 respondents, a big percent of 39.3% feared PPFP use because heavy bleeding, 28.6% couldn't use it due to fear of pain, and 1.8% could not use because of fear of being divorced.

3.4. Personal attitude toward PPFP

12(21.4%) perceived PPFP as a very good idea, and 14(25%) perceived it as a good idea, while the majority (53.6%) perceived it as a bad idea

From figure 2, majority (51.8%) of the respondent refused to use or to recommend anyone to use PPFP and minority (48.2%) accepted to use or to recommend another person to use PPFP.

3.5. Availability of equipment and supplies for PPFP use.

When the respondent was asked about availability of equipment and supplies for PPFP use, majority (86%) of the respondents said Kiryandongo Hospital have the equipment needed and supplies for the PPFP use and only (14%) said the health facility do not have adequate equipment and supplies for PPFP use.

3.6. Preference of the health worker to administer PPFP methods

Majority (46.5%) of the postpartum mothers prefer that the PPFP should be offered to them by female health worker, 28.6% said the PPFP can be offered by male health workers and only (25%) of the respondent preferred to be worked on by any of the health workers.

Table 2: showing the access of information on PPFP by the respondent

VARIABLE	RESPONSE	FREQUENCY	PERCENTAGE
Have you ever heard of PPFP	Yes	38	67.9
	No	18	32.1
If yes, where did you hear from	Hospital	19	50
	My husband	4	10.5
	A friend	3	7.9
	Others	12	31.6

Table 3: showing the uptake of PPFP within 6 weeks after birth and the factors affecting it

VARIABLE	RESPONSE	FRE-QUENCY	PER-CENT
Have you ever used PPFP?	Yes	6	10.7
	No	50	89.3
If yes, What time after delivery did you use?	Within 48 hours after birth	2	33.3
	From 48hours-2 weeks	0	0
	Between 2 weeks to4 weeks	0	0
	Between 4 weeks to6 weeks	4	66.7
If no, what were the reason for not using	Religion does not allow it	12	24
	Culture does not accept	6	12
	No one informed me about it	10	20
	I was still waiting for my period to resume	5	10
Maternal cause of fear for using PPFP	Fearing the side effects	17	34
	It's painful	16	28.6
	Heavy bleeding	22	39.3
	Expulsion	7	12.5
	Fear of infection	4	7.1
	Fear of divorce	1	1.8
	None	6	10.7

Table 4: Level of knowledge of health worker (H/W) on PPFP administration.

Rating H/W knowledge	**Frequency**	**Percentage (%)**
Highly knowledgeable	38	67.9
Fairly knowledgeable about PPFP administration	16	28.6
Not knowledgeable about PPFP	2	3.6
Total	**56**	**100.0**

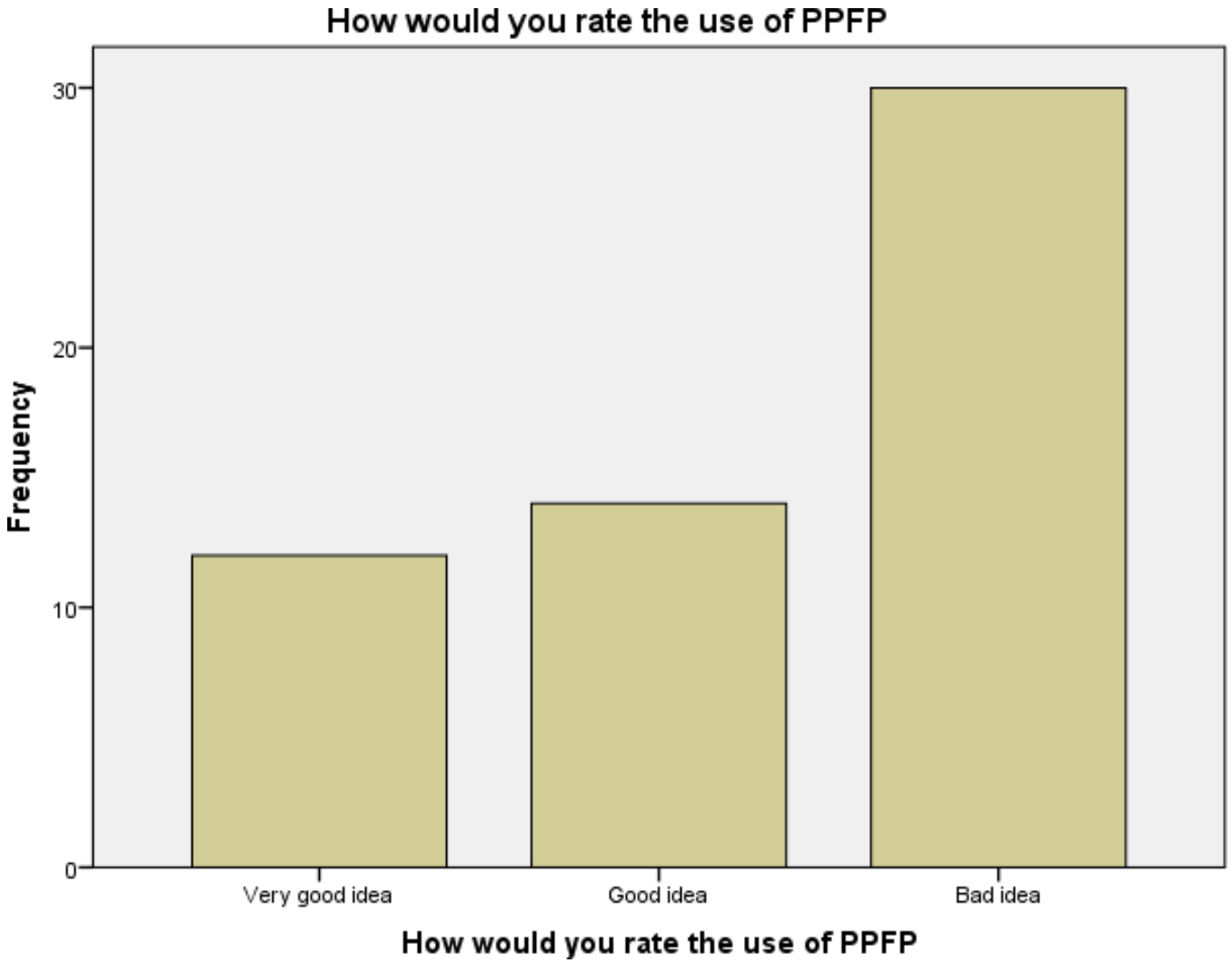

Figure 1: showing the rating of the use of PPFP

Knowledge of the health workers about PPFP were rated to be highly knowledgeable, fairly knowledgeable and not knowledgeable. A greater percent (67.9%) rated the Kiryandongo hospital health workers to be highly knowledgeable about PPFP, and a lesser percent 3.6% of the respondent rated the health workers as not knowledgeable about PPFP as indicated in table 4

This table indicate that less than half (35.7%) of the respondents reported, the health facility has no challenges which can hinder them from using PPFP however report from those who have ever had challenges at the health facility showed that, majority (33.9%) of the respondents associated low uptake to inadequate counselling by the health workers, equal percentage (12.5%) said uncooperative and inadequate staffing respectively are the reasons for low uptake. The lowest percentage 5.4% of respondent associated the low utilization to too long waiting hours at the health facility.

3.7. Association between socio demographic characteristics and uptake of PPFP from 0-6 weeks after birth.

As shown in table 6, a chi- square analysis revealed that there is a significant association between age and uptake of PPFP where mothers at a younger age are more likely to use PPFP within 6 weeks after delivery [$x^2(1)$

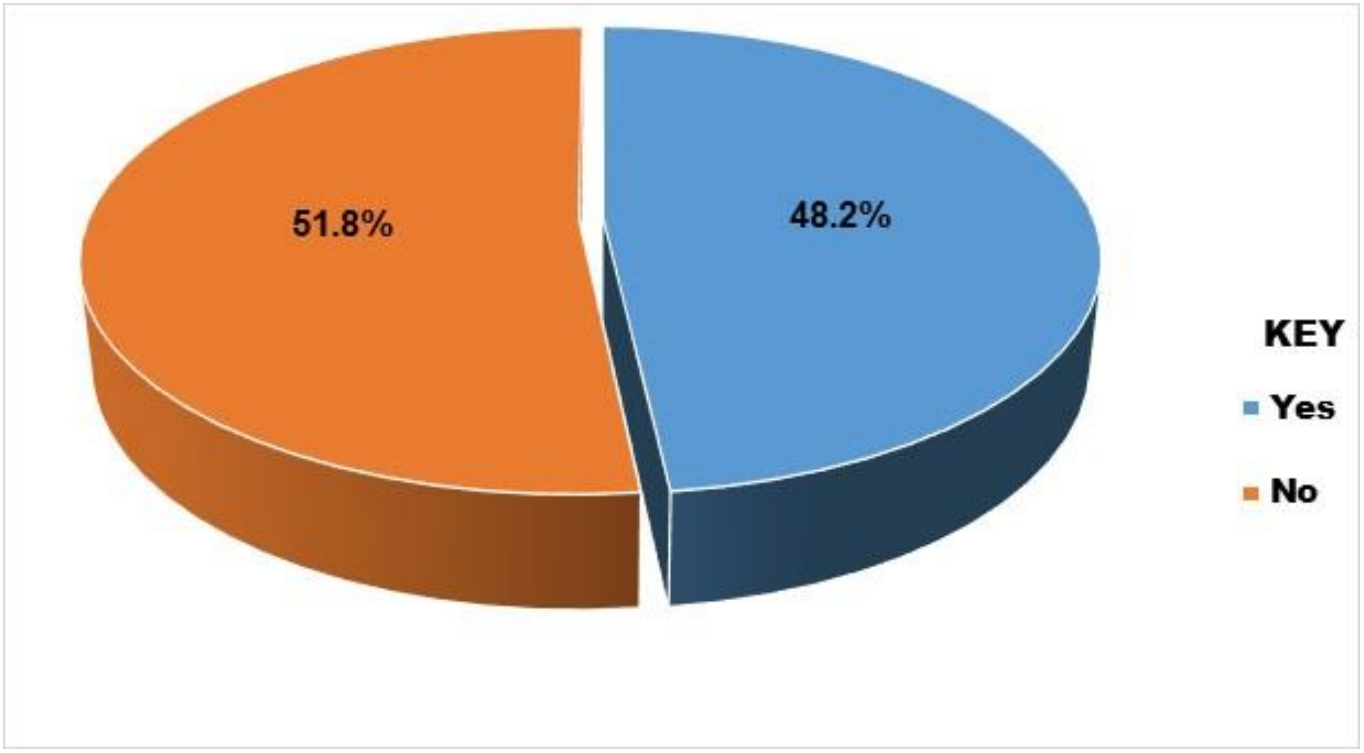

Figure 2: Showing the recommendation of use of PPFP

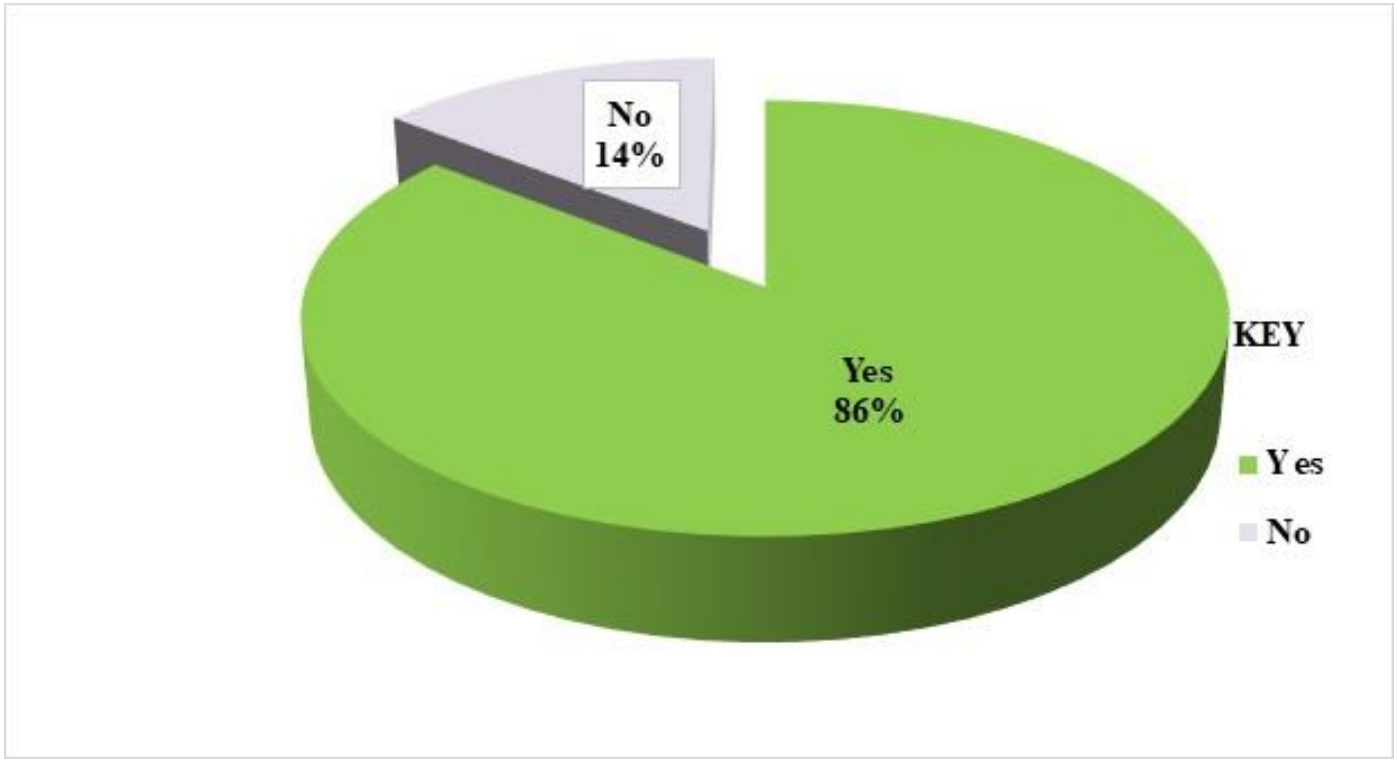

Figure 3: Availability of equipment andsupplies for PPFP use.

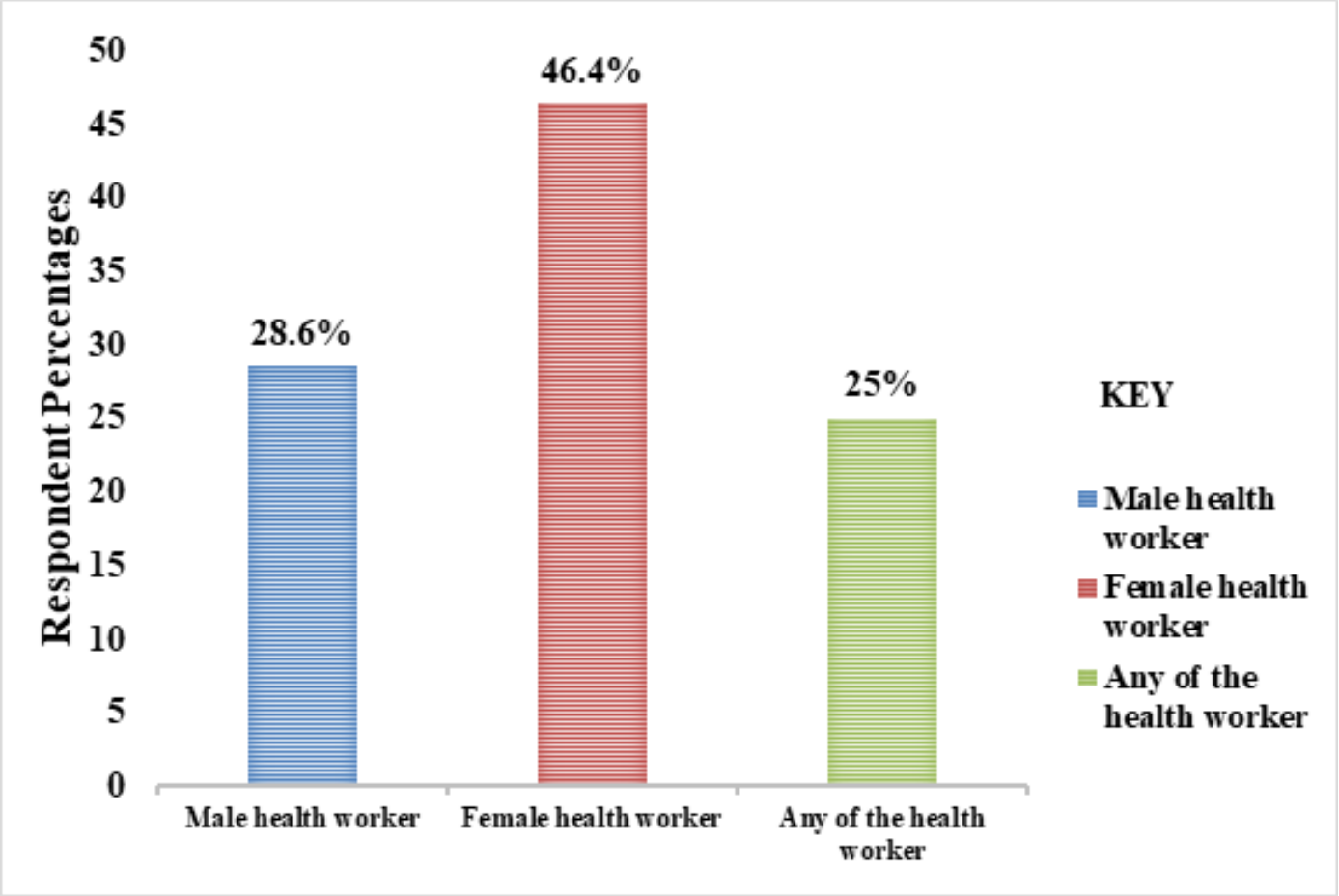

Figure 4: Preference of the health worker to administerPPFP methods

Table 5: Maternal perceived challenges hindering mothers from PPFP use at the Health facility

Health facility challenge hindering PPFP use	Frequency	Percentages (%)
Inadequate counselling about PPFP	19	33.9
Too long waiting hours	3	5.4
Uncooperative health workers	7	12.5
Inadequate staffing	7	12.5
No challenges from the health facility	20	35.7
Total	**56**	**100.0**

=6.222[a]; p<0.045]. There is also significant association between religion and uptake of PPFP [x^2(1) =6.257[a]; p<0.044]

3.8. *Association between attitude and uptake of PPFP from 0-6 weeks after birth.*

As shown in table 7, a chi- square analysis revealed that there is a significant association between attitude and uptake of PPFP where mothers who perceived PPFP to be both very good and good are more likely to use PPFP within 6 weeks after delivery [x^2(1) =7.840[a]; p<0.020].

In the same way, there is also a significant association between Hospital challenges and uptake of PPFP where challenges such as inadequate counselling, long waiting time, inadequate staffing and uncooperative health workers may affect the use PPFP within 6 weeks after delivery [x^2(1) =10.114[a]; p<0.039].

Table 6: Association between socio demographic characteristics and uptake of PPFP from 0-6 weeks after birth

VARIABLE	UPTAKE OF PPFP FROM 0-6 WEEKS AFTER BIRTH			
	YES	NO	Pearson chi-square value	p-value
AGE				
15-24	5	16	6.222a	0.045
25-34	1	20		
35-45	0	14		
Religion				
Catholic	6	23	6.257a	0.044
Anglican	0	26		
Others	0	1		
Marital status				
Married	6	31	3.451a	0.063
Single	0	19		
Tribe				
Munyoro	5	17	5.519a	0.063
Acholi	1	28		
Others	0	5		
Occupation				
Farmer Student	6 0	28 1	4.348a	0.361
Civil servant	0	9		
Shop vender	0	1		
Others	0	11		
No of children				
1-4	6	39	6.105a	0.412
5-6	0	7		
Above 6	0	4		
Level of education				
None	2	6	4.274a	0.233
Primary	4	25		
Secondary	0	7		
Tertiary	0	12		

4. DISCUSSIONS:

Data analysis and interpretations revealed the following major findings under each of the objectives as stated below;

4.1.

4.1.1. Socio demographic factors influencing the low uptake of PPFP

The study showed that (37.5%) of the respondents belonged to age group 15-24 and a similar percentage also belonged to 25-34 respectively, a substantial percentage (30.4%) of respondents had only one child, meaning the majority were young mothers within their active reproductive phase who intend to have 4 or more children during their reproductive age. This shows that the majority are still interested in having more children following their first or second delivery.

The study found that mother at a younger age are more likely to use PPFP immediately after delivery than those who are above 35 years. This is in line with a study done by Gahungu et al.,

Table 7: Association between hospital challenges, attitude and uptake of PPFP from 0-6 weeks after birth.

VARIABLE	UPTAKE OF PPFP FROM 0-6 WEEKS AFTER BIRTH			
	YES	NO	Pearson chi-square value	p-value
Is Hospital supplies enough				
Yes	5	43	0.031a	0.860
No	1	7		
category of Health worker to give you service				
Male	6	10	1.120a	0.29
Female	0	26		
any	0	14		
KNOWLEDGE OF HEALTH WORKERS				
Highly knowledgeable	4	12	5.342	0.069
Fairly knowledgeable	2	24		
Not knowledgeable	0	14		
Hospital challenges				
Inadequate counselling	0	17	10.114a	0.039
Long waiting time	0	3		
Uncooperative health worker	3	4		
Inadequate staffing	1	6		
No challenge	2	20		
Rating the use of PPFP				
Very good	3	9	7.840	0.020
Good	3	11		
Bad	0	30		
Would you recommend someone to us PPFP				
Yes	6	32	3.183	0.074
No	0	18		

(2021) which cited that the age of women, either young or old, depending on the type of contraceptives, can affect the PPFP

This study found that, almost all mothers were Christians. Meaning the general trend of low PPFP use across all the churches could be attributed to doctrines which negatively influences the use of family planning methods. This correspond with Alemayehu Gonie (2018), who found that in Ethiopia, the low acceptance of the immediate PPFP was highly associated with religious beliefs.

In this study, acceptance of PPFP was likely to be higher among women who never went to school or stopped in primary compared to the highly educated women. This variation might indicate that highly educated women spend most of their time at the work place and rarely attend antenatal clinic or family planning counselling and the less educated women easily understand and trust information from health workers without much biasness as they are considered to be knowledgeable in society.

The study found that the high refusal percentage of (51.8%) is associated to respondents' fear about PPFP side effect such as lower abdominal pain, heavy bleeding, infections, fear of expulsion and fear of being divorced. This finding agreed with (Alemayehu Gonie, 2018) who attributed reasons for refusal to fears of complications (24.8%), religious beliefs (19.8%), and husband refusal (17.7%). It shows that maternal un-

resolved fears or misconception can be a potential barrier to effective decission making about PPFP use.

This study found that, there was a direct relationship between women's perception of the usefulness of PPFP and the preferred time for PPFP use The majority of mothers who perceived PPFP as bad preferred late use of the FP methods.

4.1.2. Health facility factors influencing the low uptake of PPFP

Tsigue, Yolande, Austine, Abdoulaye, & Blami (2018), reported that, interruption of effective PPFP services is associated with delayed procuring of PPFP equipment for insertion this finding contradicts with finding in this study which showed that, majority (86%) of respondents reported Kiryandongo Hospital had all the necessary equipment and supplies for PPFP administration. It's therefore evident that the low uptake of these methods could be associated with other health facility factors such as availability of other family planning option, health professional attitude, inadequate counselling, unskilled health professionals, and gender of the available health workers.

This study found that a substantial percentage of the respondents rated the health workers as highly knowledgeable although uptake was low. Monga A (2011) report showed that, health service provider's knowledge and ability to offer PPFP methods greatly influences the mother's choice for PPFP use. Contrary to this study, a report from Rwanda showed that, underutilization of PPFP was due to inadequate knowledge and unskilled health workers in the health facility (MOH Rwanda, USAID, MCS program, 2018). This variation could be that respondents in this study assumed that the health workers were knowledgeable.

This study revealed that majority of mothers feel comfortable having PPFP offered by female health workers compared to male health workers. Similar findings by (Clelanda, Alib, & Lenka Benovaa, 2017) showed that, "some women preferred female health workers to offer FP methods due to privacy purpose". This was consistent with report from (Nuria, Moshabela, Owusu- Ansah, Kapungu, & Geller, 2018) who found that in rural setting of Ghana gender of the health service provider was considered a potential barrier to PPFP use since majority of female respondents reported feeling more comfortable having PPFP offered by a female health provider compared to male health providers. This marked preference for the service provider could be because of need for privacy, difficulty expressing self to opposite sex, cultural norms which restrict women exposing their body to men who are not their husband.

5. Conclusion:

In conclusion, it's deduced that the commonly identified socio demographic factors included age groups, religion and attitude were significantly associated with the utilization of PPFP within 0-6 weeks, extreme fear and misconception of pain, infertility, heavy bleeding, and infection, this also included unauthentic sources of information about PPFP. These socio demographic factors are made worst by some health facility factors such as inadequate counselling of mothers, uncooperative health workers and often few skilled service providers leading to overwaiting by the clients were also significantly associated with PPFP within 0-6 weeks utilization. These can be reduced by strengthening the health facility ability to adequate disseminate accurate information to mothers and to community at large.

5.1. Recommendation

Ministry of health in conjunction with none governmental bodies should set out clear policies about dissemination of information about family planning methods to mothers. This will help to control missed out of important information and address inaccurate information about family planning services.

Healthcare providers should build the capacity of community health workers to promote effective community awareness about PPFP and its advantages to families and society at large.

There is need to train all health service providers about need for PPFP services to fami-

lies. This will promote health workers confidents and accuracy when counseling mothers.

Further research should be conducted among health workers, and among mothers living in urban setting in order to determine a general-reasons for low uptake in the different health facility in the country.

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7. LIST OF ABBREVIATIONS

ANC - Antenatal care
IPPF - Immediate postpartum family planning
IUD - Intra uterine device
POPs - Progesteron only pills
PPFP - Postpartum family planning
UDHS- Uganda Demographic Health Survey
WHO - World Health Organisations

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