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# Knowledge Attitude and Barriers to the Use of Family Planning Among Married Men and Women at Fort Portal Hospital-Kabarole-Uganda.

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## ABSTRACT

According to the Uganda Demographic and Health Survey, most women and men knew some family planning methods but only about 29% of married women were using contraceptives. 20% of women had an unmet need for family planning. We examined knowledge, attitudes and contraceptive practice as well as factors related to contraceptive use in Fort Portal region Uganda. Methods: Data were collected between Sept-Nov 2023 among 160 married couples using a multi-stage sampling design. Quantitative data was based on semi-structured questionnaires and was triangulated with qualitative data collected during focus group discussions. We compared proportions and performed logistic regression analysis. The concept of family planning was well-known in the studied population. Sex-stratified analysis showed pills and injectables were commonly known by both sexes, while long-term contraceptive methods were better known by women, and traditional methods as well as emergency contraception by men. Formal education was the most important factor associated with better knowledge about contraceptive methods (aOR = 2.07, p,0.001), in particular among women (aOR women = 2.77 vs. aOR men = 1.49; p,0.001). In general, only 1 out of 160 men ever used contraception, while 65% and 44% of females ever used and were currently using contraception respectively. The high knowledge of contraceptives did not match with the high contraceptive practice in the study area. The study demonstrated that mere physical access (proximity to clinics for family planning) and awareness of contraceptives are not sufficient to ensure that contraceptive needs are met. Thus, projects aiming at increasing contraceptive use should contemplate and establish better counselling about contraceptive side effects and method switches. Furthermore, in all family planning activities, both wives' and husbands' participation should be considered.

**Keywords:** Family planning, Contraceptive use, Women, Men, Married couples.

## INTRODUCTION

The population of any society depends primarily on its territory or physical environment for sustenance. Most of its food and other needs largely derive from the environment, which consists essentially of land and its derivatives [1]. Unfortunately, while populations of nations increase over time, the various land masses on which these populations depend for sustenance are relatively fixed. Herein, lies the general concern about population size and growth rate [2]. However, the key to understanding overpopulation density, but the number of people in an area relative to its resources and the capacity of the environment to sustain human activities [3]. It was Malthus who first raised the alarm that a stage would reach in the world population when the food supply would not match population growth. Many authors have since reiterated the

concern of Malthus [4]. While the developed countries have managed to overcome the Malthusian prophesy, the same is being fulfilled in developing countries. In Africa, the problem of food shortage is associated with social problems ranging from poverty, scarcity of land, hunger and environmental degradation, to political and social instability [5]. Nigeria, with a population of over 140 million has become the largest country in Africa in terms of population. Also, according to [4], Nigeria is already facing a population explosion. The result of the population explosion is that food production cannot match the growing population, and there is an inadequate water supply, a high unemployment rate and an increase in crime in the country. In Nigeria today, the birth rates are higher than the world average [6, 7]. Thus, there is a need

for drastic measures to reduce the population. In the same vein, many developing countries like Korea, Brazil, India and Bangladesh have successfully applied family planning programs as a panacea for overpopulation. Uganda has also adopted a family planning strategy to curb the high rate of population growth that it is presently experiencing. However, the adoption rate of the family planning method is still slow [8]. Globally, it has become a concern for the whole world as to how to save the world from destruction and devastation that would be the consequence of overpopulation [9]. Individually, all the countries in the world are taking up measures to limit and control the population of their country but then in most of the countries the rules are not rigid and the counter actions are not stern. Therefore, the measures have been followed properly. Family planning has been the keyword in the run for development which the third world countries, particularly, Nigeria have been suggested towards reducing the high fertility rate in the country.

#### **Statement of Problem**

Around the world, the increase in the rate of fertility, especially in less developed nations is worrisome that all measures including contraceptive devices suggested or put in place at national, community and household levels in reducing it seem not to have had much impact [10]. Over the years, family planning policy has helped tremendously in reducing poverty. As the

#### **Study design**

This was a cross-sectional study designed to assess the knowledge, attitude and barriers to the use of family planning among married men and women who visit FRRH.

#### **Area of Study**

The study was conducted at FRRH which is located in Fort Portal City about 300.2km west of Kampala. The hospital caters for the population of the Rwenzori sub-region at the foothill of the Rwenzori Mountains in western Uganda, close to Queen Elizabeth National Park encompassing districts of Kasese, Rubirizi, Kamwenge, Bunyangabu, Kabarole, Bundibugyo and the eastern part of DR Congo; with overall population over 3 million people.

#### **Methods of data collection**

Methods detailed included a description of the study design, study area, study population, sample size determination, sampling technique, inclusion criteria, exclusion criteria, study variables, research instruments, pretesting of data collection tools, data collection procedures, data management, data analysis and presentation, ethical considerations, study

number of destitute people in the world kept growing, the issue of population was having an increasing impact on poverty and development [11]. In Uganda, 44 per cent of pregnancies are unplanned. One approach to decreasing unmet needs is promoting male involvement in family planning. Male disapproval of the use of family planning by their female partners and misconceptions about side effects are barriers to family planning globally and in Uganda in particular. However, statistics reveal that Africa's destitute population has dropped from 250 million in 1979 to 30 million at present. In rural areas, the proportion of destitute people declined from 30.7 per cent to 3 per cent in the same period. Therefore, to encourage the citizens and households to adopt family planning policies and spread the concept of bearing healthier children rather than as many children as possible, the African governments keep increasing funds for family planning and other reproductive health in poverty-stricken areas to reduce the population and poverty among the population. Based on the analysis, it is crucial that detailed scientific research be conducted to examine the factors influencing the use of family planning among married men and women attending family planning clinic at FRRH since there is no available data collected [12]. Therefore, this research aimed to determine the knowledge, attitude and barriers to the use of family planning among married men and women who visit FRRH.

#### **METHODOLOGY**

limitations and dissemination of results [13].

#### **Target population.**

All the married men and women visiting FRRH constituted our target population.

#### **Study Population.**

All the sexually active women aged 18-55 years of age visiting FRRH constituted the study population provided they met the inclusion criteria.

#### **Inclusion criteria**

Married Men and Women aged 18-55 years who will have consented.

#### **Exclusion criteria**

- Singles
- Married couples outside the age bracket
- Very sick patients
- Mentally abnormal individuals

#### **Sample size determination**

Modified Daniel's Formula was used to estimate the sample size for this study. To calculate the sample size for the study [14]

Where:

n was the sample size

Z was the standard normal deviate or variant (at 5% type 1 error and  $p < 0.05$ , Z was 1.96)

P was the expected proportion of characteristics being measured in the target population based on previous studies (For this study, it was estimated at 87.6% or 0.876) [15].

d was the absolute error or level of statistical significance (For this study set at 0.05) Thus by using this formula,

Therefore, 167 couples (334 individuals) were considered as the required sample size

#### **Sampling Technique.**

The method that was employed in selecting a sample from the population was a simple random sampling technique. The simple random sample aimed to reduce the potential for human bias in the selection of cases to be included in the sample. Each of the men and women in the study population had equal chances of being selected.

#### **Data collection methods and management.**

Data was collected using a structured interview-based questionnaire [16]. The questionnaire was prepared in English language and translated to Lutooro during the interview process where necessary. Data was collected on sociodemographic variables, knowledge of family planning methods, the utilization and attitude towards using family planning and barrier. The questionnaire was pre-tested in 5% of the total sample and necessary amendments were considered by getting 20 participants not part of the sample size in a different hospital (KIU-TH). Agreement of 80% indicated the reliability of the questionnaires.

#### **Data collection procedure**

An introductory letter was provided from the KIU-WC and presented to the Hospital Administrator FRRH who permitted data collection. I introduced myself to the participants and explained to them the purpose of the research. Consent forms were given out and signed by willing participants. Questionnaires were given to respondents to fill and those who were not able to read and write were guided then I checked through the filled questionnaires before leaving the data collection area to ensure completeness.

#### **Data processing and analysis**

The data was entered, cleaned and analyzed using SPSS Version 24. Descriptive statistics like the frequency, proportion and mean were used. The

following operational definitions were used:

**Knowledge:** I used a fourteen-item composite score of the knowledge to measure the knowledge level of respondents regarding family planning, and methods of family planning each correct answer was awarded a score of 1 while each wrong answer was awarded a score of 0. The cumulative mean score of knowledge of participants about family planning was estimated using a mean score [17]. Based on this, those who scored greater than or equal to the mean value were considered as having good knowledge and those who had scored less than the mean were considered to have poor knowledge. **Attitude** I selected five items to measure attitude towards proxy variables of benefits of using family planning. I used five scales (Strongly disagree, Disagree, Neutral, Agree and strongly agree) to measure the level of agreement on each selected item. **Barrier:** Barriers were assessed using questions having "True", "False" or "Don't know" responses on the respondents' views regarding the health system, and personal-related and knowledge-related barriers to using family planning. The collected data was presented in terms of frequency, and percentages and transformed into tables and graphs.

#### **Quality assurance and quality control**

A pre-test was conducted on 5% of the sample. Based on the pre-test, modifications were made to the questionnaire. The data compilation system and data completeness were checked and strictly controlled by the principal investigator.

#### **Ethical considerations**

The research was subjected to approval by Kampala International University, Western Campus, Research Board. A research permit for and permission to conduct data collection was sought from the Medical Superintendent, FRRH. Care was taken to ensure that all those who agreed to participate in the study did so voluntarily, and gave their written informed consent. To obtain informed consent, then I explained the aims and objectives of the study to all those who participated and they were allowed to ask for any clarification. Any information collected was kept confidential and no names appeared on research documents. Any participant could opt out of the research at any stage. No benefits in the form of money, gifts or any materials were given to research participants to be involved in the study [18].

## **RESULTS**

### **Socio-Demographic Characteristics**

A total of 160 out of 167 sampled couples responded, equating to a response rate of 95.8%. All women were between 18 and 55 years old (as per inclusion criteria), with a median age of 30 (IQR = [25;35]). The median

age among males was 36 (IQR = [30;45]) (see Table 1). Almost two-thirds of the women ( $n = 105$ , 66%) had not received an education, but 40 (25%) had completed primary education; among men, 36 (23%) had not received an education while 86 (54%) had

completed primary schooling. Batooro were the principal ethnic group accounting for 139 (87%) individuals; 9(6%) others were banyankole, 3(2%) Bakonjo, 3 (2%) bakongo, 1 (1%) Bahima, and 3 (2%) from other ethnic groups. The majority of the respondents, 147 (92%) women and 145(91%) men, were Catholic; the second most prevalent religion was Protestant Christianity with 11(7%) women and 11 (7%) men. Education levels were different across these two most prevalent religions: 12 (4%) Catholics had completed secondary education in comparison to 16 (6%) protestant Christians.

Agriculture was the main occupation of the interviewees with 144 (90%) men and 131(82%) women; 14 (9%) of the women reported being housewives. The median income of couples was (100,000), which is approximately 27.7\$, per month, according to information obtained from the wives. Daily laborers had a median income of 200,000 Ughs

per month, and government employees 500,000 Ughs. The median household size was 5 with a median of 3 children, and 80 (50%) households comprised of five to seven members. Literate respondents had smaller household sizes than the illiterate. The median age at first marriage for men aged 16–45 was 21 and 16 (for women aged 20–49. There were 40 (25%) males and 105 (66%) females who married before age 18. The median duration of the couple's marriage was 11 years. Among the husbands, 44 (27%) stated having been married already before the current union. One-third of the female respondents (n = 60, 38%) reported having ever lost at least one child; 115(72%) reported ever having lost at least one boy, 96(60%) at least one girl. More than 97% of the study participants had access to health facilities providing family planning services in their surroundings (at least health post i.e. Primary level health care in Uganda (can serve 2,000–6,000 individuals).

**Table 1: Socio-Demographic Characteristics of contraceptive methods**

Characteristics at individual level	male N=160	female N=160
median age	36 (IQR = [30;45])	(IQR = [25;35]). 30yrs
Education		
no education	36 (23%)	105 (66%)
primary level	86 (54%)	45 (25%)
Religion		
Catholics	145(91%)	147 (92%)
Protestants	11 (7%)	11(7%)
Occupations		
farmers	144 (90%)	131(82%)
housewives		14 (9%)
median age at marriage	21	16
ever had a child who died in childhood		n = 60, 38%
Characteristics at household level		
Media income of couples	100,000 ugsh	
median household size	5	
median duration of marriage	11 yrs.	

### Fertility preferences

A majority wanted to have more children: 116 (73%) among the men, 104(65%) among the women. The median desired number of children before using family planning among both women and men was 4 (IQR = [3;5]). Of 44 women who had reached or exceeded their desired number of children, 16 (37%) still reported a need for more children; on the other hand, among the men having reached or exceeded that number, 38 out of 71(53%) wanted more children. Overall, 52(46%) respondents of the 115 desiring more Children expressed a sex preference for the next child. Among men, 24 (34%) wanted a boy versus (10%) a girl; among women, these numbers were respectively (27%) and (17%).

Sex preference varied depending on the number of boys and girls already living in the family. Respondents with no boys had a distinct desire to have a boy as the

next child. This preference disappeared among women once they had at least one boy and among men once they had two boys. A similar preference for a girl is noticed in respondents who did not have girls yet, although the extent of this preference is more limited. On average, both men and women had a preference for a boy if they had at least one girl.

### Knowledge of Family Planning

The concept of family planning was well known to respondents: 150 (95%) women and 155 (97%) men responded ever heard of it. The median number of methods of contraception that were known among men was 5 (IQR = [2;8]) which was the same among women 5 (IQR = [3;6]); No relationship was found between knowledge level and age, religion or ethnic affiliation. Formal education, on the other hand, was associated with a higher knowledgeability about contraceptive methods, in particular among women

Method-specific knowledge levels varied from 12% for vaginal contraceptives (diaphragm, foam, jelly) to 94% for injectable contraceptives. Differences were found between men and women (Table 2). Only short-term hormonal methods like the contraceptive pill and injectable contraceptives were consistently well-known

by both sexes. The least known were the permanent methods, traditional methods and emergency contraception. Major differences between women and men were noted for the long-term hormonal methods. Similarly, knowledge of contraceptive use decreased with increasing age even when correcting for sex.

**Table 2: Knowledge of contraceptive methods (expressed in percentage).**

	total=320	male=160	female =160	p value
Short term hormonal methods	95%	99%	92%	
Pills	91%	93%	81%	0.005
Injectable	94%	98%	84%	<0.0001
Long-term hormonal methods	80%	95%	65%	
IUCD	41%	52%	32%	<0.0001
Implants/ Norplant	79%	63%	64%	<0.0001
Barrier methods	62%	60%	63%	
Condoms	61%	60%	63%	0.285
Diaphragms/foam/jelly	12%	18%	6%	0.0001
Permanent methods	43%	36%	49%	
Male sterilisation	13%	16%	6%	0.0001
Female sterilisation	41%	35%	47%	0.0001
Traditional methods	41%	30%	52%	
Standard days method	32%	43%	40%	0.0001
Lactational amenorrhoea method	15%	9%	22%	0.0001
Rhythm method	25%	22%	29%	0.0001
Withdraw method	21%	22%	19%	0.160
Emergency contraception	15%	9%	25%	0.0001



### Attitudes towards Family Planning

Of the 320 respondents, 93% (297) were in favour of family planning; logistic regression showed that factors associated with a more positive attitude towards family planning were: being a man, young age and being literate. Male respondents were asked specifically whether they would support their wives to use family planning. Of the 160 male respondents, 145 (91%) answered positively and 8 (5%) negatively. This finding was corroborated during the focus group discussions with married men.

### Contraceptive Practice/barriers

We did not consider husbands' number of children at first contraceptive use as only 1 (0.5%) males reported having ever used contraceptives. Condom use was thus very low. Among women, 104 (65%) ever used a method of contraception; 70 (44%) were using contraception at the time of the survey. This difference in contraceptive use between men and women was corroborated by the focus group discussions as these showed that both married women and men mostly considered contraceptive use as a woman's task: "What will I do in a family planning clinic, contraception is a woman's business, I will just give my wife the necessary financial support she needs" (Male, 43 years). 84 (53%) wives had one to two children at their first contraceptive use. The median number of children a woman had when starting contraception was 2 (IQR = [2-2]) which corresponds to 2 children less than what they considered the ideal number of children. The most commonly used methods when starting contraception were injectable (61 out of 160, 38%) and oral (37 out of 160, 23%) hormonal contraceptives. The prevalence of these hormonal contraception methods was much related to the age of the woman. Injectable methods were most common among younger women

while oral contraceptives were more frequently used by older women. Of the 70 women who were using contraceptives at the time of the survey, 58 (83%) were using injectable and 8 (11%) oral contraceptives. Multivariate analysis showed that higher current use of contraception among women was associated with being literate. The same factors were also determinants for contraceptives having ever been used. Reasons given by males for not using contraception included being recently married 49 (31%) and lack of knowledge of the different types of methods 53 (33%). The reason for not using contraception given by both males and females was the desire to have children (82 (52%) men and 74 (46%) women). Among women, fear of side effects was reported by 42 (26%) as the reason for not using contraception (see Figure 1). Likewise, the qualitative findings also indicate fear of contraceptives' side effects as a barrier to use contraception by women: "Women don't use contraceptives because they don't want to get paid by the side effect of pills and injectable" (Female, 27 years) Additional results from focus group discussions indicate that males are at least partly responsible for women not using contraceptives sometimes husbands oppose wife use of contraceptive because they think she does not want to give birth and instead she has an intention to go for another man" (Female, 34 years) Among women, 27 (38%) of current contraceptive users reported ever having switched between methods, with 66 (94%) of them giving lack of comfort as one of the reason and 39 (56%) fear of side effects. Likewise, the qualitative part supports this result. "I used one type of contraceptive and it resulted in burning sensation and excessive menses so I changed to another contraception method" (Female, 23 years).

## DISCUSSIONS

Despite the recent increase in contraceptive use, Uganda, one of Africa's most populous countries, is known to have a low contraceptive prevalence and high total fertility. The objective of the study presented in this paper was to investigate differences among males and females regarding knowledge of contraceptive methods, Attitudes and contraceptive practice Barriers among married men and women visiting FRRH Kabarole –Uganda. The results of this analysis demonstrate that more than 97% of the couples had access to health facilities that deliver family planning. The median household size of five in the study area (Fort Portal) was comparable to the national household size (4.5 persons), especially that of rural areas (4.9 persons). Literacy was found to be

linked to smaller household sizes, which is in line with previous findings. Age, at first marriage, was lower in our study population compared to national figures. For females aged 20–49 years, the median age at first marriage was 16 years, i.e. one year younger than the national median (17.8 years). Among men aged 20–59, a one-year difference with the national median was observed (22 years vs 23.1 years). This also corroborates general trends that men marry at older ages than women. Similar to [19], this study revealed that more men than women have a desire for more children. This suggests that the low use of contraception among men is partly a well-reasoned decision, and not only a consequence of limited knowledge. In this study the mean ideal number of

children was 4.2 and 4.6 among men and women respectively. This is in contrast to the national figures that show a difference in the mean ideal number of children between men and women, i.e. 5.9 and 4.9 respectively. The inconsistency with this study could partly be explained by a different formulation of questions since we inquired about the ideal number of children before starting contraception, instead of the actual desired number of children. Furthermore, we identified discrepant results with respect to the desired number of children and the desire to have additional children. Considerable numbers of couples that had reached the desired number of children still desired more. Research should be done exploring the causes of this finding. With regards to sex preference, respondents with no boys had a distinct desire to have a boy as the next child; the same pattern of wanting a girl was observed among couples that didn't have a girl yet. However, the extent of the preference for a girl was more limited. In addition, the preference was stronger among men, a finding that is supported by the results of a study conducted in Uganda in which most men (48%) reported that they would like more sons than daughters. This might be due to cultural norms around son preference or, as suggested by others, the interest in more sons could be based on subsistence reasons, such as economic security and maintaining their status within the traditional family structure. From the focus group discussions, a woman (26 years) described that she wants to have five males and three females; because the male stays with me but after marriage female follows her husband. Moreover, this study reveals nearly 36% of women reported having child deaths of which almost 70% were boy children. This could be the other possible explanation for boy sex preference. The high level of knowledge on at least one form of contraception among the participants of this study (96%) is in line with previously reported national figures (98.4%). In this study, it was observed that no significant difference between men and women about knowledge: the average number of methods known in both sexes was 5.4 contraceptive types. In contrast, at the national level, the average number of contraceptive methods known by men is higher than women (6.3 and 5.4 respectively). As such, men included in this study were less knowledgeable about different methods compared to the average Ugandan man. In the present study, short-term hormonal contraceptive methods like the pill and injectable contraceptives were consistently well-known by both sexes. Permanent methods, traditional methods and emergency contraception on the other hand were the

least known contraceptive methods. Compared to the results from the [19] women and men are more familiar with long-term and standard day methods, but in the case of barrier methods (diaphragm/jelly and male condom) and emergency contraception, the reverse is true for the study population. In addition, our study identified major differences in knowledge of emergency contraception between the two sexes. The limited knowledge of women on emergency contraception suggests that this type of contraception is not part of the standard information package that is given to women in our study area. Overall, our respondents had a positive attitude towards family planning (91%), but less than 1% of the males and 64% of the women reported having ever used any type of contraception. Other studies have already described similar findings, i.e. high awareness but low utilization of contraceptives, making this situation a serious challenge in developing countries. The [19] reported a current contraceptive prevalence rate of 29.3% for married women, which is lower than our finding (43%). A reason for this could be that the majority of our respondents have access to health facilities at the study site. Concerning method-specific contraception, injectable (39%) and oral hormonal contraceptives (21%) were the main methods used. Compared to [19], a noteworthy finding in our study is the low use of implants, suggesting that health facilities in our study area are not able to deliver this service. Among background characteristics of women, literacy, age, the number of children, and being highly supportive of family planning were found to be important indicators of current contraceptives; this is confirmed by different studies. Fear of side effects was identified as the reason for not using contraceptives among married women, a finding that has been described already in other studies conducted in Uganda and BMC. Our qualitative study findings also assured that fear of side effects is one of the most important reasons of not using contraceptives by women. In addition, this study reported that men's reasons for not using contraception were being recently married and the desire for more children. The latter is also one of the most important reasons of not using contraception among women. In general, in the study area the findings indicate a prevailing belief that contraception is only a women's business. This study has limitations resulting from the design that was used, in the sense that cross-sectional studies do not allow to establish cause-effect relationships. In addition, an important limitation is the exclusion of



couples with pregnant women from this baseline study as per the intervention protocol. This affects the contraceptive prevalence rate and could potentially affect some other indicators too. The group of pregnant couples however represented only

### CONCLUSION

The analysis of this study provides information on married men and women on knowledge, attitudes and contraceptive practice in Rwenzori region Uganda these results demonstrate that good knowledge among males and females was observed, yet differences in knowledge of specific contraception methods exist. The study reveals that mere physical access (proximity to clinics for family planning) and awareness of contraceptives are not sufficient to ensure that contraceptive needs are met. I also noticed the existence of a sex preference for boys both among men and women. Condom use by men is above the national average but it is low compared to most Sub-Saharan African countries. It is evident from this study that high knowledge of contraception is not matched

7% of all couples from our sampling frame. This leads us to believe that the effect on the figures is probably relatively small. A final potential limitation is reporting bias. It also suffered from social desirability as it is a community-based study.

with high contraceptive use. Among the reasons for not using contraception, wanting to have a child and the side effects of contraceptives were given by men and women respectively.

### Recommendations

Family planning interventions should pay particular attention to both wives' and husbands' participation in family planning, while at the same time further educating married women and men on specific methods of contraception and their possible side effects. Moreover, a considerable amount of child death mainly boy child linking with boy sex preference reflects family planning interventions to see the ways beyond only for contraceptive purposes.

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