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Family Planning Practices among Teenage Mothers in Rural Uganda: An Exploratory Study in Bugoye Sub-County

By David Santson Ayebare, Palka Patel, Geren Stone, Moses Ntaro, Dan Guiles, Jessica Kenny, Grace Nyangoma, Enid Muhindo, Andrew Christopher Wesuta, Fred Bagenda, Michael Matte, Moses Wetyanga, Peter Chris Kawungezi, Raphael Mbusa, Rabbison Muhindo, Sarah Masika, Shem Bwambale, Stephen Baguma & Edgar Mugema Mulogo

Mbarara University of Science and Technology

Abstract- *Background:* Utilization of family planning services among teenagers in resource constrained settings is faced with challenges in regard to proximity to the health facility which is prevalent in rural Uganda. Evidence on the contextual challenges and bottom-top interventions with regard to teenage mothers is limited. This study identified major health related challenges teenage mothers face in a dire need to access family planning services and proposed areas of interventions in rural underserved context of south western Uganda.

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Family Planning Practices among Teenage Mothers in Rural Uganda: An Exploratory Study in Bugoye Sub-County

David Santson Ayebare [α], Palka Patel [σ], Geren Stone [ρ], Moses Ntaro [ω], Dan Guiles[¥], Jessica Kenny [§], Grace Nyangoma [χ], Enid Muhindo [ν], Andrew Christopher Wesuta [θ], Fred Bagenda [ζ], Michael Matte [£], Moses Wetyanga [€], Peter Chris Kawungezi [₣], Raphael Mbusa [₴], Rabbison Muhindo [₲], Sarah Masika [₳], Shem Bwambale [₫], Stephen Baguma [₥] & Edgar Mugema Mulogo [₢]

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Methods: Data was obtained from a cross-sectional study involving an exploratory qualitative approach using a combination of in depth interviews, Key informant interviews and a Focus Group Discussion. Data was collected from September to December 2017. Framework analysis sequentially combining content and thematic analyses was used to synthesis emerging themes.

Findings: Inadequate knowledge, fear of negative effects and reliance on traditional herbs as alternatives to modern family planning limited utilization of family planning services among teenage mothers. Participants presumed that upon sensitization of teenage mothers and engaging their male partners were major interventions to improve utilization of family planning services in Bugoye Sub-county.

Conclusions: Mainly individual level factors influence the practices of teenage mothers towards accessing FP services. Interventions should be tailored to address these factors that limit access to FP services by adolescents.

Keywords: teenage mothers, rural underserved, family planning, bugoye sub-county, uganda.

Author α ω θ ζ £ ₣ ₢: Department of Community Health, Mbarara University of Science and Technology, PO Box 1410, Mbarara, Uganda.
e-mails: ayebaredavid@gmail.com, ntaro2001@gmail.com, wesandc@gmail.com, bagendaf@gmail.com, mattemicheal18@gmail.com, pkawengezi@mustresearch.org, emulogo2000@gmail.com
Author σ ρ ¥ §: Center for Global Health, Massachusetts General Hospital, 125 Nashua Street, Boston, MA 02114.
e-mails: palka.r.patel@gmail.com, GSTONE@partners.org, guilesdan@gmail.com, JKENNEY4@partners.org
Author χ ν € ₴ ₲ ₳ ₫ ₥: Bugoye Health Centre, P.O. Box 149, Kasese.
e-mails: grace.nyangoma02@gmail.com, mendyenny@gmail.com, moswetyanga@gmail.com, raphealmbusa176@gmail.com, muhindorabbison@gmail.com, masikasarah100@gmail.com, bwambaleshem@yahoo.com, bagumastephen3@gmail.com

Abbreviations: FP: Family Planning, ANC: Antenatal care, FGD: Focus group Discussion, TBA: Traditional birth attendants, UNFPA: United Nations Family Planning Association, WHO: World health organization.

I. Introduction

Globally, an estimated 21 million pregnancies occur among teenagers of ages 15–19 years in developing countries with almost half of which (49%) are unintended[1] and this is less than the required 100% access to family planning services by 2030 [2]. Teenagers in sub-Saharan Africa have one of the highest birth rates compared to teenagers in the other regions of the world, this accounts for a significant proportion of the total fertility among the countries in the region [3]. However, although family planning services offer chances for a teenager to avoid unplanned pregnancies through counseling, education, access to contraception and access to safe abortion, its utilization remains a major challenge because it is prevalent and its impact on health and education outcomes among teenagers is perplexing[4]. In African countries, socio-cultural and other challenges in persuading teenagers to engage with health services have been reported [5].

In Uganda teenage pregnancy is high and yet pregnancy and childbirth are the leading causes of death among teenagers aged 15–19 in low and middle-income countries [6].Universal access to sexual and reproductive health services and rights by 2030, including family planning, is a priority in the global Agenda for Sustainable Development, as is laid out in Goals 3 that focuses on ensuring good health and promote wellbeing at all ages and 5 to achieve gender equality and empower all women and girls [7]. Among the significant indicators to the footpath to Sustainable Development Goal 3 are the proportion of women in reproductive age who have their need for family planning satisfied with modern methods and the adolescent birth rate[2]. Also, there was a total fertility rate of 5.4 children, the highest in the world with the highest rates of pregnancy among teenagers with high unmet need for family planning utilization at 30.4%[8].

The high teenage birth rates reflect the vulnerabilities they experience and the lack of opportunities available for them such as end to education [9]. This is linked to the dominant laws and policies to prevent contraception in relation to age or marital status [10]. Besides, health workers in Uganda are unable to provide contraceptives to teenagers due to their own personal beliefs and biases or misinformation about laws and policies. Further, teenagers may often be unaware of where or when contraceptives are available, unable to afford them, or unable to easily access a contraceptive service-delivery point. Existing barriers in Uganda inaccessible service locations, particularly in rural settings [11].

In resource-poor contextual settings, family planning services are characterized by either lack of or existing policies coupled by lack of financial autonomy to provide basic needs in addition to transport to the health facilities[12]. Even when teenagers are able to access contraceptives, they are reluctant to admit that they are sexually active or are embarrassed to ask for contraceptives especially in rural settings where education levels are low and stigma is high [13]. The existing scholars show that the available interventions to address teenage pregnancy are disproportionate in various contextual settings in terms of magnitude and its allied factors. This study therefore aims at identifying the challenges faced by teenage mothers in accessing family planning and related interventions tin Bugoye Sub-county in South western Uganda.

II. Methods

This was a cross-sectional design using qualitative approach to data collection. Interviews were conducted with teen mothers and male partners, midwives, the focal person and the health faciltyin charge in Bugoye Sub-county, Kasese district, southwestern Uganda. Nyangonge and Muramba 1 are villages at differing distances from Bugoye Health Centre III (BHC III) with Muramba 1 nearer than Nyangonge. It was presumed that access to BHC III was affected by distance, means of transport and associated costs Teenage mothers in the two villages of Nyangonge and Muramba I were selected through purposive sampling of one woman aged 14-17 per village who had given birth were eligible for inclusion in the study and were interviewed. Male partner selected using chain referral sampling and interviewed. Traditional Birth Attendants (TBA) was selected using chain referral sampling to speak with one TBA in each study village. The study was conducted among midwives; individual interviews with all midwives at the health center were also conducted before the larger focus group discussion. Individual key Informant Interview with BHC III In-Charge and Focal person were also conducted. Approval was obtained from the Research Ethics Committee of Mbarara University of Science and Technology.

III. Data Collection

Following common recommendations for sample size in qualitative investigations advise of between five and twenty-five[14]or, elsewhere, greater than 6 interview participants in order to ensure elucidation of key themes during data collection[15]. In this study, a total of 8 interviews and one FGD were conducted. Two teenage mothers, two male partners, two TBAs, one health facility in-charge and one Focal person participated in the study.

Subsequently, upon consent face–to-face interviews were conducted with teenage mothers, male partners and two TBAs in the two villages of Nyangonge and Muramba I. Interviews were conducted with In-Charge and Focal person of Bugoye HC III. Also, a Focus Group Discussion (FGD) with midwives at Bugoye HC III was conducted. Discussion guides were used to provoke data from all the respondents. Interviews with health workers were strictly in English while the TBAs, teenage mothers and male partners were done in the local language of Lhukonzo. Translated discussion guides were used. Responses were digitally voice recorded and transcribed verbatim.

IV. Analysis

Transcripts were reviewed and reread. Framework analysis methods were used to develop the initial codes, final codes and themes, while thematic approach was sequentially used to group themes into the broad outcomes of interest in the study. Consequently all the emerging themes were synthesized into three broad maternal child health attributes.

V. Results

a) *Major health-related Challenges of Teenage Mothers to access Family Planning*

Most participants described inadequate knowledge of family planning services, fear of the negative side effects linked to family planning and use of traditional alternatives were the main challenges affecting family planning utilization among teenage mothers in Bugoye Sub-county.

b) *Inadequate knowledge of where to access family planning services*

Participants reported that teenage mothers lacked adequate knowledge for the whereabouts of venues for the availability of family planning services. Being young, they have very little knowledge of the whereabouts of family planning and find it difficult to avoid unwanted pregnancy. One participant said:

…few women [teen mothers] use family planning, even if they [teenage mothers] wish to avoid pregnancy… the first reason why it is few people (women utilizing family planning) is that they have not got adequate knowledge about whereto get the service (Partner, Village 2)

c) *Fear of the negative side effects linked to family planning*

Almost all the participants showed concern that immediate and future side effects hindered appointments for family planning utilization. Participants reported side effects such as being barren, cancer and nausea.

"No, I can't use it. I have a complication, so I fear that family planning may make me barren… one needs to agree with the husband then she can go for family planning…usually their husbands refuse. They don't want to get barren"

(Teenage mother, Village 1)

This communication corresponded with the views of the male partner:

"I heard that sometimes they (health workers) can administer an implant to you (the woman) and it may prevent you from conceiving again, or it could cause you some sickness, but I did not understand the kind of sickness that is caused by using the implant. Yes. And on the other hand, they would say that the implant is good, so I would get confused and by then, I was still very young. And I did not know what to follow" (Partner, Village 1).

d) *Use of Traditional Alternatives in Family Planning*

Participants also thought that use of traditional medicine hindered use of available modern family planning methods. Women resorted to the use of local herbs as substitutes. As such, one participant explained:

"… She [referring to his wife] then told me that she fears injections and pills but then had got someone to give her herbs. Ummm, so that is the method (herbs) we (referring to his wife) eventually used"

(Partner, Village 2)

However, some respondents strongly disputed the effectiveness of traditional herbs.

"It (herbs) is a lie. Some people just speak because they want to extort money. They say they have local herbs that would delay pregnancy. Those are lies. There is no method apart from pills, injections and others found in the health facilities that can prevent a woman from becoming pregnant"

(Teenage Mother, Village1).

e) *Suggested interventions*

Some of the suggested interventions to the challenges teenage mothers faced were not particular for adolescents but also other women in the area.

f) *Increase sensitization programmes*

In order to improve awareness among the population, sensitization programmes were suggested.

"Its lack of awareness in the community because we need to talk to those male partners like when there is gathering such as funerals or weddings, we are supposed to tell the community that when the mother is pregnant, you (the man) are supposed to escort her to the health facility"

In addition, there was a challenge of lack of equitable equipment such as stretchers in the community associated with rough terrains.

…we don't have stretchers, so if you start experiencing labour pains like if you're almost delivering and you were not aware that your pregnancy id due, they make a local stretcher from logs, they tie the logs together and they add a cloth, then they put you on that locally made stretcher

(Teenage mother, Village 2).

Participants suggested provision of a cost shared vehicle ambulance with access to the 24 hour call center for improving the referral system, provision of an incubator. One participant confirmed:

… We make sure there is transport means, if you refer they are able to go. But even an ambulance is necessary. Because what about at night, if you refer in the night? Of course, you can't go to the village and start looking for cars and motorcycle, so you get an ambulance, put the patient and take to the health *center IV for assistance. More to that, even protection of the midwife. She must protect herself by putting on sterile gloves, aprons, gumboots, goggles, to prevent/protect her … to prevent her from infections*

(Midwives, FGD, Bugoye Health Centre III).

g) *Motivate and engage male partners*

Participants suggested that household programs that include but not limited to counseling for teenage pregnancy, spousal support, modern family planning methods and early signs of pregnancy. The team also received views that linked health package for male spouses and a transport voucher system for the couple will improve male partner involvement and engagement. Also, bringing Maternal Child Health (MCH) services closer through monthly integrated outreaches and consider family planning methods through VHTs and incorporating VHTs in MCH wards.

… male involvement; it is still a problem because if there is a problem with the mother, and you try to health educate for instance if you health educate the mother alone, when she reaches home and tells the partner, he (the partner) just keeps quiet and does not care. So male involvement is still a challenge (Health worker1)

Similarly, one study participant affirmed:

> *…we just give a health education talk; we talk about the benefits of family planning to the mother, to the baby, to the community, to the father and to the nation. So, in that health education talk, we tell them the types of family planning that we offer here [Bugoye Health Centre) and that are available,*
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> (Health worker 1).

Implications in the study shows appreciation of continued priority to mothers who come with spouses during ANC and providing health workers with incentives e.g. providing tea at night with an escort.

VI. Discussion

In a study of teenage mothers from a rural resource constrained community of differing distances from health facilities of access to health services in Bugoye Sub-county, the major health related challenges were inadequate knowledge about FP services, fear of consequential side effects and access to TBAs. The findings in our study are consistent with preliminary reports of previous authors in similar resource constrained settings. A recent literature review study about the factors associated with adolescent pregnancy in low-income and lower middle-income countries revealed that in a total of 12 articles, inadequate education, low socioeconomic coupled with insufficient access to and non-use of contraception were consistently found to be risks for pregnancy among adolescents[16]. There was certain indication that early marriage, residing in a rural area, initiation of sexual activity at an early age, belonging to an ethnic and religious minority group also increased the risk of adolescent pregnancy. However, adequate education, access to income-generating work and family support were found to protect against adolescent pregnancy. Similar to the findings of this study, there is an implication that in resource-constrained countries, as in well-resourced countries and the general rural setting, low socioeconomic status appears to increase the danger of pregnancy among adolescents. In addition, this study found that access to TBAs was a risk linked to low FP utilization similar the finding in the review [16] in that specific contexts such as cultural traditions including early marriage and inaccurate beliefs about contraception were eminent.

Similar to our study, [17] reported that diverse terrains affected access to health services by adolescents especially those residing in rural and remote areas. Additionally, in regard to fear of negative effects associated with FP, [18]reported myths and misconceptions among adolescents regarding family planning, preferably at early ages. Also, [19]in agreement to the findings in this study found that in Kenya increased risks of unintended repeat pregnancies among postpartum adolescents and family planning (FP) providers at two maternal and child health clinics in Kenya were lack of FP knowledge, community misinformation, and insufficient counseling and time with health care providers all contributed to adolescent anxieties about FP. However, it was reported that as adolescents transition to motherhood, they felt more encouraged to use FP implying a need for increased awareness of FP benefits. Similar to our findings and other scholars, [19]while examining the role of socio-cultural inhibitions in the use of modern contraceptives in rural Uganda conducted in 2012 among populations in the districts of Mpigi and Bugiri in rural Uganda persistence of socio-cultural beliefs, continued reliance on traditional family planning practices and misconceptions and fears about modern contraception greatly affected FP use. Socio cultural expectations and values remain impediments to using family planning methods suggesting a dire need to eradicate the cultural beliefs and practices that obstruct clients from using contraceptives, as well as a need to scale-up family planning services and sensitization at the grassroots.

In an array of the diverse challenges faced by teen mothers especially given the long distance coupled with diverse terrains in Bugoye Sub-county, increased awareness through community sensitization outreaches in addition to participation of male partners were the suggested interventions that can enhance access and utilization of FP. This finding is in line with those of [20] who reported inefficiencies among health workers in Uganda suggesting the need for training and equipping health care workers with the aim if improving the provision of reproductive health services to adolescents. Similarly, [21]concurred when it showed that adolescents in Uganda, both unmarried and married, face many sexual and reproductive health risks stemming from early, unprotected, and unwanted sexual activity despite inadequate access to sexuality education, and to accessible, affordable, and appropriate contraception. Besides, 25% pregnancies in Uganda among adolescents[22]. In line with this study, access to contraceptive information and services by sexually active adolescents is one of the interventions that require urgency to implement in order meet the contraception needs of adolescents while dismantling barriers that hinder adolescents from accessing family planning services. Additionally, increasing access to family planning services through community-based distribution of contraceptives and scaling up youth-friendly family planning information and services that are accessible, non-discriminatory, confidential and non-judgmental is vital.

In this study, fear of consequential side effects in addition to low male participation of family planning was reported similar to [23]who identified that low participation by males was crucial to the success of family planning programs in addition to women

empowerment. It was shown that male involvement leads to contraceptive acceptance and continuation, and safer sexual behaviors. Though inadequate choice and access to methods, attitudes of husbands towards family planning, perceived fear of negative effects, poor quality of available services, cultural or religious disagreements and gender-based obstacles are certain of the reasons for low utilization of family planning. The intentions of low uptake of FP were revealed to be the desire to have more children, wife or partner refusal, fear of consequential side effects, religious prohibition, lack of awareness about contraceptives and the thinking that it is the only issue for women. Views about uptake of family planning services including approval by husbands and current use of family planning methods were associated with male involvement in the services utilization.

In line with [23]similar to our study realized that many men express fear safety and inconvenience of modern family planning methods such as general sickness, menstrual disturbance, weight gain or weight loss, nausea, weakness, infertility, and malformation of newborns. Also, lack of couple communication, trust and couple counseling are major obstacles for the involvement of men in family planning. In addition, lack of communication between couples influences perception towards contraceptive use. In support, adolescents often lack basic reproductive health information, knowledge, and access to affordable confidential health reproduction for reproductive health[24].

It was noted by [25]that health providers have failed to achieve successful male involvement in pregnancy care especially in rural and remote areas where majority of the underserved populations live. Besides, the paradoxical influence of TBAs and use of herbs was identified. TBAs trained and equipped to ensure better care and quick referral identified was back in 1997showed a controversial finding. Turinawe, Rwemisisi [25]showed that TBAs were beneficial to both men and women in that TBAs sensitized men using both cultural and biomedical health knowledge, and become allies with women in persuading men to make available resources needed for maternity care. Also, [25]found that men trust and have confidence in TBAs and suggested that closer collaboration with TBAs provides a suitable platform through which communities can be informed and men actively carried on board in supporting maternal health services for women in rural communities.

In regard to this study, [26]from a health worker perspective indicated that in Kabwe district, Zambia health systems barriers include long distances to healthcare facilities, stock-outs of favorite methods, lack of policies enabling contraceptive access in schools, and undesirable provider attitudes. Also, community level barriers comprised experience with contraceptive side effects, myths, rumours and misconceptions, societal stigma and negative traditional and religious beliefs. Besides, health systems enablers consisted of political will from government to expand contraceptive services access, integration of contraceptive services, [27]in a study at Four hundred and twenty four females of reproductive ages were selected from both Inpatient and Outpatient Departments of Atiak Health Centre IV indicated that long distance to health facility, unavailability of preferred contraceptive methods, absenteeism of family planning providers, high cost of managing negative effects, wish for large family size, children dying less than five years old, men forbidding women from using family planning and lack of community leaders' involvement in family planning programme.

In addition, fear of consequential side effects and myths were reported by [28]who even realized that in developing countries, largely male dominated culture is eminent and the side effects of FP methods and the treatment of side effects and male involvement in which men showed little interest in participating in family planning issues were the major barriers to family planning services. According to [29]in relation to this study reported that adolescents in Kenya experience a higher risk of mistimed and unwanted pregnancy compared to older women, fear of consequential side effects and adverse reactions were a most important barriers to practice. Many fears were based on myths and misconceptions. Besides, most adolescents indicated that they learnt about both true consequential side effects and myths from their social links.

This study has demonstrated that various limitations to this work should be considered. This study being a cross-sectional study, limited our ability to actual health challenges that cause low utilization of FP and predictive interventions to curb the challenges identified. Second, the tools were self-constructed and pretested in Lukonjo and English and administered in communities of varying geographical scopes which could be affected by the diverse regional differences. The study was conducted within one Sub-county of Kasese District and the findings may not be directly transferable to other rural settings or districts of Uganda. Public transport in the study area is worse than in more remote areas.We expect our findings cannot provide the magnitude of the challenges and the corresponding interventions.

VII. Conclusion

Teen mothers in rural poor constrained settings of rural western Uganda mainly face individual level factors that influence the practices of teenage mothers towards accessing FP services. The adolescent friendly interventions should be tailored to address these factors that limit access to FP services by adolescents.

Availability of data

The data used to support the findings of this study are available from the corresponding author upon request.

Competing interests

The authors declare no conflicts of interest regarding the publication of this paper.

Authors' contributions

DSA was involved in the design, implementation, data analysis, interpretation of findings and write up of the paper. EMM, FB, MN, BB and PL were involved in the conception of idea, design, and implementation, interpretation of findings and review of the paper. PCK, ACW, RN, SM, RM, MM, GN, EM, MW and SB were involved in design, implementation, analysis and write up of the paper. GS, DB, LC, PP, JK, RR, SMM and DG were involved in conception of the idea, design, review and write up of the paper.

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Ethical approval and consent of participants

This study was approved by Research Ethics committee of Mbarara University of science and Technology. The team obtained written informed consent from study participants.

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