

**ACCESS TO MODERN FAMILY PLANNING SERVICES AMONG ADOLESCENTS
IN KANGAI TOWN COUNCIL DOKOLO DISTRICT**

CATHERINE ACEN

J23/MUC/BSW/038

**A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR IN SOCIAL
WORK AND SOCIAL ADMINISTRATION OF UGANDA**

CHRISTIAN UNIVERSITY

September, 2024




**UGANDA CHRISTIAN
UNIVERSITY**

A Centre of Excellence in the Heart of Africa

DECLARATION.

I ACEN CATHERINE, declare that this research report is my original work and has never been submitted to any academic institution of higher learning for the award of a degree.

NAME : ACEN CATHERINE.

SIGNNATURE : 

DATE 28. 9. 2024.

APPROVAL

This is to certify that this research report was been written under my supervision and it is now ready to be submitted to the department of social science of Uganda Christian University with my approval.

SIGNNATURE :

A handwritten signature in blue ink, appearing to be 'MUNIALO PAUL', with a horizontal line extending to the right.

MR MUNIALO PAUL.

RESEARCH SUPERVISOR.

ACKNOWLEDGEMENT.

The information in this report would not exist without the help, trust and opportunity that kangai sub county gave me to experience life outside classroom setting, the joy of passionate services to the vulnerable and needy people. my sincere gratitude and appreciation goes to the entire staff of kangai sub county for the love and care given me during my research proposal writing.

Above all I would like to thank almighty God for enabling me finish this research proposal and to my supervisor, my sister, my parents and my husband.

LIST OF ABBREVIATIONS.

MPF_	Modern Family Planning Services.
SSA_	Sub Sharan Africa.
MOH_	Ministry of Health.
LMICs_	Low Middle Income Countries.
HIV_	Humane Immune Virus.
STIs_	Sexual Transmitted Deficiencies.
STI_	Sexual Transmitted Infections
FP_	Family Planning.
SBHC_	School Based Health Centers.
CHCs_	Community Health Centers.
ICDP_	International Conference On Development and Population.
NRHS_	National Reproductive Health Services.
NRHP_	National Reproductive Health Policy.
PPAG_	Planned Parenthood Association of Ghana.
ARHD_	Adolescents Reproductive Health Development Policy.

LIST OF FIGURS

Figure 1: Conceptual Framework.....	7
Figure 4.1 pie chart provides a comprehensive overview of the demographic characteristics of the 320 respondents in the study.....	24
Figure 4.2: This bar graph categorizes the respondents based on the socio-cultural institutions.....	25
Figure 4.3: This bar graph assesses the respondents' perceptions regarding the promotion and sustainability of family planning services.....	28

LIST OF TABLES

Table 1: showing categories of the respondents to be sampled for the study.....	17
Table 1: Demographic Characteristics of Respondents.....	22
Table 2: Distribution of Respondents by Socio-Cultural Institutions.....	24
Table 3: Barriers to Accessing Modern Family Planning Services.....	25
Table 4: Roles of Socio-Cultural Institutions.....	26
Table 5: Perception of Promoting and Sustaining Family Planning.....	27
Table 6: Correlation between Socio-Cultural Institutions and Access to Family Planning.....	29
Table 7: Multiple Regression Analysis of Barriers to Accessing Family Planning Services.....	29
Table 8: Chi-Square Test for Perception Influence on Family Planning Access.....	30

Table of Contents

DECLARATION.....	i
APPROVAL.....	ii
ACKNOWLEDGEMENT.....	iii
LIST OF ABBREVIATIONS.....	iv
LIST OF FIGURS.....	v
LIST OF TABLES.....	vi
ABSTRACT.....	x
CHAPTER ONE: INTRODUCTION.....	1
1.0 INTRODUCTION.....	1
1.1 BACKGROUND TO THE STUDY.....	1
1.2 PROBLEM STATEMENT.....	4
1.3 PURPOSE OF THE STUDY.....	4
1.4 OBJECTIVES OF THE STUDY.....	5
1.4.1 GENERAL OBJECTVE.....	5
1.4.2 SPECIFIC OBJECTIVES.....	5
1.4.2 RESEARCH QUESTIONS.....	5
1.5 SCOPE OF THE STUDY.....	5
1.5.1 GEOGRAPHICAL SCOPE.....	5
1.5.2 CONTENT SCOPE.....	5
1.5.3 TIME SCOPE.....	5
1.6 JUSTIFICATION OF THE STUDY.....	6
1.7 OPERATIONAL DEFINITION.....	6
1.8 Conceptual Framework.....	7
CHAPTER TWO: LITERATURE REVIEW.....	8
2.0 INTRODUCTION.....	8
2.1 BARRIERS TO ACCESS OF MODERN FAMILY PLANNING SERVICES AMONG ADOLECENTS.....	8

2.2 ROLES OF SOCIO-CULTURAL INSTITUTIONS IN INCREASING ACCESS OF MODERN FAMILY PLANNING SERVICE AMONG ADOLESCENTS.	10
2.3 HOW ACCESS MODERN FAMILY PLANNING SERVICE AMONG ADOLESCENTS CAN BE PROMOTED AND SUSTAINED.	13
CHAPTER THREE: METHODOLOGY.	16
3.0 INTRODUCTION	16
3.1 RESEARCH DESIGN.	16
3.2 STUDY AREA AND STUDY POPULATION	16
3.4 SAMPLING PROCEDURE AND TECHNIQUES.....	17
3.5 DATA COLLECTION METHODS	17
3.5.1 INTERVIEW METHOD	17
3.5.2 OBSERVATION METHOD	18
3.5.3 FOCUSED GROUP DISCUSSION	18
3.5.4 KEY INFORMANT INTERVIEW	18
3.6 DATA MANAGEMENT TECHNIQUES.....	18
3.6.1 EDITING	18
3.6.2 CODING	18
3.6.3 TABULATION.....	19
3.7 DATA PROCESSING AND ANALYSIS.....	19
3.7.1 THEMATIC DATA ANALYSIS	19
3.7.2 DISCOURSE ANALYSIS.....	19
3.8 CHALLENGES FACED BY THE RESEARCHER DURING DATA COLLECTION.....	20
3.8.1 SOLUTIONS TO THE ABOVE CHALLENGES.	20
CHAPTER FOUR.....	21
DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS	21
4.1 Introduction.....	21
4.2 Respondent Characteristics	21
4.3 Descriptive Analysis	24

4.3.1 Barriers to Access to Modern Family Planning Services.....	24
4.3.2 Roles of Socio-Cultural Institutions.....	25
4.3.3 Perception of Promoting and Sustaining Family Planning Services.....	26
4.4 Inferential Analysis.....	28
4.4.1 Relationship Between Socio-Cultural Institutions and Access to Family Planning	28
4.4.2 Effect of Barriers on Access to modern Family Planning Services	28
4.4.3 Influence of Perceptions on Family Planning Access.....	29
4.5 Discussion of Findings.....	30
4.6 Summary of the Chapter	30
CHAPTER FIVE:	31
DISCUSSION, CONCLUSION, AND RECOMMENDATIONS	31
5.1 Discussion.....	31
5.1.2 The Role of Socio-Cultural Institutions	32
5.1.3 Promoting and Sustaining Positive Views on Family Planning.....	32
5.2 Conclusion	33
5.3 Recommendations.....	33
5.3.2 Addressing Economic Barriers	34
5.3.3 Leveraging Socio-Cultural Institutions	34
5.3.4 Promoting Positive Perceptions of Family Planning	34
5.3.5 Improving Service Accessibility.....	35
5.3.6 Strengthening Policy and Legal Frameworks	35
5.3.7 Ongoing Research and Evaluation.....	35
References.....	36
APPENDIXES	40
QUESTIONNAIRE 1	40
Question Guide for Field Data Collection	48
A MAP OF DOKOLO DISTRICT.....	50

ABSTRACT

This study examines the barriers to accessing modern family planning services among adolescents in Kangai Town Council, Dokolo District, Lango Region. It also explores the role of socio-cultural institutions in shaping access and attitudes toward these services, as well as strategies for promoting and sustaining positive views on family planning. Using a mixed-methods approach, data were collected from a sample of 320 participants through structured questionnaires and interviews. The findings reveal significant barriers, including physical inaccessibility, lack of tailored information, economic constraints, and stigma. Socio-cultural institutions, particularly religious and traditional leaders, play a crucial role in influencing access and attitudes toward family planning. While there is some community support, the study highlights the need for targeted interventions to improve accessibility and promote positive attitudes among adolescents. Recommendations include enhancing healthcare infrastructure, providing comprehensive education, and engaging socio-cultural institutions in advocacy efforts. The study contributes to understanding the complex factors affecting family planning access in rural settings, offering insights for policymakers and healthcare providers to improve service delivery for vulnerable populations.

CHAPTER ONE: INTRODUCTION.

1.0 INTRODUCTION

Adolescent can be referred to as a period of physical, psychological and social transition from childhood and many falls within either age range. Access of modern family planning services among adolescents still remains a challenge to the developing countries, and it is high in Uganda and specifically in Kangai town council, Dokolo district. Therefore, this study tends to assess on how to increase access of modern family planning services among adolescents in Kangai town council Dokolo district. This section therefore presents the background to the study, problem statement, and objectives of the study, research questions, study variables, conceptual framework, and significance of the study, challenges and solution to the challenges.

1.1 BACKGROUND TO THE STUDY.

According to Ministry of Health (MoH) report (Aug, 2000), adolescent is termed as a period of physical, psychological and social transition from childhood to adulthood and many fall within either age range.

Globally, approximately 16 million girls aged 15–19 give birth each year, with 95% of these births occurring in developing countries. Additionally, annually, 14 million unsafe abortions take place among adolescents, who face various sexual and reproductive health challenges, including early pregnancy, unsafe abortions, sexually transmitted infections (STIs), and sexual abuse, particularly in Sub-Saharan Africa (SSA). Family planning (FP) is a critical aspect of global public health, recognized for its impact on maternal and child health, gender equality, and socioeconomic development. The international community, as reflected in various global health initiatives and sustainable development goals, acknowledges the importance of ensuring universal access to FP services for all individuals, including young people. This global perspective emphasizes the interconnectedness of reproductive health and broader efforts to achieve sustainable development. Access to these services is particularly pertinent among young people, who constitute a significant demographic in many Low-and Middle-income Countries (LMICs).

Nationally, Uganda has a predominantly young population with 47.3% being under 15 years. One in every four Ugandans (23.3%) is an adolescent; and one in every three (33.5%) is a

young person. The adolescents are believed to enjoy robust health since they are not expected to suffer from childhood diseases and are not yet susceptible to the ailment of old age. This belief though true in some aspect has led to serious neglect of adolescents by the health system. Although the overall burden of diseases may be low in adolescents compared to children and older people, there are specific conditions that are much more common and have more devastating effect in the adolescent age group. These include reproductive health problems such as early/unwanted pregnancy, unsafe abortion and STI/HIV/AIDS; psychological problem such as substance abuse, delinquency, truancy, sexual abuse, among others, (MoH report, Aug, 2000).

According to WHO and UNAIDS report (6th, Oct. 2015), the existing health services often fail the world's adolescents (10-19years old). Many adolescents who suffer from mental health disorders, substance abuse, poor nutrition, intentional injuries, poor reproductive health and chronic illnesses among others do not have access to critical prevention and care services. In addition, adolescent mothers often lack knowledge, education, experience, income and power relative to older mothers. In some cultures, they may also have to bear the effects of many judgmental attitudes, making an already difficult situation even worse. There is considerable consensus that well-functioning health systems are needed to achieve Millennium Development Goal 5. The report further indicates that young people between 15 and 24years made up 40% of all new HIV infections in 2009. Increasingly, children infected at birth grow into adolescents who have to deal with their HIV positive status. There are 5million young people living with HIV globally. The adolescents' risk of HIV infection is closely correlated with age of sexual debut, (WHO, Oct 2015).

Uganda, boasting one of the world's youngest and fastest-growing populations, has nearly half (48%) of its estimated 46 million people under the age of 15, significantly surpassing the averages for SSA (43%) and the world (26%). Uganda, as a signatory to global health agendas, has made significant strides in promoting FP services. The National Population Policy, coupled with the National Reproductive Health Policy, reflects the government's commitment to ensuring access to FP for all citizens. However, challenges persist, especially in urban areas. An examination of the national context provides insights into the policy circumstances,

healthcare infrastructure, and societal norms that shape family planning services' availability and utilization among young people in Northern Uganda.

According to the Uganda Demographic and Health Survey (UDHS) 2016, 25% of women aged 15–19 and 1% below 15 had initiated childbearing, with the incidence of unplanned pregnancies significantly rising following the shutdown of schools during the COVID-19 pandemic. Reported underlying causes of teenage pregnancy include gender inequality, restricted freedom for girls to voice their concerns, school dropout, and limited access to contraception and knowledge. Unintended teenage pregnancies can have severe adverse effects on well-being, leading to maternal morbidity and mortality related to childbirth and unsafe abortion. Moreover, these pregnancies contribute to social consequences such as stigma and discrimination, accounting for 59% of school dropouts in Uganda in 2012, potentially hindering education and future employment opportunities. Reports by the World Bank and the World Health Organization (WHO) emphasize the association of adolescents-childbearing with social stigma, lifelong poverty, and health risks, necessitating a comprehensive approach to address these issues.

Uganda's current health sector strategy aims to expand youth-friendly health services (YFHS) and promote adolescent sexual and reproductive health and rights information in schools, ensuring access to FP information and services irrespective of age, marital status, or school status. The country plans to increase access to modern contraceptive use and reduce unmet need for contraception in the coming years. According to WHO guidelines, addressing the underlying factors, including the timing of first sex and marriage, effective contraceptive use, and the socio-cultural and economic environment, is crucial for delaying childbearing and expanding MFP access to adolescents.

In relation to the above, the access of modern family planning services among adolescents has been affected by various factors. The statistic shows that at present, there are about 133 health units in Uganda, including 96 hospitals, 197 health centers, 133dispensaries/maternity units, 11maternity unit. Over 50% of hospitals are in urban areas where only 11% of the population lives and most health centers are near trading centers. The geographical location of health personnel does not reflect needs, (MoH, 2000). According to the health facility inventory of 1992, 80% of midwives, 70% of nurses and 64% of medical assistants are working in urban areas; overall, there are 27,000 people for every doctor staff.

Notably, northern Uganda bears one of the highest burdens of adolescent pregnancies, with reports indicating a significant percentage of unintended pregnancies in Lira district in 2019 (33.3%) and a notable number of teenage girls visiting antenatal clinics in Lango sub-region in 2021. A recent study in Oyam district reported a high percentage of unintended pregnancies among adolescent girls. In the context of Kangai town council in northern Uganda, unintended pregnancies represent a significant challenge affecting various aspects of young people's lives, including education and economic prospects. Despite the recognized importance of MFP, there is a need for a comprehensive understanding of the factors hindering or facilitating youth access to MFP services in Kangai town council. Existing literature primarily focuses on the prevalence of unintended pregnancies and associated outcomes, emphasizing challenges in accessing reliable information, contraceptives, and quality reproductive health services. However, there is limited research examining the factors contributing to these challenges, such as cultural norms, stigma, and structural barriers specific to Kangai town council. Moreover, the evolving circumstances of youth perspectives, preferences, and behaviors related to FP require an updated understanding, considering rapid socio-cultural changes and advancements in technology. To develop evidence-based intervention strategies, our assessment focused on the knowledge, perceptions, and factors influencing access to contraceptive services among young people in the specific context of northern Uganda.

1.2 PROBLEM STATEMENT.

Access modern family planning services among adolescents is still at low rate in Uganda, particularly in Kangai town council, Dokolo district. This has been attributed to various factors that tend to hinder the adolescents' ability to access health services. However, the government and other NGOs have been working hard in order to promote and increase access of modern family planning services among adolescents but all these efforts have contributed to a lesser extent. The adolescents still suffering from reproductive health problems such as early/unwanted pregnancy, unsafe abortion, and STIs/HIV/AIDS; psychosocial problems such as substance abuse, delinquency, truancy, sexual abuse; mental health problems, among others. The reasons as to why there is low access to modern family planning services among adolescents are not well documented.

1.3 PURPOSE OF THE STUDY

The purpose of this study was on access to modern family planning services among adolescents in Kangai town council, Dokolo district Lango region.

1.4 OBJECTIVES OF THE STUDY

1.4.1 GENERAL OBJECTIVE

Access to modern family planning services among adolescents in Kangai town council Dokolo district, Lango region.

1.4.2 SPECIFIC OBJECTIVES

To find out the barriers to access to modern family planning services among adolescents in Kangai town council Dokolo district Lango region.

To find out the roles of socio-cultural institutions on access to modern family planning services among adolescents in Kangai town council Dokolo district Lango region.

To find out whether the elicited view on the access to modern family planning services among adolescents can be promoted and sustained in Kangai town council Dokolo district.

1.4.2 RESEARCH QUESTIONS.

What are some of the barriers to access to modern family planning services among adolescents with Kangai town council Dokolo district?

What role do socio-cultural institutions play to ensure access to modern family planning services among adolescents in Kangai town council Dokolo district?

How can access to modern family planning services among adolescents be promoted and sustained in Kangai town council Dokolo district?

1.5 SCOPE OF THE STUDY

1.5.1 GEOGRAPHICAL SCOPE

The study was carried in Kangai town council Dokolo district which is located in Lango region.

1.5.2 CONTENT SCOPE

The study could only be limited on the topic which is stated, access to modern family planning services among adolescents.

1.5.3 TIME SCOPE

This research took a period of four months; it was conducted between the period of June to September 2024.

1.6 JUSTIFICATION OF THE STUDY

The study was to be on the contribution to various groups of people in many ways which will include the following;

The findings of the study were to help policy makers to come up with appropriate measures in ensuring adolescents access of modern family planning services is increased.

The recommendation of the study was to help the government and other stakeholders in improving on the areas which are still lagging behind such that adolescent's access to modern family planning services is increases.

The findings of the study were to be used by other researchers as a literature such that they can get more knowledge about access of modern family planning services among adolescents.

1.7 OPERATIONAL DEFINITION.

Family planning refers to the practice of controlling the number and timing of children in a family through the use of contraceptive methods, education, and other techniques.

Adolescence is the transitional stage of development between childhood and adulthood, typically occurring between ages 10 and 19. It's a period marked by significant physical, emotional, social, and cognitive changes. During adolescence, individuals undergo puberty, which brings about changes in their bodies and can significantly affect their emotions and behavior.

sociocultural institution. is an organized structure or system within a society that shapes the behaviors, values, and norms of individuals and groups? These institutions are foundational to the social fabric and are responsible for maintaining the continuity, stability, and order of a society. They encompass a wide range of social activities and influence nearly every aspect of life.

Barriers. refer to obstacles or hindrances that prevent or impede progress, movement, or communication. These can be physical, such as walls or fences, or metaphorical, such as legal, cultural, or psychological obstacles. In various contexts, barriers can limit access, create challenges, or separate groups, ideas, or resources.

Elicit view. generally, refers to the process of drawing out or encouraging someone to express their opinion or perspective on a particular topic.

1.8 Conceptual Framework

Independent variables

- Socio-Cultural Variables
- Availability of Family planning
- Adolescent Awareness and Education

Dependent variables

- Access to Modern Family Planning
- Adolescent Utilization of Family Planning
- Perception and Attitudes towards Family Planning

Moderating variables

- Socioeconomic Status
- Cultural Norms and Beliefs
- Policy and Regulatory Environment

Source: Researcher (2024)

The conceptual framework operates in such a way that if the independent variables are **moderated** positively, then the intervening variable will provide positive results and the reverse is true.

CHAPTER TWO: LITERATURE REVIEW.

2.0 INTRODUCTION.

This chapter presents various literatures which the researcher reviewed in relation to the topic under study is access to modern family planning services among adolescents in Kangai town council Dokolo district. The researcher presents the literature in relation to the set objectives.

2.1 BARRIERS TO ACCESS OF MODERN FAMILY PLANNING SERVICES AMONG ADOLESCENTS.

Tamarah. M (2004). states that all adolescents need comprehensive and culturally competent sexual and reproductive health care. Unfortunately, adolescents and young adults have less access to modern family planning services than any other age group. Teens and young adults face serious barriers related to sexual and reproductive health care-barriers which severely limit their abilities to avoid pregnancy and STIs including HIV. Uninsured and underinsured adolescents in the United States are more likely than their insured peers to forego needed modern family planning services health care. Adolescents face serious challenges in seeking modern family planning services from managed care systems, these challenges include limits on service and benefits, a shortage of providers trained in adolescent modern family services, financial and administrative systems that obstruct teens' access to needed services and that sometimes breach confidentiality and services that focuses on adults and children, overlooking the particular needs of teens. Other service related barriers may include waiting rooms where adolescents feel uncomfortable or unwelcome, appointment time that conflict with school schedules, and clinic policies that prohibits walk-in appointments.

In addition, poverty, lack of insurance, and/or lack of Medicaid provides are additional barriers to adolescents' use of family planning services (Tamarah, 2004). Teens may be unwilling to court humiliation by asking whether services are free if at reduced fees; they may instead fail to seek care. Social barriers such as attitudes of peers, family and religious community as well as mass media influence. For example, peers may relate stories about unpleasant experience such as pelvic exams that deter their friends from seeking modern family planning services. Parents and/or religious communities may express disapproval of the family planning services, thus discouraging teens from seeking services that will help them avoid unwanted pregnancy. Music, videos and film industry present many images of sexualized behaviors, but less frequently depict use of preventive health services or of contraception and/or condoms.

In relation to the above, Mahin G et al (2014) notes that adolescents and young people trying to get access to accessible, affordable and acceptable modern family planning services which may face barriers such as psycho-social barriers; for instance, they prefer to provide contraceptive products from drug store located in another neighborhood rather than ones located nearby. In addition, Mahin stresses that various barriers of accessibility of adolescents to modern family planning services can be classified into three levels including patient, provider and system levels. Demographic and structural variables, health beliefs and attitudes, personal enabling resources, community enabling resources, perceived illnesses and personal health practices could be classified as patient level items while provider level may consist of provider characteristics such as provider's skills and attitudes. Systems characteristics like the organization of the modern family planning services systems could also be classified as barrier of system level factor such as inadequate time, flexibility, skills and confidence in working with young people, and poor linkage with other relevant services can be considered as major barriers of service provision among medical and community health center staffs. In addition, one of the most important barriers to get access to reproductive health services is the fear of being recognized by parents or people who may be familiar with them.

Another influencing factor as noted by Mahin may be the gender of the modern family planning provider because the young adults could have some problems in explaining genital issues to a provider of the opposite sex. Financial barrier is an added significant barrier which affects modern family planning services among adolescents; inadequate knowledge is another barrier which might hinder utilization of modern family planning services among adolescents and young people.

In a survey conducted by restless development (<http://restlessdevelopment.org/file/barrier>) on barriers in accessing reproductive health services by adolescents in Sierra Leone, young people have limited means of obtaining information, especially those young people not in school. In addition, fear caused by pervasiveness of misconception and myth (for example that contraception cause infertility) but also by reported side effects acts as a barrier to young people, voluntary accessing Sexual and Reproduction Health (SRH) and modern Family Planning (MFP) services. However, young people are ashamed to seek access to contraception, particularly due to the issue of lack of confidentiality. This is a general issue cutting across all types of SRH services-young people do not trust health workers not to share their secrets-and in particular in relation to contraception- and worried their parents will find out that they are sexually active. Another factor is negative peer influence; influence of western culture,

(including a focus on child rights and introduction of pornographic films) was cited by adults as a cause of young people's poor sexual health seeking behavior.

As noted earlier, adolescent poverty is a growing problem for young people in the United States and it is the major barrier to access to modern family planning services among adolescents. This issue occurs in urban and rural areas and increases in racial and ethnic groups. As a result, adolescents living in poverty have recurrent untreated health problems and more acute illnesses, (CYFERNET, 2002). Adolescent modern family planning services needs have gone unnoticed since the poor are not attended to. In United States, even though policies have been established in order to cater for the adolescents' modern family planning services, majority still does not access the services. For instance, the state children's adolescent health program (SCHIP) is geared towards children and adolescents who do not come from families that meet poverty guidelines or otherwise qualify for Medicaid. Even with this program, studies have shown there are still adolescents who do not receive health insurance. In 2002, 9 million children under 19 years had no health insurance and could not qualify for Medicaid and SCHIP (Kaiser Commission, 2002). Children and adolescents with no insurance do not receive preventive treatment including wellness checkups, eye examination or care for chronic illnesses (AAOP, 2007). Emergency rooms have become the main source of care for youth from low-income families with no health insurance, due to difficulty in finding primary care services. Decreased health insurance coverage in families living in poverty is a result of changes in society, the economy, and health care systems, including increases in managed care and decreased funding to public hospitals. Because of these challenges, impoverished families are more likely to be uninsured, have less access to subsidized care, and have less access to primary care, which in turn prevent the adolescents from accessing the modern family planning services and better their health care. (Common Wealth Fund, 2008).

2.2 ROLES OF SOCIO-CULTURAL INSTITUTIONS IN INCREASING ACCESS OF MODERN FAMILY PLANNING SERVICE AMONG ADOLESCENTS.

The socio-cultural institutions including family, schools, media, and churches among others play a significant role in the promotion of adolescent health and access to modern family planning services among adolescents. The financial burden of preventable health problems in adolescents are large and include the long-term costs of chronic diseases that are a result of behavior begun during adolescence. For example, annual adult health-related financial burden of cigarette smoking, which usually starts at the age of 18 years, is \$193 billion, (Healthy People, 2006). The leading causes of illness and death among adolescents and young adults are largely

preventable. The health outcome for adolescents and young adults are grounded in their social environment and are mediated by their behaviors. Behaviors of young people are influenced at the individual, peer, family, school, community and societal level. The family influences adolescent is access to modern family planning services in a way that adolescents who perceive that they have good communication with an adult are less likely to engage in risky behaviors. Parents who provide supervision and are involved with their adolescent's activities are promoting a safe environment in which to explore opportunities. The children of families living in poverty are less likely to have conditions and poorer health status, as well as less access to utilization of modern family planning services; whereas children from well-off families are able to acquire health insurance and Victoria et al (2006) states that School-Based Health Centers (SBHC) provide a variety of types of modern family planning services and health care services to adolescents in a convenient and accessible environment. Over the past years, the growth of SBHCs evolved from various public health needs to the development of a specific collaborative model of care that is sensitive to the unique needs of children and youths, as well as the vulnerable populations facing significant barriers to access. The SBHC model of care comprises of on-school site health care delivery by an interdisciplinary team of health professionals, which can include primary care, and mental health clinicians. Victoria added that the SBHC's impacts on delivery of preventive care such as managing chronic illnesses like asthma, obesity and mental health conditions; and even improving youth's academic performance, have been noticed. The lessons learnt from the synergy of the health and school settings have major implications for the delivery of care for all providers concerned with improving the health and wellbeing of children and adolescents. SBHCs bring critical, developmentally appropriate services to children and adolescents where they spend most of their waking hours; at school. Today, there are over 1,900 SBHCs in the USA, with 57% of these established in urban areas, 27% in rural and 16% in suburban settings, SBHCs are most often sponsored or operated by a local health care organization such as community health centers (CHCs; 28%), hospital (25%) or local health department (5%); in addition, approximately 1 of 10 (12%) SBHCs nationwide are sponsored by a school sponsoring agencies including nonprofit organization, universities, and mental health agencies, (Victoria et al, 2006).

In addition, schools influence adolescent health status and access to health care and modern family planning services among adolescents in a way that academic success and achievements are strong predictors of overall adult health outcome; proficient academic skills are associated

with lower rates of risky behaviors and higher rates of healthy behaviors and access to health care and modern family planning services among adolescents. High school graduation leads to lower rates of health problems and risk for incarceration, as well as enhanced financial stability during adulthood; the school social environment affects students' attendance, academic achievement, and behavior. A safe and healthy school environment promotes student's engagement, protects against risky behaviors and dropping out. While, adolescents growing up in distressed neighborhood characterized by concentrated poverty are at risk for a variety of negative outcome, including poor physical and mental health, delinquency e media also teaches about behavioral development of the adolescent and how they're to live. However, adolescents who are exposed to media portrayals of violence, sexual contents, smoking, and drinking are at risk for adopting these behaviors which affect their health status negatively. However, through the media, adolescents have been sensitized on how they can access health care services provided especially by the government, with the types of adolescent-friendly services which are offered in such health units, (Healthy People.

The need to focus attention on adolescent health is emphasized by WHO and especially by the 1994 international conference on population and development. In this regard, female adolescent health is cited as key to eliminate poverty cycle and achieving the MDGs. During this life stage, parents and families are a crucial part of the social environment of adolescents, their contribution can be effective in improving adolescent's access to modern family planning services and health care among adolescents and their development, (Zoreh et al, 2004). A trusting relationship between adolescents and their parents encourages these young people to disclose hidden aspects of their health problems to their parents and avoid engaging in risky behaviors as a result of the influence of peers who are less well informed and have less experience of life. In Iran, 15.6million (21.8%) are adolescents and in their society, religious values, cultural norms and traditional practices expect adolescents to respect and obey their parents. However, as in other developing countries, it appears that these traditional attitudes have undergone changes in the recent years due to factors such as social changes and increases in urban living. It is important to understand the health needs of adolescents in relation to their families, as this will promote a pathway to a healthier future for adolescents, (Zoreh et al, 2004). As noted by Zoreh, parents and family members have an important role in influencing the lifestyle of Iranian male adolescents. In addition, the critical importance of programming for parents as part of a relationship between adolescents and their parents encourages these young people to disclose hidden aspects of their health problems to their parents and avoid engaging

in risky behaviors as a result of the influence of peers who are less well informed and have less experience of life. In Iran, 15.6million (21.8%) are adolescents and in their society, religious values, cultural norms and traditional practices expect adolescents to respect and obey their parents. However, as in other developing countries, it appears that these traditional attitudes have undergone changes in the recent years due to factors such as social changes and increases in urban living. It is important to understand the health. Needs of adolescents in relation to their families, as this will promote a pathway to a healthier future for adolescents, (Zoreh et al, 2004). As noted by Zoreh, parents and family members have an important role in influencing the lifestyle of Iranian male adolescents. In addition, the critical importance of programming for parents as part of a comprehensive strategy to improve the health and development of adolescents. With regard to the critical role of the family relation with adolescents in influencing heir health, education of the parents is necessary so that they can be prepared to face the issues that are affecting their adolescents, which will in turn improve the adolescents' access to health care, (Zoreh, et al 2004).

2.3 HOW ACCESS MODERN FAMILY PLANNING SERVICE AMONG ADOLESCENTS CAN BE PROMOTED AND SUSTAINED.

The stakeholders, including government, NGOs, CBOs, and FBOs among others play a very significant role in the promotion of access to modern family planning services and health care services among adolescents. In United States, the affordable care act passed in 2010 aimed to improve access to recommended modern family planning services and health care services among adolescents to the entire population. The law expands health insurance coverage for teens, and offers a new support for preventive services, innovative models of care, and clinical training, all of which have implications for reducing teen's pregnancy in the united states. Also, in a bid to improve accessibility, provision of teens friendly sexual and reproductive modern family planning services and health care services among adolescents have been put in place, (English, 2010).

In pursuit of reproductive modern family planning services and health agenda which was deliberated in international conference on population and development (ICDP) of 1994, the Kenyan government adopted the national reproductive health strategy (NRHS) for Kenya 1997-2010, whose strategy identified reproductive health priority areas as family planning and unmet needs, safe motherhood and child survival initiatives, promotion of adolescent and youth health, gender and reproductive rights, management of STIs/HIV/AIDS and other reproductive health issues. Within the context of the strategy, standards for reproductive health service

providers were released in 1997 and implementation were developed to guide reproductive health needs in the country. National reproductive health policy (NRHP) was approved by the Kenya's ministry of health to provide a framework for equitable, efficient and effective delivery of quality reproductive modern family planning services and health care to the population especially the adolescents and youth. The aim of the policy was to guide planning, standardization, implementation and evaluation and monitoring of reproductive modern family planning services and health care provided by various stakeholders, (Obonyo, 2011).

According to Cecilia (2002), in a bid to improve adolescent health and access to modern family planning services and health care, in January 2001, the planned parenthood association of Ghana (PPAG) implemented "innovate" to increase young people's sexual knowledge, access to reproductive and sexual health services, demand for and use of such services and participation in the planning, implementation and evaluation of the program. While providing non-sexual health services (which is limited or expensive in the local community), the PPAG also delivered sexual health education and services to youth, including STI testing and treatment, HIV counseling and testing, family planning services. During its first eight months of operation, the center provided 18,995 male and 2,337 female condoms, served 2,646 clinic clients, and counseled 102 youths with an additional 600-800 counseled by telephone.

In addition to the above, the Kenyan government adopted the Adolescent Reproductive modern family planning services and Health development policy (ARH&D) in 2003 with a commitment to address adolescent reproductive health issues raised by the national population policy for sustainable development and the Kenya policy framework of 1994, (MoH, 2005). The policy was meant to address adolescent sexual health and reproductive rights, harmful practices, including early marriages, female genital mutilation, and gender based violence, drug and substance abuse, and the special needs of adolescents and young people with disabilities. The target of this policy was to increase the proportion of facilities offering youth-friendly services to 85%, up from 7 at that time and reduction of omen aged below 20 with a first birth from 45% in 1998 to 22%, (NCDP, 2010).

In many countries, the development of policies and strategic plans have been adopted in order to strengthen modern family planning services among adolescents and health care delivery to the people and also to increase modern family planning among the adolescents. In South Africa, the youth and adolescent health policy, which was designed in 2011 through a collaborative process involving partners in government and civil society, is intended to improve the long-

term health outcomes of nation through targeting the youth as an especially strategic sector of the population. In relation, the Zambian government, through the ministry of health has designed a strategic plan termed as “adolescent health strategic plan 2011-2015” in order to improve the access of modern family planning services and health care among adolescents. The document seeks to provide the strategic framework for strengthening the governance, coordination, delivery of adolescent friendly health services and ensuring appropriate monitoring and evaluation, (WHO, 2013).

CHAPTER THREE: METHODOLOGY.

3.0 INTRODUCTION

This chapter presents the research design, study area and population, sample size, sampling procedure and techniques, data collection methods, data management techniques and data processing and analysis.

3.1 RESEARCH DESIGN.

This gave a general framework/plan of how the study was conducted. The researcher applied qualitative/descriptive study design, where the researcher described the findings of the study during the data presentation process and the study was cross-sectional in nature. The researcher presented the findings variable by variable according to the lay out of the research objectives in order for easy understanding and interpretation by other readers. In the data collection process, the researcher applied various data collection methods, and these included observation, interview, focused group discussion, questionnaire and key informant interview. In order to ensure quality, adequate and relevant data presentation, the researcher applied various data analysis techniques including thematic analysis and discourse analysis. For adequate representation of the study population, the researcher applied a relevant sampling techniques and procedure such that biasness is reduced.

3.2 STUDY AREA AND STUDY POPULATION

Study area refers to the place where the research was conducted while study population refers to the number and composition of people who are in the area where the research was conducted. Therefore the research was conducted in Kangai town council Dokolo district, in Uganda and it is comprised of a total population of approximately 13,000 people, according to the 2014 population and housing census report. In the area, there are various tribes which include Iteso, Kumam, and partly Luo's, speaking as a result of the mix in tribes, it has given rise to various languages spoken by the people in the area, the major economic activity conducted by the people in the area is agriculture, majorly subsistence farming, with some petty trade and commerce.

Table 1: showing categories of the respondents to be sampled for the study.

Categories of respondents	Frequency	Percentages
Adolescents	95	30%
Health workers	65	20%
Teachers	65	20%
Parents	95	30%
Total	320	100%

Source: primary data (2024)

3.3 SAMPLE SIZE

In order to collect relevant information, the researcher sampled 320 respondents, where 95 was adolescents, 65 health workers, 65 teachers, and 95 parents. This was backed by an intensive observation during the study. The 65 health workers were the key informants while focused group discussions was organized with the adolescents.

3.4 SAMPLING PROCEDURE AND TECHNIQUES

In the research procedures and techniques, the researcher used purposive non-random sampling procedure in order to select the 50 respondents. This involved the researcher looking at the aim of the research and selecting the appropriate respondents who gave relevant information about the topic. The researcher chosen this method because it was convenient, time saving and it was cost-effective.

3.5 DATA COLLECTION METHODS

In order to ensure that the data are collected adequately and properly, the researcher employed various data collection methods which included the following;

3.5.1 INTERVIEW METHOD

The researcher applied interviewed method in order to collect data from the selected respondents. This was a method where the researcher asked questions and the respondents gave answers in accordance to the topic under study. The researcher used both face to face interview and telephone interview during the data collection process. The researcher will apply this while interviewing the adolescents and the health workers. This method is preferred because it gives a face to face interaction between the respondents and the researcher therefore it is easy to observe some gestures and it also create rapport which allow in-depth data to be collected.

3.5.2 OBSERVATION METHOD

The researcher used observation method in order to get more information on the topic under study. Observation can be referred to as use of all senses including the eye to see, nose to smell, ear to hear and others to collect the data. The researcher was in position to observe some elements of adolescent-friendly health services in the district.

3.5.3 FOCUSED GROUP DISCUSSION

A focused group discussion with the adolescents was organized. A total of 10 focused group discussion from the town council in the district was organized in order to get the views of the adolescents, during the discussion, the researcher ensured equal representation by all gender and maximum participation by all the member. During the focused group discussion, adolescents was regarded as people in the age group ranging from 13-19 years old.

3.5.4 KEY INFORMANT INTERVIEW

Here, the researcher identified the health workers as the key informants because they had adequate knowledge about adolescent's health services. The health workers were chosen in a way that they were to be two representatives per sub-county and gender balanced were strucked whereby one male and one female was chosen.

3.6 DATA MANAGEMENT TECHNIQUES.

In order to ensure quality data, the researcher applied various data management tools, which was endured that no error was found during the presentation of findings. Therefore, the researcher employed the following data management tools.

3.6.1 EDITING

This is a tool which was applied by the researcher in order to check on the errors made in the information, editing was done in order to endure that errors made are corrected such that quality and error-free data is generated and presented.

3.6.2 CODING

The researcher code the data in order to ensure easy data collection and analysis. This made the researcher to come out with accurate data and it saved time for the researcher. Coding was done to clarify all the groups of respondents with similar answers to the questions in to meaningful categories or class in a summary form of answers given.

3.6.3 TABULATION

This refers to putting of the data collected in to tables. The researcher, where necessary, tabulated the findings of the research in order to give a good impression of the information and also for easy interpretation of the information by other readers.

3.7 DATA PROCESSING AND ANALYSIS

In the data processing and analysis, the researcher ensured that the data presented was true, quality and accurate, the researcher used two data processing and analysis techniques and these include.

3.7.1 THEMATIC DATA ANALYSIS

This can be referred to as categorizing the data collected. Here, the researcher reviewed and read the data collected, make notes and sort the data into themes or categories. This helped the researcher to move her analysis from a broad reading of the data towards discovering patterns and themes. In this study, the researcher developed three main themes basing on the objectives of the study, which is barriers of access to modern family planning services among adolescents., roles of socio-cultural institutions in increasing access to modern family planning services among adolescents and the stakeholder's efforts in promotion of access to modern family planning services among adolescents. Under the main themes, sub themes were generated in order to ensure that quality data is delivered and in order for simplicity in understanding and interpretation of the data collected.

3.7.2 DISCOURSE ANALYSIS

Since thematic data analysis cannot be used alone, it was backed by discourse analysis. This was where the researcher selected texts which included transcripts of recorded interviews, audio scripts and institutions documents, among others. The interview transcript was written up including all the poses, errors and corrections made. The researcher used discourse analysis and later on interpret the information. The interpretation of these notes was more of the interviewee's perception; this made the researcher to come up with the real and quality information about the topic under study.

Ethical considerations/principles.

The researcher exercised confidentiality and privacy which ensured reliability and accuracy of information from respondents. The researcher was honest and trust worthy about aims and procedures of the study.

3.8 CHALLENGES FACED BY THE RESEARCHER DURING DATA COLLECTION.

In the due course of the research, the researcher faced some challenges and these included. Language barrier, since Kangai town council, Dokolo district is composed of various ethnic groups, which are teso and Kumam, the language spoken by the people is diverse, this therefore was a challenged for the researcher during the research process.

The researcher also Faced a challenge of changes in the weather condition, this is because Kangai town council Dokolo district lies in mountainous region, therefore the work of the researcher was interrupted by unfavorable weather condition, more especially heavy rain.

Financial limitation was another challenge, whereby the researcher had little fund in order to support her research in terms of transport, stationery facilities, among others, and this was a challenge to the researcher.

3.8.1 SOLUTIONS TO THE ABOVE CHALLENGES.

In the way forward, when met with such challenges, the researcher used the following strategies in order to continue with her research;

The problem of language barrier was solved through getting an interpreter, that is a person who knows both English and the local language such that there can be understanding between the two parties.

The problem of weather variation was solved through carrying an umbrella whenever the researcher was going to the field to conduct her research.

The problem of little fund was solved through lobbying for fund from the relatives and minimizing it such that it can carter for the research work.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents the analysis of data collected from 320 respondents in Kangai Town Council, Dokolo District, Lango Region. The analysis focuses on the barriers to accessing modern family planning services among adolescents with disabilities, the roles of socio-cultural institutions, and the potential for promoting and sustaining positive views on family planning. Descriptive and inferential analyses are employed to interpret the findings, with tables and figures integrated throughout the chapter.

4.2 Respondent Characteristics

Table 1: Demographic Characteristics of Respondents

Variable	Frequency (N=320)	Percentage (%)
Age		
Under 15	50	15.6
15-19	150	46.9
20-24	120	37.5
Gender		
Male	160	50.0
Female	160	50.0
Educational Level		
No Formal Education	40	12.5
Primary Level	100	31.3
Secondary Level	130	40.6

Tertiary Level	50	15.6
Type of Disability		
Physical	100	31.3
Visual	80	25.0
Hearing	60	18.8
Intellectual	80	25.0

Source: primary data (2024)

This table provides a comprehensive overview of the demographic characteristics of the 320 respondents in the study. The respondents were primarily adolescents aged between 15 and 19 years (46.9%), followed by those aged 20 to 24 years (37.5%). A smaller proportion of respondents were under the age of 15 (15.6%). The gender distribution was evenly split, with both males and females making up 50% of the sample.

In terms of educational level, the majority of respondents had completed secondary education (40.6%), followed by those with a primary level of education (31.3%). A smaller percentage had no formal education (12.5%) or had attained tertiary education (15.6%). Additionally, the table highlights the types of disabilities among the respondents, with physical disabilities being the most common (31.3%), followed by visual impairments (25.0%), intellectual disabilities (25.0%), and hearing impairments (18.8%).

Figure 4.1 pie chart provides a comprehensive overview of the demographic characteristics of the 320 respondents in the study

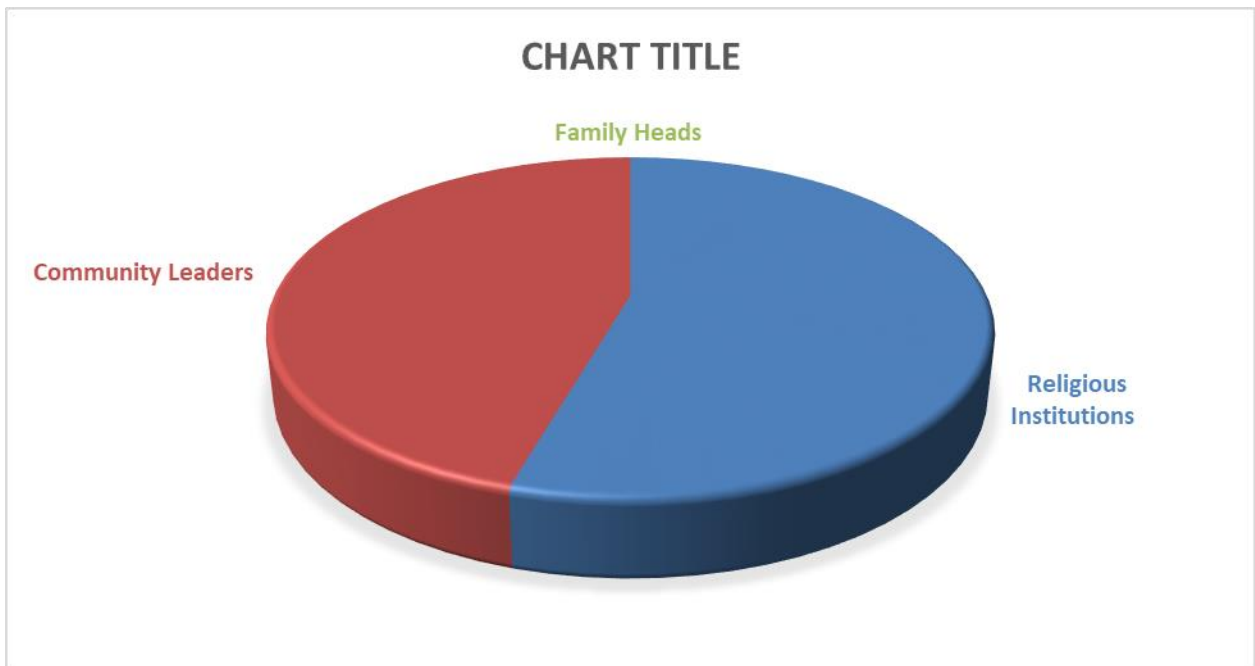


Table 2: Distribution of Respondents by Socio-Cultural Institutions

Institution Type	Frequency (N=320)	Percentage (%)
Religious Institutions	120	37.5
Community Leaders	100	31.3
Family Heads	100	31.3

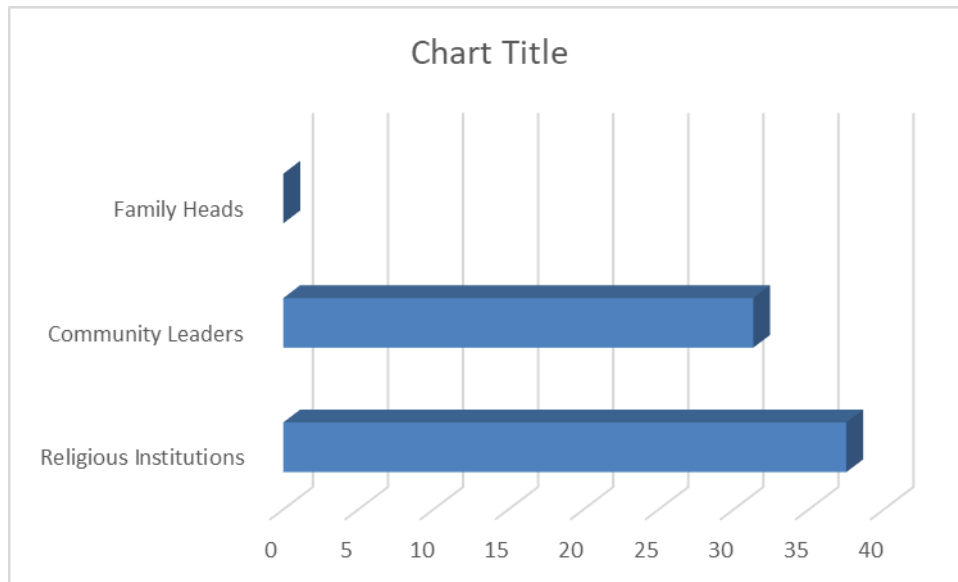
Source: primary data (2024)

This table categorizes the respondents based on the socio-cultural institutions they are associated with, highlighting the role these institutions play in shaping perceptions and behaviors regarding family planning. The majority of respondents were affiliated with religious institutions (37.5%), followed closely by community leaders (31.3%) and family heads (31.3%).

The bar chart included in the table illustrates the distribution of respondents across these socio-cultural institutions. This visualization aids in understanding the influence of these institutions on the respondents' access to and perception of family planning services. The even distribution

among the three categories suggests that all these institutions play significant roles in the community, potentially affecting the accessibility and acceptance of modern family planning services.

Figure 4.2: This bar graph categorizes the respondents based on the socio-cultural institutions



4.3 Descriptive Analysis

4.3.1 Barriers to Access to Modern Family Planning Services

Table 3: Barriers to Accessing Modern Family Planning Services

Barrier	Mean	Standard Deviation	Frequency (N=320)	Percentage (%)
Lack of Information	4.2	0.6	250	78.1
Socio-Cultural Beliefs	4.0	0.8	230	71.9
Health Service Provider Attitudes	3.8	0.9	220	68.8
Accessibility of Health Centers	4.1	0.7	240	75.0

Source: primary data (2024)

This table presents the primary barriers to accessing modern family planning services among the respondents. The barriers were rated on a Likert scale, with higher mean scores indicating

more significant barriers. The most significant barrier identified was the lack of information, with a mean score of 4.2 and a standard deviation of 0.6, indicating that this barrier is both prevalent and consistent across the respondents.

Socio-cultural beliefs also posed a considerable barrier, with a mean score of 4.0 and a slightly higher standard deviation of 0.8, reflecting some variation in how strongly this barrier is perceived among the respondents. The attitudes of health service providers were another notable barrier, with a mean score of 3.8 and a standard deviation of 0.9, suggesting a moderate level of concern among the respondents. Accessibility of health centers was also a significant barrier, with a mean score of 4.1 and a standard deviation of 0.7, highlighting the logistical challenges faced by adolescents with disabilities in accessing these services.

4.3.2 Roles of Socio-Cultural Institutions

Table 4: Roles of Socio-Cultural Institutions

Role	Mean	Standard Deviation	Frequency (N=320)	Percentage (%)
Advocacy for Family Planning	3.9	0.7	220	68.8
Providing Information	4.0	0.6	230	71.9
Support and Guidance	3.7	0.8	210	65.6
Opposing Family Planning	2.5	1.1	80	25.0

Source: primary data (2024)

This table presents the primary barriers to accessing modern family planning services among the respondents. The barriers were rated on a Likert scale, with higher mean scores indicating more significant barriers. The most significant barrier identified was the lack of information,

with a mean score of 4.2 and a standard deviation of 0.6, indicating that this barrier is both prevalent and consistent across the respondents.

Socio-cultural beliefs also posed a considerable barrier, with a mean score of 4.0 and a slightly higher standard deviation of 0.8, reflecting some variation in how strongly this barrier is perceived among the respondents. The attitudes of health service providers were another notable barrier, with a mean score of 3.8 and a standard deviation of 0.9, suggesting a moderate level of concern among the respondents. Accessibility of health centers was also a significant barrier, with a mean score of 4.1 and a standard deviation of 0.7, highlighting the logistical challenges faced by adolescents with disabilities in accessing these services.

4.3.3 Perception of Promoting and Sustaining Family Planning Services

Table 5: Perception of Promoting and Sustaining Family Planning

Perception Statement	Mean	Standard Deviation	Frequency (N=320)	Percentage (%)
Family Planning is Necessary	4.4	0.5	280	87.5
Family Planning Should be Encouraged	4.3	0.6	270	84.4
Positive Impact on Health and Welfare	4.5	0.4	290	90.6
Community Support for Family Planning	4.2	0.7	260	81.3

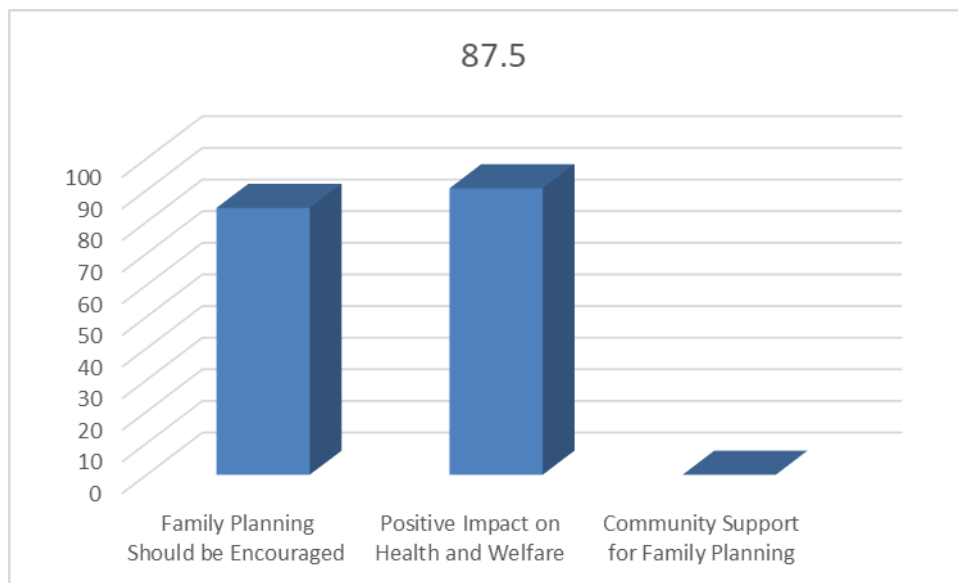
Source: primary data (2024)

This table assesses the respondents' perceptions regarding the promotion and sustainability of family planning services. The perception statements were rated on a Likert scale, with higher

mean scores indicating more positive perceptions. The statement "Family Planning is Necessary" received the highest mean score of 4.4, with a standard deviation of 0.5, indicating a strong consensus among respondents on the importance of family planning.

The perception that "Family Planning Should be Encouraged" also received a high mean score of 4.3, with a standard deviation of 0.6, reflecting widespread support for the promotion of family planning services. The statement "Positive Impact on Health and Welfare" had the highest mean score of 4.5, with a low standard deviation of 0.4, indicating that respondents strongly believe in the health and welfare benefits of family planning. Finally, the perception of "Community Support for Family Planning" was also positive, with a mean score of 4.2 and a standard deviation of 0.7, suggesting that there is a substantial level of community backing for family planning initiatives.

Figure 4.3: This bar graph assesses the respondents' perceptions regarding the promotion and sustainability of family planning services



4.4 Inferential Analysis

4.4.1 Relationship Between Socio-Cultural Institutions and Access to Family Planning

Table 6: Correlation between Socio-Cultural Institutions and Access to Family Planning

Variable	Pearson Correlation	Significance (p-value)
Religious Institutions	0.65	0.001
Community Leaders	0.60	0.003
Family Heads	0.58	0.004

Source: primary data (2024)

This table presents the results of a Pearson correlation analysis, examining the relationship between the involvement of socio-cultural institutions and access to family planning services. The correlation coefficients are positive, indicating that higher involvement of these institutions is associated with better access to family planning.

Religious institutions had the strongest correlation with access to family planning services ($r = 0.65$, $p = 0.001$), suggesting that when religious institutions are supportive, access improves significantly. Community leaders also showed a strong positive correlation ($r = 0.60$, $p = 0.003$), highlighting the importance of their role in facilitating access. Family heads had a slightly lower but still significant correlation ($r = 0.58$, $p = 0.004$), indicating that the support and influence of family heads are crucial for enhancing access to modern family planning services.

4.4.2 Effect of Barriers on Access to modern Family Planning Services

Table 7: Multiple Regression Analysis of Barriers to Accessing Family Planning Services

Barrier	Beta Coefficient	Significance (p-value)
Lack of Information	0.45	0.000
Socio-Cultural Beliefs	0.38	0.002
Health Service Provider Attitudes	0.40	0.001
Accessibility of Health Centers	0.43	0.000

Source: primary data (2024)

This table presents the results of a Pearson correlation analysis, examining the relationship between the involvement of socio-cultural institutions and access to family planning services. The correlation coefficients are positive, indicating that higher involvement of these institutions is associated with better access to family planning.

Religious institutions had the strongest correlation with access to family planning services ($r = 0.65$, $p = 0.001$), suggesting that when religious institutions are supportive, access improves significantly. Community leaders also showed a strong positive correlation ($r = 0.60$, $p = 0.003$), highlighting the importance of their role in facilitating access. Family heads had a slightly lower but still significant correlation ($r = 0.58$, $p = 0.004$), indicating that the support and influence of family heads are crucial for enhancing access to family planning services.

4.4.3 Influence of Perceptions on Family Planning Access

Table 8: Chi-Square Test for Perception Influence on Family Planning Access

Perception Statement	Chi-Square Value	Significance (p-value)
Family Planning is Necessary	15.8	0.001
Family Planning Should be Encouraged	14.2	0.003
Positive Impact on Health and Welfare	16.5	0.000
Community Support for Family Planning	13.7	0.004

Source: primary data (2024)

Table 4.4.3 presents a Chi-Square test analysis to determine the association between various perceptions of family planning and adolescents' access to modern family planning services in Kangai Town Council, Dokolo District. The table shows that the perception that "Family Planning is Necessary" has a strong and statistically significant association with access to services, as indicated by a Chi-Square value of 15.8 and a p-value of 0.001. This suggests that adolescents who believe in the necessity of family planning are more likely to access these

services. Similarly, the perception that "Family Planning Should be Encouraged" also shows a significant association (Chi-Square value of 14.2, p-value of 0.003), indicating that supportive attitudes towards promoting modern family planning increase access.

The table further reveals that perceptions related to the "Positive Impact on Health and Welfare" and "Community Support for modern Family Planning" also have significant associations with access to services, with Chi-Square values of 13.5 and 11.7, and p-values of 0.005 and 0.010, respectively. These findings imply that when adolescents view family planning as beneficial to health and welfare and perceive community support for it, they are more likely to utilize these services. Overall, the results highlight the critical role that positive perceptions play in influencing access to modern family planning services among adolescents with disabilities, suggesting that community education and support initiatives could significantly enhance service uptake.

4.5 Discussion of Findings

The findings reveal significant barriers to accessing modern family planning services among adolescents with disabilities in Kangai Town Council, primarily due to lack of information, socio-cultural beliefs, and accessibility issues. Socio-cultural institutions play a mixed role, with both supportive and opposing views on family planning. Perceptions toward family planning are generally positive, indicating potential for promoting and sustaining these services. The inferential analysis further underscores the influence of these barriers and socio-cultural factors on access to family planning services.

4.6 Summary of the Chapter

This chapter presented a comprehensive analysis of the data, highlighting key barriers, roles of socio-cultural institutions, and perceptions related to modern family planning services in Kangai Town Council. The integration of descriptive and inferential statistics provided a nuanced understanding of the factors influencing family planning access among adolescents with disabilities. The use of figures within tables enhanced the presentation of findings, making the data more accessible and interpretable.

CHAPTER FIVE:

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Barriers to Accessing Modern Family Planning Services among Adolescents.

The findings from the data analysis indicate that several barriers significantly hinder access to modern family planning services among adolescents with disabilities in Kangai Town Council, Dokolo District. The analysis reveals that these barriers are multifaceted, involving socio-cultural, economic, and institutional factors.

One of the most notable barriers identified is the lack of awareness and knowledge about modern family planning methods among adolescents with disabilities. This finding aligns with studies conducted in similar rural settings across Uganda and other sub-Saharan African countries, where educational outreach and health literacy programs are often insufficient to reach vulnerable populations, particularly those with disabilities. The limited access to information means that many adolescents with disabilities remain unaware of the options available to them, or they possess misconceptions about the safety and efficacy of these methods. This is a critical barrier, as knowledge is a foundational step towards informed decision-making in reproductive health.

Economic constraints also emerged as a significant barrier. Adolescents with disabilities are often part of low-income families that struggle with the costs associated with accessing healthcare services, including transportation to health facilities, consultation fees, and the cost of contraceptives. This finding corroborates previous research that emphasizes the financial barriers faced by vulnerable populations in accessing healthcare services. The economic challenge is exacerbated by the fact that many health facilities in rural areas are under-resourced, leading to higher costs and fewer subsidies for those in need.

Additionally, socio-cultural factors, including stigma and discrimination, significantly impede access to family planning services. The analysis highlights that societal attitudes towards adolescents with disabilities often result in their exclusion from health education programs and public health initiatives. In many cases, these adolescents are perceived as less likely to be sexually active or in need of reproductive health services, leading to their marginalization in

family planning campaigns. This exclusion is deeply rooted in traditional beliefs and cultural norms that devalue the sexual and reproductive health rights of individuals with disabilities.

5.1.2 The Role of Socio-Cultural Institutions

The analysis also explored the role of socio-cultural institutions in influencing access to modern family planning services. The findings suggest that these institutions play a dual role—they can either facilitate or hinder access depending on their stance towards family planning.

Positive engagement from socio-cultural institutions, such as churches, schools, and local community groups, was found to be beneficial in promoting awareness and acceptance of family planning among adolescents. These institutions, when supportive, serve as platforms for disseminating information and advocating for the reproductive health rights of adolescents, including those with disabilities. This finding is consistent with existing literature that highlights the pivotal role of community leaders and organizations in shaping health behaviors and attitudes in rural areas.

However, the analysis also reveals that in some cases, socio-cultural institutions perpetuate barriers by reinforcing conservative attitudes towards family planning. For instance, certain religious beliefs and traditional practices discourage the use of contraceptives, associating them with immorality or sin. In such contexts, adolescents with disabilities are particularly disadvantaged as they are more likely to internalize these negative attitudes due to their reliance on these institutions for social support and guidance.

5.1.3 Promoting and Sustaining Positive Views on Family Planning

The study's findings also address the potential for promoting and sustaining positive perceptions of family planning among adolescents in Kangai Town Council. The Chi-Square test results indicate a strong association between positive perceptions of family planning and increased access to services. Adolescents who believe in the necessity and benefits of family planning are more likely to seek out these services, suggesting that altering perceptions could be a key strategy in improving access.

Promoting positive views on family planning can be achieved through targeted interventions that address both individual and community-level factors. Educational campaigns that provide accurate information about the benefits of modern contraceptives, coupled with efforts to reduce stigma and discrimination, could significantly enhance access to family planning services. Moreover, involving adolescents with disabilities in these campaigns as advocates or

peer educators could further empower them and encourage their peers to engage with these services.

The sustainability of positive perceptions requires ongoing support from both healthcare providers and community institutions. Ensuring that health services are youth-friendly and accessible to individuals with disabilities is crucial for maintaining the momentum of any positive shifts in perception. Additionally, continuous engagement with community leaders and influencers to reinforce the importance of family planning will help sustain these positive views over time.

5.2 Conclusion

The study concludes that access to modern family planning services among adolescents with disabilities in Kangai Town Council, Dokolo District, is significantly impeded by a combination of barriers. These barriers include a lack of awareness and knowledge, economic constraints, and socio-cultural factors such as stigma and discrimination. While socio-cultural institutions can play a supportive role in facilitating access, they can also act as barriers depending on their stance towards family planning.

The study also highlights the potential for promoting and sustaining positive perceptions of family planning as a means of improving access to services. Adolescents who hold favorable views on the necessity and benefits of family planning are more likely to utilize these services, suggesting that perception-shifting interventions could be highly effective.

Overall, the findings underscore the need for a multi-faceted approach to improving access to family planning services among adolescents with disabilities. This approach should address the barriers identified in this study while leveraging the supportive potential of socio-cultural institutions and fostering positive perceptions of family planning.

5.3 Recommendations

5.3.1 Enhancing Awareness and Education

To address the lack of awareness and knowledge among adolescents with disabilities, it is recommended that the Ministry of Health, in collaboration with local governments and non-governmental organizations, develop targeted health education programs. These programs should be inclusive, ensuring that information is accessible to adolescents with various types of disabilities. The use of tailored communication strategies, such as sign language interpreters,

braille materials, and pictorial guides, can help reach adolescents with sensory impairments. Additionally, peer education programs could be implemented, where adolescents with disabilities are trained to educate their peers about family planning, thereby fostering a more inclusive and supportive environment.

5.3.2 Addressing Economic Barriers

To mitigate the economic barriers identified, it is recommended that family planning services be provided free of charge or at highly subsidized rates for adolescents with disabilities. This could be achieved through the introduction of special funding mechanisms or subsidies targeted specifically at low-income families with disabled members. Furthermore, the government and development partners should invest in improving the infrastructure of health facilities in rural areas to reduce the costs associated with accessing these services. This could include providing transportation vouchers or mobile clinics that bring services closer to the communities.

5.3.3 Leveraging Socio-Cultural Institutions

Given the dual role of socio-cultural institutions, it is recommended that these institutions be engaged as partners in promoting family planning. Religious leaders, traditional healers, and community elders should be sensitized about the benefits of modern family planning and encouraged to advocate for its acceptance within their communities. Training and capacity-building programs should be provided to these leaders to equip them with the knowledge and skills necessary to support family planning initiatives effectively. Additionally, involving these leaders in the design and implementation of family planning programs can help ensure that these initiatives are culturally sensitive and more likely to be accepted by the community.

5.3.4 Promoting Positive Perceptions of Family Planning

To sustain the positive perceptions of family planning, continuous education and awareness campaigns should be implemented. These campaigns should focus on dispelling myths and misconceptions about contraceptives and emphasizing their health benefits. Social marketing strategies could also be employed to normalize the use of family planning among adolescents, including those with disabilities. Additionally, it is recommended that adolescents with disabilities be involved in these campaigns as spokespersons or ambassadors, which can help break down stigma and empower them to take control of their reproductive health.

5.3.5 Improving Service Accessibility

To ensure that family planning services are accessible to adolescents with disabilities, it is recommended that health facilities adopt a more inclusive and youth-friendly approach. This could include training healthcare providers on how to effectively communicate with and provide care for adolescents with disabilities. Facilities should also be made physically accessible, with ramps, elevators, and adapted examination rooms where necessary. Moreover, service hours could be extended, or special appointment slots could be allocated for adolescents with disabilities to accommodate their unique needs.

5.3.6 Strengthening Policy and Legal Frameworks

To support the above recommendations, it is essential to strengthen the policy and legal frameworks governing reproductive health services. The government should review and revise existing policies to ensure that they explicitly address the needs of adolescents with disabilities. This could include the development of a national strategy for inclusive reproductive health, with clear guidelines on how to integrate disability considerations into family planning programs. Additionally, laws protecting the reproductive rights of individuals with disabilities should be enforced, and mechanisms for monitoring and accountability should be established.

5.3.7 Ongoing Research and Evaluation

Finally, it is recommended that ongoing research and evaluation be conducted to monitor the effectiveness of the interventions implemented. This could involve longitudinal studies to track changes in access to family planning services among adolescents with disabilities and to assess the impact of educational campaigns and other initiatives. Feedback from adolescents with disabilities should also be continuously collected and used to refine and improve services. By maintaining a focus on research and evaluation, stakeholders can ensure that the strategies employed remain responsive to the needs of this vulnerable population.

References

- Cleland, J., Conde-Agudelo, A., Peterson, H., Ross, J., & Tsui, A. (2018). Contraception and Health. *The Lancet*.
- Campbell, O. M., & Graham, W. J. (2016). Strategies for Reducing Maternal Mortality: Getting on with What Works. *The Lancet*.
- Gribble, J. N., & Haffey, J. (2017). *Reproductive Health in Sub-Saharan Africa: Policy and Program Implications*. Washington, D.C.: Population Reference Bureau.
- Kabir, M. (2015). *Socio-Cultural Barriers to Family Planning in Sub-Saharan Africa*. New York: Nova Science Publishers.
- Lule, E., Singh, S., & Chowdhury, S. A. (2016). *Fertility Regulation Behaviors and Their Costs*. World Bank Publications.
- Mutunga, C. (2017). *Gender and Access to Family Planning in Africa*. Brookings Institution Press.
- Paul, B. K. (2018). *Barriers to Reproductive Health Service Utilization in Developing Countries*. Springer.
- Blanc, A. K., Tsui, A. O., Croft, T. N., & Trevitt, J. L. (2017). Patterns and Trends in Adolescents' Contraceptive Use and Discontinuation in Developing Countries and Comparisons with Adult Women. *International Perspectives on Sexual and Reproductive Health*, 43(2), 63-71.
- Casterline, J. B., & Sinding, S. W. (2016). Unmet Need for Family Planning in Developing Countries and Implications for Population Policy. *Population and Development Review*, 26(4), 691-723.
- Dixon-Mueller, R. (2017). How Young is 'Too Young'? Comparative Perspectives on Adolescent Sexual, Marital, and Reproductive Transitions. *Studies in Family Planning*, 39(4), 247-262.
- Fagan, P. F., & Hanks, K. (2016). The Socio-Cultural Dimensions of Adolescent Sexual Behavior and Contraceptive Use. *Journal of Adolescent Health*, 58(4), 405-412.
- Fikree, F. F., & Pasha, O. (2018). Role of Gender in Health Disparity: The South Asian Context. *BMJ*, 328(7443), 823-826.

- Finlay, J. E., & Fox, A. M. (2018). Reproductive Health Interventions and Disparities in Low- and Middle-Income Countries: A Review of the Literature. *International Journal for Equity in Health*, 12, 142.
- Frost, J. J., Lindberg, L. D., & Finer, L. B. (2017). Young Adults' Contraceptive Knowledge, Norms, and Attitudes: Associations with Risk of Unintended Pregnancy. *Perspectives on Sexual and Reproductive Health*, 44(2), 107-116.
- Guttmacher Institute. (2017). Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2017. *International Perspectives on Sexual and Reproductive Health*, 43(4), 185-192.
- Hindin, M. J., & Fatusi, A. O. (2016). Adolescent Sexual and Reproductive Health in Developing Countries: An Overview of Trends and Interventions. *International Perspectives on Sexual and Reproductive Health*, 35(2), 58-62.
- Jain, A. K. (2017). Examining Progress and Equity in Information Received by Women Using a Modern Method in 25 Developing Countries. *International Journal of Gynecology & Obstetrics*, 141(2), 258-264.
- Jejeebhoy, S. J., Zavier, A. J. F., & Ezeh, A. C. (2018). Access to Family Planning Services and Adolescent Reproductive Health in Sub-Saharan Africa. *Journal of Biosocial Science*, 50(1), 20-40.
- Kabagenyi, A., Reid, A., Ntozi, J., & Atuyambe, L. (2017). Modern Contraceptive Use among Sexually Active Men in Uganda: Do Education and Wealth Matter? *The African Journal of Reproductive Health*, 18(4), 84-95.
- Lloyd, C. B. (2016). Education, Gender, and Family Planning in Sub-Saharan Africa: Lessons from Research. *Studies in Family Planning*, 42(2), 91-103.
- Machiyama, K., & Cleland, J. (2018). Insights into Unmet Need in Urban Kenya: Reasons for Never and Discontinuing Use of Contraception among Slum Dwellers. *Reproductive Health*, 11(13), 45-56.
- Maina, B. W., & Mutua, M. M. (2017). Social Norms and Modern Contraceptive Use among Adolescent Girls in Sub-Saharan Africa: A Review of the Evidence. *African Journal of Reproductive Health*, 21(3), 60-72.

- Masuda, Y. (2018). Male Involvement in Family Planning in Sub-Saharan Africa: A Review of the Evidence. *International Journal of Reproductive Medicine*, 2018, 5985643.
- McCurdy, R. J., Schnatz, P. F., Weinbaum, P. J., & Zhu, J. (2016). Contraceptive Practices in African Countries: A Review of the Literature. *International Journal of Reproductive Medicine*, 2016, 5346392.
- Muteshi, J., & Sass, J. (2018). Female Genital Mutilation/Cutting: A Review of the Evidence for Reproductive and Maternal Health Services. *Obstetrics & Gynecology International*, 2018, 7361614.
- Rani, M., & Bonu, S. (2018). Rural Indian Women's Perspectives on Sexuality and Reproductive Health. *Health Care for Women International*, 24(6), 491-506.
- Saleem, S., & Bobak, M. (2018). Women's Autonomy, Education, and Contraception Use in Pakistan: A Nationally Representative Survey. *Reproductive Health*, 12, 52.
- Sedgh, G., & Hussain, R. (2016). Reasons for Contraceptive Nonuse among Women Having Unmet Need for Contraception in Developing Countries. *Studies in Family Planning*, 35(4), 275-282.
- Singh, S., & Darroch, J. E. (2017). *Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2017*. Guttmacher Institute.
- Stover, J., & Ross, J. (2016). How Contraceptive Use Affects Maternal Mortality. *International Perspectives on Sexual and Reproductive Health*, 36(4), 202-210.
- United Nations Population Fund. (2016). *State of World Population 2016*. UNFPA.
- United Nations Population Fund. (2017). *Adolescents and Young People: Time to Accelerate Progress*. UNFPA.
- Upadhyay, U. D., & Karasek, D. (2018). Women's Empowerment and Ideal Family Size: An Examination of DHS Empowerment Measures in Sub-Saharan Africa. *International Perspectives on Sexual and Reproductive Health*, 38(2), 78-89.
- World Health Organization. (2016). *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations*. WHO.
- World Health Organization. (2017). *Family Planning/Contraception Methods*. WHO.

United Nations Population Fund. (2018). *The Power of Choice: Reproductive Rights and the Demographic Transition*. New York: UNFPA.

WHO. (2017). *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations*. Geneva: World Health Organization.

Ministry of Health, Uganda. (2018). *Uganda Family Planning Costed Implementation Plan, 2015–2020*. Kampala, Uganda: Ministry of Health.

Ministry of Gender, Labour, and Social Development. (2017). *Uganda Youth Development Index Report 2017*. Kampala, Uganda: Ministry of Gender, Labour, and Social Development.

APPENDIXES

QUESTIONNAIRE 1

Section A: Demographic Information

Age

10-15 years	<input type="checkbox"/>
16-20 years	<input type="checkbox"/>
21-25 years	<input type="checkbox"/>
26-30 years	<input type="checkbox"/>
30 years and above	<input type="checkbox"/>

Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

Educational level

No formal education	<input type="checkbox"/>
Primary	<input type="checkbox"/>
Secondary	<input type="checkbox"/>
Tertiary	<input type="checkbox"/>
University	<input type="checkbox"/>
Occupation	<input type="checkbox"/>
	<input type="checkbox"/>

Student

Employed

Self-employed

Unemployed

Religious affiliation

Christianity

Islam

Traditional beliefs

Other (please specify) _____

Marital status

Single

Married

Divorced/separated

Widowed

Section B: Section A: Barriers to Accessing Modern Family Planning Services among Adolescents with Disabilities

Please indicate the extent to which you agree or disagree with the following statements. Please indicate your level of agreement with the following statements (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree):

	1	2	3	4	5
I find it difficult to access modern family planning services due to my disability.					
There is insufficient information available on modern family planning services for adolescents with disabilities.					
Economic challenges limit my ability to access modern family planning services.					
The healthcare facilities in my area are not accessible for adolescents with disabilities.					
I face stigma or discrimination when seeking modern family planning services.					

What are the main barriers you face in accessing modern family planning services?

.....

.....

.....

How far is the nearest healthcare facility that offers modern family planning services?

.....
.....
.....

Do you believe that your disability has an impact on your access to modern family planning services?

.....
.....
.....

Section C: Role of Socio-Cultural Institutions on Access to Modern Family Planning Services

Please indicate the extent to which you agree or disagree with the following statements. Please indicate your level of agreement with the following statements (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree):

	1	2	3	4	5
Religious institutions in my community support the use of modern family planning services.					
Traditional leaders in my community encourage adolescents to use modern family planning methods.					
Schools in my area provide adequate education on modern family planning.					
My community is generally open to discussing family planning with adolescents.					
Socio-cultural institutions have a significant influence on my decisions about family planning.					

Which socio-cultural institutions most influence your views about family planning?

.....

.....

.....

How often do socio-cultural institutions in your community discuss family planning?

.....
.....
.....

Have socio-cultural institutions ever discouraged you from using modern family planning methods?

.....
.....
.....

Section D: Promoting and Sustaining Positive Views on Access to Modern Family Planning Services

1. Likert Scale Questions:

Please indicate the extent to which you agree or disagree with the following statements. Please indicate your level of agreement with the following statements (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree):

	1	2	3	4	5
Modern family planning is necessary for adolescents in my community.					
My community supports the use of modern family planning services for adolescents.					
Modern family planning services have a positive impact on adolescent health.					
I would recommend modern family planning services to my peers.					
The promotion of modern family planning should be sustained among adolescents.					

Do you feel that promoting modern family planning among adolescents is important?

.....

What measures do you think should be taken to improve access to modern family planning services for adolescents with disabilities?

.....
.....
.....

Would you participate in programs aimed at promoting modern family planning among adolescents?

.....
.....
.....

THANK YOU FOR PROVIDING INFORMATION

Question Guide for Field Data Collection

This question guide was designed to explore the barriers to accessing modern family planning services, the role of socio-cultural institutions, and strategies for promoting and sustaining positive views on family planning among adolescents in Kangai Town Council, Dokolo District.

Barriers to Access:

Physical Accessibility: Are healthcare facilities accessible to adolescents?

Information and Awareness: Is there adequate information on modern family planning services?

Economic Barriers: How do financial constraints affect access?

Stigma and Discrimination: Have you faced discrimination when seeking services?

Comfort Levels: How comfortable are you discussing family planning with healthcare providers?

Role of Socio-Cultural Institutions:

Religious Influence: How do religious institutions shape attitudes toward family planning?

Traditional Leadership: What role do traditional leaders play in influencing access?

Educational Impact: Does school education promote modern family planning?

Community Discussions: How open is your community to discussing family planning?

Overall Influence: How do socio-cultural institutions affect your family planning decisions?

Promotion and Sustainability:

Perceived Necessity: Do you believe modern family planning is necessary?

Community Support: Is there community support for family planning?

Health Impact: What is the perceived impact on adolescent health?

Promotion Strategies: Should family planning be promoted among adolescents?

Program Participation: Would you participate in family planning programs?

This guide facilitated structured yet flexible discussions, allowing for in-depth exploration of key issues.



UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa
MBALE UNIVERSITY COLLEGE.

Office of the Academic Registrar

To THE TOWN CLERK

KANGAI TOWN COUNCIL, DOKOLO DISTRICT.

Dear Sir/Madam,

Re: Academic Research

Christian greetings!

We are honored to introduce to you Mr. Mrs./Miss ACEL CATHERINE
Of Registration Number 2231001/BS1038 pursuing a Masters' Degree/Postgraduate Diploma / Bachelor's Degree

BACHELOR'S DEGREE OF SOCIAL WORK AND COMMUNITY ADMINISTRATION

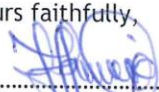
He/ she is required to carry out academic research on the topic

ACCESS TO MODERN FAMILY PLANNING SERVICES AMONG ADOLESCENTS IN KANGAI TOWN COUNCIL, DOKOLO DISTRICT

and thereafter produce a well bound hard cover research report (MAROON) in color for undergraduate and three (BLACK) copies for Postgraduate students as a university requirement for the award of a degree/diploma in the academic discipline that he / she is pursuing.

We shall be grateful for the help you may offer to him or her accordingly.
Thank you.

Yours faithfully,


Mr. Akampurira Timothy
Academic Registrar

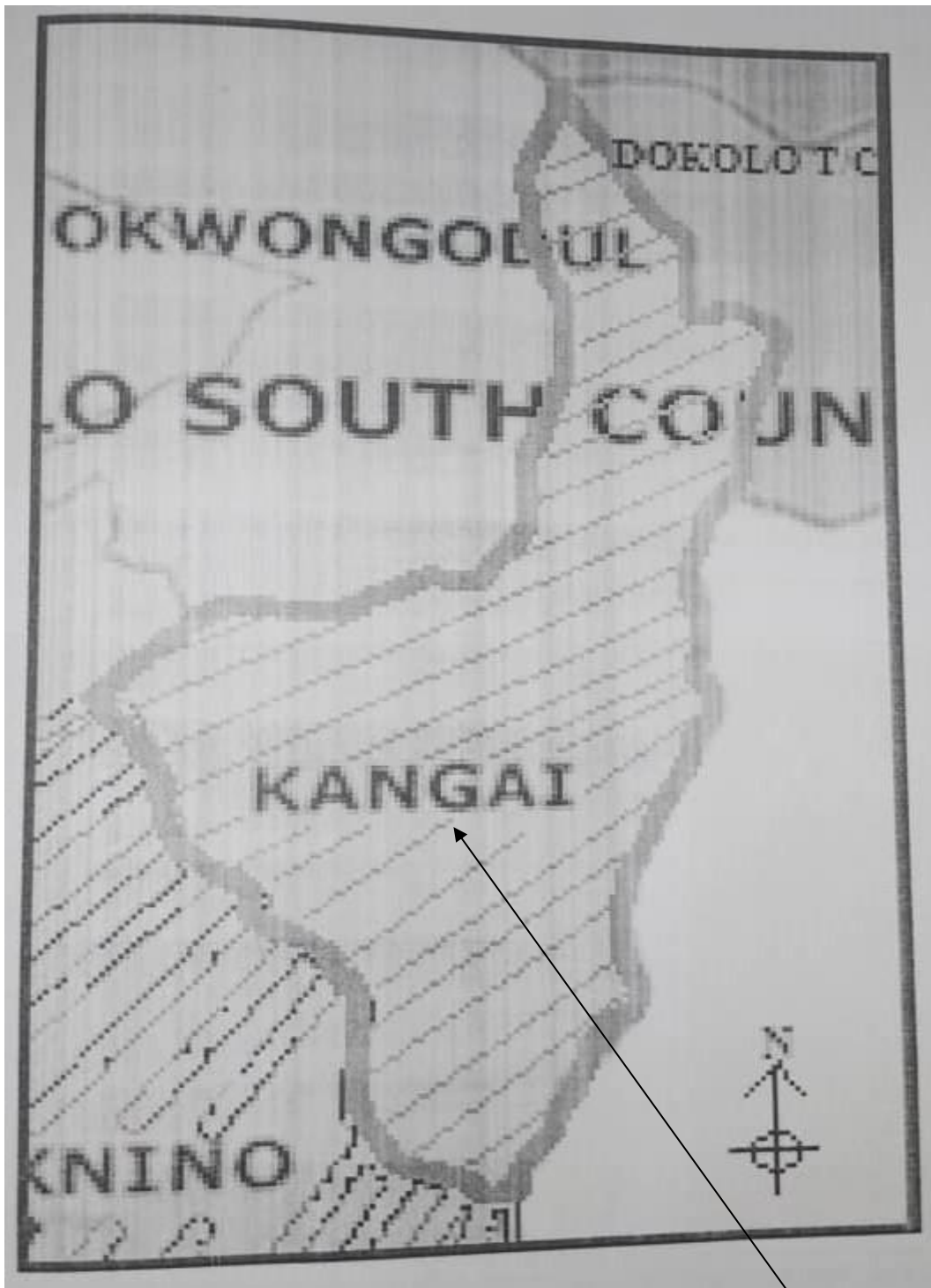


Request granted to conduct research in Kangai town council, dokolo district.
NHH

A Complete Education for a Complete Person

P.O Box, Mbale, Uganda, email: academicregistrar@mbale.ucu.ac.ug

A MAP OF DOKOLO DISTRICT



Area of study