FACTORS INFLUENCING FEMALE CONDOM USE AMONG FEMALES ATTENDING FAMILY PLANNING SERVICES AT ENTEBBE GENERAL HOSPITAL WAKISO DISTRICT,UGANDA

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MASTER OF PUBLIC HEALTH

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ACCEPTENCE SHEET

This master's thesis entitled " Factors influencing use of female condoms among females attending family planning services at Entebbe General Hospitall Wakiso District ,Uganda", prepared and submitted by wanyenze lucy in partial fulfillment of the requirements for the award of degree of Master of Public Health was hereby accepted.

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DECLARATION

I, **Wanyenze Lucy**, hereby declare that the information contained in this research thesis entitled: "**FACTORS INFLUENCING FEMALE CONDOM USE AMONG FEMALES ATTENDING FAMILY PLANNING SERVICES AT ENTEBBE GENERAL HOSPITAL WAKISO DISTRICT,UGANDA"** represents my original information as a result of independent interpretation. Indebtedness and due acknowledgement has been accredited to the researched work of others.

……

Wanyenze Lucy **Date.**

DEDICATION

I, dedicate this research thesis to the strong people behind my career specifically my parents for their endless efforts and strong background to my education. Thanks Dad and Mum.I also dedication the same to my children , immediate relatives.and to my work mates.

Please know that you are the reason for this successive achievement and you have been a pillar of faith and hope that has seen me through the difficult and weakest moments of my life.

Thanks for the moral support you have shown me God bless you.

BIOGRAPHIC SKETCH

The author was born on the 14th day of December, 1972 to Mr. Yeremiya Cherotin and Mrs Nataliya Sambazzi in Bulambuli District in Eastern Uganda.

She went to Kaminy Primary School from 1976 to 1982 for PLE, Jioned Sebei Senior Secondary School from 1983 to 1986 for “O” Level and thereafter from 1987 to 1989 for “A” Level in the same school.

In 1991, She joined Mbale Medical School for a Diploma in Clinical Medicine and Community Health upto 1994 .

On 24th January 1996 She began working as a Clinical Officer in Mityana for 10 years then transferred to Entebbe General Hospital upto date (2018)

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The author also works as a research assistant in many researches for UVRI Entebbe based/located at Entebbe General Hospital.

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Lastly but not least much thanks to my chief-Editor-Jimmy,

May the great lord bless all of you

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ABBREVIATIONS

HIV/AIDS	:	Human immunodeficiency virus infection/ Acquired Immune Deficiency Syndrome
MOH	:	Ministry of Health
STIs	:	Sexually Transmitted Infections
UBOS	:	Uganda Bureau of Statistics
UNFPA	:	United Nations Population Fund

ABSTRACT

WANYENZE LUCY, School of Graduate Studies, Bugema University, SEPTEMBER, 2018. **"FACTORS INFLUENCING THE USE OF FEMALE CONDOMS AMONG FEMALES ATTENDIG FAMILY SERVICES AT ENTEBBE GENERAL HOSPITAL WAKISO DISTRICT, UGANDA."**

Advisor: Peter Vuzi, Ph.D.

The study was set to determine the factors influencing the use of female condoms among females attending family planning services at Entebbe general hospital. Its specific objectives included establishing the proportion of women using female condoms, determining the influence of personal factors, community factors, and health system factors respectively on use of female condoms among females aged 15 to 49 years.

The study adopted a cross sectional study design in which both quantitative and qualitative in data was collected from 117 randomly selected females using questionnaires, and 5 purposively selected health workers from the family planning unit using the key informant guide respectively. The study found the proportion of women ever using female condoms at 38.5% and none of the personal factors influenced use. Results found supportive roles of other women (AOR = 3.79; 95% CI: 1.05-13.64; p = 0.042) and that of the male spouses with regard to the use of the femidom (AOR = 4.44; 95% CI: 1.61-12.23; p = 0.004) were the community factors associated with female condom use. The study found the availability of female condoms at the health facility (AOR = 0.31; 95% CI: 0.10-0.93; p = 0.037) was the only health system predictor of female condom use. The qualitative results also agreed with the above quantitative findings.

The study based on the findings with respect to the specific objectives concluded that there was a significant use of the female condom among women that are characterized by good health seeking behaviors with regard to family planning services. It also concluded that the role of other women and the male partners alongside locational availability of femidom were pertinent when considering ways to improve the use on the female condoms among the women.

The study recommended among others that the government through its line Ministry of Health should develop and institutionalize interventions that promote roles played by other women with regard to use of the female condom in the community. It also recommended that the civil society organizations whose thematic areas are reproductive health in collaboration with the health professionals should adopt alternative outlets to the female condoms access like the retail centres, lodges and beaches in addition to health facilities found in the communities to increase female condom use among the women of reproductive age.

CHAPTER ONE

INTRODUCTION

Background of the Study

Female condoms refer to contraceptive devices that are made of tinny rubber with a soft but loose fitting pouch with a ring on each end which has to be inserted into the vagina of a woman prior to sexual intercourse.Also termed as either internal condom or femidom, a female condom was also defined as a device that was used as a barrier to stop sperms from entering the uterus of the women following a sexual intercourse.

On the worldwide scene, utilization of the female condom was known to serve as an important tool when it came to implementing a plan on when to give birth and how many given that it helped the women from having unintended pregnancies (Mathenjwa, 2010). The utilization of female condoms also had its significance embedded in helping to protect women against sexually transmitted infections (STIs)among which was Syphillis alongside gonorrhea (Weeks, Zhan, Li, Hilario, Abbott & Medina, 2015). The utilization of female condom was also known to empower women giving them a greater sense of self-reliance and autonomy, and enhance dialogue and negotiation with their sexual partners (Mantell, Stein, and Susser, 2008).

Quite unfortunate is that while millions of couples are known to be in the need of effective protection against unwanted pregnancy and sexually transmitted infections, HIV inclusive, the acceptability and therefore the utilization of the internal condom as a device remained unacceptably low as indicated by the 0.7% of overall condoms circulated by donor nations globally(United Nations Population Fund, 2010).In the developing countries evidence of the use of female condom is not well documented.

In the Sub Saharan Africa,the use of female condoms is acknowledged to be an important prevention option to enable women to protect themselves(Mantell, Smit, Exner, Mabude, Hoffman, et al., 2015). Unfortunately evidence of low utilization is eminent as indicated by an estimated 3.3 billion people who were involved in risky sexual acts, leading to 910,000 new HIV infections with the women boring a disproportionally high cost alongside the burden of unwanted pregnancies (UNAIDS, 2016). The females are extremely affected by HIV/AIDS scourge despite the use of female condoms being described as a pertinent protection option (Peters and van Driel F., and Jansen, 2014).

In Uganda, the utilization of female condoms remains to be described as low right from the time of its first marketing a way back in1998 by Marie Stopes International when the device was indicated as unacceptable (Ministry of Health, 2009).The use of the female condom is known to serve as an effective STI and pregnancy prevention technology currently available and thus efforts towards its use should be compromised in anyway (PATH and UNFPA, 2006). Its use is also necessary to achieve wide declines in HIV/ AIDS transmission (Vermund and Hayes, 2013). Studies have indicated a significant potential for female condoms uptake in the general population with appropriate promotions (Jones, Kashy, Villar-Loubet and Weiss, 2013) but the several individual, socio-economic, and cultural factors that influence uptake of their use need to be understood (Moore, Beksinska, Rumphs, Festin, and Gollub, 2015). It is important that factors associated with the utilization of female condoms be determined as different risk factors are pertinent in informing appropriate strategies (Kher, 2008). It is against this background that this study ascertains female Condom Utilization and Associated Factors

among Females of Reproductive Age Attending Family planning services at Entebbe General Hospital

Statement of the Problem

In Uganda, evidence showed that the utilization of female condoms amongst women of reproductive age remained disproportionality low despite its known significance of curtailing transmission of STIs alongside preventing unwanted pregnancies (Natukunda, 2014). The Country Demographic Health Statistics showed that only 0.1% of the women in a sexually active relationship moreover in either Kigezi and not educated happen to have used the female condoms as of the year 2016 (UBOS and ICF, 2017). This by implication shows that up to 99% of the women in a sexually active relationship have never used a female condom. In Entebbe Hospital, evidence showed that the use of the femidom among females is as low as 0.089% (Entebbe Hospital Family Planning Enrolment Report, 2016).This figure is much lower than the national average yet the area is characterized by high sexual activity given its possession of abundant recreation areas. Efforts that have seen an increased availability following the procurement support and other health interventions aimed at increasing female condom utilization through promotions and advocacy for reduction in the prices by the Ugandan Ministry are yet to be fruitful.Proper understanding of factors that explain uptake by females is important to reverse such poor female condom utilization trends.Studies to this effect unfortunately remain rare that even in Entebbe area, documented evidence in regard to use and associated factors remain unseen. If not addressed, the low or noutilization of female condoms is likely to increase transmission rates of STIs and HIV infections. In addition such low use of female condoms is likely to increase not only

unintended or unplanned pregnancies but also exacerbate the country's mortality rates as a result of increased STI transmission rates and preventable health related expenditures by government. It was thus necessary that proper understanding related to the factors that influence utilization of female condoms among females is unearthed and documented if appropriate and informed interventions are to be developed.

Research Questions

1. What is the proportion of women aged 15 to 49 years attending family planning services at Entebbe general hospital utilize female condoms?
2. What personal factors influence use of female condoms among females attending family planning services at Entebbe general hospital?
3. What community factors influence use of female condoms among females attending family planning services at Entebbe general hospital?
4. What health system factors affect use of female condoms among females attending family planning services at Entebbe general hospital?

Objectives of the Study

The general objective of this study was to determine the factors influencing the use of female condoms among females attending family planning services at Entebbe general hospital as to inform appropriate interventions to promote their use.

Specific Objectives

1. To establish the proportion of women using female condoms among females aged 15 to 49 years attending family planning services at Entebbe general hospital
2. To determine the personal factors influencing use of female condoms among females attending family panning services at Entebbe general hospital

3. To find out the community factors influencing use of female condoms among females attending family planning services at Entebbe general hospital

4. To ascertain the health system factors affecting use of female condoms among females attending family planning services at Entebbe general hospital

Hypotheses of the Study

Personal, community and health system factors are not significant predictors of female condom use among women aged 15 to 49 years attending family planning services at Entebbe general hospital

Significance of the Study

Health Care Practitioners: The study results are meant to be useful for health care services providers in understanding the reasons behind the low female condoms uptake as to come with optimal approaches of redress.

Females: The research findings of this study are meant to be significant to the female of reproductive age through specifically developing a sense of consciousness towards the benefits of their uptake.

Policy makers: The results of this study are meant to provide guidance in coming up with appropriate policy measures to increase the uptake of Female condoms. It would also form a basis for institutionalization of female condoms program.

Academicians: The results and recommendations are not only meant to form a basis for further research but also add to the available literature, particularly in relation to female condom use.

Scope of the Study

This study established the factors that influenced use of female condoms among females. It specifically limited itself and established the personal factors, community factors and the health system factors that affect use of female condoms among females of reproductive age. The study was undertaken in Entebbe general hospital within Wakiso district. It limited itself to information related to female condom use and associated factors from June to July 2018. The period of time was of choice because it represented that time adequate enough to capture information from the required number of respondents to adequately address the study objectives.

Limitations to the Study

In this study, certain difficulties were encountered for instance the women participants had fear to give some information in relation to the use of female condoms . Here the researcher used indirect questioning to get an appropriate response. In addition the time to carry out the study adequately was limited. Here the use of research assistants helped mitigate limitation.

Theoretical Framework

This study was underpinned by the Health Belief Model (HBM) as postulated by the likes of Rosenstock et. al (1958). This model which was extended by the likes of Janz and Becker (2004), had it that if a person in this case the women feel susceptible to a condition in this case getting pregnant or sexually transmitted infections and the severity was high, a cue to action may encourage behavior change into their use. The Health belief model was a useful model for explaining use given that the use of some reproductive health approaches were associated with some beliefs and vary across

cultures. In this study therefore self-efficacy alongside perceived control was of much interest as they were associated with utilization of female condoms and demographic characteristics influence their use among women. The perceived severity and perceived susceptibility underpinned the current study undertaking with the aim of improving use of female condoms as to curtail vulnerability to unwanted pregnancy or even developing sexually transmitted infections. Besides, perceived susceptibility and severity were predictive of several health-protective behaviors like utilization of female condoms in this study.

On the other hand with regard to self-efficacy it was postulated that individuals in this case women who perceived high levels of self-efficacy were more likely to uptake. In other words it provided such individuals with confidence to use such female condoms. In the HBM model were the Intermediating factors like the social aspects of life and demographics alongside the mediating variables like education attainment that are perceived to indirectly influence the behavior of the women through influencing an individual's perceptions of susceptibility and severity. This having been said, in this study based on the Health Beliefs model it was argued that certain factors are perceived to influence utilization of female condoms and unearthing them was key to come up with health promotion and preventive strategies.

Conceptual Framework

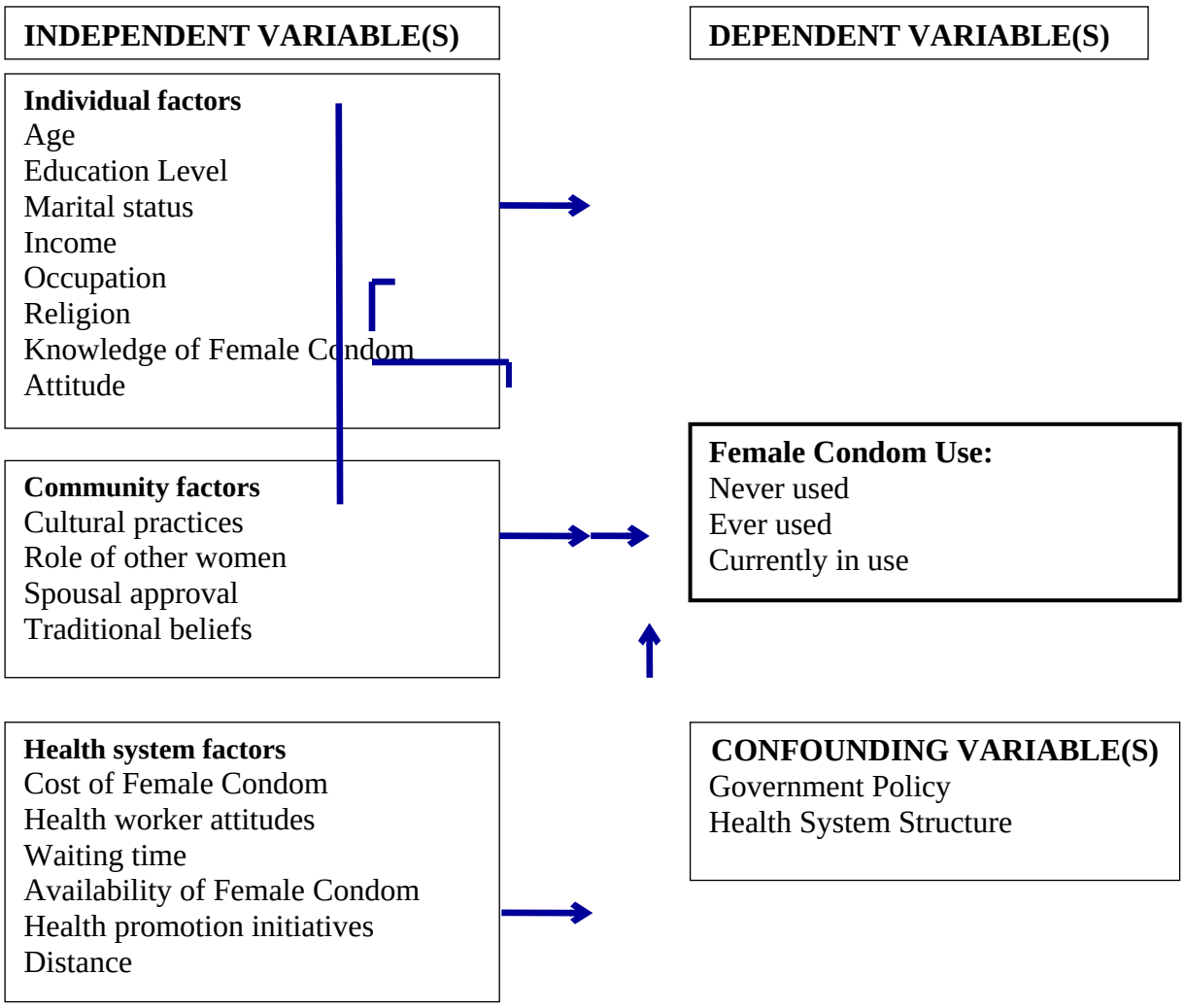

Figure 1: Conceptual Framework

Operational Definition of the Key Terms

Age: This term was used to mean the time years that the women of reproductive age would have spent while still alive since their birth date. It was measured on an ordinal scale as a = 18-25, b = 25-35, c = 35 - 45, d = 45 and above.

Education status: This term was used to mean the highest level of formal education that had been reached by the women of reproductive age. It was measured on an ordinal scale as 1-None, 2-Primary, 3-Secondary, and 4- Tertiary

Marital Status: In this study the term was used to mean the legal status of the women's relationship with the male partner as applied to Ugandan marriage laws. It was measured nominally as 1-Single, 2-Married, 3-Divorced and 4-Others

Income: This term was used to refer to the perceived level of what the women earned from the work they were engaged in as a livelihood. It was measured using a ordinal scale such that 1- Low, 2- Average and 3 - High.

Occupation Status: In this study was used to mean the kind of work that the women were involved in as a livelihood. It was measured on a nominal scale as 1-None, 2- Business, 3- Public servant and 4 - Others

Attitude: This term was used to mean the perception of different women towards female condom use. It was measured on a nominal scale as 1- Positive, 2-Negative

Knowledge of Female Condom: In this study it was used to mean the acknowledgement of possessing information about female condoms. It was measured on a nominal scale as 1-Yes, 2-No

Role of other women: This term was used to mean the extent to which parts played by other females facilitate female condom use amongst females of reproductive age It was measured on an ordinal scale as 1-Stronly disagree, 2-Disagree, 3-Agree, 4-Strongly disagree

Spousal approval: It was used to mean the extent to which males in sexual relationships approve of the women using female condoms. It was measured on a nominal scale as 1-Yes, and 2-No

Traditional beliefs: This term was used to mean the views within the community about the use of female condoms. It was measured on a nominal scale as 1-Yes, 2 - No.

Cost of Female condom: This term was used to mean the affordability or charges on accessing the female condoms from the health facilities. It was measured on a nominal scale as 1- Yes, 2 - No

Waiting time: The term was used to mean the time taken for women seeking reproductive health services to be served.. It was measured on a nominal scale as 1- 0-2 hrs, 2- More than 2 hours

Availability of Female Condoms: was used to mean readiness of the female condom services at the facilities. It was also measured on an ordinal scale as 1-Stronly disagree, 2-Disagree, 3-Agree, 4-Strongly disagree.

Health promotion initiatives: This in the study was used to mean the extent the health system informed the public about female condom use and its significance. It was measured on a nominal scale as 1-Yes, and 2-No

Distance: This referred to the distance in kilometers between residency and the facilities where female condoms are accessed. It was measured on an ordinal scale as: 1-Up to 2km and 2- More than 2 km

Female Condom Use: This referred to whether female condoms are used by women of reproductive age or not. It was measured using an ordinal scale thus 1-Never, 2-Ever used, 3-Currently used

CHAPTER TWO

LITERATURE REVIEW

The Prevalence of Female Condom Use Among Women

Studies report the use of the female condom as serving an effective STI and pregnancy prevention technology available now that enables couples to reduce their risks (PATH and UNFPA, 2006). Unfortunately the UNAIDS (2015) reports that only 4.9% of married women worldwide use condoms with a much lower proportion of only 1.3% in sub-Saharan Africa. In South Africa, though knowledge of the female condom among sexually active females over the age of 15 years was relatively high at 77.75%, use was low at 7.16% (Guerra and Simbayi, 2014). Similarly, in Cameroon the percentage of sexually experienced female students who had ever used female condoms during sexual intercourse was very low (8%), despite high levels of knowledge (67.3%) (Tarkang and Bain, 2015). These studies report contradicting figures in as far as the use of female condom are concerned which gap the current study clarified

According to Uganda Health Marketing Group, the 1.2 million condoms procured in 2017 remain in stores and government warehouses with uptake being dismally low at less than 2%. According to a study by the Ministry of Health (2018) on use of female condoms in select districts, a paltry 2 per cent of women requested the condoms. Interestingly even women prefer their men using condoms compared to them embracing femidom, the female condom. This was despite the prevalence of HIV/AIDS remained 3 per cent higher for women than men. These studies do not reveal the picture in as far as Entebbe and its surroundings are concerned, which gap this study exoplored.

Individual Factors Influencing Use of Female Condoms Among Women

In study undertaken aimed at promoting female condoms in HIV voluntary counseling and testing centres, Mungaala et al., (2009) established that only 65% of women aged of 30-44 years were able to access female condom due to the fact that it was an effective and reliable tool for family planning as an alternative to male condom. Therefore, easier accessibility had probably contributed to high usage of female condom among women of to be higher in these subgroups. In both multivariable underlying determinant model and the full multivariable model urban women who were of age 35-39 years and 40-44 years were more likely to ever have used female condom compared to women in the age group 15-19 years. This compared well with a study done by Dominique & Richte (2005) on factors associated with use of the female condom in Zimbabwe which showed that majority (68%) of women in elder age group (35 years to 44 years) were more likely to use female condom especially those in urban areas due to availability of information. These studies were however undertaken in Kenya and Zimbabwe respectively not in Uganda which evidence gap was of interest in this study.

In another study to ascertain the hindrances to using female condoms, Seedat (2011) establishes that young women are less likely to use female condom because they were shy to buy or to go to the clinic to ask for female condoms. We also found that urban women who perceived themselves as accessing female condom were more likely to use female condom compared to those women who were not able to access female condom. This study only assumed that when women are shy they are not likely to use femidoms which may not be the case which gap this study investigated to fill.

Kassie et al., (2008) conducted a study on the pattern of knowledge and condom use among population groups in Ethiopia and they found 68% of women had knowledge of female condom as a contraceptive method because most of these women would prefer use a reliable family planning tool due to the time they spend at school and may previously attended antenatal clinics where they are taught on how to use it, and they may not be shy to ask for or buy female condoms. Therefore, better knowledge of female condoms as a contraceptive method prior to intercourse, probably this had contributed to high female condom use in these subgroups. Furthermore, the findings in this study indicated that both urban and rural women with higher education were more likely to ever use female condoms compared to those women who had lower education. This study was however not specific to female condoms which gap the current study clarified.

Kassie et al., (2008) a study conducted in Ethiopia on the pattern of knowledge and condom use indicated that education increased the ability of women to be able to access information from diverse sources. Further, this decreased their vulnerability to myths and misconceptions about female condoms. As such the findings of this study were expected. Similar findings have been shown by Exavery et al., (2012) showed thatwomen with at least secondary education were twice as likely to use female condoms compared to those who had never been to school or had a primary education only. Further education played an imperative role in societal transformation and education enhances women self-esteem, self-confidence, ability to make decision and freedom of expression concerning their sexual and reproduction inclination. It also placed women in positions where they are able to talk about HIV transmissibility, prevention and treatment which lessen their vulnerability to misconceptions about the use of condoms (Lagarde, et al., 2011). These

studies do not however reveal whether education actually translated into use of femidom which gap this study investigated.

Mativo et al., (2010) established that majority (59%) of women who use female condoms were those who were on separation (not living with their spouse) and widowed compared to those who never married but within Kiamba District in Kenya. These could be due to the fact that women who are not living with their spouse do not trust their sexual partner and possibly do not fail to negotiate for female condom use for fear of contracting HIV or STIs infections. In comparison the likes of Joseph (2011) after conducting a study about the threats of AIDS and condom use in a Nigerian rural community found that the majority (78.6%) of the women who were not living together with spouse reported using female condom because they did not trust their sexual partners and they acknowledged (60.2%) that proper use of female condom had the capacity to prevent STIs and HIV infection. Different however Runganga (2012) and Matshalaga (2013) state that for married couples or people in steady relationships, condom use was almost non-existent, as it indicated lack of trust and/or the fact that someone wanted to use a condom because she or he is already infected. These studies are however contradicting which gap this study explored to fill.

Kassie (2008) established that lack of proper knowledge and misconceptions about the female condom reduced its use. The perception that female condom use does not give total protection against HIV may appear to have influenced some men's choice for male condoms or abstinence since they could not have a guarantee to trust their sexual partner. Additionally, a study in Zimbabwe by Dominique & Richte (2012) found that women and men were reluctant to use a female condom due to its perceived low

effectiveness for STI and also because of low perceived risk of contracting HIV/AIDS. Further, the ability to practice safer sex depended on confidence, communication and trust in the partner and the relationship. These studies were however done in the community not in those seeking health care services which gap this study proposed to fill using females attending family planning services at Entebbe general hospital.

Cort and Modeste (2012) conducted a study among high school and university students in Zimbabwe and investigated the extent to which knowledge of AIDS was associated with two components of the Health Belief Model: attitude toward female condom use, and intentions to use female condom in future sexual encounters. The results indicated that knowledge of AIDS was not significantly related to any of the two dependent variables. However, belief in the efficacy of female condoms, and lack of knowledge on how to use female condom use were some of the factors associated with low use of female condoms. It was concluded that lack of education about and familiarity with female condoms were prominent factors contributing to non-use of female condoms. Different however Mantell et al., (2008) noted that rural women who knew a place where to get female condoms were more likely to use female condom than those who did not know a place to get it. On the other hand both urban and rural women who knew a place where to get female condom use were less likely to report condom use in the proximate determinant model. In contrast, Bedimo et al. (2013) found that in Nigeria the urban and rural women who knew a source of female condom were more likely to report female condom use. In that study majority (52%) of the women of reproductive age reported using female condom if they knew the source of female condom and when faced with the threat of contracting HIV/AIDS infection. This according to that a significant relationship

existed between knowing the source of female condom, the perception of the female condom as a protective device against HIV/AIDS and willingness to use it. These studies provided contradicting results that need clarification which gap this study explored to fill following a mixed methods approach.

Dominique and Richte (2012), found that urban women were more likely to access female condom due to the fact that they are able to access information concerning to female condom use easily compared to rural women. However Steinberg et al.,(2013) found that female condoms are used if they were able to be accessed. This was based in a summary report on AIDS from the International Center for research on Women in Guatemala, India, Jamaica, and Papua New Guinea, women reported. In disagreement Lyons (2013) points out that condoms are often viewed with skepticism and mixed feelings in countries with a high prevalence of HIV infection. Despite its benefits, in Africa, condom use was faced with resistance from Christian,religions as well as Traditionalists The author found that that regardless of the role female condoms play in family planning and in avoiding the spread of sexually transmitted infections (STIs) including HIV/AIDS, their use remained associated with immorality and infidelity among women. In support Srikanthan and Reid, (2008) found that religions may have negative perceptions towards the use of condoms, both as contraception in family planning and as a preventive measure against the spread of sexually transmitted diseases, and this may negatively affect programmes that are aimed at reducing the spread of HIV/AIDS. The studies do not however reveal to what extent the factors investigated such as residence and religions influence use of the femidom which gap this study investigated.

Campbell and Kelly (2009), found out that the dual protection of female condom against sexually transmitted infections, cancer and prevention of pregnancies was associated with female condom use. In addition to this duo protection, other reasons that were raised included; as a family planning tool. This confirmed the study conducted by Nicolosi et al., (2014), where it was stated that one of the factors associated with female condom were its protection against sexually transmitted infectious and prevention of unwanted pregnancies. Again these studies do not reveal the actual extent to which duo protection increased use which gap the current study intended to address.

Vijayakumar et al., (2009), revealed that female condoms were acceptable to many women, offered a useful alternative to women who may desire to use dual protection methods. A later study revealed another finding linked to sexual pleasure. This study found that while women recognized the dual protection offered by the female condom, the fact that they liked it was linked to sexual satisfaction.In support Francis-Chizororo and Natshalanga, (2014), found that it could be inserted before foreplay, a positive factor also stated by males during the focus group discussions in a study conducted in Zimbabwe among sexually active women and men . The reviewed studies were however based on a review of studies on the female condom not emprically established which gap this study intend ed to fill using females visiting Entebbe general hospital.

Studies report mixed attitudes among both male and female study subjects towards the female condom. Farr (2014), found that among US and Latin American women, most women liked using the device, would recommend it to others and would select it above other barrier methods. According to Mantell *et al.*, (2008), use of the

female condom could empower women, give them a greater sense of self-reliance and autonomy, and enhance dialogue and negotiation with their sexual partners. The latter study only provided information of the benefits of the femidom not how attitudes adffected its use which gap this study investigated to fill.

The findings of a review conducted in the US by Severy and Spieler (2000), revealed that many men prefer the female condom to the male condom because it was less constricting, and makes sex more pleasurable and more natural. In contrast Ford and Marthie (2013), found that female condoms faced a number of barriers to their use including clients' distrust of unfamiliar methods, inconvenience, insertion difficulties and reluctance among male partners. Ford and the colleague concluded that women may discontinue their use because of their partner's opposition, and that male opposition to female condom usage varied in different setting. These studies were quite confusing in that while the former was among the males the latter was about the females which gap this study investigated specifically using the females.

Community Factors Influencing Use Of Female Condoms Among Women

Elliot and James (2013), reported that there was still stigma associated with female condom due to the fact that women face challenges in most African societies with regard to making decisions regarding safer sex. Kamya et al., (2013), conducted a study on factors associated with female condom use in an urban village of Kampala, Uganda, where it was found that the prevalence of consistent female condom use in Kampala was one of the lowest in urban of Kampala (about 1%). The low use was partially attributed to the fact that community members were concerned that female condoms would give women too much freedom. In contrast to the finding in urban village of Kampala,

Uganda, misconceptions and myths impeded a true understanding of female condoms.Different however Busza and Baker (2013), found that people feared that the femidom could get stuck in the womb or stomach that the semen could be captured and taken to a witch doctor, and there were rumours that it was laced with HIV. The results do not provide the full magnitude of the effect which gap this study filled by adopting quantitative approaches.

Busza and Baker (2013), found that women also feel reluctant to speak to their partners about protection, which was not surprising as partner objection was the main reason for abandoning female condom use in Cambodia. These characteristics may or may not be present; indeed, sex may take place with little or no communication whatsoever and/or may be coerced. Shapiro and Ray, (2007), established however that in many cultures discussing sex was taboo, making the delivery of education to health workers and the discussion of safer sex by them with people living with and at risk of HIV very challenging. The latter study did not however reveal how such situations like being a taboo explain femidom use which gap the creent study investigated

Ankrah and Attika (2009), establishes that cultural taboos prevented women from discussing intimate subjects, such as female condoms with male partners.. Similarly, Bekinska et al.,(2008), pointed out that the main issue when introducing a contraceptive method was over coming partner opposition. Buck et al., (2010), however found that female condoms were the least preferred method compared to the diaphragm and male condoms, mainly because of their obviousness and partial coverage of outer-genitalia that interfered with sexual pleasure. The former studies however remined silent about how

being a cultural taboo actually affected use of the femidom which gap this study would ascertain among women attending family planning services at Entebbe general hospital.

In the study by Farr (2014), reasons for inconsistent female condom use among participants varied between US and Latin American subjects, with the latter reporting partner objection as one of the main reasons for not using the female condom consistently. In support Welsh et al., (2011) , found partner co-operation as being a key issue in an African study assessing the impact of introducing the female condom (. The researchers reported that the use of the female condom depended on the willingness of the male partner. But the likes of Osubor, Fatusi and Chiwuzi (2008) , found that traditional beliefs were not associated with female condom use in Nigeria. It came out in the focus group discussion that some women their culture do not allow them to discuss female condom use with their sexual partner and they also stated that it was disrespectful and a taboo to tell your sexual partner (husband) to use female condom. Gupta (2010), thus placed a woman at a relative disadvantage in the ability to introduce or female condom use within sexual partnership. The results are however contradicting which gap the current study would attempt to clarify.

Health System Factors Influencing Use of Female Condoms among Women

UNAIDS, (2010), found that providers such as Family Health International (FHI), Netherlands Development Cooperation (NDC) and Planned Parenthood Association of Zambia (PPAZ) claimed that the device was too complicated or awkward to use and thus they did not offer it to clients. In disagreement Seedat (2012), argued that such provider behaviors and attitudes made a clear contribution to the inadequate interest

from the clients and donors. These reviewed studies were however only claimed without emprical backing which gap the current study intended to clarify.

Egger et al., (2010) pointed out that lack of easy availability and a reliable supply of quality female condom most likely contributed to low use of female condoms. The impact of providing health-education material and male co,ndoms on condom use in Managua, Nicaragua was investigated. Out of 19 included motels, 11 motels were mainly used by sex workers and their clients and eight were mainly used for non - commercial sex. A total of 6463 couples attended the motels in 24 days. On 3106 (48.0%) occasions, at least one used male condom was retrieved. Male condom use was more frequent for commercial sex than for non-commercial sex. Condom use increased for commercial and non-commercial sex workers if male condoms were available in the room. Direct handing out of condoms to couples was similarly effective for commercial sex but less effective for non-commercial sex. The interpretation was that in Latin America, motels were key locations for promoting the use of condoms and these findings had important implications for HIV-prevention policies. This study was however done in Latin America moreover among commercial and non-commercial sex workers not women attending health facilities which gap this study explored to fill.

Dominique and Richte, (2012), found that lack of easy availability and a reliable supply of quality condoms were some of the factors associated with lower utilization among couples in Zimbabwe . Yomi et al., (2012), also report ed about a qualitative study conducted in Yaounde and Douala, Cameroon, and found that female condom availability was associated with female condom use. But King (2015), cites reasons for the poor uptake of the FC as not undertaking enough procurement, and weakened advocacy issues

towards the Female condom. However PATH (2015), during a conference held in Baltimore 2015 finds accessibility and cost were among concerns relating to female condoms experiences. Hoffman, (2008) however found that although many couples could have benefited from the dual protection of the female condom if not ready for pregnancy, they either have never heard of it, and even if they have heard of it, they are not able to obtain it. To the author the female condom was still not generally accessible actually accessible to a very small fraction (0.28%). The results in this study only use d descriptive analysis methods without inferential analysis which gap the study explored by using both merthods.

Seal and Ehrhardt, (2010), found that within New York City only one male out of 71 heterosexuals had previously used a female condom as barrier protection and the majority of men possessed little or no knowledge about this barrier method. Collumbien et al., (2012), revealed that among the 2,087 men aged 18-35 years, female condoms were used during 2% of marital sex acts and 10% of non-marital sex acts. The latter study fail ed to report on how the low use and were moreover done among the males not the females themselves which gap this study explored to fill..

Roth et al., (2011), conducted a study on factors associated with female condom use in India. The study findings provided some insights on the need to address issues of privacy regarding female condom purchase and use. The authors notably found that the lack of privacy in stores and the social stigma associated with female condom use were indicated as the most significant factors associated with female condom use. This study was however conducted amongst HIV positive females not the general population of when attending health care facility which gap this study expolored to fill.

Summary of ldentified Research Gaps

The reviewed studies showed that the use of female condoms was generally low and a number of factors influenced their utilization. Amongst which was age, residence, marital status, knowledge, attitudes and traditional beliefs.

There however existed some contradictions with few studies pointing to Uganda. This study proposed to make use of both quantitative and qualitative approaches to unearth and clarify such gaps.

CHAPTER THREE

METHODOLOGY

This chapter gave the procedure that was taken by the researcher so as to achive the set objectives of the study.The methodology section provided the Research Design, locale of study,study population, target population, sample size, sampling procedure and the data collection procedure with regard to the study about female condom use and the associated risk factors among women of reproductive age attending family planning services at Entebbe General Hospital.. It also provided the research tools, validity, reliability, data analysis and anticipated limitations.

Research Design

The study followed a cross- sectional study, employed quantitative methods of data collection. This method was chosen because it collected information from a sample and made measurements at one single point in time. It saved time compared to follow up prospective study designs. The study research data was collected for a period of 2 months between June and July, 2018.

Qualitative and quantitative analysis was used to provide detailed understanding of the research problem. Quantitative approach was used because it allowed numerical estimation of the magnitude of the problem under study. Qualitative approaches was used to explore traits and settings that could not have been easily described numerically

Locale of the Study

This study was carried out at Entebbe General Hospital. This hospital located approximately 23 miles, southwest of Kampala, Uganda's largest capital and

administrative city. The hospital had a 200 bed capacity. This setting was preferred because it served as a referral center for the various areas inclusive of Kalangala lslands.

Study Population

In this study, the study population included all women aged 15 to 49 years with in Uganda. The motivation for this population was because it was the one actively involved in giving birth and who required planning their birth spacing and as well more vulnerable to sexual related infections.The target population included all women of reproductive aged 15–49 years who were attending family planning services at Entebbe General Hospital during study time.

Sample Size

It was estimated that modern family planning methods in which female condom use was part were chosen by up to 30% of the women of reproductive age in Uganda (UBOS and ICF International, 2011). The sample size as per the study was computed using a formula Kirsch Leslie (1965) formula (Kish and Leslie. 1965).

Sample size (n_s) = $\dfrac{n}{1 + \frac{n}{N}}$

Where $N = \dfrac{Z\alpha^2 * P(1-P)}{\delta^2}$

P= proportion of women used modern family planning methods = 30%.

1-P = the proportion of women not used modern family planning methods,

so 1-P = 0.70

Z_α = Standard normal value corresponded to set level of confidence= 1.96

δ = degree of accuracy = 5%.

N = 184 - the approximate number of women of reproductive age in one month based on Entebbe General Hospital records.

$$n_s = \frac{1.96^2 * 0.3\,(1-0.3)}{0.05^2}$$

$$= 322.6944$$

$$\approx 323$$

$$\text{Sample size } (n_s) = \frac{323}{1 + \frac{323}{184}}$$

n = 117.222

n ≈ 117

The study would therefore collect data from 117 women of reproductive age attending family planning services at Entebbe General Hospital. In addition qualitative data would be collected from 5 health workers as key informants.

Sampling Procedure

In this study, all women of reproductive age who visited the family planning department at Entebbe General Hospital during the study period were eligible for recruitment. Consecutive enrollment of the patients followed a random sampling approach until the required sample size was achieved.

Research Instruments

The study obtained information from all the targeted respondent women of reproductive age used the questionnaire. The questionnaire was designed with respect to the research questions gathered information from all the respondent women of reproductive age. In particular a questionnaire contained closed ended questions was used

to elicit quantitative information respectively from the women of reproductive age. This instrument was of choice because of ease of administration and high response rate.

Validity and Reliability

Validity: The instruments were pretested in a pilot study in Mukono hospital used 10 women of reproductive age. The intention was to keep the sample size for the main survey un contaminated. Based on the feedback, amendments were made to remove any ambiguities, discrepancies and the overall content. The questions were well adjusted as a way that ensured that what was answered reflected the true information that was required from the field thus validity. To establish the Content Validity Index (CVI), the questionnaire was given to experts in reproductive health who rated 4 and 5 for each of the items with regard to the relevance of each item in the instrument to the specific objectives. The CVI computed used the following formula:

$$\text{CVI} = \frac{K}{N}$$

In this formula K was the total number of items in the questionnaire declared valid by experts in reproductive health and N was the total number of items in the questionnaire.

Reliability: A pilot study was carried out in Mukono Hospital to test the reliability of the research instrument. In this study however, the reliability of the questionnaire was determined by computing Cronbach's Alpha whose formula was as below;

$$\alpha = \frac{(N \times C)}{[V + (N - 1) \times C]}$$

In specific terms N was taken to be the number of variables in the questionnaire and c was the average correlation among all pairs of variables. On the other hand was the average variance. The Chronbach alpha coefficient higher than the recommended minimum of 0.7 meant that the instrument used was highly reliable.

Data Collection Procedure

A request for an introductory or approval letter was sought from the Dean of School of Graduate Studies, Bugema University which introduced the researcher to the management of Entebbe General Hospital as well as the District Health Officer Entebbe Municipality so that they allowed the researcher to gather data in the Hospital. During the week prior to the official data collection, research Assistants who are fluent in Luganda were trained and a meeting was done each day with the principal researcher for any clarifications and adjustments possible. All women of reproductive age were then informed about the study and its importance. Informed consent sought before enrolment by signing or thumb printing on the consent and assent forms. The women were informed that their participation was highly voluntary and that they were free to withdraw from the study at any point they feel without any penalty. They were be notified about their privacy and identification numbers were be used to ensure anonymity. In case of publication, the participants would be consulted for authority if their names are to be used. The data collected was stored in a lockable box where the researcher was the only one to access the keys. The computer system to be used in the data entry and analysis encrypted with a password only known to the principal investigator.

Data Analysis

The data collected was first entered in a computer into a SPSS version 20.0 which system would as well be used during the analysis phase. The application was chosen because it was easy to use and moreover produced results in a matter of seconds. Frequency distribution tables and graphs were processed and used in the presentation of the demographics and as well objective one. These presentation approaches were chosen because they provided much more detail and were easy to understand.In the case of objective 2 to 4, the cross tabulations and Pearson's chi-square analysis was used to ascertain the factors associated with the utilization of female condoms. Only those factors with p-values less than the degree of accuracy of 5% would be considered significantly associated. The Pearson's chi-square test statistic was chosen because the data related to the variables was categorical in nature.

Ethical Considerations

The researcher first obtained a letter of introduction from the concerned authorities at Bugema university after ensuring the requirements for undertaking a research study had been met. Thereafter ethical cleareance was sought from TASO REC after verifuing that the study was of benefit and could cause no harm to participants.

During the data collection process, the females who sought family planning services at Entebbe general hospital were informed about the purpose of the study as to secure their informed consent. They were also permited to voluntary participation and withdrawal at any time of their choice wihout compromising on the family planning services that they sought. To ensure privacy a single consenting female was handled in a

private environment while confidentiality was ensured by use of identity numbers instead of their names.

The data so collected was stored in a lockable box only accessible by the principal investigator. In addition the computer system used was encrypted with a password only known to the researcher. In case of dissemination, consent was sought from the participants as a way of seeking their permssion.

CHAPTER FOUR

RESULTS AND DISSCUSSION

Introduction

This chapter presented the findings of the study determining the factors influencing the use of female condoms among females attending family planning services at Entebbe general hospital as to inform appropriate interventions to promote their use. Starting with the demographic characteristics, the chapter provided results with respect to the study objectives.

Demographic Characteristics of Respondents

The study targeted a total of 117 women of reproductive age attending family planning services at Entebbe General Hospital of which it received 100% response rate. The descriptive results with regard to the demographic characteristics of these women were as presented in table 1 below.

Table 1: Demographic characteristics of the females attending family planning services

Demographic characteristics		**Frequency (N = 117)**	**Percentage (%)**
Age in years	18 - <25	47	40.2
	25- 35	40	34.2
	36-45	20	17.1
	Above 45	10	8.5
Education level	None	18	15.4
	Primary	28	23.9
	Secondary	53	45.3
	Tertiary	18	15.4
Marital status	Single	36	30.8
	Cohabiting	17	14.5
	Married	51	43.6
	Separated/Widowed	13	11.1
Monthly income(Ushs)	< 50,000	47	40.2
	50,000-<100,000	20	17.1
	100,000-<200,000	33	28.2
	200,000 above	17	14.5
Occupation	Housewife	34	29.1
	Employed	41	35.0
	Unemployed	26	22.2
	Others specify	16	13.7
Religion	Christian	87	74.4
	Moslem	20	17.1
	Others(Traditionalists)	10	8.5

Age in years

The research findings as in table 1 show that the majority females that were attending family planning services at Entebbe General Hospital were in the age bracket of 18 to less than 25years 47(40.2%). The minority respondents were above 45 years 10 (8.5%) but with a good number of respondents were in the age bracket of 25 to 35 40 (34.2%) whereas some other few were in the age bracket 36 to 45 20(17.1%). These results are not comparable to those earlier found by Mungaala et al., (2009) established that only 65% of women aged of 30-44 years were able to access female condom due to the fact that it was an effective and reliable tool for family planning as an alternative to male condom.

Education level

According to the table 1, the study established that the majority of respondents had gone up to at utmost secondary level of education 53(45.3%), followed by those who went up to primary level 28(23.9%). Results indicated the minority respondents who went up to tertiary level 18 (15.4%) and never went to school 18(15.4%).

Marital status

The research results in relation to marital status established that most of the respondents were married 51(43.6%) as compared to the fewest respondents who had either separated or widowed 13(11.1%). Results also indicated a good number of respondents who were single 36(30.8%) as some respondents were cohabiting 17(14.5%).

Monthly income

The study results showed that majority respondents were earning less than from Ushs 50,000 monthly 47(40.2%) as compared to the minority respondents who were earning from Ushs 50,000 to less than 100,000 monthly 20(17.1%). Findings also reveal

that the monthly payment of a good number of respondents was within Ushs 100,000 to less than 200,000 33(28.2%) and others were earning from Ushs 200,000 and above 17(14.5%).

Occupation

The research findings in relation to occupation indicated most of the respondents as employed 41(35.0%). This was compared to the minority respondents who were living other ways than the specified in the questionnaire 16(13.7%). Results further revealled that some respondents were working as housewives 34(29.1%) while others were unemployed 26(22.2%).

Religion

The study findings reveal that more than a half of the respondents were Christian 87(74.4%). Results also indicate respondents who were Moslem 20(17.1%) whereas others belonged to other different religions than the mentioned in the questionnaire 10(8.5%).

The Proportion of Women Using Female Condoms among Females Aged 15 To 49 Years Attending Family Planning Services at Entebbe General Hospital

The first objective of the study was to establish the proportion of women using female condoms among females aged 15 to 49 years attending family planning services at Entebbe general hospital. The results in this regard were as shown below;

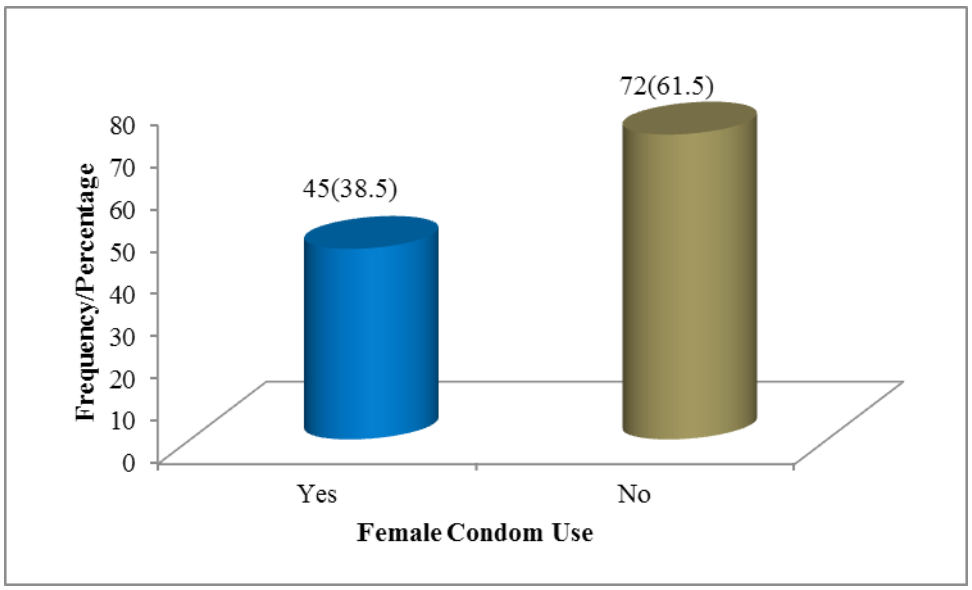

Figure 2: Female Condom Use among Females Attending Family Planning Services

The study results as in figure 2 indicated that majority of female respondents aged 15 to 49 years had never used condoms 72(61.5%). Results presented in the figure above showed that the minority respondents had ever used condoms 45(38.5%). This finding showed how unwelcoming the females attending family planning services were in as far as femidom use was and illustrated that perhaps support programs need to be further institutionalized. This result was agreed to during the interviews with the health workers as follows;

"*Most used-pills and Least used female condoms*", Female, 34 years

The researcher disagrees with this result just like Guerra and Simbayi, (2014) found the use of female condoms low at 7.16% in South Africa despite high knowledge. The results are different from those found by Ministry of Health (2018) on use of female condoms which paltried 2 per cent of women as requesting for the female condoms.

Knowledge, positive attitude, spousal support has greatly increased female condom use as evidenced by high responses by respondents.

Personal Factors Influencing Use of Female Condoms among Females Attending Family Planning Services at Entebbe General Hospital

The second objective of this study was to determine the personal factors influencing use of female condoms among females attending family planning services at Entebbe general hospital and the descriptive results in this regard were as shown below;

Table 2: Personal Factors Influencing Use of Female Condoms among Females

Personal factors		**Frequency (N = 117)**	**Percentage (%)**
Knowing about a female condom	Yes	76	65.0
	No	41	35.0
Meaning a female condom	Tinny rubber with a soft fitting pouch with a ring inserted onto the penis prior sexual intercourse	11	9.4
	Tinny rubber with a soft fitting pouch with a ring inserted into the vagina prior to sexual intercourse	64	54.7
	None of the above	42	35.9
Recommend a friend	Yes	65	55.6
	No	52	44.4

Source: Primary

The research findings in relation to personal factors specify that majority respondents had knowledge about female condom use 76(65.0%) as compared to the minority respondents who knew nothing about female condom 41(35.0%). Results indicate majority respondents as understanding female condom as tinny rubber with a soft fitting pouch with a ring inserted into the vagina prior to sexual 64(54.7%).

Findings further revealled that most females attending family planning services would recommend friends or relatives to use female condom 65(55.6%). This result implied that most females have good attitudes towards female condom use.

The Community Factors Influencing Use of Female Condoms omong Females Attending Family Planning Services at Entebbe General Hospital

The third objective of this study was to establish the community factors influencing use of female condoms among females attending family planning services at Entebbe general hospital and the descriptive results were as presented below;

Table 3: Community Factors Influencing Use Of Female Condoms Among Females

Community factors		**Frequency (N = 117)**	**Percentage (%)**
Cultural practices regarding female condom use	Any woman found with a condom is divorced	29	24.8
	Women found buying or with condoms are barred from the community	31	26.5
	Others (No practices seen)	57	48.7
Opinions of fellow women	It is the prostitutes that use female condoms	60	51.3
	Women who care about their health are free to use female condoms	57	48.7
Male sexual support for female condoms	Yes	48	41.0
	No	69	59.0
The beliefs traditions hold about female condoms	It is traditionally acceptable for women to use their condoms	41	35.0
	It is abominable and shameful for women to use their own condoms	34	29.1
	It is only the men that can use condoms	42	35.9

Source: Primary

The study findings in relation to community factors indicated that the majority respondents reported no practices related to female condom use 57(48.7%). Results also indicated that women found buying or with condoms are barred from the community as reported by the respondents 31(26.5%) whereas other respondents reported that any woman found with a condom is divorced 29(24.8%).

The research findings showed that other women have opinions that it was the prostitutes that use female condoms 60(51.3%) whereas a few say that women who care about their health are free to use female condoms 57(48.7%).

Findings show that majority males do not support female condom use 69(59.0%) as compared to the minority who support the use of female condoms 48(41.0%).

The study results indicate that most of the respondents traditionally believe that it was acceptable for women to use their condoms 41(35.0%) whereas others believe that it was only the men that can use condoms 42(35.9%) as the minority believe that it was abominable and shameful for women to use their own condoms 34(29.1%).

Health System Factors Affecting Use of Female Condoms among Females Attending Family Planning Services at Entebbe General Hospital

Table 4: The Health System Factors Affecting Use of Female Condoms Among Females

Health system factors		Frequency (N = 117)	Percentage (%)
Affordability of the female condom	Affordable	83	70.9
	Unaffordable	34	29.1
Question asking by health workers when seeking health services related to sex	Few questions	67	57.3
	Many questions	50	42.7
Receptiveness of the health workers when seeking for female condoms	Receptive	63	53.8
	Not receptive	54	46.2
Waiting time	< 2 hours	56	47.9
	> 2 hours	61	52.1
Failure to get supplies used in sexual related activities when sought	Yes	55	47.0
	No	62	53.0
Promotion initiatives about female condoms	Yes	49	41.9
	No	68	58.1
Distance to your nearest health facility	<2 kilometers	63	53.8
	> 2 Kilometers	54	46.2

Most of the females attending family planning services find the female condom 83(70.9%) Receptiveness of the health workers when seeking for female condoms, the health workers receptive 63(53.8%) and ask few questions whenever health services related to sex were sought 67(57.3%) though with very substantial instances when health workers ask many questions 50(42.7%).

The study found there were no instances of failure to get supplies used in sexual related activities when sought among most females attending family planning services 62(53.0%) though a substantial proportion of them fail to get the services 55(47.0%).

Most of the females attending family planning services according to the results move for a distance of less than 2 kilometers to the nearest health facility 63(53.8%).

The study findings also show most females wait for more than 2 hours when seeking health services 61(52.1%) with many indicating no promotion initiatives about female condoms in their communities of residence 68(58.1%).

Bivariate Results for the Factors Affecting Use of Female Condoms

Table 5: Bivariate Results of the Personal Factors Affecting Use f Female Condoms

Personal factors		Female condom use		O.R (95%CI)	P-Value
		Yes N (%)	No N (%)		
Age (years)	18 - <35	27(31.0)	60(69.0)	0.300(0.709-0.127)	**0.005***
	Above 35	18(60.0)	12(40.0)		
Highest education level	Up to Secondary	37(37.4)	62(62.6)	0.746(2.058-0.270)	0.571
	Secondary above	8(44.4)	10(55.6)		
Marital status	Single	20(40.8)	29(59.2)	1.186 (2.520-0. 558)	0.657
	Married	25(36.8)	43(63.2)		
Income in Ushs	Less than 100000	21(31.3)	46(68.7)	0.495(1.055-0.232)	0.067
	100000 and above	24(48.0)	26(52.0)		
Occupation	Unemployed	12(46.2)	14(53.8)	1.506(3.638-0.624)	0.361
	Employed, housewife	33(36.3)	58(63.7)		
Religion	Christian	35(40.2)	52(59.8)	1.346(3.219-0.563)	0.503
	Others(Moslem, traditionalists)	10(33.3)	20(66.7)		
Knowledge on female condom use	Yes	32(50.0)	32(50.0)	3.077(6.812-1.390)	**0.005***
	No	13(24.5)	40(75.5)		
Attitude	Positive	33(50.8)	32(49.2)	3.438(7.711-1.533)	**0.002***
	Negative	12(23.1)	40(76.9)		

Significant at 5% level

Age in years

The study findings in Table 4.8 indicate female condom use as being least among females 18 to less than 35 years of age(31.0%) and highest among those above 35 years of age(60.0%). This difference was statistically significant (OR=0.300; 95% CI: 0.709-0.127; p = 0.005<0.05). This implied that the age of females attending family planning

services was a significant predictor of female condom use. These results are comparable to those found by Dominique & Richte (2005) which showed that majority (68%) of women in elder age group (35 years to 44 years) were more likely to use female condom especially those in urban areas due to availability of information.

Knowledge on female condom use

Results equally showed that female condom use was highest among females knowledgeable about the female condom (50.0%) and lowest among those that are not knowledge (24.5%). This variation in knowledge about the female condom was statistically significant (OR=3.077; 95% CI: 6.812-1.390; $p = 0.005<0.05$). This implied that the knowledge of females attending family planning services was a significant predictor of female condom use. These results are comparable to those found by Kassie et al., (2008) that 68% of women had knowledge of female condom as a contraceptive method because most of the women would prefer use a reliable family planning tool.

Attitude

The study results showed that female condom use was highest among females with a positive attitude towards their use (50.8%) and lowest among those with a negative attitude (23.1%). This variation was statistically significant (OR=3.438; 95% CI: 0.711-1.533; $p = 0.002<0.05$). This meant that the attitude of females attending family planning services was an influencing factor of female condom use. Some of the health workers agreed to this by saying that;

> *"Some women who access these females can encorange others to use. "*. Female, 43 years

These results are similar to those found by Dominique & Richte (2012) that women and men were reluctant to use a female condom due to its perceived low effectiveness for STI.

Table 6: Bivariate Results of the Community Factors Affecting Use of Female Condoms

Community factors		Female condom use		O.R (95%CI)	P-Value
		Yes N (%)	No N (%)		
Cultural practices	Nothing in particular	21(36.8)	36(63.2)	0.875(1.845-0.415)	0.726
	Woman with a condom is divorced, segregated in community	24(40.0)	36(60.0)		
Other women role	Women caring about their life free to use femidom	40(50.6)	39(49.4)	6.769(19.130-2.395)	**0.000***
	Women using femidom are prostitutes	5(13.2)	33(86.8)		
Male sexual support	Yes	31(64.6)	17(35.4)	7.164(16.481-3.114)	**0.000***
	No	14(20.3)	55(79.7)		
Traditional beliefs	Traditionally acceptable	12(29.3)	29(70.7)	0.539(1.214-0.240)	0.133
	Abominable, shameful and for men only	33(43.4)	43(56.6)		

Significant at 5% level

Other women role

Other related results show the use of female condoms more among females who report other women role as welcoming for female condom use in case of protection (50.6%) and lowest among those that reported other women in the community as not welcoming to female condom use (13.2%). This difference in the reported role of other women was statistically significant (OR=6.769; 95% CI: 19.130-2.395; $p = 0.000<0.05$). This meant that other women role in the community was an influential factor of female condom use. These results are comparable to those by Farr (2014) found that most

women who liked using the device would recommend it to others and would select it above other barrier methods in the USA and Latin America.***

Male sexual support

Findings showed that in instances where the male sexual partners are supportive of the female condom use, the use of the femidom was highest (64.6%) but lowest in instances where the male sexual partners were unsupportive (20.3%). This variation in the male support role was statistically significant (OR=7.164; 95% CI: 16.481-3.114; p = 0.002<0.05). This meant that male sexual support influenced female condom use. The researcher partly agrees with this result just as early indicated by Severy and Spieler (2000) who revealed that many men prefer the female condom to the male condom because it was less constricting, and makes sex more pleasurable and more natural.

The male sexual support increase use of female condom as agreed by male healthworkre aged 46years.

Table 7: Bivariate Results of the Health System Factors Affecting Use of Female Condoms

Health system Factors		Female condom use		O.R (95%CI)	P-Value
		Yes N (%)	No N (%)		
Affordability	Affordable	39(47.0)	44(53.0)	4.136(11.037-1.550)	**0.003***
	Unaffordable	6(17.6)	28(82.4)		
Attitude of health workers	Positive	26(41.3)	37(58.7)	1.294(2.742-.611)	0.500
	Negative	19(35.2)	35(64.8)		
Waiting time	Less than 2 hours	27(48.2)	29(51.8)	2.224(4.755-1.040)	**0.038***
	Greater than 2 hours	18(29.5)	43(70.5)		
Availability	Available	12(19.4)	50(80.6)	0.160(0.367-0.070)	**0.000***
	Un available	33(60.0)			
Promotion initiatives	Yes	26(53.1)	23(46.9)	2.915(6.306-1.348)	**0.006***
	No	19(27.9)	49(72.1)		
Distance (km)	< 2 km	28(44.4)	35(55.6)	1.741(3.721-0.815)	0.151
	>2 km	17(31.5)	37(68.5)		

Significant at 5% level

Cost of the Female Condom

The findings regarding cost indicated female condom use as being highest where females reported it as affordable (47.0%) and lowest where the respondent females reported it as unaffordable (17.6%). This difference in the affordability of the femidom among females attending family planning services was statistically significant (OR=4.136; 95% CI: 11.037-1.550; $p = 0.003<0.05$). This implied that the age of females attending family planning services was a significant predictor of female condom use. These results compare well with those earlier found by PATH (2015) during a conference held in Baltimore 2015 finds accessibility and cost were among concerns relating to female condoms experiences.

Waiting time

Results relating to the waiting time show the use of the femidom mostly among females who reported a waiting time of less than 2 hours (48.2%) and lowest among those that reported waiting for more than 2 hours (29.2%). This difference in the waiting time when seeking health care services was statistically significant (OR=2.224; 95% CI: 4.755-1.040; $p = 0.038<0.05$). This meant that waiting time at the health facility was an influential factor of female condom use.

Availability

The study findings in relation to availability showed that the femidom use was highest among females who reported its unavailability in the health facility whenever sought (60.0%) and lowest among those who found it available when sought (19.4%). This variation though statistically significant (OR=0.160; 95% CI: 0.367-0.070; $p = 0.000<0.05$) could be attributed to fear of being seen getting the femidom when available.

The availability of the femidom was a significant influential factor of female condom use. These results are similar to those Egger et al., (2010) pointed out that lack of easy availability and a reliable supply of quality female condom most likely contributed to low use of female condoms.

Promotion initiatives

Lastly though not the least, findings showed female condom use was highest among females who reported promotion initiatives about the femidom in their community (53.1%) and lowest among those who reported no promotion initiatives about the femidom in their community (27.9%). This difference in the proportion of women using the femidom was statistically significant (OR=2.915; 95% CI: 6.306-1.348; p = 0.006<0.05). This meant that the promotion initiatives by females attending family planning services was an influencing factor of female condom use.

Multivariate Results for the Factors Affecting Use of Female Condoms

The study following a multivariate analysis using the binary logistic regression established the factors that independently affected use of female condoms among females that were attending family planning services at Entebbe general hospital. The results in this regard were as presented below;

Table 8: Multivariate Results of the Factors Affecting Use of Female Condoms

Factors	Outcome	Female condom use		O.R (95%CI)	P-Value
		Yes N (%)	No N (%)		
Age (years)	18 - <35	27(31.0)	60(69.0)	0.40 (0.12-1.38)	0.148
	Above 35	18(60.0)	12(40.0)		
Income in Ushs	Less than 100000	21(31.3)	46(68.7)	0.84(0.28-2.52)	0.749
	100000 and above	24(48.0)	26(52.0)		
Knowledge on female condom use	Yes	32(50.0)	32(50.0)	1.22(0.43-3.45)	0.713
	No	13(24.5)	40(75.5)		
Attitude	Positive	33(50.8)	32(49.2)	0.71(0.19-2.63)	0.612
	Negative	12(23.1)	40(76.9)		
Other women role	Welcoming to use femidem	40(50.6)	39(49.4)	3.79(1.05-13.64)	**0.042***
	Unwelcoming to use femidem	5(13.2)	33(86.8)		
Male sexual support	Yes	31(64.6)	17(35.4)	4.44(1.61-12.23)	**0.004***
	No	14(20.3)	55(79.7)		
Affordability	Affordable	39(47.0)	44(53.0)	2.61(0.69-9.84)	0.156
	Unaffordable	6(17.6)	28(82.4)		
Waiting time	< 2 hours	27(48.2)	29(51.8)	1.67(0.62-4.51)	0.312
	≥2 hours	18(29.5)	43(70.5)		
Availability	Available	12(19.4)	50(80.6)	0.31(0.10-0.93)	**0.037***
	Un available	33(60.0)	22(40.0)		
Promotion initiatives	Yes	26(53.1)	23(46.9)	0.88(0.29-2.73)	0.829
	No	19(27.9)	49(72.1)		

Significant at 5% level

The study results at multivariate level showed that the role of women in the community with regard to the femidom (AOR=3.79; 95% CI: 1.05-13.64; $p = 0.042$) and support from the male spouse with regard to the femidom (AOR=4.44; 95% CI: 1.61-12.23; $p = 0.004$) are the community factors significantly associated with female condom use. The females attending family planning services that were supported by other women in the community are 3.79 times more likely to use the female condom compared to those that are not supported by other women. Similarly females attending family

planning services that are supported by their male sexual spouses are 4.44 times more likely to use the female condom compared to those that are not supported by their male sexual spouses. These results are similar to those found by Bekinska et al.,(2008), that the main issue when introducing a contraceptive method was overcoming partner opposition.

The findings equally showed that availability of female condoms at the health facility was the only health system factor affecting their use (AOR=0.31; 95% CI: 0.10-0.93; $p = 0.037$). The females who report availability of female condoms sometimes are 0.31 times less likely to use them compared to those that reported unavailability of the female condoms at the nearest health facility. The researcher agrees with such result in that the females may be having preference to buy from the retail centres since it is affordable to majority.It is similar to those earlier found Roth et al., (2011) that some insights on the need to address issues of privacy regarding female condom purchase and use influence use.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Introduction

This chapter presented the summary of the study findings, conclusion and recommendations in relation to the study objectives. The variables discussed include individual factors, health system factors, community factors and female condom use.

Summary

The current study found that a 38.5% of the females aged 15 to 49 years attending family planning services in Entebbe General Hospital had ever used condoms.

The study established that the age (OR=0.300; 95% CI: 0.709-0.127; p = 0.005<0.05), knowledge on female condom use (OR= 3.077; 95% CI: 6.812-1.390; p = 0.005<0.05) and attitude towards female condom use (OR= 3.438; 95% CI: 0.711-1.533; p = 0.002<0.05) were significant predictors at bivariate level but insignificant when controlled for confounding at multivariate level. The female condom use was highest among females above 35 years of age (60.0%), knowledgeable about the female condom (50.0%) and with a positive attitude towards femidem use (50.8%).

The current study found the role of women in the community with regard to the femidem (AOR=3.79; 95% CI: 1.05-13.64; p = 0.042) and support from the male spouse with regard to the femidem (AOR=4.44; 95% CI: 1.61-12.23; p = 0.004) as the community factors significantly associated with female condom use. The use of female condoms was highest amongst females who reported being supported by other women for protection purposes and their male sexual partners.

This study equally established that the availability of female condoms at the health facility was the only health system factor affecting use of female condoms (AOR=0.31; 95% CI: 0.10-0.93; p = 0.037). The femidom use was more with reported unavailability at th nearest health facilities.

Conclusion

There is a very substantial proportion of females using the female condom among women that are characterized by good health seeking behaviors with regard to family planning services at the health facilities.

The role of other women and the male partners alongside locational availability of femidom are pertinent community actors when considering ways to improve the use on the female condoms among the women.

Recommendations

The government through the line Ministry of Health should develop and institutionalize interventions such as sensitization about benefits of the female condom use.

.Also should increase roles played by other women with regard to use of the female condom in the community through promotion intiatives.

The health facility workers should come up with strategies that promote involvement of male spouses thus attending services with their partners.

The civil society organizations whose thematic areas are reproductive health in collaboration with the health professionals should adopt alternative outlets like the retail centres, lodges and beaches in addition to health facilities found in the communities .

Areas of Further Studies

This study was undertaken among females that were attending family planning services at Entebbe General Hospital Wakiso district. It is possible that the results could have been different if other health facilities were to be involved. It's therefore recommended that future studies consider other health facilities for better generalization.

This study having been carried out among females that were attending family planning services failed to consider those females that have poor health seeking behaviours especially in the communities. Therefore for a better picture, it is recommended that future studies consider the factors influencing the use of the femidom in the community populations.

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APPENDICIES

Appendix I: Informed Consent Form for women of reproductive age attending family planning services at Entebbe General Hospital

Date of interview……Time…….....

Introduction

Good morning/afternoon. Iam Lucy wanyenze of Bugema University pursuing a Master's Degree in public Health. Iam carrying out a research study on factors influencing Female Condom use among Females attending family planning services at Entebbe General Hospital. Entebbe Hospital has a family planning unit under Maternal and Child Health Department. The study results are for academic purposes only but may also be used to design interventions for improving on utilization of female condoms and also health services. If you do not understand some of the words or concepts, the researcher will take time to explain them as you go along and that you can ask questions at any time.

Purpose:

This is a research study involving 117 participants and 5 key informants and it's for academic purpose only.

Type of Research Intervention

The intervention that will be undertaken involves an interview, a questionnaire, and/ or a series of finger pricks.

Participant Selection (why): You have been selected as the best choice to participate because you are females of reproductive age attending family planning services at this unit**.**

Voluntary Participation

Your choice to participate in this study is voluntary. You are free to take part in the study or not and you have the right to withdraw from the study at any time without penalty. You are also free to ask any question before or after the interview. And you will still receive all the services you are entitled too.

Procedure;

You will be asked questions regarding your knowledge about female condoms and their use. The interview will take about 45 minutes. Do you have any more questions?

Risks / Discomfort

There will be no risks in this study except some discomfort when application method is mentioned. And may be your time.

Benefits:

The information you will provide will be used to improve on the utilization of the female condoms among young adults aged 15 to 49 years. The benefits may be to the individual, to the community in which the individual resides, and benefits to society as a whole as a result of finding an answer to the research question.

Reimbursements/Compensation
There will be no Reimbursements/compensation provided to the participants as a result of your participation.
Confidentiality:
Your answers will be taken generally as a contribution towards improving the quality and the utilization of the female condoms and thus will be treated confidential, your names will not be required instead numbers will be used.

The results of this study will be kept strictly confidential, and only for research purposes. My identity will be concealed in as far as the law allows. My name will not appear anywhere on the coded forms with the information. Paper and computer records will be kept under lock and key and with password protection respectively. For any further information, I may contact TASO REC **Chairperson [DR.Bogere Daniel; +256772139126.]** .

Sharing the Results

The plan for sharing the findings with the participants: A report will be prepared, printed and 4 copies made. And distributed to Bugema University and Entebbe hospital. The research findings will be shared more broadly, for example, through workshops, publications and conferences.

Right to Refuse or Withdraw

Your choice to participate is voluntary and includes the right to withdraw.
Also your refusal to participate will not result in a penalty or a loss of benefits to which you are entitled, and that you may discontinue participation at any time without penalty or loss of benefits.

Who to Contact

You can contact Dr. Vuzi C. Peter as the Chief Supervisor and or Rosette Kabuye, Dean School of Graduate Studies Bugema University, Bugema University Research committee. TASO REC. You can as well contact the Chairperson TASO REC, DR. Bogere Daniel on Telephone No. +256772139126 fore more information.

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____Signature of Participant _____

Date _____
Day/Month/Year

If illiterate [1]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of participant**

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher _____

Signature of Researcher _____

Date _____Day/month/year

_____
1

Appendix II: Foomu Ekakasa Okukiriza Okubuzibwa

Foomu eno ya bakyala abali mu myaka egizaala era nga bettanira enkola eyekizaala ggumba okuva mu ddwaliro lya Entebbe General Hospital.

Ennaku z'omwezi kw'obuliziddwa……. Essaawa……..

Ennyanjula:

Nkulamusizza nnyabo.Nze Lucy Wanyenze okuva mu Bugema University.Nsoma ddiguli yange ey'okubiri mu mbeera z'obulamu bw'abantu eyabulijjo.Ndi mukukola okunoonyereza ku nsonga ez'ekuusa ku nkozesa y'obupiira bu kalimpitawa obwabakyala.okunoonyereza kuno kugenda kukolebwa mu bakyala abettanira enkola ey'ekizaala ggumba okva mu Entebbe Referral Hospital.Olwokuba ng'eddwaliro lino kkulu era nga ly'elijjulizibwa mu kitundu,liriko ekiwayi ekikola kukugaba obujjanjabi bw'enkola ey'ekizaala ggumba .Ekiwayi kino kitwalibwa ekitundu ky'eddwaliro ekya "Marternal and Child Health Department.

Ebinaava mu kunoonyereza kuno bigenda kweyambisibwa mu kusoma kwokka wabula biyinza okweyambisibwa mu kussaawo enkola en'eyamba mu kulongoosa mu nkozesa y'obupiira bu kalimpitawa wamu n'obujjanjabi. Bw'oba nga waliwo ekigambo ebikozeseddwa by'otategeera,omunoonyereza agenda kukuyambako okubikunyonnyola era oli wa ddembe okubaako ky'obuuza wonna w'oyagalidde.

Obukulu bw'okunoonyereza kuno:

Okunoonyereza kuno kugenda kwenyigirwamu abantu 117 ,abanaddamu ebibuuzo n'abalala abakulu 5 ab'okubuuza ebibuuzo.Ebinaavaamu bigenda kweyambisibwa mu kusoma kwokka.

Engeri okunonyereza gye kugenda okukolebwamu:

Mu kunonyereza kuno ,mujja kubaamu okuddamu ebibuuzo,olukalala lw'ebibuuzo wamu n'okuteeko ebyenkumu/omukono.

Engeri ababuzibwa gye balondeddwamu:

Olondeddwa mwabo abasaanidde okwetaba mu kunonyereza kuno kuba oli omu ku bakyala abali mu myaka egizaala abakozesa enkola ey'ekizaala ggumba okuva mu ddwaliro lino.

Okukirza okwetaba mu kunonyereza :

Okusalawo okwetaba mu kunonyereeza kuno kwa kyeyagalire.N'olwensonga eyo,oli wa ddembe okugaana okukwenyigiramu oba kukyusa endowooza yo nooteyongeerayo nakwo wadde onaaba wakati mu kubuuziibwa.Era ojja ku sigala ng'okolewako nga bulijjo mu ddwaliro lino awatali buzibu bwonna.

Enkola eyokugoberera:

Ogenda kubuzibwa ebibuuzo ebikwata ku ky'omanyi ku bupiira bw'akyala bu kalimpitawa wamu n'enkozesa yaabwo.Okubuzibwa kuno kujja kuba kwa dakiika 45.

Obuzibu obuyinza okuva mu kwetaba mu kunoonyereza kuno:

Tewali bulabe bw'amaanyi bw'ojja kufuna ng'ozzeemu ebibuuzo okuggyako wanyinza okubaawo ebibuuzo ebimu by'otawuliriramu mirembe ng'obiddamu mpozzi n'obudde bwo.

Ebirungi ebiri mu ku nonyereza kuno:

Obubaka bw'ogenda okutuwa mu kunonyereza kuno bugenda kweyambisibwa okwongera okutumbula enkola ey'okweyambisa obupiira mu bakyala abali wakati w'emyaka 15 -49.Ebinaavaamu biyinza okuyamba gwe ng'omuntu oba okugasa abantu mu kitundu gy'ova oba abantu bonna okutwaliza awamu.

Kiki kye nfuna oluvannyuma lw'okwetaba mu kunonyereza kuno?

Tewajja kubaawo kuganyulwa oba okuliyilirwa obutereevu okwengeri yonna olw'okwetaba mu kunoonyereza kuno.

Okuzibira ebyama ebiweebwayo mu kunoonyereza:

Byonna ebikukwatako by'ogenda okumpa byakukwanaganyizibwa n'ebyabalala biyambe mu kutumbula omutindo wamu n'enkozesa y'obupiira buno Era nkukakasa nti bigenda kusigala nga bya kyama era okwongera okunyweza kino tugenda kweyambisa miwendo/nnamba mu kifo ky'amannya go.

Ebinaava mu kunoonyereza kuno bijja kukuumibwa butiribiri era byakweyambisibwa mu kunonyereza kwokka awatali kwasanguza mannya g'oyo eyawa obubaka ng'amateeka bwe galagira.

Erinnya lyange terigenda kweyolekera wantu wonna ku foomu eriko obubaka obunanvaamu era empapula zonna wamu n'ebyuma bikalimagezi ebineeyambisibwa okutereka ebyama bijja kuggalirwa era ekisumuluzo wamu nennamba ez'enkizo bijja kukumibwa n'obwegendereza.

Singa mba njagala okumanya ebisingawo,nsobola okutukirira ssentebe wa TASO REC,Dokita Bogere Daniel ku ssimu +256772139126.

Okugabana ebinaava mu kunonyereza:

Waliwo enteekateeka okugabana ebinaaba bivudde mu kunoonyereza kuno n'abo abakwetabyemu.Kino tujja kukikola nga tufulumya alipoota era kopi zijja kuwerezebwa e Bugema University n'Entebbe Referral Hospital. Era ebinaazulibwa bijja kwongera okugabanwa okuyita mu kusomesebwa okwawamu,enkungaana wamu n'enkiiko.

Okusalawo kwo okugaana oba okukoma wakati ng'obuzibwa:

Okwetaba mu kubuuzibwa kuno kwa kyeyagalire,era oli wa ddembe okugaana okukwetabamu oba okukyusa mu ndowooza n'okoma mu makkati singa owulira nga tokyayagala / tokyasobola kweyongerayo.Nkukakasa nti okusalawo kwo tekulina wekujja kugotaanya engeri gwe n'abomumaka go gye mu jjanjabibwamu mu ddwaliro lino wadde mu kitundu kyo.

Ani gwe nnyinza okutukirira singa kyetaagisa ?

Muky.Rosette Kabuye. Dean School of Graduate Studies Bugema Universit

.Bugema University Research Committee.

TASO REC.

Ebbago lino lyekeneenyezeddwa era ne likakasibwa TASO REC; ng'akakiiko kano kavunaanyizibwa okulaba ng'abo ab'enyigira mu kunonyereza tebakosebwa mu ngeri yonna.

Okumanya ebisingawo ku TASO REC Kubira sseentebe; Dokita Bogere Daniel ku ssimu +256772139126.

Ekitundu ll: Ekiwandiiko ekikakasa nti okirizza okubuuzibwa:

Nzikiriza nti obubaka obuli mu kkiwandiiko kino mbusomye/ babunsomedde.Nfunye omukisa okubuuza ebibuuzo era nebidibwamu bulungiNzikirizza okwetaba mukubuzibwa awatali kukakibwa .

…….
…… ……

Erinnya ly'eyetabye mu kubuuzibwa Omukono gwe Ennaku z'omwezi (mu nnukuta ennene)

Bwaba nga tamanyi kusoma oba okuwandiika

Nkakakasa nti mbaddewo ng'ekiwandiiko kino kisomerwa oyo asabibwa okwetaba mu kubuuzibwa era kikoleddwa n'obwegendereza.Mu ngeri y'emu omuntu ono awereddwa omukisa okubuuza ebibuuzo era ne bidibwamu mu butuufu bwabyo.Nkakasa nti omuntu ono akirizza okwetaba mu kunoonyereza nga tewali amukase mu ngeri yonna.

Erinnya ly'omujulizi……
Ekinkumu ky'etabyemu……

Omukono gw'omujulizi……..

Ennaku z'omwezi ……..

Ekiwandiiko ky'omunoonyereza/ ky'asaba olukusa:

N'obwegendereza omuntu ono agenda okubuuzibwa musomedde ekiwandiiko kino mu butuufu bwakyo era nga nsinziira kubusobozi bwange,nfubye okulaba ng'omuntu ono ategeera ekigenda okukolebwa.
Nkakasa nti omuntu ono awereddwa omukisa okubuuza ebibuuzo ebikwata ku kunoonyereza era byonna by'abuzizza bimudiddwamu mu butuufu bwabyo.Mu ngeri y'emu,nkakasa nti omuntu ono takakiddwa kwetaba mu kunoonyereza wabula yeeyagalidde.
Agenda okubuuzibwa awereddwa kopi y'ekiwandiiko kino.

Amannya g'omunoonyereza:
……
…..

Omukono gw'omunoonyereza……
…….

Ennaku z'omwezi…….

Appendix III: Questionnaire for the for the women of reproductive age attending female planning services at Entebbe General Hospital

Instruction: Tick in the appropriate box [√], or write in the spaces provided.

SECTION A: INDIVIDUAL FACTORS INFLUENCING FEMALE CONDOM USE.

1. What is your age in complete years (a) 18-<25 [__] (b) 25-35[__] (c) 36- 45[__] (d) Above 45[__]

2. What is your highest Education Level? (a) None[__] (b) Primary[__] (c)Secondary [__] (d) Tertiary[__]

3. What is your marital status? (a) Single[__] (b) Cohabiting [__] (c) Married [__] (d) Widowed/Separated [__]

4. Which of the following is your monthly income category in Ugsh? (a) None (b) < 50,000 (c) 50,000 – < 100,000 (d) 100,000 - < 200,000 (e) 200,000 above

5. What is your current occupation? (a) House wife [__] (b) Employed [__] (c) Unemployed [__] (d) Others (specify)_____ [__]

6. Which of the following is your religious affiliation? (a) Christian[__] (b) Moslem[__](c) Others_____(Specify)

7. Do you know what a female condom is? (a) Yes [__] (b) No[__]

8. If yes which of the following to you is the meaning a female condom?

(a) Tinny rubber with a soft fitting pouch with a ring inserted onto the penis prior to sexual intercourse to stop sperms from entering the uterus[__]

(b) Tinny rubber with a soft fitting pouch with a ringinserted into the vagina prior to sexual intercourse to stop sperms from entering the uterus [__]

(c) None of the above [__]

9. Irrespective of the responses above, would you recommend a friend to use female condoms? (a) Yes[__] (b) No[__]

SECTION B: COMMUNITY FACTORS INFLUENCING FEMALE USE

10. Which of the following best describes what the culture says about female condom use?

(a) Any woman found with a condom is divorced [__]

(b) Women found buying or with condoms are barred from the community [__]

(c) Others _____(specify) [__]

11. In the place of your residence which of the following explains the opinions of your fellow women about use female condoms?

(a) It is the prostitutes that use female condoms [__]

(b) Women who care about their health are free to use female condoms [__]

(c) Others _____(specify) [__] 12. Does your male sexual support bring for you or request you to always get female condoms? (a) Yes [__] (b) No

. 13 Indicate which of the following best explains the beliefs you hold in your tradition about female condoms

(a) It is traditionally acceptable for women to use their condoms [__]

(b) It is abominable and shameful for women to use their own condoms [__]

(c) It is only the men that can use condoms [__]

(d) Others _____(specify). [__]

SECTION C: HEALTH SYSTEM FACTORS INFLUENCING FEMALE CONDOM USE

14. In the nearest sources of health services, indicate how affordable the female condom is to you? (a) Affordable[__] (b) Unaffordable [__]

15. For the time you have sought for health services related to sex, how many questions do the health workers ask you? (a) Few questions [__]

(b) Many questions [__]

16 In general, how receptive are the health workers when seeking for female condoms?

(a) Receptive[__] (b) Not receptive [__]

. 17 For the time you spend seeking for sexual health care services, how long in hours do you take to be served? (a) ≤ 2 hours[__] (b) > 2 hours [__]

18. Based on experiences are their times you have sought for supplies used in sexual related activities but failed to get? (a) Yes[__] (b) No [__]

19. In your place of residence, have you ever witnessed promotion initiatives about female condoms? (a) Yes[__] (b) No [__]

20 Which of the following best represents the distance to your nearest health facility from your area of residence?(a) ≤ 2 kilometers[__] (b) > 2 Kilometers [__]

SECTION D: FEMALE CONDOM USE

21. Irrespective of the responses above, have you ever had sexual intercourse?

(a) Yes[__] (b) No [__]22 . If your response is yes, have you ever used a female condom under any of the instances that you had sexual intercourse? (a) Yes[__]

(b) No[__]

23. Irrespective of the response above, how often do you use a female condom whenever you have had sexual intercourse?(a) Never used [__](b) Ever used [__]

(c) Currently in use [__]

. 24 Irrespective of all the responses above, what do you think can be done to improve use of female condoms amongst the females that engage in sexual activities in your community?_____

_____

Thanks for your co-operation

Appendix IV: Olukala Lw'ebibuuzo Ebyokuddibwamu Abakyala Abali Mu Myaka Egizaalala

Ebyokugoberera: Gololа mu kabokis ☐ oba owandiike mu mabanga agakuwereddwa ku buli kibuuzo.

1. Olina emyaka emeka?

   a) 18 – 25 ☐
   b) 25 – 35 ☐
   c) 35 – 45 ☐
   d) Gisukka 45 ☐

2. Wasoma kukoma wa?

   a) Saasoma ☐
   b) Pulayimale ☐
   c) Ssekendule ☐
   d) tendekero ☐

3. Ku nsonga z'obufumbo oyimiridde otya?

   a) Siri mufumbo ☐
   b) Nina omwami naye simubutongole ☐
   c) Ndi mufumbo ☐
   d) Ndi namwandu twayawukana ☐

4. Okola ki?

   a) Mukyala wa waka ☐
   b) Nkola/ nina omulimu ☐
   c) Sirina mulimu ☐
   d) Ebirala…… (bimenye) ☐

5. Ennyingizaayo buli mwezi egwa mu ttuluba ki nga tusinziira ku nsimbi za Yuganda?

   a) Siyingiza ☐
   b) Wansi wa 50,000 ☐
   c) 50,000 – 100,000 ☐
   d) 100,000 – 200,000 ☐
   e) 200,000 – n'okusingawo ☐

6. Oli wa nzikiriza ki?

   a) Mukulisitaayo ☐
   b) Musiraamu ☐
   c) Endala.....(nyonyola) ☐

7. obupiirsa bw'abakyala bu kalimpita wa obumanyi?

   a) Nedda ☐ b) Ye ☐

8. Bw oba ng'o bumanyi ku bino wammanga ki ekinyonnyola obupiira buno mu butuufu?

a) Kapiira akaweweevu nga kaliko omugo akambazibwa ku basajja nga tonegatta okusobola okuziyiza enkwaso okutuuka ku nnabaana.

b) Akapiira akaweweevu nga kaliko omugo omwetoloovu nga kakozesebwa omukyala mu bitundu bye ebyekyama ng'agenda okwegatta okusobola okuziyiza enkwaso z'omwami okutuuka ku nnabaana.

c) Ku biri waggulu tekuli kituufu

EKITUNDU B: ENSONGA EZIFUGA ENKOZESA YOBUPIIRA BW'ABAKYALA

9. Nga tosinzidde ku .kyozzeemu waggulu , oyinza okuwagira / okuwa mukwano gwo amagezi okukozesa obupiira bu kalimpita wa?
   a) Omukyala yenna asangingibwa n'obupiira buno agobwa mu bufumbo.
   b) Abakyala abasangibwa nga bagula oba nga balina obupiira bu kalimpita wa basosolebwa mu bitundu gye bava.
   c) Ekirala……..(nyonnyola)
10. Ku bino wammanga ki ekinyonnyola obulungi engeri obuwangwa gye bwekuusa ku nkozesa y'obupiira.
11. Ku bino wammanga ki ekinyonnyola obulungi endowooza y'abakyala banno abali mu kitundu gy'osula ku bupiira bu kalimpita wa?
    a) Obupiira bu kalimpita wa bukozesebwa bamalaaya.
    b) Abakyala abafaayo eri onulamu bwabwe balina eddembe okukozesa obupiira bu kalimpita wa
    c) Ebirala
12. Omwagalwawo akuleetera oba akuwa ku magezi okukozesa obupiira bukalimpita wa?
    a) Ye
    b) Nedda
13. Ku bino wammanga ki ekisinga okunyonnyola endowooza ze mulina mu nnono zamwe ku bupiira bwa bakyala?
    a) Kikirizibwa mu nnono omukyala okukozesa obupiira
    b) Okwambala obupiira kwa basajja bokka
    c) Ebirala
    d) lambululaa

EKITUNDU C: ENSONGA Z'OBULAMU EZIKOSA / EZIFUGA ENKOZESSA Y'OBUPIIRA BW'ABAKYALA

14. Ng'osinziira ku ddwaliro eri kuli okumpi, laga obusobozi bwo mukugula obupiira bu kalimpita wa.
    a) Bitono b) Nkumu
15. Okutwaliza awamu, enkola y'abasawo eri oyo ayagala obupiira bw'abakyala ogyogerako ki?
    a) Enkwata mbi b) Batukwata bulungi
16. Ebbanga ly'omala ng'onoonya obuyambi ku nsonga z'okwegatta mu malwaliro, kikutwalira essaawa mmeka okukolebwako?

a) Tezisukka ssaawa bbiri
b) Zisukka essaawa ebbiri

17. Ng'osinziira ku kumanyakwo, wali ogenze okufuna obuyambi obwekuusa ku nsonga a) z'okwegatta n'omukwano n'otabufuna?

a) Ye ☐ b) Nedda ☐

18. Wali olabyeko ekun kola entandikiddwawo mu kitundu kyo ng'egenderera okutumbula okukozesa obupiira bu kalimpita wa?

a) Ye ☐ b) Nedda ☐

19. Ku bino wammanga londako ekiraga obuwanvu bw'olugendo okuva w'osula okutuuka ku kifo awafunirwa obujjanjabi.

a) Kilo mita bbiri oba obutawera ☐ b) Okusukka kilomitabbiri ☐

EKITUNDU D: <u>ENKOZESA YOBUPIIRA BWA'ABAKYALA BU KALIMPITA WA</u>

20. Nga tosinzidde kw'ebyo byozeemu waggulu, wali wegasseeko n'omusajja?

a) Ye ☐ b) Nedda ☐

21. Bwoba ng'okkiriza waggulu, wali okozesezaako ku kapiira k'abakyala?

a) Ye ☐ b) Nedda ☐

22.kweba nga okudamukwo nga, ye waliokozesezako obupiri

Obupira bukalipita bwabakyala musonga zo kwegata mumukwano?

a) ye
b) nedda

23 kukyozemu wagulu,wandiokozesezako kapira akabakya ngamwegata?

a)sikozesangako

b)nalinkozesako

c)Nkozesa kati

24 Okusinzira kubyozemu wagulu,olowoza kiki ekisobola okukolebwawo okwongera

Kunkozesa yobupira bwabakyala mu bakyala abeenyigira mubikolwa ebyokwega

Mumukwano kukyalo kyo?

Appendix V: Consent Form for Key Informants

Date of interview……Time……

Introduction

Good morning/afternoon. I am Lucy Wanyenze of Bugema University pursuing a Master's Degree in Public Health. I am carrying out a research study on **Factors influencing Female Condom use among Females Attending Family Planning Services at Entebbe General Hospital.** The study results are for academic purposes only but may also be used to design interventions for improving on utilization of female condoms and also health services.

Procedure for the study

You will be asked questions regarding your knowledge about female condoms and their use. The interview will take about 15 minutes.

Benefit and risks

The information you will provide will be used to improve on utilization of female condoms among young adults aged 15 to 49 years. There will be no direct benefits to you nor risks other than your time.

Confidentiality

Your answers will be taken generally as a contribution towards improving the quality and utilization and thus will be treated confidential your names will not be required. Instead numbers will be used.

Voluntary consent

Your choice to participate in this study is voluntary. You are free to take part in the study or not and feel free to withdraw at any time during the interview. You are also free to ask any question before or after the interview.

Who to contact:

You can contact Dr. Vuzi C. Peter as the Chief Supervisor and or Rosette Kabuye, Dean School of Graduate Studies Bugema University, Bugema University Research committee. TASO REC. You can as well contact the Chairperson TASO REC, DR. Bogere Daniel on Telephone No. +256772139126 for more information.

We therefore humbly invite you to take part in the interview on the above subject. As noted the session will take approximately 15 minutes.

Respondent's signature/thumb print…….
Date……..
Name of researcher eliciting consent……
Signature……...

Appendix VI: Key Informant Guide for the Health Workers

Date of interview……Time ____minutes

1. What is your position in the family planning unit of this health facility?
2. What are your roles in family planning unit of this health facility?
3. What family planning services do you provide to women in this unit?
4. Of the above family planning services, which ones are the most used and the least used?
5. In reference to female condoms,how do you gauge the numbers of women that seek female condoms and why.
6. What personal factors in your opionion explain this female condoms utilization level in the family planning unit?
7. What are the health system factors that explain the female condoms utilization level in the family planning unit?
8. In your opionion which factors specific to community influence the currentfemale condoms utilization level in this family planning unit?
9. In your own view, what do you think can be done to improve the current female condoms utilization level in this family planning unit?
10. What else can you say about the current female condoms utilization level in this family planning unit?

Thanks of your precious time.