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Prevalence and Determinants of Contraceptive use among Female Health Care Seekers Attending Jinja Regional Referral Hospital, Jinja District Uganda.

Maimuna Hussein Ahmed

Faculty of Clinical Medicine and Dentistry Kampala International University Western Campus Uganda.

ABSTRACT

The ability of women to choose whether and when to have children improves their health, education, and employment opportunities. The factors that influence contraceptive use arecritical variables in the evaluation of family planning programs. The study looked at contraceptionknowledge, prevalence, and determinants among women of childbearing age (WCA) at Jinja Regional Referral Hospital. A descriptive cross-sectional study design was used to perform a total population study among women of child-bearing age attending Jinja Regional Referral Hospital in Jinja District, Uganda. The data was collected using a pre-tested, structured interviewer-administered questionnaire. SPSS version 21.0 was used to analyze the data. Chi-squared tests were performedto test for relationships, and binary logistic regression was employed to identify significant predictors of contraceptive use. The significance level was chosen at $p < 0.05$. The study included 295 WCA with an average age of 27.4 7.9 years. One hundred and seventy-seven women (60.0%) were multiparous. 115 (65.0%) of these had an average birth interval of 2 years. One-third had used contraception at some point in their lives, with 26.4% currently using them. Condoms were the most often used contraceptive (33.3%) among responders. Current contraceptive use was influenced by contraceptive cost ($p = 0.036$), informedchoice ($p = 0.001$), and degree of education ($p = 0.024$). The prevalence of contraception among respondents was low. The cost of contraception, informed choice, and level of education were determinants of current contraceptiveuse, and these should be leveraged for targeted interventions by all stakeholders in intervention programs.

Keywords: Women, Children, Contraceptive use, Women of Child-bearing age, Contraception knowledge.

INTRODUCTION

Family planning (FP) is regarded as one of the greatest public health successes of the twentieth century, and its global popularity is increasing. It has been defined as one of a few realistic, cost- effective interventions that can have an immediate impact on women and their families while reaching well beyond the individual level. [1] Family planning aids in the protectionof women from high-risk pregnancies, unsafe abortions, reproductive tract infections and STIs including HIV/AIDS hence, its addition to the Millennium Development Goals (MDG) and Sustainable Development Goals (SDGs) as an indicator for tracking progress on improving maternal health. [2] Family planning services include counselling/education, pre- conception care, screening/laboratory tests and family planning methods. Family planning methods include abstinence, natural family planning and all approved methods of contraception including hormonal contraception and contraceptive supplies such as condoms, diaphragms and intrauterine devices. [1]; [3] Women's ability to use contraceptives and to determine whether and when to have children enhances their education and employment chances. This, in turn, improves their income, family stability,

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mental health and happiness as well as the well-being of their children. [4] Globally, at least 200 million women want to use safe and effective family planning methods, but are unable to do so, leading to unwanted pregnancies. More than 50 million of the 190 million women who become pregnant each year have abortions. Many of these are clandestineand performed under unsafe conditions. [5] In 2019, an estimated 168,000 women inSub-Saharan Africa died from pregnancy and birth-related causes; 62,000 of these women did notwant to become pregnant in the first place. Unmet need for contraception is responsible for 19 million unintended pregnancies, 8 million unplanned births, 5 million abortions, 2 million miscarriages, 555,000 infant deaths and 255,000 newborn deaths in Sub-Saharan Africa. [5] In Uganda, the high annual population growth rate has been a major cause of concern for population experts and policy makers. [6] The Multiple Indicator Cluster Survey conducted in 2011 revealed that the contraceptive prevalence rate is 17.5% and the unmet need for contraception is 19.4%. [7] Also, [8] revealed that overall, only 10% of marriedwomen use a modern method of family planning and an additional 5% use a traditional method while only about 40% of sexually active, unmarried women are using a modern method of familyplanning, most commonly the male condom. [7] Unsafe abortions are a major reason why Uganda's maternal mortality is one of the world's highest. According to estimates, more than3,000 women die annually in Uganda as a result of unsafe abortion. [9] In Jinjadistrict, the current use of modern contraception is 19.1%. The National Urban Reproductive Health Initiative (NURHI) Midline Study Report 2019 for Jinja documents high rates of unplanned pregnancy, unsafe abortion and sexually transmitted diseases among young adults. Common reasons for not using contraceptives include lack of access to methods that meet users' needs; concerns about health and side effects; opposition from a partner on cultural or religious grounds; and problems obtaining family planning services generally, including being unable to afford contraceptives. [8] Determinants of contraceptive use are key variables in the evaluation of family planning programmes. This study will help to facilitate a better understanding of the factors that influence contraceptive use in a rural setting. Analysis of these factors will provide useful information that could lead to reforms that encourage the use of contraception which may ultimately reduce the numberof children each woman has with subsequent beneficial effects on the population and on the health status of mother and child. The study was therefore conducted to assess the prevalence and determinants of contraception among women of child-bearing age attending Jinja RegionalReferral Hospital, Jinja district with a view to improving contraceptive use status.

Statement of Problem

Several sexually active women do not use any kind of birth control, especially in the majority of the world's poorest nations, where birth control practice is low and the unmet demand for family planning is high [2]. Uganda has one of the highest fertility rates in the area, at 5.59, with adolescent childbearing being at an alarmingly high level [10]. Unplanned pregnancies among teenage girls, sexually active unmarried women, and married women, as well as a high unmet birth control requirement in Uganda and the West Nile area, expose women to pregnancy difficulties, delivery, and termination efforts [11]. In spiteof the progress in the use of birth control methods in other nations, particularly affluent countries,the uptake in emerging African countries, including Uganda, leaves much to be desired. Despite increased sensitization and awareness-raising initiatives, uptake remains low [3]. In JRRH and the Jinja district, very little research has been undertaken on the prevalence and determinants of the usage of contraceptives. As a result, the study's goal was to give information that attempted to address the information gap on this essential topic.

Aim

To evaluate the prevalence and determinants of contraceptive use among female healthcare seekers at JRRH.

Specific Objectives

- To establish the prevalence of contraceptive use among female healthcare seekersat JRRH.
- To assess the determinants of contraceptive use among female healthcare seekersat JRRH.
- To determine the possible hurdles to use of birth control methods among female health careseekers at JRRH

Research Questions

i. What is the prevalence of contraceptive use among female healthcare seekers at JRRH?
ii. What determines contraceptive use among female healthcare seekers at JRRH?
iii. What are the possible hurdles to the use of birth control methods among female health careseekers at JRRH?

METHODOLOGY

Study Design

The study was a descriptive cross-sectional study carried out at JRRH.

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Area of Study

This research was conducted in Jinja Regional Referral Hospital in Jinja Municipality, Jinja District, Uganda's Eastern region. Jinja Regional Referral Hospital, or simply Jinja Hospital, is a hospital located in Jinja, Uganda's Eastern Region. It has 600 beds, making it the largest hospital in eastern Uganda. This facility is in Jinja's downtown area, close to the Nile's source. It serves the districts of Bugiri,Iganga, Jinja, Kaliro, Kamuli, Luuka, Mayuge, Namayingo, Kayunga, and parts of Buikwe as theRegional Referral Hospital. The hospital is around 84 kilometres (52 miles) east of Mulago National Referral Hospital, which is in Kampala, the country's capital [12] Jinja Regional Referral Hospital is located at 00°25'52.0"N, 33°12'18.0"E (Google Maps) (29 October 2020).

Study Population

The study population consisted of sexually active women of child bearing age (15-49 years) whowere permanent residents in Jinja district. JRRH was purposively selected due to the presence of a functional PHC rendering family planning services in s rural setting. Thus, members of the community are exposed to FP services and commodities.

Inclusion Criteria

Any WCA health care seeker attending JRRH who will consent to take part in the study.

Exclusion Criteria

Any female health care seeker attending JRRH who will not consent to take part in the study.

Sample Size Determination

The sample size was determined using Fishers et al., 2006 formula i.e. $N=Z^2PQ/D^2$:Where;

N is the desired sample size

Z is the standard normal deviation taken as 1.96 at a confidence interval of 95%.

P is the prevalence of uptake of modern contraceptives = 15% (2011 statistics as per.

D is the degree of accuracy= 0.05.

Q= (1-P) which is the population not on modern contraceptives.

Therefore, $N= 1.96^2X\ 0.321\ (1-0.321) / (0.05)^2= 335$ is the sample size.

Sampling Technique

Convenient consecutive sampling technique with sequential recruitment whereby participants waschosen as they meet the inclusion criteria until the sample size is achieved.

Data Collection Method

A structured interviewer-administered questionnaire consisting of open and closed ended questions was used to obtain information and data relevant to the study objectives. The questionswere grouped into sections to gather information on the socio-demographic profile of the WCA, contraceptive use as well as the determinants of contraceptive use.

Data Analysis

The questionnaires were screened for completeness by the researcher, coded, entered into the IBMSPSS version 21.0 software and analysed. Univariate analysis was done for socio-demographic variables. The association between socio-demographic variables such as age, religion and level ofeducation of respondents and independent variables such as contraceptive use and factors influencing contraceptive use were analysed to determine the significance of such associations inthe studied population. Multivariate analysis using binary logistic regression was carried out usingthe 'enter approach' to further determine significant predictors of contraceptive use. The level of significance of all statistical associations was set at $p < 0.05$. Results were presented using frequency tables.

Quality Control

Before the main study, the questionnaire was pre-tested, and three research assistants were chosenbased on their command of both English and the vernacular. They were properly trained in accordance with the study's needs and objectives.

Ethical Considerations

Through the faculty of clinical medicine and dentistry at Kampala International University- Western Campus, clearance was obtained. At JRRH, permission waso be obtained from the hospital management. Respondents were informed that they had the right to decline participation or to withdraw from the study at any time they wished. Respondents were also informed that therewere no penalties or loss of benefits for refusal to participate in the study or withdrawal from it. Consent of respondents was also sought before administration of questionnaires and confidentialityof information was assured as questionnaires were anonymously filled. Community health education was given after administration of questionnaires.

RESULTS

Demographic Characteristics of Study Participants

A total of 295 WCA participated in this study. The mean age of respondents was 27.4±7.9 years. A higher proportion 119 (40.3%) of respondents belonged to the 15-24 Years age group. Majority, 185 (62.7%) of the respondents were married and over half of the respondents 152 (52.9%) had attained secondary level of education. One hundred and eighty-five (62.7%) of respondents' spouses had secondary level of education, followed by 62 (21.0%), who had primary

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education. (Table 1)

Table 1: Socio-demographic Characteristics of Respondents

Variable	Frequency (n = 295)	Percentage
Age group in years		
15 – 24	119	40.3
25 – 34	117	39.7
35 – 44	47	15.9
≥ 45	12	4.1
Mean age in years ± SD	27.4 ± 7.9	
Religion		
Islam	148	50.2
Christianity	145	49.2
African traditional religion	2	0.6
Marital status		
Married	185	62.7
Single	96	32.5

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Cohabiting	8	2.7
Widowed	6	2.0
Level of education of respondent		
No formal education	23	7.8
Primary	100	33.9
Secondary	156	52.9
Tertiary	16	5.4
Level of education of respondent's spouse		
No formal education	13	4.4
Primary	62	21.0 62.7
Secondary	185	11.9
Tertiary	35	

Prevalence of Contraceptive Utilization

One third of the respondents 100 (33.9%) had ever used contraceptives. Of these, 78 (78.0%) werecurrently using some form of contraception. The prevalence of current contraceptive use among the studied group was 26.4%. Of those who were currently using contraception, a higher proportion41 (52.6%) used condom only, 28 (35.9%) and 18 (23.1%) used OCPs and injectable contraceptiveas forms of contraception. Other forms of contraception employed were the practice of abstinence10 (3.4%), withdrawal 9 (3.0%) and lactation amenorrhea (5 (1.7%). (Table 2)

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Table 2: Prevalence and Factors Influencing Contraceptive Use among Respondents

Variable	Frequency (n = 295)	Percentage
Ever used contraceptives		
Yes	100	33.9
No	195	66.1
Current contraceptive use (n=100)		
Yes		
No	78	78.0
Forms of contraceptive used (n=78)	22	22.0
Condom only		
Oral contraceptive pills		
Injectable Contraceptive	41	52.6
Abstinence		
Condom + any other method	28	35.9
Withdrawal		
Lactation Amenorrhoea Method	18	23.1
Others**		
Factors affecting contraceptiveuse* (n = 78)	10	12.8
Informed choice Cost of contraceptive	9	11.5
Access to FP services	9	11.5
	5	6.4
	4	5.1
	36	46.2
	23	29.5
	22	28.2

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Partner's decision	16	20.5
Exposure to messages		
Factors affecting nonuse of contraceptive* (n = 195) Partner's decision	5	6.4
Cost of contraceptive	89	45.6
Lack informed choice		
Lack of exposure to messagesNo reason	53	27.2
level of efficacy	46	23.6
Against my culture		
Against my religion	39	20.0
Side effect of contraceptives		
	36	18.5
Access to FP services		
	34	17.4
	26	13.3
	24	12.3
	19	9.7
	17	8.7

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Factors Affecting Contraceptive Use

Among current contraceptive users, informed choice 36 (46.2%), cost of contraceptive 23 (29.5%)and access to FP services 22 (28.2%) were the 3 most important factors that affected contraceptive use. Among respondents who had never used contraceptives, partner's decision 89 (45.6%), cost of contraceptive 53 (27.2%) and lack of informed choice 46 (23.6%) were the 3 mostimportant factors that affected contraceptive non-use. (Table 2) The use of contraceptives was found to be higher among respondents aged between 15-24 years 33 (27.7%), followed by 25-34 years 32 (27.4%), 35-44 years 11 (23.4%) and ≥45 years 2 (16.7%)age groups. The association between age and use of contraceptives was however not statistically significant (p = 0.810). Half of respondents who practiced African traditional religion 1 (50.0%) used contraceptives while 48 (33.1%) of Christians and 29 (19.6%) of Muslims used contraceptives. The association between religion and use of contraceptives was statisticallysignificant (p = 0.021). (Table 3)

Table 3: Socio-demographic Characteristics and Contraceptive Use of Respondents

Variable	**Use Of Contraceptives**		
	Yes **(n=78)**	**No** **(n=217)**	**Test statistic/p-value** **(n = 295)**
Age group in Years			
15 – 24	33 (27.7)	86 (72.3)	X^2 = 0.964
25 – 34	32 (27.4)	85 (72.6)	p = 0.810
35 – 44	11 (23.4)	36 (76.6)	
≥ 45	2 (16.7)	10 (83.3)	
Religion			
Islam	29 (19.6)	119 (80.4)	Fisher's Exact = 7.5
Christianity	48 (33.1)	97 (66.9)	p = 0.021
African traditional Religion	1 (50.0)	1 (50.0)	
Marital status			
Married	50 (27.0)	135 (73.0)	
Single	23 (24.0)	73 (76.0)	Fisher's exact = 7.8 p = 0.045
Cohabiting	5 (62.5)	3 (37.5)	
Widowed	0 (0.0)	6 (100.0)	

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Level of education of respondent			
No formal education	4 (17.4)	19 (82.6)	X^2 = 12.698 p = 0.005
Primary			
Secondary	22 (22.0)	78 (78.0)	
Tertiary	42 (26.9)	114 (73.1)	
	10 (62.5)	6 (37.5)	
Level of education of respondent's spouse No formal education	6 (46.2)	7 (53.8)	X^2 = 9.474 p = 0.023
Primary	12 (19.4)	0 (80.6)	
Secondary			
Tertiary	45 (24.3)	140 (75.7)	
	15 (42.9)	20 (57.1)	

A higher proportion of respondents who were cohabiting 5 (62.5%) used contraceptives comparedto respondents who were married 50 (27.0%) or single 23 (24.0%). No widowed respondent usedcontraceptives. The association between marital status and use of contraceptives was statistically significant (p = 0.045). Use of contraceptive was found to be higher among respondents with tertiary level of education 10 (62.5%) followed by those with secondary level 42 (26.9%), primarylevel 22 (22.0%) and no formal education 4 (17.4%). This difference in use of contraceptive observed with increasing level of education was statistically significant (p = 0.005). A greater proportion of respondents whose spouses had no formal education 6 (46.2%) used contraceptivesas compared with those respondents' spouses who had tertiary level of education 15 (42.9%), secondary level of education 45 (24.3%) and primary level of education 12 (19.4%). The association between respondent's spouse level of education and use of contraceptives was statistically significant (p = 0.023). (Table 3).

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Other Factors Influencing Contraceptive Use AmongRespondents

A higher proportion of respondents who cited cost of contraceptive as a factor influencing their use of contraceptives 23 (34.3%) used contraceptives compared to 55 (27.0%) of respondents whodid not cite it. The association between cost of contraceptive as a factor influencing contraceptive use and use ofcontraceptive was not statistically significant (p = 0.248). (Table 4) A higher proportion of respondents whose partner's approval did not determine their use of contraceptive 62 (35.2%) usedcontraceptives compared to those whose partner's approval did 16 (17.0%). The association between partner's decision as a factor influencing contraceptive use and use of contraceptive among respondents was statistically significant (p = 0.002). (Table 4)

Table 4: Factors influencing Contraceptive Use among Respondents

Variable	**Use Of Contraceptives**		**Test statistic/ p-value**
	Yes (n=78) Freq (%)	**No (n=217) Freq (%)**	
Cost of contraceptive			
Yes	23 (34.3)	44 (65.7)	X^2 = 2.773
No	55 (24.1)	173(75.9)	p = 0.096
Partner's decision			
Yes	16 (17.0)	78 (83.0)	X^2=6.293p
No	62 (30.8)	139 (69.2)	= 0.012

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Informed choice Yes No	36 (45.0) 42 (19.5)	44 (55.0) 173 (80.5)	$\chi^2 = 9.440$ $p < 0.001$
Exposure to messages Yes No	5 (25.0) 73 (26.5)	15 (75.0) 202 (75.5)	$X^2 = 0.223$ $p = 0.880$
Access to FP services Yes No	22 (21.0) 56 (29.5)	83 (79.0) 134 (70.5)	$X^2=2.525$p = 0.112

Logistic Regression Model for Determinants of Contraceptive Use

The use of contraception was found to be higher among respondents who mentioned informed choice as a factor influencing their use of contraception 36 (45.0%) compared to respondents whose use of contraceptives was not influenced by informed choice 42 (22.1%). The association between informed choice as a factor influencing contraceptive use and use of contraceptive was statistically significant ($p < 0.001$). (Table 4) In the multivariate analysis, the variables in the modelaccounted for between 23.8% - 35.5% of the variation observed in the outcome variable (use of contraceptive). With a year increase in age, respondents were less likely by an odds ratio of 0.993to use contraceptives. This was not statistically significant ($p = 0.773$, CI = 0.949 – 1.040). (Table5) Respondents who had never been married were more likely to use contraceptives by an odds ratioof 0.509 compared to respondents who had ever been married but this was not statistically significant ($p = 0.867$, CI = 0.5092.229). With increasing levels of education, the use of contraceptives was less likely by an odds ratio of 0.613 and this was statistically significant (p =

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0.024, CI = 0.400-0.938). Being a Christian decreased the odds of using contraceptives by an oddsratio of 0.615 compared to non-Christians. This was not statistically significant (p = 0.100, CI = 0.345-1.097). (Table 5)

Table 5: Logistic Regression Model for Determinants of Contraceptive Use

Predictors	B (Regression co-efficient)	Odds ratio	95% CI for OR		P-value
			Lower	Upper	
Age	-0.007	0.993	0.949	1.040	0.773
Marital status					
Never married	0.063	1.065	0.509	2.229	0.867
Ever married*		1			
Level of Education	-0.490	0.613	0.400	0.938	0.024
Religion					
Christians	-0.485	0.615	0.345	1.097	0.100
Non-Christians*		1			
Cost of					
Contraceptive	-0.894	0.409	0.178	0.943	0.036
Yes		1			
No*					
Partner's decision	0.380	1.462	0.678	3.152	0.332
Yes		1			
No*					
Informed choice	1.137	0.321	0.152	0.678	0.003
Yes		1			
No*					
Exposure to	0.083	0.920	0.286	2.960	0.889
Messages		1			
Yes					
No*					

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Access to FP services					
Yes	0.357	1.429	0.714	2.860	0.314
No*		1			

*Reference category, R^2 = 23.8%- 35.5%, CI = Confidence Interval

Respondents whose use of contraceptives was influenced by cost were 0.409 times less likely to use contraceptives and this was statistically significant (p = 0.036, CI = 0.178-0.943). Respondentswho cited their partner's decision as a factor influencing their use of contraceptives were more likely by an odds ratio of 1.462 to use contraceptives and this was not statistically significant (p =0.332, CI = 0.678-3.152). Respondents whose use of contraceptives was influenced by informed choice were more likely to use contraceptives by an odds ratio of 0.321 and this was statistically significant (p = 0.003, CI = 0.1520.678). Respondents who stated that exposure to messages on contraception was a factor influencing their contraceptive use were less likely by an odds ratio of0.920 to use contraceptives. This was not statistically significant (p = 0.314, CI = 0.714-2.860). (Table 5)

DISCUSSION

Prevalence of Contraceptive Use

This study revealed that about one in three WCA had ever used a contraceptive and one in four was currently using a contraceptive. This finding is similar to several descriptive studies in Ugandawhich have shown that the prevalence of contraceptive use has been low [13], [14] as well as the Multiple Indicator Cluster Survey (MICS) in 2019 which showed thatthe current contraceptive prevalence in Edo State was 18.5% and in South-South Uganda was 23%. [7] The 2008 and 2013 Demographic Health Surveys have also shown a consistently low contraceptive prevalence rate among women in Uganda over time [7]. The low rate of contraceptive use in Uganda results in high fertility rates, particularly in the ruralareas. High fertility rate as a result of low contraceptive use accounts for Uganda's high maternal, infant, and neonatal mortalities. [14] Other implications of low contraceptive use varies from unwanted pregnancies, sexually transmitted infections, unsafe abortions and its sequel as well as population explosion. Our study showed that Condom was the most commonly used contraceptive method in Awuyemicommunity. This is in line with the findings from a study conducted in Ilorin in 2009 and the NDHS 2013 survey. [9]; [10] The extensive marketing of condoms in response to the Human Immunodeficiency Virus (HIV) epidemic, with the active involvement of both government and non-governmental organizations, has been responsible for this increased awareness and subsequent increase in condom use. Condoms are also the preferred choice for post-partum contraception, especially among women with high parity. [9] In addition, studies in Uganda have indicated that because patent medicine stores are common sources of condoms and they are readily available over the counter at these stores, thereis much less restriction on its purchase and use compared with other forms of contraceptives. [15]

Determinants of Contraceptive Use

The reasons given in these studies for not using contraceptives were fear of side effects, objections from their partner, conflicts with their religious beliefs, objections from family members, not thinking about using contraceptives, not having sexual intercourse to have a baby, and unplanned sexual debut. Contraceptive use and choices vary widely in Uganda according to type of health facility, geopolitical zone, and within urban or rural settings. [16] Various factors, relatedto both supply and demand of contraceptives, account for these variations and contribute to the low levels of contraceptive use and choices in Uganda.[20] On the supply side are issues such as limited availability, quality, and cost of family planning services. As a consequence of limited availability, many Ugandans (particularly in rural areas) lack access to modern contraceptive andfamily planning services. In areas where services do exist, their quality is often poor, with inadequate contraceptive supplies, insufficient numbers of trained service providers, poor interpersonal skills on the part of providers, and limited essential equipment [9].

Fertility and contraceptive use in developing countries are associated with various markers of socioeconomic status, most prominent of which is women's education.[23] Women's educational status is an influential sociodemographic determinant of contraceptive use. With increasing level of

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education, there was an increase in contraceptive use. This was similar to findings of studies conducted in Indonesia and Bangladesh which also indicated that women's education had a strong positive effect on their current use of contraception. [17], and is also in line with findings from MICS survey in 2011. [9] Another study conducted in Pakistan in 2008 showed that illiteracy in women was identified one of the factors that affects the knowledge and practice of contraception as Illiterate women were at higher risk of not using any FP method thanliterate women. [18] This is not unexpected since education is believed to improve the motivation to practice birth control. Better educated women are assumed to be more willing to engage in innovative behavior, have more knowledge of contraceptive methods and of how to acquire them. Education empowers women, makes them more likely to be employed outside their home environment, and makes them more aware of their own health and the health of their children. Similarly, educated women are more likely to postpone marriage, have smaller family size, and use contraception than are uneducated women. Increasing the educational levels of women may therefore be one effective way of advancing the practice of family planning. Findings from this study revealed that partners' decision played a major role in contraceptive use,and non-use. This is in contrast with findings from other descriptive studies where a higher proportion of respondents had no reason for not using contraceptives. [19] Thisfinding corroborates the fact that significant others, especially spouses, have a huge role to play inall reproductive health issues, including contraception. The significance of this could be attributed to the fact that for a woman to use family planning services, partner's approval was critical. Otherwise if found using without the consent of partner it could be misinterpreted, thereby causing misunderstanding in the relationship. Family planning programs thus, in addition to targeting women's attitudes and behaviours should lay emphasis on involving men in reproductive health issues. The role of male partners in the achievement of reproductive health in Uganda cannot be overemphasized. A higher proportion of cohabiting respondents used contraceptives compared to married or singlerespondents. Cohabiting relationships may not have the same approval that society bestows on marriage, as couples who cohabit are regarded as individuals who have not undertaken the properrites that would make it legally acceptable for individuals to engage in sexual intercourse and havechildren. Therefore, for cohabiting couples, pregnancy may be a social stigma which both individuals may not want to risk and this may account for this finding in our study. Over one fifthof married women were found to be using a form of contraception. This is in contrast to findings from the NDHS 2013 (NCP – ICF, 2018) where less than a fifth of married women were reportedto be using a form of contraceptive. This may mean that there is a growing uptake of contraceptivesin the studied population and would in the long run translate into better family planning and invariably better control of population growth. Respondents whose partner's decision influenced their contraceptive use were 1.462 more likely to use contraceptives compared with those whose partner's decision did not influence their contraceptive use. In the typical African setting, women are usually dependent on their spouses formoney and other resources required to run the home. Contraceptives pose an extra cost in addition to the cost of housekeeping, hence women whose partners agree to the use of contraceptives are likely to have their spouse's support monetary wise compared to those whose partner's decision do not influence their use of contraceptives. The best decisions about family planning are those that people make for themselves, based on accurate information and a range of contraceptive options. Informed choice is an important principle in the delivery of family planning services. Asan aspect of informed choice, it is required that all family planning providers inform users about potential side effects of a method and what they should do if they encounter such side effects. Contraceptive users should also be informed of other methods available to them. This information assists the user in coping with side effects and thus decreases discontinuation of temporary methods. (NCP – ICF, 2018) People who make informed choices are better able to use family planning safely and effectively. Thus, health care providers have a responsibility to help people make informed family planning choices. Respondents whose use of contraceptives was influencedby informed choice and exposure to messages on contraception were more likely to use contraceptives. Exposure to messages on contraception serves as an avenue for individuals to know the various methods of contraception and gives them an opportunity to choose from the arrayof contraceptives available based on their preference. However, if there were a dearth of messageson contraception, individuals would not be informed, and this could lead to reduced uptake of

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contraceptives as was observed in this study.

CONCLUSION

The prevalence of contraceptive use was low in the studied population. Determinants of contraceptive use among sexually active WCA in the community included knowledge of contraception, age, marital status, and level of education of respondents.

RECOMMENDATIONS

More research is warranted in this field, therefore Kampala International University through its teaching hospital should aim to bridge this knowledge gap through further studies.

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