CHOICE OF CONTRACEPTIVES AMONG FEMALE STUDENTS IN
HOSTELS AROUND MAKERERE UNIVERSITY

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APPROVAL

This dissertation has been written under my supervision and has been submitted for the award of the degree of masters in Arts of Social Sector Planning and Management, Makerere University.

Supervisor

Dr. David Kyaddondo

Supervisor’s Signature: ..........................................

Date: .................................................................
Declaration
I declare that this dissertation is a result of my own independent investigation. It has not been submitted to any other institution for any award. Where the work of others has been used, due acknowledgement has been done.

Aisha Kigongo

Registration Number: 2010/HD14/786U

Signature............................ Date 11/01/2013
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MAY GOD BLESS YOU ALL
# TABLE OF CONTENTS

APPROVAL ......................................................................................................................... Error! Bookmark not defined.

ACKNOWLEDGEMENT........................................................................................................... ii

TABLE OF CONTENTS ........................................................................................................... iv

A LIST OF TABLES .................................................................................................................... viii

A LIST OF FIGURES ................................................................................................................ ix

LIST OF ABBREVIATIONS AND ACRONYMS ...................................................................... x

ABSTRACT ............................................................................................................................ xi

CHAPTER ONE ....................................................................................................................... 1

INTRODUCTION ..................................................................................................................... 1

1.1 Background to the Study ............................................................................................... 1

1.2 Problem Statement ....................................................................................................... 5

1.3 Main objective of the Study ......................................................................................... 5

1.4 Specific Objectives ....................................................................................................... 5

1.5 Research Questions ...................................................................................................... 6

1.6 Significance of the Study ............................................................................................. 6

1.7 Definition of Terms .................................................................................................... 7

1.8 Theoretical framework of choice of contraceptive use among female students .......... 8

CHAPTER TWO .................................................................................................................... 10

LITERATURE REVIEW ......................................................................................................... 10

2.0 Introduction .................................................................................................................. 10

2.1 Pattern of Contraceptive use among young people .................................................... 10

2.2 Choice of modern contraceptives by adolescent girls ............................................... 13

2.3 Constraints to access and use of contraceptives among young women .................... 16
CHAPTER THREE .......................................................................................................................... 20

METHODOLOGY .......................................................................................................................... 20

3.0 Introduction .............................................................................................................................. 20

3.1 Research Design ...................................................................................................................... 20

3.2 Study area ............................................................................................................................... 20

3.3 Study Population .................................................................................................................... 20

3.4 Sampling size .......................................................................................................................... 21

3.5 Sampling Procedure ............................................................................................................... 21

3.6 Inclusion and exclusion Criteria ............................................................................................ 22

3.7 Data collection methods ......................................................................................................... 22

Table 1: A summary of the study participants ............................................................................. 23

3.8 Data collection Procedure ..................................................................................................... 24

3.9 Study variables and their measurement .................................................................................. 24

3.10 Validity and Reliability ......................................................................................................... 25

3.11 Data management and analysis ............................................................................................. 25

3.12 Validity and Reliability ......................................................................................................... 26

3.13 Limitations of the Study ....................................................................................................... 26

3.14 Ethical Considerations .......................................................................................................... 26

CHAPTER FOUR .......................................................................................................................... 29

FINDINGS ....................................................................................................................................... 29

4.0 Introduction .............................................................................................................................. 29

4.1 Social demographic characteristics ....................................................................................... 29

Table 2: Background information and Social demographic characteristics .................................. 29

4.2 Sexual practices of female students residing in hostels around Kampala .............................. 30
CHAPTER SIX ......................................................................................................................... 54

CONCLUSION AND RECOMMENDATIONS .............................................................................. 54

5.0 Introduction .......................................................................................................................... 54

5.1 Conclusions .......................................................................................................................... 54

5.2 Recommendations for future studies .................................................................................. 54

5.3 Recommendations .............................................................................................................. 55

REFERENCES ............................................................................................................................ 58

APPENDICES ............................................................................................................................ 68

Appendix I: Consent form for female students ......................................................................... 68

Appendix II: Consent form for key informants ......................................................................... 69

Appendix III: Letter of permission to hostel custodian ............................................................. 70

Appendix IV: Letter of permission to administrators of health facilities and NGOs ............... 71

Appendix V: Questionnaire ....................................................................................................... 71

Appendix VI: Key informant Interview Guide ........................................................................... 77
A LIST OF TABLES

Table 1: A summary of the study participants ........................................................................... 23
Table 2: Background information and Social demographic characteristics............................... 29
Table 3a: Sexual behaviors of students residing in hostels around Makerere University hospital .................................................................................................................. 31
Table 3b: Nature of contraceptive known.................................................................................. 32
Table 3c: Perceived better method that would be recommended............................................... 33
Table 4a: Regularity of use of condoms...................................................................................... 36
Table 4b: Distribution of respondents on use of different contraceptive methods............... 37
Table 5: Contraceptive and source............................................................................................ 42
Table 6: Reasons for choice of where to get modern contraceptives ....................................... 44
Table 7: Alternative contraceptives available at source ............................................................ 45
Table 8: Constraints to contraceptive use.................................................................................. 47
A LIST OF FIGURES

Figure 1: Pie-chart showing usage of contraceptives among female students in hostels around Makerere University, N=236

Figure 2: Pie-chart showing methods commonly used in percentages among female students in hostels around Makerere, N=236

Figure 3: Pie-chart showing contraceptive method used and regularity among female students in hostels around Makerere, n=134

Figure 4: Bar graph showing Reasons behind Decision making on choice of contraceptives

Figure 5: Sources of contraceptives

Figure 6: Sources of commonly used modern contraceptives
### LIST OF ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency syndrome</td>
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<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>HCIII</td>
<td>Health Centre level three</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IUCD</td>
<td>Intra uterine contraceptive device</td>
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<tr>
<td>IUD</td>
<td>Intra uterine contraceptive device</td>
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<tr>
<td>KIs</td>
<td>Key informants</td>
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<tr>
<td>Mak</td>
<td>Makerere University</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisations</td>
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<tr>
<td>PI</td>
<td>The principal investigator</td>
</tr>
<tr>
<td>OC</td>
<td>Oral Contraceptives</td>
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<tr>
<td>SD</td>
<td>Standard deviation</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub Saharan African</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for Social Scientists</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Diseases</td>
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<tr>
<td>TV</td>
<td>Television</td>
</tr>
<tr>
<td>UDHS</td>
<td>Uganda Demographic Health Survey</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nation children’s Fund</td>
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<tr>
<td>UNFPA</td>
<td>United Nation Population Fund</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

Use of contraceptives among female university students has been widely studied in many countries but little on choice, pattern and constraints on use of contraceptives particularly among female students residing in hostels around Makerere University. This current study was conducted to assess how young female students chose the types of contraceptives they used. The study was conducted among female students who resided in hostels around Makerere University. Simple random sampling and systematic sampling were used to sample ten hostels and 236 female students respectively. Structured questionnaires and interview guides were used to collect data from female students and key informants respectively. Quantitative data was entered and analysed using SPSS version 17. Qualitative data was analysed by thematic content analysis.

Findings revealed that 87% of the students were aged 20-24 years and only 4% were 25 years and above; 35% were Catholics, 27% were Protestants and muslims were 17%; 99% were on degree programmes. Over 63 % of the students were in relationships with 33.3% and 31.2% having been in these relationships for 13-24 months and 25 months or more respectively. Choice of contraceptives by female university students was mainly influenced by the ease to use (38%), side effects (27%), cost (25%), and availability (24%). Male condoms (89%), oral pills (77%), and injections (64%) were the most used contraceptives and contraceptive sponges were least used. The commonest challenges facing use of contraceptives among female students were side effects (87%), religious restraints (33%), unavailability of certain contraceptive methods, opposition of male partners (30%), forgetting to use contraceptives (27%) and lack of knowledge on use of contraceptives (23%). In conclusion, choice to use a particular contraceptive depended on ease to use, side effects, cost or its availability and based on these factors male condoms, pills and injection mostly used. This is line with rational choice theory. Challenges like side effects, religious restraints, unavailability of certain contraceptive methods, and opposition from male partners face use of contraceptives. Consequently, the following were recommended: intensifying campaigns on increasing knowledge on various contraceptives and their various sources; encouraging students to be liberal and pragmatic as regards contemplating issues on reproductive health and sexual rights and restraining from influence of religious dogmas; availing condoms in hostels and involving males in campaigns on contraceptive use.
CHAPTER ONE
INTRODUCTION

1.1 Background to the Study
Globally the burden of sexual and reproductive health remains considerably worrying. Estimates suggest that sexual and reproductive conditions account for 18.4% of the global burden of disease and 32.0% of the burden of disease among women age 15-44 years (WHO, 2008). There are adverse consequences of unsafe sexual behavior such as unwanted pregnancies and sexually transmitted infections (STIs), including HIV are common among young women as well as adults (Trip & Viner 2005). And these reproductive health burdens are higher in developing countries.

Risk sexual behaviors are common when adolescents start being sexually intimate and are often linked with other health risk behaviors. The median age for first sexual intercourse in the United Kingdom dropped during the early 1990s and is now stable at around 16 years for both men and women. The disparity between the sexes observed in the early 1990s has diminished. Before the age of 15, about 18% of boys and 15% of girls report having had full sexual intercourse, with similar proportions having engaged in oral sex. Having sex for the first time at an early age is often associated with unsafe sex, in part through lack of knowledge, lack of access to contraception, lack of skills and self-efficacy to negotiate contraception, or inadequate self-efficacy to resist pressure (Tripp and Viner, 2005).

It is estimated that about 80 million unintended pregnancies are estimated to occur worldwide annually. In developing countries more than one-third of all pregnancies are considered unintended and about 19% will end up in abortion, which are most often unsafe accounting for 13% of all maternal death globally (Boonstra, 2007, Marston and Cleland, 2004).

Family planning can reduce the number of deaths among women by reducing the number of women who are at risk by averting unintended pregnancy, which account for about 30% of all birth in Sub-Saharan Africa (WHO 2010). Two-thirds of unintended pregnancy in developing countries occurs among women who are not using any method of contraception. The unmet need for contraception in developing world is estimated to be about a hundred million
(Boonstra, 2007). Yet, unwanted pregnancy among young women can be prevented through effective use of contraception. The highest rates of unintended pregnancy occur among young women, as 60% of pregnancies among 20-24 years old and 79% among 18-19 years old women are unintended (Finer & Henshaw 2006).

Traditional contraceptive methods recognized include withdrawal, periodic abstinence, use of herbs and wearing of traditional beads, but have tended to less reliable than modern contraceptives (MacPhail et al, 2007; Tripp & Viner, 2005). Modern contraceptives including hormonal, barriers and surgical methods are gaining more use even in developing countries than traditional methods (Magadi and Curtis, 2003).

Barrier methods are usually short term methods include; male and female condoms, spermicides, diaphragm, cervical cap and contraceptive sponge. A male condom is a tube of latex rubber that is rolled over the erect penis prior to contact with the vagina. A female is seven-inch long pouch of polyurethane with two flexible rings and is inserted into the vagina prior to intercourse. Spermicides are chemicals that are designed to kill sperm. A diaphragm is a soft rubber dome stretched over a flexible ring; the dome is filled with a spermicidal cream or jelly. A cervical cap is a small cup made of latex rubber or plastic (American Pregnancy Association, 2012). Hormonal methods include; birth control pills, injectables like Depo-Provera or lunelle, vaginal rings and Norplant or implants like ortoEvra patch. Hormonal contraceptives are reversible, when their use is withdrawn, a mother can be able to get pregnant again. Most of the barriers and hormonal contraceptives with exception of implants are short term contraceptives. Short term contraceptives only protects against pregnancy for a short period, say a day to a number of months (American Pregnancy Association, 2012).

The other contraceptive methods are permanent and are surgical in nature. They include tubal ligation which involves the cutting of a woman’s fallopian tubes and vasectomy which involves cutting the man’s sperm ducts (American Pregnancy Association, 2012).These permanent contraception methods are usually done to couples that are no longer interested in having any more children in future. Permanent contraception methods are not wise decision for young couples especially those who have not yet had any children or a desired number of children.
There was high rate of unwanted pregnancies in Uganda. Singh et al (2005) in a study on the incidence of induced abortion in Uganda found that each year, an estimated 297,000 induced abortions were performed in Uganda, and nearly 85,000 women were treated for complications. According to this study abortions occurred at a rate of 54 per 1,000 women aged 15-49 and accounted for one in five pregnancies. The same study also found that nationally, about half (50%) of pregnancies were unintended and resulted from an unmet need for effective contraceptives (Singh et al., 2005).

It is also recognized that contraceptive use is an integral component of reproductive health and have positive effect on the health of women. Its promotion has potential benefits of reducing poverty, maternal and child mortality, unsafe abortion, prevention from cancers, sexually transmitted infection and HIV (Cleland et al 2006). In spite of these benefits the unmet need for family planning services remains very high in developing countries (Casterline and Sinding, 2000). Uganda Demographic Health Survey (MoH, 2006) reported that just over half (52%) of women (15-49 years) who had ever used a contraceptive method, 42 percent had used a modern method, and 21 percent had used a traditional method. In about half of all unwanted pregnancies, conception occurs due to inadequate guidance to use contraception effectively, poor choices or attitudes towards contraceptives and lack of motivations (Byamugisha et al, 2007). Comprehensive sex education is also absent and contraceptive use remains low among adolescents and young women. The age of sexual initiation is progressively reducing, mean age as early as 15 years has been found in some communities resulting in high pregnancy and abortion rates (Okpani & Okpani 2000).

A number of studies have been done on choice on contraceptive methods among women. In a cross-sectional study involving 550 randomly selected respondents among women attending family planning clinics in Ibadan, Nigeria, it was found that consideration about personal health (86.0%) and husband's approval (74.9%) were major determinants of respondents use of contraceptives (Moronkola, Ojediran and Amosu, 2006). In a similar development, a study carried out in Kenya using data from the 1989, 1993 and 1998 Kenya Demographic and Health Surveys to examine trends and determinants of contraceptive method choice revealed that use of
injectables was notably high among rural women who were uneducated, less exposed to family planning messages and whose partners disliked family planning use (Magadi and Curti, 2003).

In a qualitative study that explored perceptions towards and utilization of contraception among HIV-positive, reproduction-age women 18-45 in Kericho, Kenya, an area with high HIV and low contraceptive prevalence rates, it was found that perceptions about side effects, opinions of the male partner, and HIV disease progression played important roles in contraceptive decisions (Imbuki et al, 2010).

Nelago (2007) conducted a study on contraceptive choice and use of methods among young women aged 15-24 in Namibia using data from Namibian Demographic and Health Survey (NDHS) for 2000 and focus group discussions conducted with young women aged 15-24 in June/July 2004. This revealed that whilst there is provision, levels of contraceptive use were still low and choice of contraceptive method was restricted to injectables and to some extent, condoms. Uninformed and unsupportive parents were identified as major barriers to young women’s ability to use contraception consistently. Lack of support from nurses, and the broader community, unfriendliness from health providers, lack of public spaces, lack confidentiality and privacy also hindered women’s use contraceptives. The education level, marital status, number of children and work status were important individual factors affecting whether and what kind of contraception young women would use. For example, increased education was significantly associated with a greater likelihood of using contraception. Furthermore, young women in urban areas had more positive attitudes towards using contraceptives.

Contraceptive prevalence is documented to be highest among urban and educated women, including young people. However, how choice of a particular contraceptive out of the many available options is not known. Moreover female students aged 17-19 in hostels around universities, are in an environment posing high risky sexual behaviors and without effective choice of contraceptives could lead to high number of unwanted pregnancies and threatening abortions. This of course disrupts the academic concentration of the affected students. This current study therefore would help in establishing the use of contraceptives among female students aged 15-24 in Uganda and what socio-demographic, health and perceptual factors determine choice of use of particular contraceptives.
1.2 Problem Statement
Choice of contraceptives is a key concern in promoting family planning and reproductive health in general. While contraceptives are more available and accessible to young people in higher education institutions in urban areas compared to out of school, lower classes and in rural communities, failure to make the right contraceptive choice from an appropriate source might affect the outcomes of contraceptive use among this category. Several studies have been done about choice of contraceptives among married women in Africa (Moronkola, Ojediran and Amosu, 2006; Magadi and Curti, 2003; Imbuki et al, 2010; Nelago, 2007), but little on the young school going people. Young female students have different sexual relationships from their married counterparts which often do not usually have immediate aim of child bearing, more over use of permanent family planning methods like tubal ligation or vasectomy means no future chance of having any (more) child hence effective contraceptives and this of course is a precarious decision at such a prime age. Only choice of reversible contraceptive methods can be suitable the young school going people. Again coupled with academic demands, young female students needed to carefully decide on the most appropriate contraceptive to use that would not burden them in terms of side effects or cost. Thus to promote an efficacious use of contraceptives among young female students in higher education, it was important to understand the underlying considerations they make in choosing type of contraceptives. This study therefore examined how female students chose contraceptives, the determinants in making such choices, the patterns of contraceptive use and the constraints therein.

1.3 Main objective of the Study
The purpose of the study was to assess how young people choose types of contraceptives, with a specific focus on female students residing in hostels around and studying in Makerere University or neighboring higher education institutions.

1.4 Specific Objectives
1. To examine the patterns of using modern contraceptive methods among of female students in hostels around Makerere University.
2. To identify decision making process in the choice of modern contraceptives among female students in hostels around Makerere University.
3. To examine constraints to utilization of contraceptives among female students in hostels
around Makerere University.

### 1.5 Research Questions

The above objectives had the following research questions:

(i) What are the patterns of using modern contraceptive methods among female students in hostels around Makerere University?

(ii) What is the decision making process in choice for modern contraceptives among female students in hostels around Makerere University?

(iii) What are the constraints to utilization of contraceptives among female students in hostels around Makerere University?

### 1.6 Significance of the Study

The study provided in-depth information on pattern of contraceptive use, the decision making process and constraints involved therein among young female students particularly in Uganda. Based on the rich founded information from this study, contraceptive service providers are in a better position to understand the contraceptive needs of especially young female students in the country.

To those in practice, the study also helped in the assessment of the quality of information young female students had on contraceptives and which would then consequently shape efforts in educating young female students on contraceptive use in the country.

To Policy, findings in study would also inform policy makers on the gaps in the policies that affect young women’s reproductive health especially contraceptive needs.

In addition the study findings were significant for several groups including those involved with affairs of young female students like counselors, psychologists, students’ hall wardens and parents.

To future/ further research, findings from this study would inevitably be important to researchers especially in the field of reproductive health.
1.7 Definition of Terms

Concepts used in this study were defined so that readers could understand researcher’s interpretation of these key terms.

**Contraceptives:** Refers to agents that when used prevent the occurrence of pregnancy.

**Family planning:** Implies the use of contraceptives to plan the size of a family with respect to number of children to have and when to have them.

**Modern contraceptives:** Contraceptives that are based on scientific knowledge of the process of conception

**Traditional contraceptives:** Contraceptive methods which are prescribed or supplied by traditional healers or methods used traditionally in specific cultures without any prescription.

**Unmet contraceptive need:** Refers to the proportion of women who are sexually active and are not willing to get pregnant but are not using any modern contraceptives method.

**Reproductive Health:** is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive processes, functions and system at all stages of life. It implies that people are able to have responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (World Health Organization, 2012).

**Knowledge:** is defined as facts, information and skills acquired by a person through experiences or education, the theoretical or practical understanding of a subject (Oxford University, 2011).

**Attitude:**- Oxford dictionary defines attitudes as “a settled way of thinking or feeling about something” (Oxford University, 2011). In this study attitudes are opinions and feelings of respondents on contraceptive use

**Choice:** An act of selecting or making a decision when faced with two or more possibilities (Oxford University, 2011).

**Choice of contraceptives:** From the above definition of choice , choice for contraceptives means is making decision on what contraceptive method, a couple uses.
1.8 Theoretical framework of choice of contraceptive use among female students

This study adopts the rational choice theory, also known as choice theory or rational action theory. Rational choice theory is a framework for understanding and often formally modeling social and economic behavior (Blume and Easley, 2008). Rationality (here equated with "wanting more rather than less of a good") is widely used as an assumption of the behavior of individuals in human decision-making. The basic idea of rational choice theory is that patterns of behavior in societies reflect the choices made by individuals as they try to maximize their benefits and minimize their costs. In other words, people make decisions about how they should act by comparing the costs and benefits of different courses of action. As a result, patterns of behavior will develop within the society that result from those choices (Allingham, 2002). The idea of rational choice, where people compare the costs and benefits of certain actions, is easy to see in economic theory. In general, according to this theory, people choose the object that provides the greatest reward at the lowest cost. The theory assumes among others that an individual has full information about exactly what will occur due to any choice made. An individual has the cognitive ability and time to weigh every choice against every other choice. This theory emphasizes making most desirable choices based on preferences sought from the various alternatives (Arrow, 1989).

In reference to current study, it was envisaged that female students in hostels around Makerere University who use contraceptive base on various factors such as side effects, cost, ease to use, the health histories or rather they are influenced by beliefs or persuasions in their religions, cultural background, relationships or perceptions in choose what method to use. For instance a female student of low income status was more likely to choose a very cheap contraception method like natural methods or not completely avoiding using any and the reverse can be true.

The major weakness with this theory however that is the practitioners of strict rational choice theory never investigate the origins, nature, or validity of human motivations (why we want what we want). “That is, they do not examine the biological, psychological, and sociological roots that make people see the benefits encouraging them to act the way they act. Instead, they only focus on the costs of doing so (Foley, 1998). As regards this study, it was assumed that females’ choice of a contraceptive method and source can be determined by the costs of those contraceptives and costs to the sources as well as non-monetary factors such as physical and
psychological side effects like causes barrenness and diseases like cancer or efficacy or ineffectiveness associated by a particular contraceptive.
2.0 Introduction
This chapter presents a review of literature on study variables identified in the preceding chapter. Special attention was paid to contraceptive use utilization, choice, factors for choice and barriers in Africa and, in particular, sub-Saharan Africa and few studies done in Uganda.

2.1 Pattern of Contraceptive use among young people
Recent African studies have shown that young people are becoming increasingly active sexually at early age. In Kenya for example, 62% of never married male students age 11 to 17 years and 30% of females had already had sexual intercourse. The median age at first intercourse was 14 for males and 17 for females (Tenkorang & Maticka-Tyndale, 2008). In South Africa a national survey of contraceptive use and pregnancy among women age 15-25 years old showed that 67.9% reported ever having had sex. At age 24 years over two thirds of young South African women are sexually active and 50 percent have been pregnant, yet only half have ever used contraceptives. The high level of sexual activity and unprotected sex are placing these young

A multinational study conducted in four Sub-Saharan African nations shows divergent to what might be generally thought, very young adolescents in these four SSA countries are not all sexually naïve. Almost one-third of 12–14 year old girls and boys in Uganda and boys in Malawi have either experienced some form of intimate sexual activity such as sexual intercourse, kissing, fondling or they have had a boyfriend or girlfriend. This proportion is much lower in Burkina Faso and Ghana, but even in these two countries about 1 in 10 very young adolescents have had some sort of intimate sexual activity, ranging between 7–12% (Bankole et al., 2007). A variety of safe and effective contraceptives are available and efforts are made to increase availability and access to them. In spite of this unintended pregnancy remains a considerable social and public problem (Adewole et al, 2002). Lack of adequate knowledge and awareness has been found to be associated with lack of contraceptive use among young women. Its use has been found to be associated with having previously been pregnant, meaning it is only after a pregnancy that young women are educated about and subsequently offered contraceptives services (MacPhail et al, 2007).
The use of modern contraceptive methods among adolescents in some communities has been found to be low. Only 30.4% of sexually active adolescents were found in a study in Nigeria to be using any form of modern methods and only 6.2 percent use condom. Many of the adolescents reported that they relied on traditional methods such as periodic abstinence and coitus interruption (Okpani & Okpani, 2000). In spite of significant risk of unwanted pregnancy and induced abortion the practice of contraceptives was found to be very low among young female undergraduates in Ethiopia (Tamire & Enqueselassie, 2007).

Comprehensive sex education is absent and contraceptive use remains low among adolescents and young women. Sexually transmitted diseases often occur while the age of sexual initiation is progressively reducing, mean age as early as 15 years has been found in some communities resulting in high pregnancy and abortion rates (Okpani & Okpani, 2000). Many young women do not feel comfortable discussing sexual issues with parents or other key adults with whom they can talk about their reproductive health concerns (Whitaker et al. 1999). Limited discussion on sexual matters with the adolescents usually leads to little knowledge on safer sexual practices like use of contraceptives (Karim et al, 2003).

Although demographic factors may shape a young woman’s desire to make use of a particular choice of contraceptives (for example, students may have more modern attitudes towards health care), socio-economic status of an individual and her household determines her economic ability to do so (Magadi & Curtis, 2003). In terms of socio-economic factors, the determinants of reproductive health-service use have been found to be most consistent with a woman’s educational attainment (Magadi et al., 2000).

Griffiths and Stephenson (2001) in a study on contraceptive use among women in India found that women who were more attached to their culture rarely sought health services including use of contraceptives. Indeed earlier studies such as Goodburn et al (1995) note that in many cultures, the use of reproductive health services is an alien concept, because services are perceived as existing solely for curative purposes.
On the other hand, a woman’s previous exposure to health care services has been shown to be a strong predictor of her propensity to make use of available reproductive health services (DeGraff et al., 1997). Bloom et al. (1999) found that contact with health care professionals during pregnancy leads to an increased likelihood of postpartum contraceptive use. A woman’s positive previous experience with health care professionals can instill confidence in and familiarity with care services, so that she may be more likely to use reproductive health services on future occasions. Interest has grown in examining community influences on individual health outcomes so as to place and characterize health care seeking behavior of the community, including levels of economic development and the community’s health care infrastructure (Magadi et al., 2000; and Stephenson & Tsui, 2002). A community has the potential to influence the health of an individual in several ways. Community attitudes and practices relating to health influence individual health care decision strongly (Rutenberg & Watkins, 1997). Clearly, the level of a community’s economic development can influence health directly through the association between poverty, deprivation and poor health and indirectly through access to health care services and social support systems (Diex-Roux, 1998).

Economic development is positively related to health outcomes as a result of its relationship to increased female decision making power, through the increased likelihood of female labour force participation and through positive attitudes towards the use of health care services (Belmonte et al., 2000). There was however dearth knowledge on the dimension of household influences on the use of sexual and reproductive health services. This was crucial especially for young women who were still in the care of parents.

Some pregnant adolescents have attributed their pregnancy to lack of knowledge of contraceptives and how to access them (Garenne et al, 2000). While other authors have suggested that contraceptive education programmes should reach out to both men and women and provide accurate information on the risks of pregnancy, the benefits of birth spacing, and the safety and possible side effects of contraception, and encourage positive attitudes toward family planning (WHO, 2008). Lack of awareness and poor knowledge of contraceptives methods has been found to be common among young women seeking for abortion. And that it was necessary to ensure dissemination of correct and appropriate information to young women about contraceptives. The main sources of information for young women about contraceptives
are friends, radio and nurses (Oye-Adeniran, et al., 2006) where clients of family planning services have prior counseling about side effect of methods of chosen help to counter side effects. The level of awareness of available contraceptives has been found to be high in some communities but good knowledge of different contraceptive methods was very low (Onwuzurike & Uzochukwu, 2001). Therefore there was need for women to receive information about contraception and promote women’s right to control their reproductive health, generate awareness and dispel myths about contraceptives (Shoveller et al, 2007).

A study among four nations in Sub Saharan Africa: Uganda, Burkina Faso, Ghana and Malawi showed that awareness of contraceptive methods was generally high among young adolescents. With the exception of Burkinabé males and females and Malawian females, at least 8 in 10 young female and male adolescents had heard of at least one contraceptive method. In Burkina Faso, Malawi, and Uganda more males reported awareness of contraceptives than their female counterparts. Accurate knowledge of emergency contraception among young people on contraceptive method has been found to be low and that only few have accurate and detailed information regarding emergency contraception. Many who report familiarity with emergency contraceptive were found to be having misinformation and very few knew the correct timing of use. Lack of detail and accurate information on contraceptive was found to have resulted in reluctance to adopt family planning method as some would want to know its side effects and contra indications (Tamire & Enqueselassie, 2007). Among university students in Ethiopia it was only about 44 percent who have ever heard about emergency contraceptives, however below 10 percent of them have the correct knowledge of when to use it (Tamire & Enqueselassie, 2007).

2.2 Choice of modern contraceptives by adolescent girls

Studies show different factors determining contraceptive choices, and there are marked differences between countries. Age and stage of life is a major determinant of contraceptive choice (Scott & Glasier, 2006). Although contraceptive use has increased among young women in recent years, consistent reliance on effective form of contraception remains low. Reasons for inconsistent contraceptive use are not easily characterized, as they are as diverse as they are complex (Davies, 2006). Even though continuous correct use of contraceptives during all periods of risk can greatly reduce the likelihood of unintended pregnancy, many women have
difficulty adhering to such a regimen over a long period. A better understanding of why young women have difficulty using contraceptives continuously even when they do not want to become pregnant will strengthen programs and policies that are designed to reduce unintended pregnancy. Women’s attitude towards pregnancy prevention, service providers, experience with contraceptive methods, socioeconomic and sexual partners characteristics are some factors that affect use of contraceptives (Frost et al, 2007).

Major factors which influenced the choice of contraceptives for users were convenience and effectiveness, so where users are offered a range of commodities that effective and convenient usage will likely increase. 88.5% were found to be satisfied with current contraceptive methods (Oye-Adeniran et al, 2006). Most women at family planning clinics had been found to have decided already which contraceptive methods they want and that failure to obtain that method was probably the biggest deterrent to adoption and sustained use (Cleland, 2006).

Addition of a new method has been found to attract new users and raises overall frequency of use (Ross et al, 2001). Rising adherence and continuation rate difficulty are not different from other forms of prolonged medication (Osterberg & Blaschke, 2005). Despite being sexually active, majority of adolescents do not always use methods like condom or use them inconsistently (Ohene & Akoto, 2008). Contraceptive behavior was studied in a national household survey among Greek females, ages 16-45 years, in 2001. The sample of 797 was representative of the Greek female population. The most common current contraceptive method was the condom, at the rate of 33.9 %, followed by withdrawal at 28.8 %, OC at 4.8% and IUD at 3.6%. Using Condoms have a number of benefits including ease and convenience to use, preventing STIs and unwanted pregnancies, being sexy, having no side effects and being cheap (Planned Parenthood Federation of America Inc. (2017). Unfortunately the above results might not be relevant in Uganda because all the studies were not carried in among Ugandans nor females students of age bracket 15-24 years as intended in this study. Therefore this current study could reveal more accurate results on contraceptives use among female students aged 15-24 years than the above results.

Partners’ communication influences contraceptive decisions. Young women who communicate less frequently with their sex partners about prevention issues are less likely to use
contraceptive consistently. Culture that discourages openness and honest discussion about contraceptive use has been found to limit access to accurate, protective information and therefore increase risk taking by young women (Davies et al, 2006). There was need to involve male partners and work on developing communication skill of a young adult in sexual relationship as a solution to limited contraceptive use (MacPhail, 2007). Ambivalence feeling towards pregnancy interferes with effective contraception and that young women require motivation. Indeed female partners usually resort to use of secrecy promoting methods like pills or injections in instances particularly where men tend to oppose use of contraceptives (Cover et al., 2013).

Reports from developed countries show that the use of emergency contraceptives/EC varies from place to place and the knowledge on correct use varies from 83% in Sweden to less than 60% in developing countries (Altankhuyagiin et al., 2007). For Wegene et al’s study (2007), it was found out that the lowest percentages (10%) was observed at the Addis Ababa University and Unity University College, Ethiopia on the knowledge, attitudes, and practices affecting the use of EC. Findings from several studies indicate that even women, who indicate that they know how to use EC, often report they have never used it (Larssson et al, 2006).

Considerable evidence was also found in existing literature that broadening the choice of contraceptive methods increases overall contraceptive prevalence (Magadi & Curtis, 2003). The provision of a wide range of contraceptive methods increases the opportunity for individuals to obtain a method that suits their needs. Ross et al. (2001) confirm that prevalence of contraceptive use is highest in countries where access to a wide range of methods is uniformly high. However, studies of contraceptive use and contraceptive methods choice among young women in countries in sub-Saharan Africa are few, probably because of the generally low contraceptive prevalence in the region. Researchers have primarily focused on contraceptive use and method choice among married women, leaving the vulnerable unmarried young women unattended. A growing need, though, exists for an examination of contraceptive use and methods choice patterns among young women. In addition, improving contraceptive access and use is vital to overcome the challenge of unintended pregnancy among unmarried young women.
Cost of contraceptives has been shown to influence the choice of source from which care is sought. In a study of the use of antenatal care in India, Griffiths and Stephenson (2001) show that although women perceive private services to offer greater quality care, the cost of such services often makes them unaffordable. Socio-economic indicators such as urban residence and household living conditions (Magadi et al., 2000) and employment status have also proven to be strong predictors of a woman’s likelihood of using reproductive health services.

Literature also showed that despite being sexually active the majority of adolescents and young women do not always use condom. Either because they don’t know where to obtain them or how to negotiate for their use (Ohene & Akoto 2008) and this bring out the importance of addressing the unmet need of young adults by providing access to basic reproductive health information and youth friendly services that would enable them to take control of reproductive health decisions (Senbeto et al, 2005). Access to contraceptive services including emergency contraception would prevent consequences of unprotected sex such as unintended pregnancy and unsafe abortion. Pregnant young women do not commonly receive social support and are usually sent out of schools which often compromise their opportunity for education and future (Tamire & Enqueselassie, 2007).

2.3 Constraints to access and use of contraceptives among young women

Some identified barriers to effective contraceptives are lack of concern over the possibility of pregnancy, perceived invulnerability to pregnancy, forgetfulness (Kaufman et al, 2003), institutional policy on contraceptives, socio-cultural norms, poor access regarding location (Shoveller et al 2007) and low socioeconomic status (Frost et al, 2007).

Davies et al (2006) reports that male partner resistance, fear of male partner’s rejection, discomfort buying or carrying contraceptive are barriers that are likely to persist over time despite continuous exposure and experience, unless specific skills are acquired. Fear of losing a sexual partner for insisting on use of condom has been shown to be a barrier to condom negotiation among female adolescents, especially when communication and assertive skills were inadequate (Davies et al, 2006).
Further, fear of side effects, poor knowledge of available methods and individual religion are major barriers to contraceptive use. Oral pills that hormonal for instance are associated with side effects such as nausea, weight gain, sore or swollen breasts, small amount of blood, or spotting, between periods, lighter periods, mood changes and in severe cases cause Abdominal pain (stomach pain), chest pain, severe headaches, eye problems (blurred vision) and swelling and/or aching in the legs and thighs (Monson and Schoenstadt, 2010). On the other hand, barriers like condoms and diaphragms are rejected due to allergic effects or discomfort associated during especially sexual intercourse (Monson and Schoenstadt, 2010). Indeed a majority of female students might not bear the burden of severe contraceptives side effects in that they would affect their concentration on studies. Hence were likely to avoid any contraceptives that were disturbing to their health. On the other hand, the Catholic Church disapproves the use of modern contraceptives and it has been the major reason for non-contraceptive use among the predominantly catholic South Eastern region of Nigeria (Oye-Adeniran et al, 2006).

In studies done in New Zealand Breheny and Stephen (2007) found that few pregnant adolescents attributed their pregnancies to lack of knowledge of contraceptives or difficulty obtaining them, but rather to positive or ambivalent feelings about pregnancy. They noted that lack of concern over the possibility of pregnancy has been found to be a common barrier to effective contraceptive use. Many young mothers have failed to access contraceptive because they did not care about the possibility of becoming pregnant. Indifference also influence their use of contraceptive even when it is available, removing their motivation to use it effectively. Perceived low risk to pregnancy has also acted as a barrier to access and use of contraceptives. And this is a common theme among young women who had been using contraceptive irregularly and those who had not used contraceptives at all (Breheny & Stephen, 2007). It was however envisaged that female students in this study, more so being with higher education are much more aware of their body biology and the risk for pregnancy without use of contraceptives.

It is important in the current study to focus on barriers to the use of contraceptives young women constantly face barriers to effective contraceptive use. Many had used a range of
strategies to overcome barriers to effective contraception without success and some pregnant adolescents have attributed their pregnancy to difficulty in obtaining contraceptives (Garenne et al, 2000). In spite of growing efforts and successes in increasing availability and access to these contraceptives, unintended pregnancy remains a considerable social and public health concern, an indication that contraceptives were not properly used.

However, some authors like Muia et al (2002) offered some solutions such as using adult support, concrete sex education that was personalized to young women’s experience and target contraceptive messages to young women would encourage a broad based understanding of preventing unplanned pregnancy as the responsibility of the community.

Other barriers are lack of knowledge of where to get the contraceptives and not discussing family planning with partner have been found to be barriers to family planning and risk for sexually transmitted infection among young women (Ohene and Akoto, 2008). Inaccessibility to contraceptives was found to be the major cause of unwanted pregnancy and subsequent unsafe abortion in Ethiopia (Senbeto et al, 2005). In many countries access to family planning methods was initially restricted to health facilities, under strict control of medical practitioner, eligibility criteria and constraints such as written consent of husband, proof of marital status, age or parity, excessive revisit schedule and insistence that only menstruating women be allowed to start contraception (Campbell et al, 2006). The success of family planning programmes has been linked to dismantling of administrative and medical barriers that impede quick, convenient and appropriate access to methods (Cleland et al, 2006). Static health facilities continue to be the dominant source of family planning and geographical access is considered a possible major constraint on uptake of services.

Cleland et al (2006) also argued that in most societies women are found to be prepared to travel long distance for advice and contraceptives, especially for methods which require infrequent or no further visits. He added that poor quality of service is a major important constraint to effective access to family planning programme. Wonder was whether female students in Kampala have to travel long distance in order to get contraceptives. If this was not the case, then what were the other factors influencing their choices and decisions to use contraceptives. Some aspects of these were continuity of supplies, presence and competence of staff, treating
patient with dignity and reasonably privacy. The above studies focused at normal population including those out of school. This study focused on a completely different population; of female students who more likely to be knowledgeable on health matters including use of contraceptives and yet in urban setting and some of them in mixed hostels, a lifestyle that could increase their sexual activity hence more need for use contraceptives, experiences and knowledge surrounding their use.

Gaps in literature

- Earlier studies focused at normal population including those out of school and married women. The married women have legitimacy to have family planning, yet young girls are morally not expected to indulge into sexual behaviors hence use of family planning.

- Literature discusses factors for access, however it doesn’t discuss choice, how do the young girls choose what they use and what not to use. Thus the study focused on closing this gap.
CHAPTER THREE
METHODOLOGY

3.0 Introduction
This section describes the research methodology, delimitation of the study, geographical area, research design, target population, sampling method, data collection and analysis, validity and reliability of the study and ethical considerations.

3.1 Research Design
The study employed a cross-sectional design which employed both quantitative and qualitative components. Casual design investigated the cause and effect relationship between two or more variables. A cross sectional survey allowed data to be collected on spot from the study subjects and this made it time saving, quite cheaper as compared to longitudinal studies where data is repeatedly collected in a given study (Olen and Marie, 2004). In this case of this study, pattern of contraceptive use and the associated influencing factors among female students in hostels around Makerere University hostels were studied.

3.2 Study area
The study was conducted among female student hostels around Makerere University. Makerere University was surrounded by about thirty five hostels occupied by girls and include the following:- Akamwesi hostel, Mulago View Girls’ hostel, Paradise Hostel, Kasamba hostel, Main road hostel, Breathed Girls hostel. Sir Pinto girls’ hostel, Fiona hostel, JB girls’ hostel, Fatuma hostel, Douglas villa hostel, Nakiyingi hostel, Cheds hostel, Paramount, Mariam hostel, WatAl-Shadai A and B hostels and Bascon hostel among others. These hostels were in a range of as near as 5 metres to as far as 1.5 kilometers from Makerere University main campus’ boundary. For hostels that were mixed, students of the same sex occupy specific rooms or floors, that is to say, only female students or only male students occupy particular rooms or floors in the hostels (Makerere University, Dean of Students' Department, 2007).

3.3 Study Population
The study population was the female students between 18 and 24 years residing in hostels around Makerere University and in higher institutions of learning.
3.4 Sampling size

The sample size was calculated using Kish’s formula below:

\[ n = \frac{Z^2 \cdot P \cdot Q}{d^2} \]

Where:
- \( n \) = sample size
- \( d \) = Precision of the study was set at ±5%
- \( z \) = Standard normal deviation corresponding to the 95% confidence interval; which is 1.96
- \( p \) = expected proportion of population practicing FP = 20% =0.2 (MoH, 2006)
- \( q \) = 1 - \( p \) = 1-0.2 = 0.8

Given that \( z = 1.96 \), \( p = 0.67 \), \( q = 0.33 \) & \( d = 0.5 \)

Therefore, from the above sample size is:

\[ n = \frac{1.96^2 \times 0.2 \times 0.8}{0.05 \times 0.05} \]
\[ n = 0.614656/0.0025 = 246 \]


Final sample \( N = \frac{n}{1-NRR} \)
\[ = \frac{246}{1-0.062} \]
\[ = \frac{246}{0.938} \]
\[ N = 262 \]

Hence the calculated sample size was 262 but only 236 were interviewed giving a response rate of 90% (236/262*100).

3.5 Sampling Procedure

A list of all hostels around Makerere University and occupied by female students was compiled and updated. There were about 52 hostels around Makerere University, of which 19 were only girls’ hostels (Makerere University, Dean of Students' Department, 2007). It was from these 19 only girls’ hostels that study participants were sampled. Sampling only girls’ hostels eased the
formulation of sampling list of names for girls that were sampled. It also eased the process of replacement where necessary. The capacities of the hostels depended on their sizes and ranged from as low as 30 to nearly 200 occupants. The average capacity for a hostel was 60 occupants (Makerere University, Dean of Students’ Department, 2007).

Of the 19 hostels, each was given a number from 1 to 19. For good representation, half the number of the hostels, i.e. (1/2 of 19) was sampled, this equivalent to 10 hostels. A table of 10 random numbers between 1 and 19 representing the hostels were sampled and generated by Random Number Generator. A Random Number Generator is a computer programme that generates a table of random numbers of your choice (Stat Trek, 2012). Systematic sampling was then used to select students from a list of girls in each of the 10 selected hostels. Sampling interval was calculated for each selected hostel. With 262 students, about 24 students were to be sampled from each of the 10 hostels.

3.6 Inclusion and exclusion Criteria

**Inclusion criteria:** Female students aged between 18 years and above, resident in the selected hostels and willing to participate in the study were recruited in the study. Sampled students who refused were replaced by the next immediate on the list.  

**Exclusion criteria:** Female students who were sampled and visited or called two times for fall-backs without being found or accessed were excluded and replaced by immediate names on the list. Female students who were unwilling to respond or sick were excluded from the study.

3.7 Data collection methods

Data collection was conducted in November 2014 from female students residing in girls’ hostels around Makerere University. Both quantitative and qualitative data collection methods were used. Quantitative data collection method involved use of a structured questionnaires. Key informant interviews were conducted to complement on quantitative findings.

3.7.1 Structured questionnaire

A structured questionnaire was used to collect quantitative data. This was administered to the 236 sampled female students as determined by the sample. The questionnaire was used to collect
data on: Background and demographic characteristics of the female students, pattern of use and choice of contraceptives, influencing factors in choice of contraceptives, moderating factors and constraints in choice of contraceptives. The questions were both close and open ended. The questionnaire was administered in by the research assistants that were recruited and trained, supervised by principal investigator.

3.7.2 Key informant Interviews

Of the 10 planned key informants, nine were interviewed; three practitioners in private health facilities; two FP practitioners from government health facilities (Mulago National Referral hospital and Kawala HCIII), two from Makerere University hospital and one official in NGOs working on Family planning (one from an NGO) around Makerere University and one staff from Makerere University guidance and counseling centre. The key informants were interviewed face to face for in-depth interviews using an interview guide. These interviews were conducted by the principal investigator herself, who took notes for the interview responses. See table 1 for summary of table of respondents. One key from government facility was omitted because of saturation of responses from these facilities.

Table 1: A summary of the study participants

<table>
<thead>
<tr>
<th>Category of study participants</th>
<th>Units</th>
<th>Total of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Female students</td>
<td>Girls Hostels</td>
<td>236</td>
</tr>
<tr>
<td>2 Key informants</td>
<td>Private health facilities</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Government health facilities</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>NGOs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Staff from Makerere University hospital</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Staff from Makerere University counseling centre</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>245</td>
</tr>
</tbody>
</table>
3.8 Data collection Procedure

Four female data collectors were trained by the researcher prior to data collection. Female data collectors were found suitable because it was easier for female students to open up any private information to fellow women than it would be if the data collectors were males. The principal investigator (PI) obtained an introductory letter from the department of graduate studies and research, which was attached to letters of permission to hostel custodians and health facility and NGO administrators for permission. Study participants were briefed about the study by the data collectors or principal investigator and then requested for consent to participate in the study. Only study participants who consented by signing on the consent forms were considered for interview. Questionnaires were administered to respondents face to face at the selected hostels by the researcher and the research assistants daily from morning to evening. The four data collectors and the principal investigator always collected data from each selected hostel as a group except to fall-backs. This ensured that participants from the selected hostels were systematically interviewed once and minimized incidents of repeat visits or over staying at any hostel for data collection. Interviews with KIs were made on appointments.

3.9 Study variables and their measurement

In this study, the pattern of choice of contraceptives constituted the dependent variable and categorized them at two levels as; use or non-use and short term or long term contraceptive use. Decision making on use of contraceptive was an independent variable and was influenced by socio-demographic characteristics including age (less than 20, 20-24 or 25-29); religion (Muslim, Catholic, protestant, SDA, Born again and others), locality of origin (urban or rural), education level (diploma or degree course), nature of sexual relationship (In or not in a sexual relationship within the last four months), and social-economic status (how often parents/guardians send her assistance in two months); sources of contraceptives (private or government health facilities) and student’s health history (has ill health or has good health) and student’s perception on use contraceptives (Good or poor).

The moderating factors considered as constraints accessibility constraints like unavailability, cost, lack of variety, unfriendliness and long distances; psychological constraints such as lack of concern over the possibility of pregnancy, forgetfulness and discomfort in buying or carrying
contraceptives; social constraints like lack of knowledge of available methods and religion and fear of side effects.

3.10 Validity and Reliability
The design of the instruments, that is, structured questionnaire and an interview guide were guided by findings from the literature. The content validity of the questionnaire was ensured by using standardized reproductive health tools as a guide while preparing the questionnaire and through consultation with my supervisor. The tools were reviewed by my supervisor and later given to a reproductive health consultant, an expert in the field of family planning services and research for further guidance. The tools were pre-tested and refined according to feedback from those who participated in the pre-testing. Conducting the pre-testing of the tools helped in making the necessary corrections and solving the emerging problems to improve the data collection process. Careful phrasing of each question to avoid ambiguity was ensured for reliability of the tools. Tools were prepared using easy to understand words.

3.11 Data management and analysis
3.11.1 Quantitative Data Management
The questionnaire forms were properly filled by serial number and entry was done by the principal investigator using Statistical Package for Social Scientists (SPSS) version 17.0. Data was cleaned, checked for inconsistencies and missed values by running preliminary frequencies. Backup data was made by saving the data set on other personal computer, two flash disks and attaching the data set to my e-mail.

3.11.2 Quantitative Data analysis
Univariate analysis was done to generate frequencies and percentages for background information such as age, religion, locality of origin (urban or rural), education level, nature of sexual relationship and social-economic status related to the study participants. Univariate analysis was also used to indicate the sources of contraceptives, predictors and pattern of contraceptive use and constraints to pattern of contraceptive use.
3.11.3 Qualitative Data Analysis

Notes written during the interview with the key informants were type set, edited and transcripts were ready for analysis and storage. Thematic content analysis was done for the qualitative data generated. Transcripts from KIs were repeatedly read while noting patterns, developing codes, themes and sub-themes. Matrices were made along themes and data sources. The extracted themes and noted patterns were used in triangulating the quantitative findings based on the study objectives.

3.12 Validity and Reliability

The design of the instruments, that is, structured questionnaire and an interview guide were guided by findings from the literature. The content validity of the questionnaire was ensured by using standardized reproductive health tools as a guide while preparing the questionnaire and through consultation with my supervisor. The tools were reviewed by my supervisor and later given to a reproductive health consultant, an expert in the field of family planning services and research for further guidance. The tools were pre-tested and refined according to feedback from those who participated in the pre-testing. Conducting the pre-testing of the tools helped in making the necessary corrections and solving the emerging problems to improve the data collection process. Careful phrasing of each question to avoid ambiguity was ensured for reliability of the tools. Tools were prepared using easy to understand words.

3.13 Limitations of the Study

First, some students concealed certain truth especially on use of contraceptives or their sexual relationships. But this was counteracted by assuring students confidentiality of the information and building a very good rapport before commencing the interview. To some extent, some of the sampled students might hesitate to participate in the study. This was counteracted by fully explaining the purpose of the study to the hostel administrators and students and assuring students of confidentiality.

3.14 Ethical Considerations

Ethics were duly observed in the conduct of this study. Thus ethics of autonomy, included confidentiality, anonymity, privacy and dignity of study participants were observed and
participation in the study was after voluntary consent. All participants were informed about the objectives of the study and that this was mainly an academic research with no direct benefits. Informants were also informed of their rights to participate or not. The study proposal was approved by the higher degrees committees of SWSA and School of Social Sciences at Makerere University. While at each sampled hostel, permission was sought from respective hostel administrators or custodians. Each sampled student was requested for a written informed consent. Interviews were conducted in environments that would allow privacy like in corners of reading rooms, outside of the hostel, in hostel gardens or neighboring restaurants. Confidentiality and anonymity was assured to the respondents and ensured throughout data collection, analysis and reporting phases.

3.14.1 Autonomy of participants
All participants were approached with respect and honor. Their participation in the study was sought by signing on consent form. No individual was coerced, induced or deceived to participate in the study. The right of individual not to participate or to withdraw from participation was respected.

3.14.2 Confidentiality and Anonymity
Participant in the study were assured of the protection of their identity. Only initial and signature of participant appeared on the consent form. During data entry the consent form was separated from the questionnaire and the questionnaire was just given an ID number which was an order in which the questionnaire was entered into the SPSS data base. Confidentiality of information given by study participants was assured. No information will be released either in written or verbal form. After data collection, data was accessed only by the data entrant and PI. When it came to disclosure of results;
The results were disseminated in the format of a research report. This report hasn’t disclosed to the readers any secrets or weakness of the participant or hostels where the study was conducted. A copy of the report was made available to Makerere University administration and other institutions from where participating students are studying from the schools where this study is conducted.
3.14.3 Privacy and dignity

All participants had the right not to answer any part of the questionnaire if they consider it will have an adverse effect on them. Privacy and dignity was ensured in this study, data collectors or the PI visited the study participants in their hostels. Each study respondent was interviewed by one data collector and in quite place, free from interruption by the rest of the hostel members. Such a place was a participant’s room, in the reading room or on the verandah of the hostel.
CHAPTER FOUR
FINDINGS

4.0 Introduction
This chapter presents the study findings based on the objectives of the study. The study covered a total of 245 who included 236 female university students and nine key informants who included three from private health facilities, two from government health facilities, one from NGO’s, two from Makerere University hospital and one staff from Makerere University Guidance and Counselling Centre.

4.1 Social demographic characteristics
As indicated below, table 1 shows the background information on students who responded.

Table 2: Background information and Social demographic characteristics

<table>
<thead>
<tr>
<th>Details</th>
<th>Total number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 20 years</td>
<td>19</td>
<td>8%</td>
</tr>
<tr>
<td>20-24</td>
<td>206</td>
<td>87%</td>
</tr>
<tr>
<td>25-29</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>83</td>
<td>35%</td>
</tr>
<tr>
<td>Protestants</td>
<td>63</td>
<td>27%</td>
</tr>
<tr>
<td>Muslims</td>
<td>40</td>
<td>17%</td>
</tr>
<tr>
<td>Seventh day Adventist</td>
<td>18</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Programme</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree</td>
<td>234</td>
<td>99%</td>
</tr>
<tr>
<td>Diploma</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Original Locality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>57</td>
<td>24%</td>
</tr>
<tr>
<td>Urban</td>
<td>179</td>
<td>76%</td>
</tr>
</tbody>
</table>

Source: Field data, November 2014
Age
From table 2 above, the majority (87%) of the students were between 20 -24 years. Only 4% were above 25. This was further confirmed by KIs in both government and private clinics as one of them said:

“Given the programmatic design, mission and vision of the youth corner at RHU, we are more geared into serving diverse young persons. They are usually between 15 -24 years. Most of them fall between the ranges of 15years to 24 years” (An officer in one of the Non –Government Organisation working on reproductive and sexual health and rights around Makerere University).

Religion
The biggest percentage (32%) of female students residing around Makerere University hostels were Catholics, followed by Protestants (27%) and Moslems making (17%). Other religions include seventh day Adventists.

Home Residence
The study explored the original residence of students prior to joining the hostels. The majority of the students reported to have come from urban areas by a percentage of 76% and 24% are said to have come from rural areas.

4.2 Sexual practices of female students residing in hostels around Kampala
One’s sexual behavior is very important in determining the use for contraceptives. Individuals who are abstaining from sex are more likely to refrain from using any contraceptives than their counter who are sexually active. Students were asked about their sexual behaviours and the results are presented in table 3a.
Table 3a: Sexual behaviors of students residing in hostels around Makerere University Hospital

<table>
<thead>
<tr>
<th>Currently in Sexual relationship</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>147</td>
<td>62.3</td>
</tr>
<tr>
<td>No</td>
<td>89</td>
<td>37.7</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Duration of relationship**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 months</td>
<td>15</td>
<td>10.2</td>
</tr>
<tr>
<td>7-12 months</td>
<td>37</td>
<td>25.2</td>
</tr>
<tr>
<td>13-24 months</td>
<td>49</td>
<td>33.3</td>
</tr>
<tr>
<td>25 and above</td>
<td>46</td>
<td>31.2</td>
</tr>
<tr>
<td>Total</td>
<td>147</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Nature of relationship**

<table>
<thead>
<tr>
<th>Nature</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>8</td>
<td>4.6</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>29</td>
<td>16.8</td>
</tr>
<tr>
<td>In a serious courtship</td>
<td>63</td>
<td>36.4</td>
</tr>
<tr>
<td>Just a beginning a relationship</td>
<td>37</td>
<td>21.4</td>
</tr>
<tr>
<td>Friends with benefits</td>
<td>29</td>
<td>16.8</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>173</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Field data, November 2014*

**Status of relationship**

As expected, majority of the females acknowledged being in relationships (62.3%) and just about one third denied to have been having sexual relationships (37.7%). Among those who said to be in a relationship, majority (64.5%) reported to have been in those relationships for more than a year. However, 10% of the students reported recent relations of just 6 months and below. This implies that most females residing in Kampala hostels are sexually active and therefore would require access to contraceptives. Many of the relationships have been fairly long. More than a year is where about 1/3 (31%) are above two years.
Nature of relationship
Students were asked about the nature of sexual relationship that female students at university were involved. This study revealed that the biggest percentage (36.4%) were in a serious courtship, few are married (8%), some are just in a beginning relationship (21.4%) and 16.8% reported to have been in a relationship for just, that is, just having sex with their friends with no strings attached. The others, that is, (4%) said to have been in long distance relationship in which the parties met once in a while. Data from key informants also indicated the majority of the university female students were involved in causal relationship, more so with married men.

4.3 Patterns of use of contraceptives
One of the objectives of the study was to explore the patterns of use of contraceptives among female students residing in hostels. In order to achieve the above objective, the study asked students about awareness and perceptions of the modern contraceptives and if the actually use them. The findings are summarized in the table below:

4.3.1 Awareness of modern contraceptives
Awareness of modern contraceptives is key to one’s choice and use of contraceptives. The study therefore explores the range and nature of the modern family planning methods that university student residing in hostels were aware of and the findings are presented in table 3b below

Table 3b: Nature of contraceptive known

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Condoms</td>
<td>211</td>
<td>89%</td>
</tr>
<tr>
<td>Oral</td>
<td>181</td>
<td>77%</td>
</tr>
<tr>
<td>Injections</td>
<td>150</td>
<td>64%</td>
</tr>
<tr>
<td>Female condoms</td>
<td>112</td>
<td>47%</td>
</tr>
<tr>
<td>Norplants/implants</td>
<td>76</td>
<td>32%</td>
</tr>
<tr>
<td>Intra–uterine</td>
<td>72</td>
<td>31%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>51</td>
<td>22%</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>44</td>
<td>19%</td>
</tr>
<tr>
<td>Nuvaring/vaginal ring</td>
<td>41</td>
<td>17%</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>36</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Field data, November 2014  
NB: More than one response was accepted
From table 3b above, most female university students knew at least one or more modern contraceptive methods but the most commonly known method was the male condom (89%), followed by oral pills (77%), and Injectaplan (64%). Other methods including natural contraceptive methods like using safe days, moon beads, calendar methods were known by (4%) of the respondents. However (14.4%) didn’t know about modern contraceptive methods and the attitude displayed was that they even didn’t want to use any of the methods.

4.2.2 Perceptions about best contraceptives

The study assessed the perceptions of female university students had over the modern contraceptive methods by asking them which ones they would recommend for their male and female friends and results are illustrated in the Table 3c below.

<table>
<thead>
<tr>
<th>Recommended method</th>
<th>To females</th>
<th></th>
<th>To males</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Male condom</td>
<td>74</td>
<td>31.40%</td>
<td>201</td>
<td>95.70%</td>
</tr>
<tr>
<td>Injectables</td>
<td>47</td>
<td>23.30%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Oral pills</td>
<td>37</td>
<td>18.30%</td>
<td>2</td>
<td>0.90%</td>
</tr>
<tr>
<td>Female condoms</td>
<td>21</td>
<td>10.40%</td>
<td>1</td>
<td>0.50%</td>
</tr>
<tr>
<td>Norplant /implants</td>
<td>16</td>
<td>7.90%</td>
<td>2</td>
<td>0.90%</td>
</tr>
<tr>
<td>Iud</td>
<td>15</td>
<td>7.40%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>11</td>
<td>5.40%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Vaginal ring</td>
<td>2</td>
<td>0.90%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>2</td>
<td>0.90%</td>
<td>4</td>
<td>1.90%</td>
</tr>
<tr>
<td>Contraceptive Sponge</td>
<td>1</td>
<td>0.50%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Moon bead</td>
<td>1</td>
<td>0.50%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>202</strong></td>
<td><strong>100%</strong></td>
<td><strong>210</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

*Source: Field data, November 2014*

When the respondents were asked individually about which method of modern contraceptive that they would recommend to a female friend, majority recommended male condoms (74%). Injectable were preferred second (19.3%) and reasons given were that injection was affordable,
convenient to use and more discreet if a female user didn’t want the partner to find out. Oral pills were also recommended and preferred (18.3%). As would be expected, for males, the most highly preferred and recommended methods were the male condoms (95.3%) and vasectomy (1.9%).

4.4 Utilization of modern contraceptives by female students residing in hostels

Hostels around Makerere University are mostly occupied by students at Makerere University (Mak) and other neighbouring institutions like Makerere Institute of Social Development, Makerere Business Institute, Makerere Metropolitan Business and Management Institute and Law Development centre. The majority of these students are youthful and sexually active and yet would they (females) wish not get pregnant when pursuing their academics. Females residing in hostels around Makerere University, main campus were asked about their usage of modern contraceptives, the sources for such contraceptives, reasons for choice of the contraceptive methods and the results are given in subsequent sections.

4.4.1 Use of Modern Contraceptives by female students residing in hostels around Makerere University

Sampled females students aged 18-24 years in the sampled hostels were asked whether they used any contraceptives in the last four months and the results are in figure 1 below.

Figure 1: Pie-chart showing usage of contraceptives among female students in hostels around Makerere University, N=236

Source: Field data, November 2014
From the pie-chart above, more than a half i.e. 134/236 (56.8%) of the female university students residing in hostels around Makerere University acknowledged using a modern contraceptive method for the last four months as illustrated in the figure 2 below;

![Pie chart](chart.png)

**Figure 2:** Pie-chart showing methods commonly used in percentages among female students in hostels around Makerere, N=236

**Source:** Field data, November 2014

The respondents were asked which contraceptives, they used most, and male condoms were the most commonly used modern contraceptive method (39.3%), followed by oral contraceptives at percentage of (32.6%) and injectaplan at (12.6%). Other modern contraceptives as illustrated in the table above are not commonly used by the female university students.

Interviews with key informants, particularly health practitioners at health facilities around Makerere University also confirmed that male condoms were the most used. For instance one of the key informant said:
“Male condoms are freely given at the hospital and students often ask for them. We don’t work weekends but at least we endeavor to live a box of condoms outside, but by the time we come back on Monday for a new week, you find that the boxes have been emptied. (Counselor, Makerere University Hospital)”

**Regularity in use**

Respondents (female students) were asked how regularly they used the contraceptives and results are table 4a below.

<table>
<thead>
<tr>
<th>Regularity of use</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94</td>
<td>63.90%</td>
</tr>
<tr>
<td>No</td>
<td>52</td>
<td>35.40%</td>
</tr>
<tr>
<td>Don’t remember</td>
<td>1</td>
<td>0.70%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Field data, November 2014*

From table 4a above, 63.9% of the students reported to regularly use modern contraceptive methods. Among those with regular use, 22.2% said to use contraceptives whenever they have sexual intercourse while 20% used on a daily basis (20%). A few (2.2%) only used contraceptives when they are not in their safe days (information not in the table 4a).

On the other hand (35.4%) did not regularly adhere or use the modern contraceptive methods i.e. only once in a while and one student didn’t even remember the last time she used a modern contraceptive method though she has ever used.

Across tabulation was done for contraceptive method used and regularity and results are in figure 3 below.
Table 4b: Distribution of respondents on use of different contraceptive methods

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>Yes</th>
<th>No</th>
<th>I don’t remember</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>23</td>
<td>20</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>Injections</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Male condoms</td>
<td>37</td>
<td>16</td>
<td>0</td>
<td>53</td>
</tr>
<tr>
<td>Female condoms</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Intra-uterine-contraceptives</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Norplant/Implants</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nuva ring/vaginal ring</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
<td>41</td>
<td>1</td>
<td>134</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
<th>100.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>25.00%</td>
<td>48.80%</td>
<td>100.00%</td>
<td>32.80%</td>
</tr>
<tr>
<td>Injections</td>
<td>17.40%</td>
<td>2.40%</td>
<td>0.00%</td>
<td>12.70%</td>
</tr>
<tr>
<td>Male condoms</td>
<td>40.20%</td>
<td>39.00%</td>
<td>0.00%</td>
<td>39.60%</td>
</tr>
<tr>
<td>Female condoms</td>
<td>0.00%</td>
<td>2.40%</td>
<td>0.00%</td>
<td>0.70%</td>
</tr>
<tr>
<td>Intra-uterine-contraceptives</td>
<td>7.60%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.20%</td>
</tr>
<tr>
<td>Norplant/Implants</td>
<td>6.50%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td>0.00%</td>
<td>2.40%</td>
<td>0.00%</td>
<td>0.70%</td>
</tr>
<tr>
<td>Nuva ring/vaginal ring</td>
<td>2.20%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Other</td>
<td>1.10%</td>
<td>4.90%</td>
<td>0.00%</td>
<td>2.20%</td>
</tr>
</tbody>
</table>
From figure 3 above, male condoms were most regularly used (40.2%) and followed by oral pills (25.3%).

4.5 Choice of contraceptives
The core objective of the study was to explore the process of making a decision in choice of a particular method of family planning or modern contraceptive by female hostel students and reasons for basis of choice.

4.5.1 Reasons behind the choice of contraceptives
All female university students utilizing modern contraceptives were asked the reason behind the choice of what contraceptive they use and below are the results in figure 4.
Convenience in use was the most cardinal factor (40%) when choosing a contraceptive method. As reported in the previous section, the male condom was most commonly reported contraceptive used. This is well associated with the Information from key informants which indicated that condoms were the most convenient method as one of the key informants said:

One has to take pills on a daily basis yet for condoms, one uses them according to convenience thus end up choosing one method over the other. (Nurses at Makerere University Hospital).

Next to the condom were the Emergency pills, also recognized by the female students as convenient for use to be convenient for use as one of the students said:

Emergency pills are taken at the time when they need to be taken hence being convenient for the relationships they are in. (Female students).
The other prevalent reasons for choice of a contraceptive method were: no/less side effects (28%), affordability (26%), and availability (25%).

In addition to ease in use was the factor of less side effects (28%), affordability (26%) and availability (25%).

The above attributes were too applicable to mostly to the condoms. In most health facilities they are issued free of charge and even if a student is buy them, at least the cheapest goes as low as 500 Ug shillings. Cost i.e. Some services are offered free of charge in some health facilities like Makerere university hospital, all short term contraceptive methods which it provides are free of charge i.e. condoms, pills, injectaplan etc. Same applies to Reproductive health Uganda at the youth corner, condoms are given at free cost. Hence female university students, end up deciding to settle for some methods over the others.

From the statistics above, the second reason that influences female university students about choice of a particular method is side effects (28%). The side effects associated with some modern contraceptive methods influence choice of a method. For instance, many students complained of nausea, weight gain, loss of sexual appetite, dryness among ladies, weight loss, continuous bleeding (particularly injectaplan) and some users of contraceptives fail to get their periods over a long time. The effect of side effects in influencing choice of contraceptive method was further appreciated by some key informants.

*Pilplan causes change in the menstrual cycle thus discouraging many to continue and end up opting for some other methods over the others”* (Private clinic doctor)

Some female university students choose a particular method because of peer influence and bandwagon effect. When they see a colleague using a particular method or majority of people, they also follow suit and want use the same methods (6.5%). Whilst, some contraceptive users were just advised by others to choose a particular modern contraceptive method (4%).

Some respondents cited other reasons such as the method being discreet, being multipurpose, (other modern family planning methods had more than one advantage over the others like condoms, help prevent STI’s and unwanted pregnancies at the same time) while others just wanted to give it a try. The study revealed that some contraceptive users decide to use methods that their spouses may not recognize or come to know especially, if the spouses (most especially
the men) are not interested in use of contraceptives. In such circumstances, contraceptives like injections are most suitable as pointed by some of the key informants.

*Depo Provera is the most commonly sought method here because ladies need their privacy and don’t want the spouses to know about it since some men are sometimes against it (key informant government facility).*

*Some male partners may not be okay with the spouse using modern contraceptives hence when such disagreements come up, the female partner will choose to use a modern contraceptive method which will be discreet like injectables, I.U.D’s etc. (NGO Service provider).*

### 4.5.2 Source of contraceptives

As reflected in the previous section, availability and cost of contraceptives is crucial in the decision making of the method used. Female students were asked about the common sources of contraceptives which they use and the figure 5 below illustrates the findings.

**Figure 5: Sources of contraceptives**

![](image)

*Source: Field data, November 201*

Female university students residing around Makerere University often get their modern contraceptive methods mostly private sources, particularly from pharmacies (26%), drug shops
(19%) surrounding the university, and private health facilities (25%). Government health facilities like Mulago hospital take up a very small percentage i.e. (6%). Other students just get from their friends and use what they have most especially oral contraceptives and condoms. Others (3%) find modern contraceptive methods in supermarkets, and university halls or hostels. Sometimes, some facilities affiliated to NGO’s send out peer educators to different hostels and distribute condoms. Makerere university hospital also gives out condoms at free cost. Some students choose to get their modern contraceptive methods from the clinics surrounding Makerere University. Private facilities are more known sources of modern contraceptives. Some female university students particularly those not using modern contraceptives proved not to know where to get modern contraceptive methods. Across-tabulation of type and source of contraceptive was made (see table 5 below).

### Table 5: Contraceptive and source

<table>
<thead>
<tr>
<th></th>
<th>Oral pills</th>
<th>Injections</th>
<th>Male condoms</th>
<th>Female condoms</th>
<th>Intra-contraceptive</th>
<th>Norplant/Implants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
<td>9</td>
<td>8</td>
<td>12</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7.70%</td>
<td>8.80%</td>
<td>10.30%</td>
<td>4.80%</td>
<td>14.30%</td>
<td>16.70%</td>
</tr>
<tr>
<td><strong>Private clinics</strong></td>
<td>48</td>
<td>43</td>
<td>51</td>
<td>34</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>41.00%</td>
<td>47.30%</td>
<td>43.60%</td>
<td>54.80%</td>
<td>62.90%</td>
<td>55.60%</td>
</tr>
<tr>
<td><strong>Friends</strong></td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2.60%</td>
<td>3.30%</td>
<td>3.40%</td>
<td>1.60%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Non-government organization</strong></td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>9</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9.40%</td>
<td>13.20%</td>
<td>11.10%</td>
<td>14.50%</td>
<td>14.30%</td>
<td>22.20%</td>
</tr>
<tr>
<td><strong>Pharmacies</strong></td>
<td>52</td>
<td>34</td>
<td>47</td>
<td>21</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>44.40%</td>
<td>37.40%</td>
<td>40.20%</td>
<td>33.90%</td>
<td>20.00%</td>
<td>19.40%</td>
</tr>
<tr>
<td><strong>Drugs shops</strong></td>
<td>42</td>
<td>27</td>
<td>39</td>
<td>18</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>35.90%</td>
<td>29.70%</td>
<td>33.30%</td>
<td>29.00%</td>
<td>11.40%</td>
<td>5.60%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4.30%</td>
<td>4.40%</td>
<td>4.30%</td>
<td>1.60%</td>
<td>2.90%</td>
<td>2.80%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>117</td>
<td>91</td>
<td>117</td>
<td>62</td>
<td>35</td>
<td>36</td>
</tr>
</tbody>
</table>

*Source: Field data, November 2014*
For most of the contraceptives, private clinics were the major source; IUD (62.9%), norplants (55.6%), female condoms (54.8%), injections (47.3%), and male condoms (43.6%)

**Figure 6: Sources of commonly used modern contraceptives**

![Bar chart showing sources of commonly used modern contraceptives]

**Source: Field data, November 2014**

**4.5.3 Reasons for Choice of where to get Modern contraceptives**

Respondents were asked about the factors behind the choice of source for contraceptives used and table below illustrates the findings
Table 6: Reasons for choice of where to get modern contraceptives

<table>
<thead>
<tr>
<th>Reasons for choice of Source for contraceptives</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free of charge</td>
<td>20</td>
<td>8%</td>
</tr>
<tr>
<td>It’s cheap</td>
<td>61</td>
<td>26%</td>
</tr>
<tr>
<td>It’s very near</td>
<td>72</td>
<td>31%</td>
</tr>
<tr>
<td>It offers very good quality services</td>
<td>40</td>
<td>17%</td>
</tr>
<tr>
<td>Friendly services providers</td>
<td>35</td>
<td>15%</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Field data, November 2014

The reasons why female students choose to go to particular places over the others are because of the distance (31%) i.e. some facilities are preferred because of convenience and they don’t have to move long distances. Others go to particular facilities because of the cost i.e. services offered there are cheap (26%). Other female university students choose to get their modern contraceptive methods from particular facilities because of the quality of care and customer service (17%). Some facilities offer youth friendly services (15%). Few respondents had other reasons (2%) why they choose to go to particular facilities.

Private clinics in particular were preferred for most of the contraceptive method because of quality and quick services they offered. This was confirmed by information from key informants.

*The female university students will opt for health facilities that provide youth friendly services that will make them feel at home instead of feeling out of place and stigmatized. If the environment is welcoming and provides youth friendly services, then it will help in the decision making process. (Youth officer at one of the NGOs in reproductive health services).*

*Young female students tend to have a lot of stigma when it comes to use of modern contraceptive methods, and it gets worse when they line up amongst big women in our ques hence opting for other some quick methods that they find convenient over the others, like pills that coming to line up for a depo Provera. (Doctor at one of the government health facilities visited).*
4.5.4 Alternative contraceptives available at source

In order to ensure that choice was not forced by what are available, female students were asked if the sources of contraceptives had other methods that they could choose from and results in table 7 below.

Table 7: Alternative contraceptives available at source

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male condoms</td>
<td>124</td>
<td>53%</td>
</tr>
<tr>
<td>Oral pills</td>
<td>122</td>
<td>52%</td>
</tr>
<tr>
<td>Injections</td>
<td>95</td>
<td>40%</td>
</tr>
<tr>
<td>Female condoms</td>
<td>65</td>
<td>28%</td>
</tr>
<tr>
<td>Norplants/implants</td>
<td>38</td>
<td>16%</td>
</tr>
<tr>
<td>Intra-uterine contraceptives</td>
<td>37</td>
<td>16%</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Spermicidal</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Nuvaring/virginal ring</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Others</td>
<td>3</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Field data, November 2014

The most commonly reported available modern contraceptive methods in all facilities are the male condoms (53%), followed by oral pills (52%) and injections/ depo Provera (40%). The least available methods are the long term methods like cervical cap (3%) and contraceptive sponge (4%).

4.6 Constraints to utilization of contraceptives

The study explored constraints to utilization of modern contraceptive methods among female university students residing in hostels around Makerere University and findings are illustrated in
the table 8 below.

From table 8 below, the biggest reported constraint to utilization of modern contraceptives use was the side effects (87%) that were associated with the use of some modern contraceptive methods. Among the side effects mentioned were: nausea, weight gain, loss of sexual appetite, dryness among ladies, weight loss, continuous bleeding (particularly injectaplan) and some users of contraceptives failing to get their periods over a long time. The problem of side effects as deterrent to contraceptive use was also appreciated by key informants as detailed below.

*Pilplan causes change in menstrual cycle, loss of sexual appetite and fluids among the ladies. Thus discouraging them to use modern contraceptive.*

(Youth officer at one health facility).

To some, the constraint was religion since some religions are against the use of modern contraceptive methods like Catholics, born again (33%). This problem was indeed appreciated by the key informants as one of them said:

*“Religious aspect. Some religions like Catholics are against the use of modern family planning methods”* (Youth officer at an NGOs health facility).

Another constraint that majority of the female university students face is the lack of agreement between partners (30%). Some female university students don’t have sufficient knowledge about modern contraceptive methods which in turn affects utilization and choice (23%). This was confirmed by key informants below.

*There are a lot of myths surrounding contraceptive use such as infertility, deformed babies etc. hence this discourage many to use the service.*( Doctor at one of the government health facilities visited).

*Knowledge about modern contraceptive use. There are a lot of myths surrounding contraceptive use such as infertility, deformed babies etc. hence this discourages many to use the service.* (Doctor at a government health facility).
Table 8: Constraints to contraceptive use

<table>
<thead>
<tr>
<th>Constraints to contraceptive use.</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of side effects.</td>
<td>206</td>
<td>87%</td>
</tr>
<tr>
<td>Religion</td>
<td>77</td>
<td>33%</td>
</tr>
<tr>
<td>Lack of agreement between partners.</td>
<td>71</td>
<td>30%</td>
</tr>
<tr>
<td>Forgetting to use contraceptives.</td>
<td>63</td>
<td>27%</td>
</tr>
<tr>
<td>Lack of knowledge of available methods.</td>
<td>54</td>
<td>23%</td>
</tr>
<tr>
<td>Spouse reluctance.</td>
<td>43</td>
<td>18%</td>
</tr>
<tr>
<td>Uneasiness in buying contraceptives.</td>
<td>32</td>
<td>14%</td>
</tr>
<tr>
<td>Lack of money to purchase contraceptives.</td>
<td>22</td>
<td>9%</td>
</tr>
<tr>
<td>Un friendliness of medical personnel.</td>
<td>18</td>
<td>8%</td>
</tr>
<tr>
<td>No variety of family planning services or contraceptives.</td>
<td>18</td>
<td>8%</td>
</tr>
<tr>
<td>Long distance to where the modern contraceptives are.</td>
<td>18</td>
<td>8%</td>
</tr>
<tr>
<td>Cost i.e. services are expensive.</td>
<td>16</td>
<td>7%</td>
</tr>
<tr>
<td>Lack of concern over the possibility of getting pregnant.</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Unavailability of family planning services.</td>
<td>13</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Source: Field data, November 2014*

*NB: More than one response was accepted*
To a smaller extent, forgetfulness (27%) is also a constraint to use of modern contraceptive methods. Some female university students may even forget the date when to go back for depo provera injection and this can lead to unwanted pregnancies.

Disagreements with spouses was also cited as a constraint to use of contraceptives 30%. While one of the partners especially the female students may be interested in using contraceptives, their male spouses are not interested and they would wish to have children or having unprotected sex. The disagreements between spouses over use of contraceptives was re-echoed by some key informants as illustrated below.

*Male involvement. Some females don’t feel free with their partners so they opt to do it alone such that the partner doesn’t find out. (Youth officer at one of the NGOs in reproductive health services).*

Furthermore, cost of modern contraceptive methods may be a problem to a given proportion some female university students (7%). Some female university students reported lack of money to purchase or pay for modern contraceptive methods. Other constraints to utilization of modern contraceptive methods are lack of concern over the possibility of getting pregnant (6%). Some facilities don’t have a variety of modern contraceptive method especially the small drug shops and clinics (8%). This implies that students will opt for sources and modern contraceptive methods that are cheap and cost effective.

A long distance to sources of contraceptives was also mentioned as a constraint to use of contraceptives (8%). This is why they preferred to obtaining contraceptive services from private clinics, pharmacies or drugs at a fee instead of cheaper or free services from government facilities that were far. One of the key informants acknowledged this problem and said:

*“Long distance from campus to the family planning clinic. (Youth officer at one of the NGOs health fascility”).*

Reluctance in use of services was another problem. Some of the respondents especially those that used short term methods like pills or injections mentioned that they were reluctant to use the methods especially when they knew they would not have sex.

*If client takes pill and sex is not an everyday activity, she might stop using. (Youth officer at one of the NGOs health fascility”).*
CHAPTER FIVE
DISCUSSION

5.1 Introduction
In this chapter, discussions of findings were made and the discussions flow inherently regardless of the order results are arranged in chapter four.

5.2 Discussions
Findings in this study have shown the different aspects in the choice of contraceptives by campus girls residing in hostels around Makerere University. It has been revealed that over 63% of the girls residing in hostels around Makerere University were in some kind of relationship, with the majority (36.4%) of them reporting that there were in serious courtship. Most of these relationships had lasted seven months and above. This was indicative that these female students residing in hostels around Makerere University were sexually active. This revelation is line with related studies (Slaymaker et al., 2009). Demographic and health survey data for Masaka and Rakai districts between 1988 to 2006 indicated that the median age of sexual initiation among women was 16.4 years (Slaymaker et al., 2011).

The core objective of the study was to explore the process of making a decision in choice of a particular method of family planning or modern contraceptive by female hostel students and reasons for basis of choice as guided by the rational choice theory. Basing on the rational choice theory, the patterns of behavior in societies reflect the choices made by individuals as they try to maximize their benefits and minimize their costs. In other words, people make decisions about how they should act by comparing the costs and benefits of different courses of action (Blume and Easley, 2008; Allingham, 2002). Accordingly choice of the most common used modern contraceptives such as male condoms, pills and injectables whose choice was influenced by ease to use as the major reason. Male condoms in particular served double protection role i.e. preventing STIs and unwanted pregnancies. On the other hand, contraceptive pills are taken on daily basis. Likewise, injectables are given on regular basis say after every one or three month/s. The ease to use male condoms is also explained by adequate knowledge communities have on male condom use. This collaborates with past literature (Planned Parenthood Federation of America Inc., 2017). Federation of Parenthood Federation of America Inc. enumerates the benefits of using condoms including ease and convenience to use, preventing STIs and
unwanted pregnancies, being sexy, having no side effects and being cheap. National statistics show that long acting methods are preferred among Ugandan women while condoms are more popular among adolescents. The majority of the community health education campaigns including the national Obulamu campaigns on HIV and STIs prevention involve demonstrations on using male condoms. Male condoms, pills and injectables are also cheap and therefore female university students can afford them. For instance, a packet of condom with three pieces cost on average, 1000 Uganda shillings (0.26 Cents) and this is quite little and affordable. Some brands of condoms are given free in many government and non-government health facilities including at Makerere University hospital. Some students keep these condoms in their hostels and easily share with friends who need them.

Owing to low costs and ease use of male condoms, pills and injectables, these contraceptives were more available in health facilities particularly in the private health facilities (clinics, drug shops and pharmacies) which were the most source mentioned source of modern contraceptives. Clinics in particular were the most preferred sources of contraceptives for university female students. Clinics were preferred for reasons such as being near their hostels besides offering quick, quality and friendly services. Male condoms are also less associated with side effects (Planned Parenthood Federation of America Inc., 2017).

Cost of contraceptives at the sources was also a determinant of choosing a place. This was line with literature (Tessema et al, 2016). Tessema et al (2016) found out that Participants identified proximity to facility and cost as important considerations for choosing a source, the mode of travel and time to source were never mentioned directly as reasons for choosing a facility. Some sources like government facilities particularly Makerere University Hospital, Mulago National referral hospital, and Kawala HCIII University hospital provided contraceptives like condoms free of charge. This collaborates with previous studies (Pallin et al., 2013). In Uganda the public sector/facilities distribute condoms fully subsidized (free) condoms. The above three government health facilities are in proximities of university students residing in hostels around Makerere University.

The problem of cost is well recognized by the by the government and has demonstrated an increased commitment to increase funding for family planning and reproductive health (FP/RH) commodities and improve access to contraceptives through increased budgeting. The GOU has
increased its expenditure on procurement of contraceptives and selected RH supplies more than fivefold—from approximately UGX 1.4 billion in FY2009/10 to UGX 7.5 billion in FY2012/13. This has made reproductive health supplies more readily available in health facilities at the lower levels. (The Uganda Family Planning Costed Implementation Plan, 2015–2020 (FP-CIP))

Private for profit health facilities including clinics and pharmacies were most reported sources of modern contraceptives (25%). Pharmacies and other private health facilities were followed by drug shops. This is perhaps because the private sector is more available in the private setting and accessible to the girls. More still private sources possibly are more friendly as they are less congested. High number of respondents reporting not knowing the sources of the contraceptives used could be explained by the facts the contraceptives used especially the condoms were brought by their male partners; therefore the female partners were more likely not to know the sources. Also, private health facilities, pharmacies and drugs were the most common sources of contraceptives possibly because they are near students’ residential areas and therefore more accessible. Good quality and friendly services particularly offered by private health facilities influenced seeking of services from these facilities. Private health facilities try their best to provide better quality services as a way to attract and retain clients. Previous studies have indicated that private health facilities usually offer better quality services (Tessema et al., 2016). Tessema et al. (2016) in a systematic review of 11 studies done in Africa on factors determining quality of care in family planning services found that quality of family planning services was positively associated with privately owned health facilities. Policy is supporting increased involvement of the private sector in providing family planning services (Nambatya, 2013).

The majority of the students occupying hostel around Makerere University are youthful and sexually active and yet would they (females) wish not get pregnant when pursuing their academics. Hence many choose to use modern contraceptives i.e. More than a half, 134/236 (56.8%) of the university female students residing in hostels around Makerere University acknowledged using at least one modern contraceptive method in the four months that preceded the survey period of this study.
Findings in this study are consistent with the study done on contraceptive use, knowledge, attitude, perceptions and sexual behavior among female University students in Uganda among female Makerere University Students (Nsubuga et al., 2016). They also found out male condoms (88.4%), pills (86.7%) and injections (50.3%) were the most known modern contraceptive methods among University female students. The above methods were popular because they were more readily available at health facilities.

While nearly 60% of the university female students were using modern contraceptives, they faced some challenges. The major constraints to using modern contraceptives were: fear of side effects (87%) such as nausea, weight gain, loss of sexual appetite, dryness among ladies, weight loss, taking long without having menstrual periods, and continuous bleeding was the most constraint of using contraceptives particularly for injectables and pilplans. This constraint was acknowledged by both the students and key informants such as youth officers, doctors, and counselors at health facilities around Makerere University. This finding is collaboration with previous studies (Monson and Schoenstadt, 2010; Davies et al., 2006). Oral pills particularly are associated with side effects such as nausea, weight gain, sore or swollen breasts, small amount of blood, or spotting, between periods, among others (Monson and Schoenstadt, 2010).

The influence of religions particularly Catholics and ‘Born Agains’ was another constraint to contraceptive use. The majority of students (35%) were Catholics. The noticeable non use of contraceptives in South Eastern region of Nigeria is associated to the Catholic Church doctrines that condemn use of contraceptives (Oye-Adeniran et al, 2006).

Choice of contraceptives is also determined by support or the lack of it disagreements from male spouses. Condoms are not chosen in circumstances where male spouses do not support contraceptive use instead a girl might opt for non-visible methods. Reluctance in use of contraceptives has been reported by past studies (Breheny and Stephen, 2007; Oye-Adeniran et al, 2006). Studies done in New Zealand Breheny and Stephen (2007) found that few pregnant adolescents attributed their pregnancies to lack of concern over the possibility of pregnancy. Many young mothers failed to access contraceptive because they did not care about the possibility of becoming pregnant. Perceived low risk to pregnancy has also acted as a barrier to access and use of contraceptives (Breheny & Stephen, 2007).
Knowledge is key factor in choosing a particular contraceptive method. Lack of knowledge about the available contraceptive methods was also mentioned as constraint to use of contraceptives. Lack of knowledge on contraceptives was marred a lot of myths surrounding contraceptive use. For instance, contraceptive use was associated with infertility, and deformed babies. These myths discouraged students from using contraceptives. As seen in results, many of the females did not know where the contraceptives were gotten. Findings in study are agreement with past studies (Ohene and Akoto, 2008; Monson and Schoenstadt, 2010; Breheny and Stephen, 2007).
CHAPTER SIX
CONCLUSION AND RECOMMENDATIONS

5.0 Introduction
In this chapter, the conclusion and recommendations are then deducted from the preceding results and discussions.

5.1 Conclusions
Over 63% of university female students residing in hostels around Makerere University are in relationships that have lasted for quite some months, and engage in sexual activities which necessitates use of contraceptives. The choice of contraceptives by female university students was influenced by maximization of benefits and minimization of costs for the chosen contraceptives. The ease to use, absence or minimal side effects posed by the contraceptives, low cost, more availability, and advice by other users guided the students in choice of the contraceptives. Consequently, male condoms, oral pills, injections, and female condoms were the most chosen contraceptives. The behaviours or patterns exhibited in choice of contraceptives by female students indeed follows the rational choice theory. Most of the contraceptives used by students were obtained from private health facilities particularly clinics, drug shops and pharmacies. These sources are preferred because they provide quick, quality and friendly services though they are a bit expensive.

As explained in the rational choice model, cost of modern contraceptives is key determinant of choice among hostel girls. Male condoms are the most chosen contraceptives because they are cheap, readily available in health facilities, are less associated with side effects and the double benefit of preventing both STIs and unwanted pregnancies.

5.2 Recommendations for future studies
The study was done in Urban areas, however there are many adolescents and young girls in rural areas. It is therefore recommended that future studies on choice of contraceptive among rural young girls is undertaken since they might have peculiar issues and concerns regarding family planning.
5.3 Recommendations
The recommendations presented in this study are based on those given by the participants and the researchers’ own analysis. They are organized in four broad categories namely: government and university administrators, students and services providers.

5.3.1 Recommendations to government and university administrators

- Interventions that promote translation of knowledge into proper sexual and reproductive health practices including knowledge on various contraceptives and their various sources should be made available to students. This is in relation to the recommendation by FP-CIP to Increase age-appropriate information, access, and utilization of family planning among young people ages 10–24 years.

- Findings indicate that there are still false myths, information gaps and bad attitude surrounding contraceptive use. Individual attitude influences choice therefore programmers need to provide detailed information to the sexually active youths/ female students i.e. using the K.A.P approach (knowledge, attitude and practices).” This is in relation to the recommendations by FP-CIP to Promote and nurture change in social and individual behavior to address myths and misconceptions, side effects, and improve acceptance and continued use of family planning to prevent unintended pregnancies.

- Closely related to the above is media campaigns have an influence on choice of contraceptives among female university students i.e. some methods are more overly talked about than other methods hence in the end students end up neglecting other methods and putting emphasis on what they watch on TV. Therefore government should raise more awareness about all contraceptive methods during campaigns on media. Therefore, with increased sensitization through the media, peer educators in hostels and halls of residence, workshops etc. the knowledge gap, bad attitude and stigma will be closed.

- Findings reveal that at times those Health facilities serving university students around Makerere University run out of contraceptives. Therefore health facilities should be well stocked with male condoms, pills and injectables that are usually used by university.
students. This is in line with the family planning cost implementation plan for 2015-2020 where the strategic area gaps to focus on improved forecasting, procurement, and distribution and ensure full financing for commodity security in the public and private sectors (Zlatunich, & Couture, 2015).

- Findings further reveal that Young female students tend to have a lot of stigma when it comes to use of modern contraceptive methods, and it gets worse when they line up amongst big women in turn has an effect on decision making and choice. Health facilities should extend youth friendly services to the health centres that will attract them to come to the centre, make them feel at home and seek for services.

- Makerere University hospital and Makerere counseling and guidance department should continuously organize sensitization campaigns on sexual and reproductive health especially in university halls of residence and in hostels.

- Government should conduct a campaign targeting parents, sensitizing them to have close relationships with their children and be open to them about sex, contraceptives and STI's.

- Male partner involvement is still among the constraints of contraceptive use. Hence there is need to involve male partners and work on developing communication skill of a young adult in sexual relationship as a solution to limited contraceptive use.

5.3.2 Recommendations to the students

- It is clearly seen that one of factors affecting use and choice of contraceptives is the religious affiliations that some of the students are attached to like born agains and Catholics .Therefore Students have to be liberal, pragmatic as regards contemplating issues on reproductive health and sexual rights and restrain from being influenced by religious dogmas especially those that refrain them from using contraceptives.

5.3.3 Recommendations to services providers

- It’s evident in the findings that cost affects choice ,majority of most university students’ economic status is average i.e. they have basically what is enough for them to survive
therefore health facilities serving students should review their charges so that they are pocket friendly to students. Findings showed that students decried of the high charges for contraceptive services.

- Findings reveal that there is still a knowledge gap about contraceptive methods, some students didn’t know anything about them therefore Services should be extended to places where these female students spend most of their time e.g. Halls of residence, hostels e.t.c

- Closely related to the above is service providers themselves can increase awareness of contraceptives by providing integrated services within the facility. E.g. if a student has come for post abortion care, treatment of STI’S e.t.c the peer educator also finds a way and ends up talking about modern contraceptive use e.g. condoms, pills etc
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APPENDICES

Appendix I: Consent form for female students

Makerere University department of Graduate studies and Research, The Faculty of Social Sciences, Makerere University

Title of Research Project: Choice of contraceptives among female students in hostels around Makerere University

Explanation of Research study
I am ( ………………………on behalf of) Kigongo Aisha student doing masters degree in Arts of Social Sector Planning and Management at Makerere University. I am collecting data on a study on choice of contraceptives among female students aged 17-24 years in girls hostels around Makerere University. The purpose of this study is to learn about the patterns of contraceptive choice, the decision making process involved and constraints to choice of contraceptives. Information from this study will help stakeholders involved in family planning services in designing appropriate strategies to increase effective choice and use of contraceptive among young female students. Some selected young female students in girls hostels are being requested to participate in this study. Students to participate in this were chosen randomly from lists of names of all members in the selected hostels and your name was among them. There is no harm in participating in this study. Any information discussed with you will be kept confidential. Your name is not needed on questionnaire and consent forms will be detached from questionnaires and kept separately. The questionnaires will be accessed by only the data entrant and principal investigator. Your participation in this study is voluntary. You have the right to withdraw from the study at any time, choose not answer questions you are not comfortable with. If you agree to participate in this study, I will request you to answer some questions on a questionnaire and this may take about 14 minutes. By giving consent, you agree to such inspection and disclosure. I would like to ask for your permission to participate in this study.

Do you have any questions? Yes No
Do you agree to participate in this research study? Yes No

Print Name of Subject:…………………………..Subject’s Mark or Signature………………
Date…………………………

Signature of Person Obtaining Consent……………………….. Date…………………………
Appendix II: Consent form for key informants

Makerere University department of Graduate studies and Research, The Faculty of Social Sciences, Makerere University

Title of Research Project: Choice of contraceptives among female students in hostels around Makerere University

Explanation of Research study
I am Kigongo Aisha student doing masters degree in Arts of Social Sector Planning and Management at Makerere University. I am collecting data on a study on choice of contraceptives among female students aged 17-24 years in girls hostels around Makerere University. The purpose of this study is to learn about the patterns of contraceptive choice, the decision making process involved and constraints to choice of contraceptives. Information from this study will help stakeholders involved in family planning services in designing appropriate strategies to increase effective choice and use of contraceptive among young female students. You have been selected to participate in this study given your experience in providing family planning services. There is no harm in participating in this study. Any information discussed with you will be kept confidential. Your name will not be associated with the information you provide and the consent the form will be detached from your interview transcript and kept separately. The responses from this interview will be accessed by only the principal investigator. Your participation in this study is voluntary. You have the right to withdraw from the study at any time, choose not answer questions you are not comfortable with. The interview may take about 14 minutes. By giving consent, you agree to such inspection and disclosure. I would like to ask for your permission to participate in this study.

Do you have any questions? Yes No
Do you agree to participate in this research study? Yes No

Print Name of Subject:………………………………Subject’s Mark or Signature……………………………..
Date……………………………..

Signature of Person Obtaining Consent…………………………….. Date……………………………..
Appendix III: Letter of permission to hostel custodian

Makerere University department of Graduate studies and Research,

The Faculty of Social Sciences, Makerere University

Kampala, Uganda

Date--------------------------------------

The Hostel Custodian

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Dear Sir/Madam,

Application for permission to conduct a research among your residents

I the undersigned a master’s student of in Arts of Social Sector Planning and Management at Makerere University. Faculty of Social Sciences, Makerere University hereby apply for your permission to conduct a research study in partial fulfillment of the requirement for the above mentioned programme among female students residing in your hostel.

A proposal for the study has been submitted to the Makerere University department of Graduate studies and Research. A copy of the ethical committee’s approval for the study and the questionnaire are attached.

I will be very grateful if am permitted to conduct this study.

Thanks

Yours faithfully,

Ms. Kigongo Aisha
Appendix IV: Letter of permission to administrators of health facilities and NGOs

Makerere University department of Graduate studies and Research,
The Faculty of Social Sciences, Makerere University
Kampala, Uganda

Date--------------------------------------

The Administrator
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Dear Si/Madam,

Application for permission to conduct a research at your health facility/organization

I the undersigned a master’s student of Social Sector Planning and Management at Makerere University. Faculty of Social Sciences, Makerere University hereby apply for your permission to conduct an interview for a research study in partial fulfillment of the requirement for the above mentioned programme with one of your experts in family planning services..

A proposal for the study has been submitted to the Makerere University department of Graduate studies and Research. A copy of the ethical committee’s approval for the study and the questionnaire are attached.

I will be very grateful if am permitted to conduct this interview.

Thanks

Yours faithfully,

……………………..

Ms. Kigongo Aisha

Appendix V: Questionnaire
Choice of contraceptives among female students in hostels around Makerere University
Respondent category: Female university students

A) Introduction and asking consent by interviewer

Interviewer introduces herself and Purpose of the study: (The purpose of this study is to learn about the patterns of contraceptive choice, the decision making process involved and constraints to choice of contraceptives. Ask for consent (a detailed consent form to be issued to each of the respondents)

Section A. Background information and socio-demographic characteristics

Instructions: Tick in the boxes or write in the spaces provided

1. Name of hostel____________________________________________
2. How old are you? ________________
3. Religion
   1) Catholic  2) Protestant  3) Muslim
   4) Seventh Day Adventists  5) Born Again Faith
   6) Others (specific) _______________________________________
4. What program are you doing?
   1) Diploma programme
   2) Degree programme (Specify)

Nature of locality of the student’s origin

5. What is the nature of locality where have grown up from
   1) Rural  2) Urban

Nature of sexual love relationship

6. Are you currently in any sexual relationship?

7. For how long have you been in that relationship?
8. If no Have you ever had a sexual relationship?
   1) Yes  2) No
9. If yes, what is your nature of your relationship?
   a) Married
   b) Co-habiting
c) In a serious courtship  
c) Just a beginning relationship  
e) Friends with benefits relationship  
f) Others (Specify)  

**Section B: Awareness and perception towards modern contraceptive use**

10. Which methods of modern family planning do you know (tick all that you know?)

<table>
<thead>
<tr>
<th>Method</th>
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<tbody>
<tr>
<td>1) Oral Pills</td>
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<tr>
<td>2) Injectables</td>
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<tr>
<td>3) Male Condom</td>
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<tr>
<td>4) Female Condom</td>
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<tr>
<td>5) Intra-uterine-contraceptive (IUCD)</td>
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<tr>
<td>6) Norplant/Implants</td>
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<tr>
<td>7) Spermicidal</td>
<td></td>
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<tr>
<td>8) Diaphragm</td>
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<tr>
<td>9) Cervical Cap:</td>
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<tr>
<td>10) Contraceptive Sponge:</td>
<td></td>
</tr>
<tr>
<td>11 NuvaRing/Vaginal Ring</td>
<td></td>
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<tr>
<td>12) Tubal ligation</td>
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<tr>
<td>13) Vasectomy</td>
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<tr>
<td>14) Others (Specify)</td>
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</tbody>
</table>

15) None

11. According to the method listed above in qtn no 8, which one do you find better?

12. Which modern family planning method would you use?

13. Which one do you recommend to a female friend?

14. Which one do you recommend to a male friend?

**Access and availability**

15. Where do you find those particular modern family planning methods as listed in Qn 10?

**Section C: Pattern and source of contraceptive use**

16. Have you used any modern contraceptive method in the last four months?

<table>
<thead>
<tr>
<th>Type</th>
<th></th>
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<tbody>
<tr>
<td>1) Yes</td>
<td></td>
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<tr>
<td>2) No</td>
<td></td>
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</tbody>
</table>
17. **If yes in No 13**, what is the major method that you are currently using?

1) Oral Pills  
2) Injectables  
3) Male Condom  
4) Female Condom  
5) Intra-uterine-contraceptive (IUCD)  
6) Norplant/Implants  
7) Spermicidal  
8) Diaphragm  
9) Cervical Cap:  
10) Contraceptive Sponge:  
11 NuvaRing/Vaginal Ring  
12) Tubal ligation  
13) Vasectomy  
14) Other (Specify) ___________

18. What made or influenced you to choose the above method? (Multiple answers are accepted)

1) Has no/less side effects  
2) It is cheap or affordable  
3) It is readily available in most health facilities  
4) It is easy to use  
5) It is used by most people  
6) We were/I was advised to use the above method  
7) Others (specify) ____________________________

19. Do you always regularly use the above method?

1) Yes  
2) No  
3) I don’t remember

20. How often do you use the method? ______________________

21. Where do you mostly get the contraceptives you use?

1) Government facility  
2) Private health facility  
3) From friends  
4) I do not know  
5) Non-government organization  
6) Pharmacies  
7) Drug shops  
8) Others (specify) ____________________________

22. Why did you choose the above source? (After, skip to question 23).

1) It is free of charge  
2) It is cheap or affordable  
3) It is very near
4) It offers very good services
5) The service providers are very friendly
6) Others (specify) _______________________________________

23. In the source that you visited, what type of contraceptives did you find?
1) Oral Pills  
2) Injectables  
3) Male Condom  
4) Female Condom  
5) Intra-uterine-contraceptive (IUCD)  
6) Norplant/Implants  
7) Spermicidal  
8) Diaphragm  
9) Cervical Cap:  
10) Contraceptive Sponge:  
11) NuvaRing/Vaginal Ring  
12) Tubal ligation  
13) Vasectomy  
14) Others (Specify) _______________

24) What are other sources you get modern contraceptives from?

25) When do you use those other sources?

26) How often do you discuss with your spouse/partner about the use of contraceptives
   1. Weekly
   2. Monthly
   3. Quarterly
   4. Annually
   5. Don’t talk about it all

Section D: Constraints to contraceptive use

Social constraints
27. Supposing you wanted to use contraceptives, what are the factors that discourage you from contraceptive use? (Multiple answers are accepted)
1. Religion
2. Lack of agreement between partners
3. Fear of side effects
4. Lack of knowledge about the available methods
5. Lack of money to purchase the contraceptives
6. Spouse reluctance
7. Long distance
8. Forgetting to use contraceptives?
9. Uneasiness in buying or carrying contraceptives.
10. Lack of concern over the possibility of getting pregnant
11. Long distances to where family planning services are available
12. Unavailability of family planning services
13. Cost implications i.e. services to be acquired are expensive
14. Unfriendliness of medical personnel offering the services
15. No variety of family planning services or contraceptives

28. Are there issues that discourage from using contraceptives of any kind?
   1) Yes [ ] 2) No [ ]

29. If yes, what are those issues or problems?
   i) __________________________________________________________
   ii) _________________________________________________________
   iii) _______________________________________________________
   iv) _________________________________________________________
   v) _________________________________________________________

Section E: Other factors influencing the choice of contraceptive use

30. What would you attribute your getting into contraceptive use or what inspired you to start using contraceptives?
   1. Peers [ ]
   2. Parents [ ]
   3. Programmes [ ]

Thanks for your participation.
Appendix VI: Key informant Interview Guide

1. You as an individual, for how long have you been involved in providing contraceptives?
2. Who are the main clients that seek contraceptives?
3. What percentage of your clients do they constitute?
4. Why are they the main clients?
5. What kinds of contraceptives methods that are commonly sought? (Probe—short term, long term etc)
6. Why are they the main methods commonly sought?
7. What can you say about their adherence to the methods they choose to use?
8. Where do these female students usually get contraceptives they use from?
9. What is the nature of students who normally use these contraceptives? (say in terms age, religion, locality of origin, economic status, nature of relationship etc)
10. Other than your facility, where else do they choose to go?
11. What is the commonest facility they do go to?
12. From your experience, what are the factors or issues that influence the decision making process among young students while choosing a contraceptive method?
13. From your experience, what are the barriers to contraceptive use among young female students?
14. What else can you say about choice of contraceptives among young female students?

END