A Cross-sectional study on Knowledge, Attitude and Practice towards Female Condom use among Adolescents and Young Adults attending Naguru Teenage Information and Health Centre, Kampala District.

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Abstract

Objective:

This study aimed to assess the knowledge, attitude, and practice of female condom use among adolescents and young adults attending Naguru Teenage Information and Health Centre, Kampala district in July 2021.

Methodology:

A cross-sectional study was used among 384 participants. The inclusion criteria considered adolescents and young adults.

Results:

Analyses revealed that less than a quarter of the participants (24.7%) had ever used a female condom. Indeed, this is confirmed by the interval of use which was reported to be common "sometimes" (83.1%). Regarding knowledge of condom use among the participants surveyed; more-than half (86.2%) had ever heard of female condoms. The commonest sources of information on female condom use included parents, health facilities, and media outlets. Most participants didn't know how to fit a female condom (64.1%) and most reported that they didn't know how to introduce a female condom by self. Most participants (51.3%) strongly disagreed that female condom use reduces sexual pleasure.

Conclusion:

Estimates from reports from this survey reflect that few adolescents and young adults use female condoms. More efforts are required to promote the use of female condoms among these age groups. The provision of information and open discussion about female contraception could influence their knowledge, attitude, and female condom use.

Recommendations:

For the service providers, adolescents, and young adults: the provision of information and open discussion about female contraception could influence their knowledge, attitude, and female condom use. Culture, religion, and approval of the female condom approach are still strong in the national context; this is reflected in the reports from the surveyed participants in this study thus interfering with the decision to use female condoms. The inclusion of partners and religious leaders in reproductive strategies hence constitutes a positive turning point in promoting female condom knowledge, attitude, and practice.

Keywords: Knowledge, Attitude, Practice, Female condom use, Young Adults, Adolescents, Kampala district, Submitted: 2022-12-16 Accepted: 2023-01-29

1. Background of the study

The female condom (FC) is a soft, loose-fitting pouch with a ring on each end that is placed in the vagina or anus before sex forming a barrier that blocks bodily fluids and semen from entering the body. It forms a barrier that protects one from getting unplanned pregnancies and STIs including HIV (Avert, 2020). There are only 2 female condoms including FC1female condom which is made of thin soft plastic (polyurethane) and was later replaced by the FC2 female condom which is made of synthetic latex that is pre-lubricated with a silicone-based lubricant. These are the common brands of FCs including Femidom, Dominique, Femy, Myfemy, Protective, Elegance, Della, and Care (Mayo clinic, 2020).

The FCs if appropriately and unfailingly used, are said to render almost a 95% decrease in the threat of spreading HIV and about 75%- 82%effectiveness with normal use. They have comparable dual protective efficacy to male condoms(Gallo, Kilbourne-Brook, and Coffey, 2012) and are frequently regarded as the only tool that empowers women enabling them to negotiate protection with their partners thus promoting healthy behaviours and increasing self-efficacy, sexual confidence, and autonomy (Gollub, 2000). It is the only secure and effective female-initiated preventive tool that is available against HIV/ STIs and unplanned pregnancies (Ananga *et al.*, 2017).

Globally, Ever since FCs were approved by the United States Food and Drug Administration (USFDA) more than 20 years ago, Female condom supply and uptake have remained exasperatingly and very low despite its increasing demand from women themselves(Peters, Jansen, and van Driel, 2010). There are a few national programs in existence (18-20) with low supply which is often attributed to relatively high procurement costs, lack of policy and donor support compared to male condoms despite it being cost-effective for a long time (Gallo, Kilbourne-Brook and Coffey, 2012).

A scoping study that was conducted to assess the knowledge, attitude, practice, and behaviors associated with female condoms in developing countries revealed that the current FC use was less than 1% with an average of 0.04% for all countries compared with the current use of other contraceptive methods. Even with the obvious merits at both an individual and population level, the prevalence use of FC at the national level remains extremely very low despite the high awareness which insinuated that models of successful programming were still not being carried out adequately on a wide scale (Moore *et al.*, 2015). A study that was conducted among Zimbabwean women of reproductive age to assess their level of awareness and female condom uptake revealed that 36.3% of the respondents knew FC use and 83.5% of the respondents reported never using it. The same study further showed that the unavailability of female condoms and partner refusal were the major limiting factors (Chipfuwa *et al.*, 2014).

Uganda has one of the prominent adolescent pregnancy growths in Sub-Saharan Africa with a teenage pregnancy rate of 25% (NTIHC, 2016). Majority of the teenage pregnancies are attributed to a low level of sexual reproductive health knowledge (Nalubega, 2018) and low usage of condoms like female condoms (NTIHC, 2020).

An assessment was done by the MOH in Uganda on condom distribution and the dispenser distribution mechanism and found that the female condom uptake was still incredibly low with less than 100,000 female condom consumption monthly despite the continued promotion of female condoms (UAC, 2020).

There have been endeavors to promote awareness of female condom use by MOH in Uganda but still, there is limited patronage and utilization of FC among adolescents and young adults, and less attention has been put on the barriers to FC knowledge, attitude, and practices among adolescents and young adults. This study is sought to fill the gap by exploring the KAP of female condom use in a sample of adolescents and young adults attending Naguru Teenage Information and Health Centre, Kampala district to form

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interventional measures aimed at increasing the acceptability and female condom use because of their safety and cost-effectiveness.

2. RESEARCH METHODOLOGY

2.1. Study design

The hospital-based cross-sectional study design was used to select the study participants to participate in the study. This method generated quantitative data that was collected at a particular point in time using self-developed questionnaires.

2.2. Site description

This study was conducted at Naguru Teenage Information and Health Centre (NTIHC), Kampala district. It is located within Kiswa Health Centre III which is a hospital in Kampala district, Nakawa division, and has an elevation of 1154 meters. It is situated northwest of Bugolobi, close to Jazz supermarket, and south of Makerere University Business School (Mapcarta, 2020). The NTIHC was established in 1994 to provide Adolescent Sexual and Reproductive Health and Rights (ASRHR) services and information, primarily targeting young people 10-24 years old. It was founded under Kampala City Council as a small adolescent clinic by a Swedish gynecologist and Uganda volunteer midwives and social workers(NTIHC, 2020). It is said to have the biggest population of adolescents (Reporter, 2013) of whom the majority are females 65% and males 35% that seek services related to sexual reproductive health (Nakkazi, 2018). NTIHC receives approximately 370,000 young people annually whereby those who are aged between 10-14 years account for 23%, between 15-19 years at 38% and those between 20-24 years are the majority at 39%(NTIHC, 2020).

2.3. Target population

The study included all the adolescents and young adults from the Kampala district during July 2021.

2.3.1. Accessible population

The study included all those adolescents and young adults who were attending Naguru Teenage Information and Health Centre, Kampala district in July 2021.

2.4. Sample

A sample is a group of people that are taken from a larger population for measurement. So in this case, my sample was all adolescents and young adults attending Naguru Teenage Information and Health Centre, Kampala district during July 2021.

2.4.1. Selection criteria

2.4.2. ***Inclusion criteria***

All adolescents aged between 10-19 years and young adults aged between 20-24 years at Naguru Teenage Information and Health Centre, Kampala district during July 2021 and had consented to participate in this study.

2.4.3. Exclusion criteria

All those adolescents aged between 10-19 years and young adults aged between 20-24 years who refused to participate or failed to consent in this study and also those who were severely sick, mentally unstable, and couldn't talk at Naguru Teenage Information and Health Centre, Kampala district during July 2021.

2.4.4. Study variables

2.4.5. ***Dependent variable***

The dependent variable was the female condom use among adolescents and young adults at Naguru teenage information and health center, Kampala district in July 2021.

2.4.6. ***Independent variables***

These comprised of knowledge (Ever heard of Female condoms, Source of information, Source of skills on female condom usage, Age, Education level, Sex, and Income), attitude (Religious beliefs, Culture, Interference with sexual intercourse, Availability of female condoms, Affordability of female Condoms) and practice (frequency of female condom use, accessibility of female condoms and reasons for female condom

use/ non-use) towards female condom use among adolescents and young adults at Naguru teenage information and health center, Kampala district during July 2021.

2.5. Sample size determination:

In this research, the sample size was determined using Kish &Leslie formula at a 95% level of confidence and the proportion of attributes available in the study population was taken to be (5%).

The formula is written as

Where

- Is the study sample size that was required for the study
- Is the margin error allowed at a 95% level of confidence
- P is the population proportion which was at 50% since I was looking at 3 variables (knowledge, attitude, and practice)
- Is 1-p

Therefore, the sample size = is 384 participants.

2.6. Sampling procedure

A simple random sampling technique was used. Daily, the names were registered of those who wanted to participate in this study. Then numbers were written on the paper and put in the box so each individual was asked to pick a piece of paper from the box. Those who had picked an even number were allowed to participate and those who had picked an odd number were excluded from this study. An informed consent form which was written in both English and Luganda was given to each participant according to their language of preference and for those below 18 years, their informed consent forms were given to their parents or the caretaker to help in signing them. Those who signed the informed consent forms were allowed to participate in the study and those who failed to sign were not considered to be part of the study. This was done in July 2021.

2.7. Data collection techniques.

2.7.1. ***Face to Face Formal Interviews***

A self-developed questionnaire was used to collect primary data using a set of pre-determined questions designed to collect data from adolescents and young adults attending Naguru Teenage Information and Health Center, Kampala district in July 2021. This method was preferred because it was inexpensive and collected responses with minimum errors and a level of confidentiality.

2.8. Data collection tools.

2.8.1. ***Questionnaire***

A self-developed questionnaire was used to collect information from the participants on the study variables. The questions were got from the existing literature (Uchendu, Adeyera, and Owoaje, 2019; Mbelle et al., 2018; Usman et al., 2017;(Michel et al., 2019) and the questions were in the form of multiple questions or closed-ended questions and open-ended questions (like how many children do you have?). It was written in both English and Luganda. It was divided into 4 sections with 28 questions in total.

- Section A: it comprised the socio-demographic characteristics of the participants which included age, sex, tribe, marital status, the highest level of education, religion, number of children, and occupation.
- Section B: it comprised the participants' knowledge of female condom use and some of the important concerns which included Ever heard about or ever seen female condoms, their sources of information on female condoms, and their accurate knowledge of the use of Female condoms in preventing unwanted pregnancies and STI's including HIV.
- Section C: it comprised the adolescent's and young adults' attitudes towards female condom use and some of the important concerns which included interference with sexual intercourse, availability of female condoms, and affordability of female condoms using a 4-point Likert scale (strongly agree. Agree, disagree and agree).
- Section D: it comprised of the practice of female condom use of the participants and some of the important concerns which included if they

had ever used female condoms, female condom use during the first and last sexual intercourse, and accessibility of female condoms which was categorized into Yes/No and frequency of female condom use which was divided into 4 categories (always, sometimes, rarely and never)

Quality control of the tools.

1. Pretesting the tool. The data collection tools were pretested on 20 participants who were selected from Naguru Teenage Centre at China Uganda Friendship hospital Naguru to ensure that the questionnaires were clearly understood by the target participants before data collection. The aim of pretesting was to help identify gaps in the questionnaire designed to make adjustments that ensured their ability to collect the required information.

2. Training of the 2 research assistants that were going to help the respondents answer the questionnaire. This ensured that these research assistants understood and also helped the respondents to understand and fill in the questionnaire correctly.

2.9. Data analysis and presentation.

After data collection, the raw data was checked for uniformity, accuracy, and consistency. Then entered, processed, and analysis of quantitative data into the computer was done manually using Statistical Package for Social Sciences (SPSS V26) program. Quantitative data were presented in form of tables, percentages, and frequency distribution descriptively. Pearson chi-square tests were used to show the association between the socio-demographic variables and knowledge on female condom use, sociodemographic variables and attitude on female condom use, and sociodemographic variables and practice of female condom use among adolescents and young adults at NTIHC, Kampala district which implied that only variables with P-values of less than 0.05 were considered to be statistically significant.

2.10. Ethical considerations.

Ethical clearance was obtained from the Clarke International University Research Ethics Committee which allowed me to proceed with data collection. I obtained a data collection letter from the dean of Nursing and Midwifery school that I took to my study area. Clearance was obtained from the Executive Director of Naguru Teenage Information and Health Centre which allowed me to proceed with my research from there. Confidentiality was ensured by the use of unique identification numbers on each questionnaire instead of personal names. During data collection, each participant's information was kept confidential and was strictly used for the study undertaken. Every adolescent and young adult who voluntarily accepted to participate in the study had to sign an informed consent form to ensure respect and autonomy. Answered questionnaires were only accessed by the researcher and those concerned with the study. The respondents were informed that their participation caused no harm and there was no direct gain or benefit from participation however their participation was to be useful for future planning.

2.11. Plans for dissemination.

A report was to be submitted to the school of Nursing and Midwifery at Clarke International University for the award of Bachelor's in Nursing Science and Clarke International University library for future reference. Another copy is to be submitted to the Executive Director of Naguru Teenage Information and Health Centre for future health implementations towards care and health delivery to adolescents and young adults

Bias: During the period of the data collection and participant recruitment, the turn-up of the male**s** to the health facility was very low as compared to their counterparts the females whose turn-up was very high thus being less represented for the study.

3. RESULTS

3.1. Socio-demographic characteristics of the participants

Table 1 below shows the socio-demographic characteristics of the participants. The majority of the participants were aged between 15 and 19 years of age (51.3%). Regarding the gender

of the participants, most (86.2%) were females. Of the participants, the majority belonged to the catholic (59.9%) religious denomination; were single (69.8%), and had attained at least a secondary level of education (51.3%). Regarding employment status, most (86.2%) were unemployed.

3.2. Knowledge of female condom use

Regarding knowledge of female condom use among the participants surveyed; more than half (86.2%) had ever heard of female condoms. The commonest sources of information on female condom use included parents, health facilities, and media outlets. Most participants did not know to fit a female condom (64.1%) and most (88.8%) reported that they did not know how to introduce a female condom by themselves (see table 2). Self-efficacy and female condom use were low among the surveyed participants; this was reflected in the response to the question that: "do you know how to fit a female condom?" Most (64.1%) reported that they did not know how to fit a female condom.

3.3. ***A ssociation between socio-demographic variables and knowledge on female condom use***

In table 3, the association of socio-demographic characteristics and knowledge about female condom use is presented. Analyses revealed that age, gender, religion, education level, and occupation (p-values <0.01) were associated with knowledge of female condom use whilst marital status was not statistically associated with knowledge of female condom use (table 3).

3.4. Attitudes toward female condom use

In table 4, the attitudes toward female condom use among the participants surveyed are presented. The table shows that most participants (51.3%) strongly disagreed that the use of a female condom reduces sexual pleasure. Most participants i.e., either agreed or strongly agreed that religion influences their decision to use female condoms. In response to cultural norms and condom use, most (48.7%) strongly disagreed that culture influences female condom use. Regarding the affordability of condom use, most agreed that the use of female condoms is an affordable measure of reproductive health and that it is not embarrassing to collect condoms from the stores such as shops. Indeed, participants surveyed either agree or strongly agree that they can recommend the use of female condoms to their peers.

The results of analyses of the relationship between attitude toward female condom use and the socio-demographic characteristics of the participants are presented in table five. These revealed that age, gender, religion, education level, and employment status were strongly associated with attitude towards use (table 5).

3.5. Practice of female condom use

below shows the practice-related characteristics of the respondents. Analyses revealed that less than a quarter of the participants (24.7%) had ever used a female condom. Indeed, this is confirmed by the interval of use which was reported to be common "sometimes" (83.1%).

shows the reports of the estimates of the association between socio-demographic variables and the practice of female condom use. Analyses relating the practice of condom use and the socio-demographic characteristics of the participants showed that education level and age were significantly associated with the practice.

4. DISCUSSION:

4.1. Knowledge of female condom use

About the data described for knowledge, estimates in this study relating to knowledge of the use of female condoms using self-reports from adolescents and young adults using a survey design showed that self-efficacy was low despite the high response of having awareness on the existence of female condoms. This reaffirms findings from the Uganda Demographic Health Survey in 2016, which reflected that the majority had heard about female condoms as a contraceptive method. and that female condoms were not being utilized in all age groups (Uganda Bureau of Statistics,

Table 1: Socio-demographic characteristics of the participants (n=384)

Variable	Attributes	Frequency	Percentages
Age	10-14,	100	26
	15-19	197	51.3
	20-24	87	22.7
Gender	Male	53	13.8
	Female	331	86.2
Marital status	Married	116	30.2
	Single	268	69.8
Religion	Catholic	230	59.9
	Anglican	104	27.1
	Muslim	33	8.6
	Born again	17	4.4
Education level	Primary	100	26
	Secondary	197	51.3
	Tertiary	87	22.7
Occupation	Employed	53	13.8
	Unemployed	331	86.2

Table 2: Knowledge of female condom use among the participants (n=384)

Variable	Attributes	Frequency	Percentages
Know about female condoms	Yes	331	86.2
	No	53	13.8
Source of information	Media	100	26
	Health facility	197	51.3
	Parents	87	22.7
Ever seen female condom	Yes	334	88.2
	No	50	12.8
Know how to fit a female condom	Yes	138	35.9
	No	246	64.1
Know how to introduce a female condom by myself	Yes	43	11.2
	No	341	88.8

2016). Knowledge inadequacy specifically on self-use can be attributed to various factors. The majority of the population in Uganda are adolescents and young adults, and the discussion of condom use among this age group is not common. This reduces access to information and the scarce use of this method relative to other reproductive methods. This can lead to inadequate opinions and resultant non-use of female condoms. This requires intervention owing to the societal atmosphere influencing discussions on reproductive methods and the sexual behavior of this age group. The study of Esther et al. (2017) showed similar findings: the authors noted that among a Kenyan sample, knowledge among both sexes (male and female) was low. And that self-efficacy

Table 3: Association between socio-demographic variables and knowledge on female condom use (n=384)

Variable	Attributes	Knowledge of use n(%) Aware	Unaware	p-value
Age	10-14	4(7.5)	96(29)	<0.01*
	15-19	27(50.9)	170(51.4)	
	20-24	22(41.5)	65(19.6)	
	Total	**53**	**331**	
Gender	Male	53	-	<0.001**
	Female	-	331	
	Total	**53**	**331**	
Marital status	Married	12	104	0.128
	Single	41	227	
	Total	**53**	**331**	
Religion	Catholic Anglican	46	58	<0.001**
	Muslim	-	230	
	Born again	6	27	
	Total	1	16	
		53	**331**	
Education level	Primary Secondary	4	96	<0.001
	Tertiary	27	170	
	Total	22	65	
		53	**331**	
Occupation	Employed	53	-	<0.001*
	Unemployed	-	331	
	Total	**53**	**331**	

of condom use was low among most participants in Nairobi city of Kenya.

Various study findings contradict the findings on knowledge in our study including a study by (Guerra and Mthembu, 2016) revealed that knowledge of female condoms in South Africa was high. In Cameroon, (Tarkang and Bain, 2015) did a study among female students of high school in Kumba and found that 67.3% knew about the FCs and 75.6% knew that consistent and correct female condom use during sexual intercourse could prevent HIV transmission through 68.1% didn't have the knowledge on how to fit the FCs correctly. The researchers concluded that the age of the respondents and their knowledge of female condoms had no significant associations. This is contrary to our findings that age is associated with knowledge of condom use.

4.2. Attitude toward female condom use

There is a lot of disbelief and misconceptions surrounding the use of female condoms however, this study showed that most participants disagree with the notion that female condoms reduce sexual pleasure. This is contrary to those from a study in Kumba, Cameroon where the majority noted that female condoms decrease sexual satisfaction. On the other hand, culture and religion had a significant association with condom use. This finding is similar to other studies where respondents believed that due to religious beliefs they may feel guilty using it (Tarkang and Bain, 2015).

Some cultural beliefs attribute obtaining a female condom to embarrassment when obtaining the female condom. Similarly, some religions, frown on the use of condoms by their members.

Table 4: Attitude towards female condom use among the participants (n=384)

Variable	Attributes	Frequency	Percentages
Female condom use influences sexual pleasure	Agree	100	26
	Strongly disagree	197	51.3
	Disagree	87	22.7
Religion does not encourage female condom use	Strongly agree	60	15.6
	Agree	324	84.4
Culture does not accept use of female condoms	Agree	96	25
	Strongly disagree	187	48.7
	Disagree	101	26.3
Female condoms are an affordable measure	Strongly agree	54	14.1
	Agree	328	85.4
	Strongly disagree	1	0.3
	Disagree	1	0.3
It is embarrassing to collect female condoms from a store	Strongly agree	2	0.5
	Agree	99	25.8
	Strongly disagree	193	50.3
	Disagree	90	23.5
I recommend use of female condoms	Strongly agree	57	14.8
	Agree	327	85.2

4.3. The practice of female condom use.

This study revealed that less than a quarter of the participants had ever used a female condom. The low practice of female condom use can be attributed to low awareness of use and attitudes described in the previous sections. Similar studies have revealed that female condom use was only at 0.4% (Nuzzolillo, 2010). Various reasons explain the low extent of use: felt itchy and painful inside the vagina and were too noisy during intercourse as the discomforts associated with using a female condom. Provision of information and open discussion about female contraception could influence their intentions regarding female condom use as suggested by (Boyd *et al.*, 2015). Similarly,(Schuyler *et al.*, 2016) highlighted that the provision of tailored intervention, one-on-one knowledge, and development of skills regarding female condom use could influence their abilities to negotiate FC use with their sexual partners. In context, our study reveals that most partners do not encourage female condom use. Similarly, (Mugadza Gladys, Krumpen Petra, and Zvinavashe Matilda, 2016) revealed that the unwillingness of the male partner as being the commonest reason for low FC usage.

5. Limitations of the study

Some adolescents <18 years did not participate in the study undertaken as they came without their parents or their next of kin to sign the informed consent forms for their sake. The stigmatization and discrimination some adolescents feared to face from their fellow members and relatives once they got to know what they knew about female condom use. Since the study was done during the lockdown, few people used to turn up regularly which made me increase the days of the data collection to reach the target study population size.

6. Conclusions

This study aimed to assess the knowledge, attitude, and practice of female condom use among adolescents and young adults attending Naguru

Table 5: Association between socio-demographic variables and attitude towards female condom use (n=384)

Variable	Attributes	Attitude n(%) Negative	Positive	p-value
Age	10-14	6(10.5)	94(28.9)	
	15-19	29(50.9)	168(51.4)	<0.001*
	20-24	22(38.6)	65(19.9)	
	Total	**57**	**327**	
Gender	Male	53(93)	-	<0.001**
	Female	4(7)	327(100)	
	Total	**57**	**327**	
Marital status	Married	14(24.6) 43(75.4)	102	0.199
	Single	**57**	227	
	Total		**327**	
Religion	Catholic	46(80.7)	58(17.7)	<0.001**
	Anglican	4(7.0)	226(69.1)	
	Muslim	6(10.5)	27(8.3)	
	Born again	1(1.8)	16(4.9)	
	Total	**57**	**327**	
Education level	Primary	6(10.5)	94(28.7)	<0.001**
	Secondary	29(50.9) 22(38.6)	168(51.4) 65(19.9)	
	Tertiary	**57**	**327**	
	Total			
Occupation	Employed	53(93)	-	<0.001*
	Unemployed	4(7)	327	
	Total	**57**	**327**	

Teenage Information and Health Centre, Kampala district in July 2021. Estimates from reports from this survey reflect that few adolescents and young adults use female condoms. These results demonstrate that the method (female condom) is still rare among adolescents of the surveyed sub-population. More efforts are required to promote the use of female condoms among these age groups.

7. Recommendations.

For the service providers, adolescents, and young adults: the provision of information and open discussion about female contraception could influence their knowledge, attitude, and female condom use.

Culture, religion, and approval of the female condom approach are still strong in the national context; this is reflected in the reports from the surveyed participants in this study thus interfering with the decision to use female condoms. The inclusion of partners and religious leaders in reproductive strategies hence constitutes a positive turning point in promoting female condom knowledge, attitude, and practice.

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Table 6: Practice-related characteristics of the participants (n=384)

Variable	Attributes	Frequency	Percentages
Ever used a female condom by self or the partner	Yes	95	24.7
	No	289	75
Interval of female condom use	Always	65	16.9
	Sometimes	319	83.1
Female condom accessible when needed	Yes	96	25
	No	288	75
Partner encourages female condom use	Yes	73	19
	No	311	81
Motivation for female condom use	HIV prevention	12	3.1
	Unwanted pregnancy	107	27.9
	Partner support	185	48.2
	Media publicity	80	20.8
Common reasons for not using a female condom	Yes	65	16.9
	No	319	83.1

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9. List of Acronyms ans abbreviation:

FC : Female Condom
HIV : Human Immunodeficiency Virus
STIs : Sexually Transmitted Infections
MoH : Ministry of Health
UHMG : Uganda Health Marketing Group
UDHS : Uganda Demographic Health Survey
NTIHC : Naguru Teenage Information and Health Centre
ASRHR : Adolescent Sexual and Reproductive Health and Rights
AIDS : Acquired Immunodeficiency Syndrome
AIC : AIDS information Center
UAC : Uganda AIDs Commission
KAP : Knowledge Attitude and Practice

10. Source of funding:

self and my parents (Mr. Mukasa Eric Sembatya and Ms. Nakanjako Harriet).

11. Conflict of interest:

The study had no conflict of interest.

12. References:

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Table 7: Association between socio-demographic variables and practice of female condom use (n=384)

Variable	Attributes	Practice n(%) Use	None-use	p-value
Age	10-14	24(25.3)	76(26.3)	
	15-19	59(62.1)	138(47.8)	0.014*
	20-24	12(12.6)	75(26)	
	Total	**95**	**289**	
Gender	Male	8(8.4)	45(15.6)	0.052
	Female	87(91.6)	244(84.4)	
	Total	**95**	**289**	
Marital status	Married	28(29.5)	88(30.4)	0.483
	Single	67(70.5)	201(69.6)	
	Total	**95**	**289**	
Religion	Catholic	22(23.2)	82(28.4)	0.515
	Anglican	62(65.3)	168(58.1)	
	Muslim	6(6.3)	27(9.3)	
	Born again	5(5.3)	12(4.2)	
	Total	**95**	**289**	
Education level	Primary	24(25.3)	76(26.3)	0.014*
	Secondary	59(62.1)	138(47.8)	
	Tertiary	12(12.6)	75(26)	
	Total	**95**	**289**	
Employment status	Employed	8(8.4)	45(15.6)	0.052
	Unemployed	87(91.6)	244(84.4)	
	Total	**95**	**289**	

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