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TITLE: PREVALENCE AND FACTORS ASSOCIATED WITH USE OF CONDOMS AMONG ADOLESCENTS (BOYS AND GIRLS) IN SELECTED HEALTH FACILITIES INAMOLATAR DISTRICT, UGANDA

DECLARATION

I **Odongo Jimmy** hereby declare that the work contained in this proposal is original and has never been submitted to any university or institution for any award.

Signed..... Date.....28th/Feb/2023

APPROVAL

This is to certify that the research proposal has been under my supervision and is now ready for the implementation of the proposed project.

Signed: ..... Date: 02 March 2023

PROF. FLORENCE MIREMBE

(SUPERVISOR)

DEDICATION

This work is dedicated to my dear wife Mrs Okitela Peruth, children Gum J Hiram, Gum J Ethan and Gum J Nathan. To my Parents Mr and Mrs Owiny Peter Atum, Siblings, Francis, Morris, Lydia Doreen, and Joshua. To all my friends, Dr OLum James, Obong Ronald and Okello Samuel Dulson; who were supportive to me during the development of the proposal and to my course mates of Uganda Christian University. May God reward you richly!

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Above all, I thank God, for his financial blessing that I needed to go through the journey of the study up to this time.

May His name be praised! Amen!

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
DHIS 2	District Health Information System 2
WHO	World Health Organization
IUD	Inter Uterine Device
TSP	Triple Supper Phosphate
MOH	Ministry Of Health
UNICEF	United Nations Children's Fund
UDHS	Uganda Demographic Health Survey
KDHS	Kenya Demographic Health Survey
TDHS	Tanzania Demographic Health Survey
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System.

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OPERATIONAL DEFINITIONS

Adolescents are those people between 10 and 19 years of age (WHO, 2014). The majority of adolescents are, therefore, included in age based definition of "child", adopted by the convention on the Rights of the child, as a person under the age of 18 years. Other overlapping terms used in this report are youth (defined by United Nations as 15-24 years) and young people (10-24 years), a term used by WHO to combine adolescents and youth (WHO, 2014). The above definition of adolescents was adopted and used in this study.

Women with unmet need for family planning: are "those who are productive and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child" (WHO, 2015), for a period of two years or more (Sarah E, K. Bradley et al, 2012). Unmet need is especially high among adolescents, migrants, urban slum dwellers, refugees and women in post-partum period (WHO, 2015). In developing countries today, more than 220 million women, have an unmet need for family planning (UDHS, 2011).

Condom use: is when a male or female condom is used to cover the entire head and shaft of the penis (for males) and entire vulva (for female using female condom) from the beginning of sex until the end and was correctly used, thereby avoiding breakage, spillage, leakage, and slipping off from the intended position.

ABSTRACT

Condom use prevalence is a measure of number of times one uses condom during different sexual intercourse. In Africa condom is the main contraceptive use especially male condoms (about 70%). Several factors enhance use and there are also a number of factors that inhibit condom use among sexually active people including adolescents. This research determined condom use prevalence, factors that enhanced and inhibit condom use among adolescents in Amolatar district. A descriptive cross sectional research design was used; the study was conducted in four purposively selected sub-counties being mother sub-counties in Amolatar district. A total of 194 respondents were randomly selected, Descriptive statistics, Pearson chi-square tests and multivariable logistic regression were used to analyse data. Results indicate that users and non-users of condom differed in a number of socio-economic characteristics. Users were older, better educated and were manly boys. Multivariable logistic regressionresults indicate that, ease of access to condoms and affordability of condoms by adolescents enhanced the use of condom among adolescents. On the other hand, un-affordability of condom and reduction of sexual pleasure inhibited use of condoms. The prevalence of condom use in Amolatar among adolescents was found to be at 64%, however, there is need to increase it through advocacy.

Key words: Condom, Adolescents, Prevalence and Amolatar district.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

Condom use is assessed by how many times one has engaged in sex, and indicating how many of those times the person used the condom for the sexual intercourse(Welsh et al., 2001).In developing countries, male condom use accounts for close to 70% of total modern contraceptive use among unmarried sexually active adolescent girls 15-19 years (Liang, et al 2019), and it is probably not used consistently since a high percentage of women aged 15-19 years get pregnant in urban areas and 27 percent in rural areas of Uganda; whereas those married or in union have access to a wider range of methods. The proposal has three chapters: chapter one, two and three.

Chapter one contains; introduction, study background, problem statement, objectives of the study, research questions, scope of the study, justification and conceptual framework. Chapter two contains literature reviews which are work done by others but related to this study. The literature is done objective by objective and chapter three includes; methodology and methods that will be used in conduction this study.

1.1 Study background

Globally, more than 21% of adolescent girls; married or in union are using a modern contraceptive method (Liang et al, 2019). The rate of contraceptive use is much higher among unmarried sexually active adolescent girls at 51%compared to married adolescent girls at 20%; (Liang, et al, 2019).

According to the World Health Organization 2020 report an estimated21 million girls aged 15-19 years in developing countries become pregnant annually and 12 million of them give birth. The remaining 9 million end up as abortions most of which are unsafe (Bankole et al, 2008).

Family planning was needed by 1.1 billion women out of the 1.9 billion women of reproductive age (15-49 years) that lived in the world in 2019. The 1.1 billion women had intention to use contraceptive or were users. Out of this 1.1 Billion, 842million (76%) were using modern methods of contraception while traditional methods were being used by 80 million (7%) (United Nations, Department of Economic and Social Affairs, Population Division (2019).

Over all, long term or permanent contraceptive methods were relied on by 45.2% of users (female and male sterilization, IUD, implants), short term method 46.1% of users (such as condom, the pill, injectable and other modern methods) and traditional methods 8.7% of users like; withdrawal, rhythm methods etc. (UN, 2019).

Despite the successes and advances of contraceptive use thus far-like its rapid increase in Sub Saharan Africa from 4% to 15% in the last two decades (Liang, et al, 2019); estimates for the number of women in developing regions who have un met need for contraception stood at 214 Million in 2017 (Namasivayam et al, 2019).

Modern contraceptive use remains unacceptably low in Sub-Saharan Africa despite increasing awareness and knowledge about contraception (12% in Mali, 21% in Tanzania). In South Africa, a study involving 741 sexually active adolescents (14-19

years) from the Soweto township revealed that 54.2% females do not use condoms and the study did not reveal other contraceptive methods they are using (Clossonetal., 2017).

In developing countries, male condom use accounts for close to 70% of total modern contraceptive use among unmarried sexually active adolescent girls 15-19 years (Liang, et al 2019), and it is probably not used consistently since a high percentage 76.3% of women aged 15-19 years get pregnant in urban areas and 27 percent in rural areas of Uganda; whereas those married or in union have access to a wider range of methods (UDHS 2016: Liang et al, 2019). In Kenyan, use of male condom among women both married and unmarried was reported by over 60% of participants in both study arms i.e. Intervention and control sites at 6 months' period of the survey, and consistent use was around 20%. (Welsh et al, 2001). The proportion is much higher compared to that of adolescent girls at 26% after a decade (KDHS, 2014).

Almost 14% of Ugandan adolescents are sexually active by age 15 (15.5% of girls and 12.2% of boys) and over 50% by age 18 years (Rijsdijik et al, 2012). Only 5% of sexually active adolescents aged 15-19 years use contraception. Uganda also consistently has one of the lowest contraceptive use prevalence rates among East African countries. It was estimated that only 39% of married women of reproductive age used contraception in 2016 (Namasivayam et al, 2019). Comparative figures of contraceptive use in neighboring countries are seen as follows; Of all sexually active adolescent girls who are unmarried and aged 15-19 in Burundi, the majority (90.7%) are not using any contraceptive method. 1.1% use implants-which they consider to be

the most effective, 7.5% use male condoms, where as 0.7% use the pills (WHO-Republic of Burundi, 2016).

About one quarter (27%) of adolescent girls and 44% of adolescent boys who ever had sexual intercourse reported using a method of contraception in a survey in Kenya-with a large population (25% girls and 43% of boys) using modern methods. The most commonly used method by sexually active girls both married and unmarried were injectables (48%), condoms (26%) and implants (12%), although use of injectable was higher in rural than urban areas (53% and 42%, respectively) while use of condoms, implants and pills was higher in urban than rural areas- 29%, 16% and 7% respectively compared to 24%, 9% and 4% respectively which is observed in rural settings (KDHS, 2016).

Despite the high knowledge of contraceptives in Rwanda (88%) among sexually active adolescent girls, there is low utilization (39%) of contraceptives among high school sexually active adolescents hence a high adolescent pregnancy rate of 7.3% (Beyeza-Kashesya et al, 2011). Furthermore, mere 13.3% of girls and 10.7% of boys aged 15-19 used condoms in the last sexual intercourse (Tuyisenge et al., 2019). In Tanzania, of all the unmarried sexually active adolescent girls aged 15-19years, contraception methods were not being used by 60.3%. Reasons for non-use included; infrequent sex (50.2%), not being married (23.8%) and fear of side effect (18.4%). On the other hand of all the adolescent girls aged 15-19 in union 76.9% were not using a method of contraception, reasons for non-use were: breast feeding (27.0%), not having sex in

that period (infrequent sex) 21.1% and fear of side effects (15.0%), (WHO, 2010: TDHS, 2010).

In Uganda condom use prevalence is 26.4% among adolescent girls and 41.5% among adolescent boys (Ssekamatte, et al., 2022). This has resulted to high HIV prevalence of 6.2% among Ugandans and 3.7% among Uganda's adolescents, it is also reported that teenage pregnancy rate stands at 25% of which almost half is unintended (Anyanwu & Tamwesigire, 2023).

In Amolatar district, HIV prevalence was estimated to be 6.4% among the community although no aggregation was done for the adolescents and adolescent pregnancy rate was 26% in the district (Amolatar District Health report, 2022).

Knowledge of both the HIV prevention methods (faithfulness and use of condoms) is lowest among girls and boys age 15-19 years old, those who have never married and never had sex and respondents who have education. The proportion of respondents who know both HIV prevention methods is higher in urban areas than in rural areas, with the difference being more pronounced among girls (82% versus 72% than among boys84% versus 78%) (UDHS, 2016).

Most adolescents in Uganda fear seeking advice on condoms yet Adolescent Health Policy of Uganda provides that "Adolescents shall have access to HIV prevention methods and technologies. These shall include (ABC) Abstinence, Being faithful, and correct and consistent use of Condoms, medical male circumcision, treatment and any other approved by MOH" (MOH-Uganda, 2012).

1.2 Problem statement

Globally, about 21% of adolescent girls; married or in union are using modern contraceptive methods (Liang et al, 2019). In Africa, South American and Western Pacific countries, condom use among adolescents is at a prevalence of 51 to 62% (Crawford et al, 2020). In the developing world, the rate of contraceptive use among un married sexually active adolescent girls is at 51% than married or in union adolescent girls at 20%, and so is the un met need for family planning at 41% and 23% respectively (Liang et al, 2019). Also, the male condom accounts for about 70% of total contraceptive use among unmarried sexually active adolescent girls of 15-19 years; (Liang et al., 2019). Reasons for condom use include: preventing transmission of sexually transmitted infections including HIV and unwanted pregnancies leave alone being inexpensive and widely available (UNFPA 2015: WHO 2015: UNAIDS, 2015). The reasons for non-use or inconsistent use include; reduced sex frequency, a new sexual partner, causal partnerships, alcohol use and lack of condoms during time of sex (Beyeza-Kashesya et al 2011)

In Uganda, contraceptive use is fairly wide spread as 35% females of age 15-19 years and 55% males of the same age used at least a modern contraceptive method in their last intercourse; and six in ten sexually experienced adolescents (62% of males and 57% females) have ever used a method (Darabi et al, 2008). Male condoms are the most used modern contraceptive method out of the rest among Ugandan adolescents 15-19 year-old about 5-10 times more (Bankole et al, 2008).

The high rate (40%) of unintended pregnancies among the adolescents in Uganda aged 15-19 years is due to low contraceptive use of only5% within the sexually active adolescents (Beyeza-Kashesyaet al, 2011). However, UDHS (2022) gives the pregnancy rate as 25% among adolescents. Condoms have been praised to be safe and highly effective when correctly and consistently used in preventing sexually transmitted infections including HIV and unwanted pregnancies leave alone being inexpensive and widely available (UNFPA 2015: WHO 2015: UNAIDS, 2015). However, despite the perceived importance of condom use in providing protection, in Uganda condom use rate is low 26.4% among adolescent girls and 41.4% among adolescent boys (WHO-SRH, 2021) and the data of condom use and STIs infection rate in Amolatar district are lacking. There is also reported high rate of HIV infection among the adolescents 6.4% in Amolatar district (DHIS 2 Report 2022). In Amolatar district, the percentage of unintended pregnancy is even higher at 60% (HMIS Report, 2023). There is therefore a need to determine the prevalence and factors associated with use and non- use of condoms among adolescents in selected health facilities in Amolatar district.

1.3 General objective

To determine the prevalence and factors associated with use and non- use of condoms among adolescents in selected health facilities in Amolatar district

1.3.1 Specific Objectives

1. To determine the prevalence of condom, use among adolescents in selected health facilities in Amolatar district.
2. To identify the factors that enhances condom use among adolescents in selected health facilities in Amolatar.

3. To establish inhibitors to condom-use among the adolescents in selected health facilities in Amolatar.

1.4 Research questions

a) What is the prevalence of condom utilization among adolescents in selected health facilities in Amolatar?
b) What are the factors leading to condom use among adolescents in selected health facilities in Amolatar?
c) What are the inhibitors to condom use among adolescents in selected health facilities in Amolatar?

1.5 Scope of the study

1.5.1 Content scope

The study will focus on adolescent condom use, as correctly using external (male) condoms and other barriers like internal (sometimes called female) condoms and dental dams, every time can reduce (though not eliminate) the risk of sexually transmitted diseases, including human immunodeficiency virus -HIV and viral hepatitis. Using condom correctly every time can also help prevent pregnancy (Bearinger, 2011). It will also look at the prevalence of condom use in Amolatar since almost 14% of Ugandan adolescent is sexually active by 15 years and over 50% by age 18 (Rijsdijik et al, 2012).

1.5.2 Geographical scope

The study was conducted in Amolatar district. It is located in Northern Uganda with coordinates of 1° 37'59.99" N, 32° 49'59.99" E, latitude: 1.6350 and longitude:

32.8250. It is approximately 156km from Kampala via Lake Kyoga through Nakasongola district and it borders Apac in the north, Dokolo and Kaberamaido in the east, Kamuli and Kayunga in the South and Nakasongola in the west. The district covers an area of 1750.1km^2 of which 15% is under open water while 6% is under forest leaving 79% of human settlement. The district has a population of 181,956 people (UDHS, 2022) and with 16 sub counties namely; Amolatar town council, Etam and Namasale town councils including Arwotcek, Abeja, Akwon, Aputi, Opali, Agikdak, Muntu, Nalibwoyo, Agwingiri, Awelo, Etam, Namasale and Acii sub counties. It comprises 86 parishes and 589 villages all together. It has two counties of Kioga, and Kioga north. Health services are delivered by 13 health facilities that include; one hospital (PNFP), one health center IV, six health center IIIs and five health center IIs (Amolatar District local government 2020). However, the study will be focused on the /health facilities covering five sub counties of Muntu, Aputi&Etam Sub Counties and Namasale and Amolatar Town Councils.

1.5.3 Time scope

The study was meant to be done for one year from the month of March 2022 to March 2023. However due to various challenges e.g. the length of data collection, entry to mention but a few, it was not possible to finish in that time slated.

1.6 Justifications/significance of the study

According to Uganda Demographic Health Survey report 2011, there is nearly a national knowledge about condoms among Ugandan adults, but this knowledge is not translated into use as only 2.7% of adults reported condoms use regularly (UNFPA,

2014). And only 15% of sexually active adolescents aged 15-19 years have ever used a condom (Rijsdijik et al, 2012).

Dissemination of correct information about the importance of condom as well as distribution and appropriate use of available guidelines on reproductive and sexual health services and rights remains a challenge.

Findings of this work will contribute to the promotion of healthy living and minimize social economic challenges including cultural perceptions that result from limited uptake of condoms by demystifying the concerns regarding condom use through counseling and health talks that will involve the cultural and other leaders. It is also hoped that the research findings will contribute to knowledge about condom use among adolescents and will find out enablers and barriers to condom use. Information generated will also help strengthen the dissemination and use of sexual and reproductive health guidelines on adolescent services and rights. It will also contribute by adding literature to available one on condom use.

1.7 Study variables

The measurable attributes that shall vary across participants involved in this study include age, sex, religion, marital status and level of education, use of condom and non-use of condom. These are presented in the conceptual framework below:

1.8 Conceptual framework

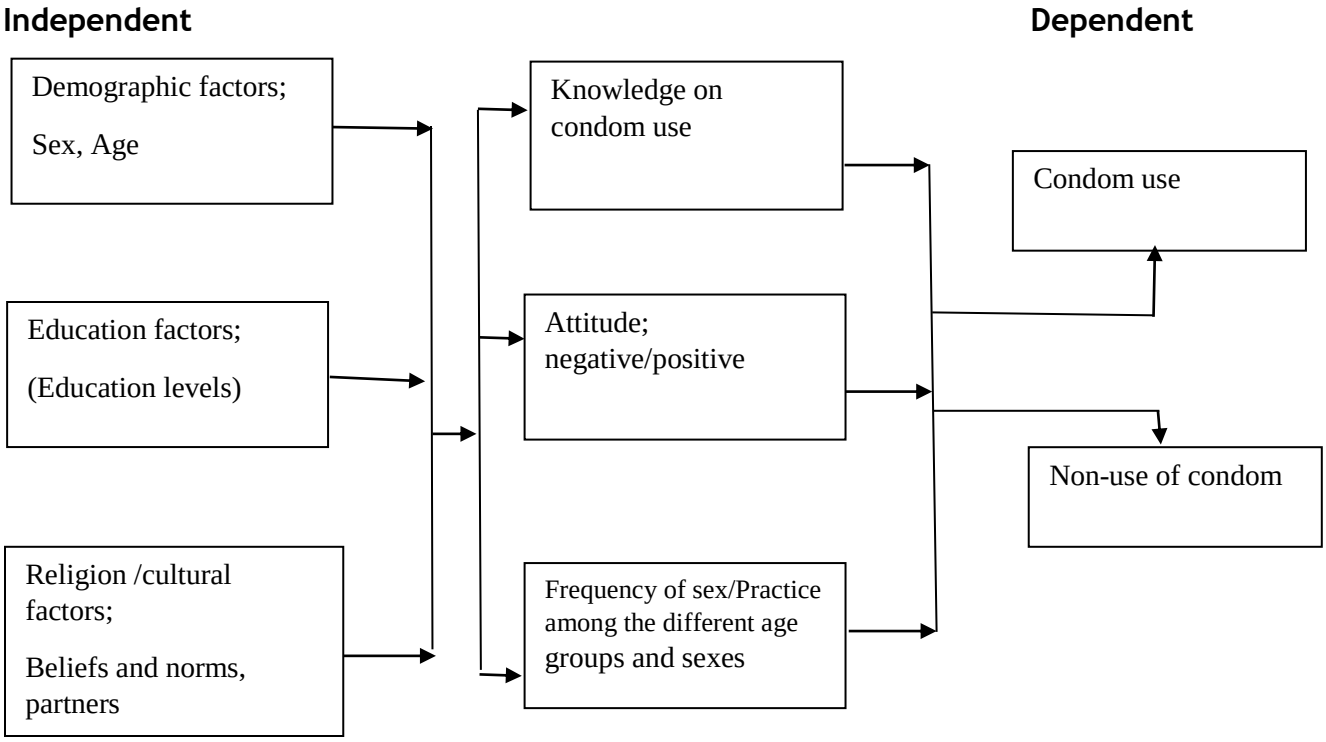

Figure 1: Conceptual Framework

Condom use or non-use is affected by a number of factors. In this case the figure 1 indicates that the decision to use condom is affected indirectly by demographic factors, education factor, religious and cultural factors, which intern affect a person's knowledge on condom use, attitude of a person and practices undertaken by the person.

This study is guided by the theory of planned behavior put by Ajzen, (1985). The theory begins by identifying the behavior of interest, when done; it focuses on the intention to perform the behavior. The theory poses that the stronger the intention the more likely it is for the behavior to be performed. However, the behavior will only be performed if one has control in terms of resources and skills. According to

Ajzen, the intention to perform a behavior depends on attitude towards the behavior, subjective norms and perceived behavioral control. One will figure if the behavior brings positive or negative out come before doing (attitude), then figure what the society feel about the behavior (Subjective norms) and finally figure out the resources, and skills to perform a behavior (perceived behavioral control). In the context of condo use one will only use condom if he/she feels no negative pressure from the society and has resources or ability to acquire condom.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.0 Introduction

The focus of this chapter is on the related work done by others elsewhere on condom usage among adolescents. The chapter has been structured into themes of condom use, prevalence of condom usage among adolescents, factors that enhance condom use among adolescents and inhibitors to condom use among the adolescents.

2.1 Condom use

Condom remains the single most efficient and available technology to reduce transmission of HIV and other sexually transmitted infections. In addition, most adolescents use condom to prevent early pregnancies. The level of condom use is still low despite the perceived importance (Wamalwa et al., 2015). This has been attributed to a number of factors. Mburano et al., (2020) pointed factors such as: family characteristics, extra- family characteristics, exposure to media and individual characteristics as factors that can either, enhance or inhibit the use of condom among sexually active people. Noll et al., (2020) assert that multiple partners among males are responsible for condom use while the reverse for females. On the other hand, Mucheri et al., (2021) noted that reduced sexual pleasure, condoms can come off inside the woman, fear of mistrust in one's partner and itchiness cause by condom and discomfort are some of the reasons why people don't use condom.

2.2 Condom use prevalence among adolescents

Yau and Adamu, (2020) in their research "Prevalence and correlates of contraceptive use" found that the prevalence of contraceptive use at the most recent sex was

75.8%, with the majority (84%) opting for condoms, 5.8% using the rhythm/calendar method and 10% is using emergency pills. Looking at the pick of the school no mention of the reason why the three schools were picked to participate.

Logie*et al.*, (2018) conducted a research titled "Sexual practices and condom use among a sample of Northern and Indigenous adolescents in Northern Canada: the findings indicate that among sexually active individuals (n=115; 18.9%) less than half (n=54; 47.0%) reported past 3 months' consistent condom use.

Agyeng *et al.,* (2019) did a study "Contraceptive use and associated factors among sexually active female adolescents in AtwimaKwanwoma District, Ashanti Region-Ghana" they used a cross sectional survey design. All the female adolescents in the selected household within the age bracket and had consented were surveyed. Results show that, a larger proportion (82.0%) of participants did not use contraceptives. Also a significant proportion 33.3% of those who used contraceptives reported using condoms with 11.1% reporting use of pills. This study focused only on female adolescents who in most cases have very limited voice when it comes to using condom and other contraceptives and they are always at the mercy of their male partners this might have affected their results. There was also an element of those who could not read and write and they were assisted by a team of the researchers this could have also skewed the results.

Pengpid and Karl, (2020) in a study titled "Prevalence and Correlates of Sexual Risk Behavior among School-Going Adolescents in Four Caribbean Countries". Data analysis was done using STATA version 15.0 descriptive statistical and logistical regression

analyses were run. From result, there was 28.4% condoms use in the last sexual encounter, 26.6% in the Dominican Republic and 33.8% in Trinidad and Tobago.

Health Communication Capacity Collaborative (HC3), (2014) did a consultative research in Washington D.C. titled "Condom Repositioning for Adolescents Expert Consultation",225 articles were reviewed and findings indicate that, among casual partners, condom use was much higher compared to serious or steady partners. For example, there was 39% lower likelihood of using condoms by adolescent's boys in a steady relationship than adolescent boys in casual relationships in Brazil.

Moreira et al., (2018) in their study "Condom use in last sexual intercourse among undergraduate students: how many are using them and who are they?" Results indicate that, the prevalence of condom use in the last sexual intercourse was 41.5% (95% CI: 38.7-44.3). Among the groups with the lowest prevalence are undergraduates who did not use a condom at the first sexual intercourse (27.5%) and those who started their sexual life at the age of 14 or less (29.3%). Their finding also shows that University students married or with a partner represented just over a quarter of the sample, and the group had the lowest prevalence of condom use at the last sexual intercourse.

Siu *et al.,* (2021) in their research "Rate of condom use among sexually active adolescents: a nationwide cross-sectional study in Taiwan from 2012 to 2016" Data was collected from 2012 to 2016 two-step probability proportional to size sampling technique was used first to select the sample schools from each geographical area and then classes to participate from the selected schools. All the students in the selected

classes were allowed to participate. Questionnaires were used to collect data. Descriptive, chi-square and logistic regression analyses were performed to generate meaningful information from the data collected. Findings from this study indicate a decreased in condom use rate from 57.07% at first sex to 25.72% at last sex. There was no statistical difference in condom use between male and female adolescents at both first and last sex, with p=0.3164 and p=0.9545, respectively. Condom use did not differ significantly between male and female across all school types.

Putra et al., (2018) conducted a study "Prevalence and determinants of condom use among male adolescents in Indonesia" the study was a cross-sectional using 1341 participants, descriptive and logistic regression for bivariate and multivariate analyses was used. The study found that, the prevalence of condom-use among male adolescents at first and last sex accounted for 25.0% and 27.4%, respectively. The study however focused on male excluding it was therefore not possible to detect how the female counterparts faired in the same area with males. This would have provided better information on condom use and the possible solutions to the issues arising from both genders.

Hooshyar *et al.*, (2018) did a study in Iran titled "Condom Use and its Associated Factors Among Iranian Youth: Results from a Population-Based Study" a non-randomized multistage sampling approach was used, questionnaires were used for collecting data which was then analyzed using STATA version 13.0, descriptive statistics, chi-square test, univariate and multivariate analyses were run. Of the 633 participants in the study, 35.1% subjects reported using a condom at last sex.

Kortsmit et al., (2019) studied postpartum adolescents; the title of the study was "Condom Use with Long-Acting Reversible Contraception vs. Non–Long-Acting Reversible Contraception Hormonal Methods among Postpartum Adolescents". A cross-sectional survey design was used. Questionnaires were used in data collection multivariate analysis was done. Results indicate a 28.8% condom use of among teenagers. Users of LARC hormonal methods were half as likely to use condom compared non-LARC hormonal methods (17.8% vs. 35.6%; adjusted prevalence ratio (aPR), 0.50; 95% CI, 0.41-0.60). Users of IUDs (15.1%) were less likely to report condom use than those using an implant (21.5%; aPR, 0.70; 95% CI, 0.51-0.98), patch, ring, or injection users (24.9%; aPR, 0.61; 95% CI, 0.47-0.79), and pill users (47.2%; aPR, 0.32; 95% CI, 0.25-0.40).

2.3 Factors that enhance condom use among adolescents

A number of researchers have done studies to assess factors that enhance condom use among adolescents; Davids et al., (2021) in a study titled "Exploring condom use decision-making among adolescents: the synergistic role of affective and rational processes" A qualitative descriptive research design was used, the participating schools were stratified into non- fee schools and fee schools. The schools were then randomly selected to participate from each stratum. Data was collected using a semi-structured interview guide, coded and analyzed. Results from this study show that, the adolescents' condom use was marked by anxieties about the future, which they thought would be compromised if they engaged in condom less sex and consequently contracted a sexually transmitted infection or became pregnant.

Meekerset al., (2003) found that male youths were more likely to use condoms especially if they had a high perceived risk of STIs, perceived effectiveness in family planning, knowledge of condom source within 10 minutes walking distance and having multiple partners, were among the factors responsible for condom us among the male adolescents. On the other hand, the factors that significantly affect the likelihood of ever having used a condom include perceived effectiveness of condoms for family planning, those that perceived condoms to be effective in family planning were 3.5 times more likely to use condoms. Condom access, perceptions of reduced pleasure, parental support for condom use, number of sexual partners, and level of education.

Szucs et al., (2019) in their research "Condom and Contraceptive Use among Sexually Active High School Students: Youth Risk Behavior Survey, United States, 2019. A cross-sectional school based biannual survey was conducted since 1991. Questionnaires were used to collect data; data was analyzed using SUDAAN version 11.0.0: RTI International. Their findings show that what enhanced students to use condom was that condom prevents pregnancy. This was indicated by 43.9% of respondents.

Noll et al., (2020) in their study titled "Associated factors and sex differences in condom non-use among adolescents: Brazilian National School Health Survey (PeNSE). Questionnaires were used during data collection; the questionnaires were sent to students' smart phones. Data were analyzed using g descriptive statistics and the Wald chi-square test of association (bivariate analysis) for the outcome of condom non-use. They found that, having multiple partners among males was responsible for condom use while the reverse for females. This clearly indicates that females are always under the mercy of their male counterparts during sexual intercourse.

Ajayi et al., (2019) in their study "Factors associated with consistent condom use: a cross-sectional survey of two Nigerian universities" the study was a cross-sectional study, the participants were stratified into females and males with proportional samples selected from both strata. Questionnaires were used as a research tools, the questionnaires were self-administered by the researchers. Data was analyzed using SPSS version 24. Descriptive statistics, adjusted and unadjusted binary logistic regressions were run. It was found that knowing one's sexual partner's HIV status increases the odds of using condom. It was also found that discussion of HIV/STIs with a sexual partner is associated with a higher likelihood of consistent condom use.

Barchi et al., (2021) studied adolescents in the Northwestern Botswana. In their study "Social and Behavioral Correlates of Adolescent Sexual Experience and Intention to Use Condoms in

Northwestern Botswana". A cross-sectional research design was used; semi structured questionnaires were used to collect data. Computer package STATA was used to analyze data. Descriptive, bivariate and logistic regression analyses were run. It was found that the major reasons for using condom was its efficacy in preventing pregnancy and protecting against HIV and other diseases that can be transmitted through sex.

2.4 Inhibitors to condom use among the adolescents

Among inhibitors of condom use, (Meekers et al., 2003) found that females believing that condoms reduced pleasure were 2.1 times more likely to report having not used a condom in the last sexual intercourse.

Sandy et al., (2019) in a study "Sexual behavior among adolescents living with the human immunodeficiency virus in Zimbabwe: educational implications" used a cross-sectional study design, questionnaires were used to gather information; assistance was given to participants who could not complete the questionnaires on their own by the researcher or the research assistant. Data was entered in Epi info version 3.5.1, exported to STATA VERSION 10. Bivariate and multivariate analyses were run. It was reported that 59.5% of the participants reported not having used condoms when they had sex. Participants gave the following reasons for not using condoms: 54.5% condoms were often not readily available; 13.7% stated that condoms reduced their sexual pleasure; 13.7% reported a lack of skill in how to use condoms; and 18.1% reported that they disliked using condoms.

Noll et al., (2020) in their study titled "Associated factors and sex differences in condom non-use among adolescents: Brazilian National School Health Survey (PeNSE). Questionnaires were used during data collection; the questionnaires were sent to students' smart phones. Data were analyzed using g descriptive statistics and the Wald chi-square test of association (bivariate analysis) for the outcome of condom non -use. Findings indicate that, substance use (smoking, drinking, and taking drugs) was strongly related to condom non-use, having many sexual partners among females was related to non-condom use.

Ajayi et al., (2019) did a study in two Nigeria universities and found that factors responsible for non-condom use were; trust on the partners, unavailability of condoms, dislike of condoms and a perception that condoms reduce pleasure. The

perception that condom reduces pleasure take the lead in the reasons for non-condom use.

Bankole et al., (2007) in their study "Knowledge of correct condom use and consistency of use among adolescents in four countries in Sub-Saharan Africa". Two stage stratified sampling design was used, first to select households and secondly to select respondent from the selected households. Questionnaires were used to collect data from prospective respondents. Descriptive and multivariate analyses were run. The study revealed that the reasons for not using condom as reported by respondents were: "felt safe" and "didn't have condom". Specifically, 28% said they felt safe and 30% reported that they didn't have condom in Burkina Faso. In Ghana 35% said they felt safe and 24% reported that they didn't have condom. In Malawi 45% said they felt safe and 37% reported that they didn't have condom and in Uganda 35% said they felt safe and 24% reported that they didn't have condom. Another reason given for not using condom in Burkina Faso and Ghana was need of getting pregnant by 29% and 22% respectively.

Mucheri et al., (2021) conducted a study titled "Knowledge of HIV Prevention Methods among Adolescents in Ghana" they employed both purposive and stratified simple random sampling for the wards and respondents respectively. Sample proportionately, proportional to size approach was used to determine the number of participants per ward to participate in the study. Data was collected using questionnaires and focus group discussion guide. Data was entered in to a computer package SPSS and analyzed. This study did not give the specific analysis run to generate meaningful information. However, results indicate the reason why some did not use condom

included: reduced sexual pleasure 49%, condoms can come off inside the woman 51%, they show lack of trust in one's partner (43%) and that condoms cause itchiness and discomfort 56%.

Cumber & Tsoka-Gwegwen, (2016) in a study "Knowledge and practice of condom use as well as perceived barriers among street adolescents in Cameroon" the cross-sectional survey which employed the use of questionnaires for data collection, snowballing sampling technique was used to get participants. Data was entered in computer package Excel 2010 and imported to SPSS and analyzed. Descriptive statistical, and chi-square tests run. The study found that inhibitors of condom use were: discomfort, painful nature, partner did not care, not have HIV and/or AIDS, condoms hinder sexual satisfaction, not having condom at the time of intercourse and being drunk and forgetting condom.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This section presents research paradigms, methods, design, study population, study area, sampling procedures, sampling techniques data quality control, ethical considerations, data analysis methods and tools used in analysing the data in the study.

3.1 Study design

A descriptive cross sectional survey, facility- based was used in this study. A mixed method of both quantitative and qualitative study approach was used. Data were collected, by using focus group discussions and questionnaires. A mix of these methods was to help in triangulation of results. Quantitative study results enabled establish the prevalence of condom use, and qualitative study findings helped ascertain factors contributing to use or non-use of condoms in the study area of Amolatar district.

3.2 Study population

The study population was the adolescents in Amolatar district who are sexually active. The focus was on those between the ages of 15-19 years.

3.3 Study area

The study area composed of the selected health facilities in the original four Sub-counties of Muntu Sub-county, Aputi Sub-County, Namasalesub-county and Awelo sub-county including one town council i.e. Amolatar Town Council where Amolatar HCIV is located. The sub-counties and the one town council cover the whole district and therefore participants were selected from all corners of the district.

3.4 Study sites

The study was conducted from five different health centers with-in Amolatar district which included one health center II in Muntu sub county, three health center IIIs each from Namasale, Aputi and Awelo sub-counties and one health center IV in Amolatar Town council but originally in Muntu; the health centers are located in the different sub-counties within the district. They are spread out in the different corners of the district.

MAP OF AMOLATAR DISTRICT SHOWING THE HEALTH FACILITIES AND SUB COUNTIES

Figure 2: Map of Amolatar Showing Sub-counties and Health Facilities

Eligibility criteria

Inclusion

- Sexually active adolescents
- Adolescents 15 to 19 years

Exclusion

- The adolescent dump and deaf because the researcher and the assistants do not use sign language.
- Sick to go through the process
- Parent /guardian refusal

3.5 Sample size calculation

Significance level was 95%. This means 95 out of every 100 samples had a true population value within the margin of error specified (5%).

A sample of 194 respondents was obtained from a sampling frame that contained 378 adolescents, using the formula,

n = $\frac{N}{1+\mathrm{N}(e)^2}$ used by Israel,(1992). Where:

n = the sample size,

N = estimated population size and

e =level of precision (0.05).

3.7 Sampling technique

The health facilities from which the adolescents get health care services were randomly selected from each cluster (sub-county) by drawing a lot. Each sub-county on average had two health facilities and only one health facility (HCII or III) was randomly selected from each cluster to participate by drawing a lot this resulted to four health facilities. However, Amolatar health center IV was purposely selected to participate being the only one in the district, bringing the total number of participating health facilities to five. A proportion to size approach (51%) was used to obtain the number of participants to be considered from each selected health facility.

The adolescents in the selected health facilities were requested to participate in the study after mobilization. The adolescents were then subjected to simple random sampling to draw out participants from each participating health facility. A random number table was used in the process and those whose numbers corresponded to that on the random number table, participated in the study

3.7 Sampling procedure

The principal investigator selected randomly the health centers to participate in the study, the target group i.e. sexually active adolescent, aged 15-19 years using simple random sampling. These included boys and girls who were found to have visited the different health centers which have health workers with skills in handling adolescents well enough. These health centers are located closed to where they (adolescents) lived and this is where they routinely go to seek health care services. The health centers were clustered according to sub-counties. This was done by putting all the health facilities in a given sub-county in one group called a cluster. Using simple random sampling technique, health centers that participated were selected. Adolescents from the selected health centers were mobilized by use of mega-phones which were available in the community and these were being used by village health team members. Radio announcement was also run in order to attract the adolescents. Three hundred and seventy-eight (378) sexually active adolescents 15 to 19 years were mobilised and came to health facilitiesand they formed a sampling frame. They were then assigned numbers by the principal investigator and his research team and 194 wereselected using a random number table to participate in the study. This was done by selecting those whose numbers corresponded to that on a random number

table. Consideration was made and information was obtained from adolescents by way of administering questionnaires. The adolescents were also mobilized into 6 groups of twelve people with three for each gender for focused group discussion. However before participating in the study, the adolescents were told of the nature of the study and the consent of all the adolescents 18 and above years was asked and they consented by signing a consent form. For the minors of age 15-17 years their parents/guidance were contacted and invited to the health facilities and asked for their consent and if allowed the minor assented by signing the assent form, hence allowing for voluntary participation.

Variability: This is the population variance of a given outcome that is estimated by the standard deviation. The researcher can use an estimate obtained from a pilot study or the reported variation from previous studies.

Type I error: Is the rejection of a true null hypothesis. In other meaning, a type I error is corresponding to the level of confidence in sample size calculation, which is the degree of uncertainty or probability that a sample value lies outside a stated limit.

Type II error: This is failure to reject a false null hypothesis; this corresponds to power, which means the ability of a statistical test to reject the false null hypothesis. Power analysis can be used to calculate the minimum sample size so that the investigator can detect an effect of a given size".

Effect size: The effect size "is the minimal difference between the studied groups that the researcher wishes to detect or the difference between estimation and

unknown parameter which researcher wants to estimate. Therefore, one can make a statement that it does not matter how much the sample estimation differs from true population value by a certain amount. This amount is called minimum effect size". Stratum

3.8 Data collection methods and tools

Questionnaires

These were used to obtain both qualitative and quantitative information from adolescents for. The questionnaires were pre-tested by giving it to 10% equivalent of the potential participants from a non-participating health center. The necessary adjustments were made to ensure accurate data was collected. The questionnaires were developed in English and translated in Luo to cater for participants who could not understand English without changing the meaning. Participants stated their views or feelings privately without worrying about the possible reaction of the researcher, though some people can be inclined to try to give socially unacceptable answers. Here participants/respondents were encouraged to answer the questions as honestly as possible to avoid drawing false conclusions from the study.

The questionnaires contained structured both open and closed ended questions. Closed ended questions facilitated collection of specific information which was easy to categorize while open ended questions ensure more details were provided by the respondents without restriction.

Focus group discussion (FGD)

Focus group discussion guide was developed and also used to collect quantitative and qualitative information from adolescents. Focus group discussions were carried out in groups at the health facility. The adolescents were requested to participate in the FGD. Seventy-two adolescent were randomly selected from the original 194 participating adolescents (36 males and 36 females) to form groups for focused group discussion. They were then grouped in two according to sex of males and females. Each sex group was sub-divided into three, for both male and female adolescents each sub-group had 12 members making a total of six focus groups. The researcher used a focus group discussion guide to direct him on what questions to ask. And audio recording was used after participants gave permission; also one of the assistants took notes and audio recording done.

3.9 Training Research assistants by the principal investigator

This was critical since the research assistants played a major role in determining quality of the data. From designing the survey to conducting interviews, entering, managing, cleaning and analyzing data. The principal investigator recruited total of four (4) data collectors' two males and two females of an average age of 28.25years organized a 2-daystraining for all the participating assistants to ensure they know the study and their roles in the study. The research assistants were taken through the proposal including data collection tools. The tools were translated from English to Luo and then back to English during the training to ensure that the meanings are not lost during data collection.

3.10 Data collection procedure for the quantitative data

A pretest study was conducted to test data collection tools to be used before the main study this helped the researcher to make the necessary adjustments needed; Data from the pretest study was not included in the analysis of main study. The researcher introduced himself to the participants and also requested the participants to introduce themselves. Respondents in both the pilot and main study were requested to consent before participating. For the minors, their parents/guardians were asked for permission to allow them participate. This was done during the mobilization exercise.

Questionnaires were distributed to respondents, the questionnaires were self-administered, filled and the researcher picked them up.

Also 72 adolescents were randomly selected from the participating adolescents (36 males and 36 females) to form groups for focused group discussion. They were grouped in to two groups and focus group discussion conducted. The focus group were conducted with two categories of adolescent i.e. first group all males and second group all females each group was sub-divide into three making a total of six group of 12 members. The adolescents were grouped according to sex to protect their views from the opposite sex which could have caused problems of shame for indulging in sex. During the discussion there was no introduction to protect their identity. Data collected was organized in themes for analysis.

3.11 Data quality control

3.11.1 Validity

The questionnaire was pretested under supervision of the principal investigator on about 10% of the sample size in an area (sub-county) which was not among the sub-counties selected to participate in the study. The necessary modifications were made by the research team before more copies were produced.

During data collection every questionnaire was checked for completeness before being collected from each study participant. The questionnaires were then reviewed on a daily basis and checked for progress by the principal investigator and one research assistant and every morning before the team move to the field, the team meet to review the previous day experience, challenges and agree on corrective measures.

3.11.1 Reliability

Reliability of the instrument were ensured by test and re-test method. The researcher gave the questionnaires to a group of respondents and re-tested with the same group. Similar responses were obtained from the same groups at different times therefore the instrument were considered reliable.

3.12 Data entry and analysis

Questionnaires were filled then checked to find out if they were consistent and complete. They were then entered into Epi Info Version 7 on a daily basis. This was earlier on designed to ensure that the data clerk makes no data entry errors. This was easily achieved by applying check codes to each of the questions to allow data that

was expected to be entered and also reject duplicated and illegal entries. After all were entered, a line list of the data entered was exported to Microsoft Excel for further data cleaning and there after exported for analysis in a statistical manner.

3.13 Data analysis

Data was analyzed using STATA version 15. Inferential and descriptive statistics were both used in the analyses. For objective one descriptive statistics was used where percentages and frequencies were generated for categorical variables and means plus standard for numerical variables using Pearson chi-square tests for categorical data. For objective two, all the variables with p value = 0.2 or less were declared significant in the bivariate analysis. Factors with P values less than 0.05 at bivariate analysis were included in a multivariable logistic regression model to determine predictor variables were independently associated with the outcome. Significance difference was defined as P-value less than 0.05 and Odds Ratio (OR) that did not include 1.0. On the other hand, focus group data inform of audio was transcribed, and put under appropriate themes in the study.

For qualitative data, analysis was done using content/thematic and narrative analyses where information was put according to themes in the dissertation and narratives as given by respondents indicated by quotations.

3.14 Approvals

The research student sought for ethical clearance to conduct the study from the ethical review committee of Uganda Christian University. Written permission was sought from the office of district chairperson (LCV) Amolatar. The district health

officer Amolatar was requested for permission to conduct the study; including health facilities and local council one (LC1) leaders where the studies were carried out (Uganda National Council for science and Technology, 2014).

3.15 Ethical consideration

The study involved human participants who were adolescents, where special concerns related to them were considered

a) Below 18years, the adolescents were given assent form after consent from their parents/guardians allowing them participate in the study and those 18 and above years were given consent form to sign before they participated in the study.
b) Guard against intimidation of the adolescents
c) Ensured voluntarism
d) Guarded about Vulnerability
e) Ensured permissions were given to avoid social harm
f) No Participants names on the questionnaires (Used numbers)

The researcher conducted the study in utmost ethical manner.

3.15.1 Consenting process

Informed consent/assent was central to the ethical conduct of this research with participants who were above or less than 18 years. Researcher obtained informed consent/assent fully from all the people who participated in the study. The informed consent/assent document was signed or thumb printed by each participant, parent or guardian and also the researcher before the study commenced. This principle

prohibited the use of incomplete disclosure of the nature of the research, deception and so called “passive consent.” Participants who were children (under 18) or not competent got consent from their parents/guardians to participate, after which they assented by signing assent form. The informed consent and assent presented information in sufficient detail relating to the research and organized and presented in a way that did not merely provide list of isolated facts, but rather facilitates the prospective participants or legally authorized representatives understanding of the reasons why one might or might not want to participate. The consent/assent process involved the following;

A statement that the study involves research, an exception of the process of the research and the expected duration of the participants’ involvement, description of the procedures to be followed and identification of any procedures were fully explained to the adolescents.

The following also governed the consent process:

- Prospective participants were free to consider whether to get involved (i.e., they were not rushed, not given payments, nor other undue influence or coercion be exerted).
- Voluntarism. A participant had the liberty to freely engage in the study and also withdraw his or her participation consent at any point in time if they felt so.
- The informed consent document was written in English and also translated to lango to ensure the participants understand all the processes. Non-English

speaking participants were given the translated document to ensure they understood what they were getting involved in and make appropriate decisions of enrolling or not enrolling in the survey.

- Those participants unable to read and write were assisted by research assistants/principal investigator to read and record their responses.
- Consent and assent forms were retained and kept with the researcher under safe custody for long as possible following conclusion of the research project for any emergency and a copy remained with each participant.

3.15.2 Privacy and confidentiality

To ensure that there was confidentiality, the questionnaires were numbered and the names of the different respondents were not required for filling in the questionnaires. Respondents were given the necessary privacy while they filled the questionnaires. This was ensured by isolating them under trees away from the other participants or any other people around them before the filling in of questionnaires were done focus group discussion were also done separately by gender under trees to avoid stigmatization. The information gathered were strictly kept confidential and could only be accessed by the research student (PI).

3.15.3 Compensation

There was no compensation for participating in the study and this was made known to the participants before they chose to be a part of the study or not.

3.15.4 Risks and benefits to participants

The risk of participating in this study may be realized when an adolescent who participates may be stigmatized especially the females by the male knowing they had been in a sexual relationship. However, there were no harm and no any violent conduct realized during data collection.

No benefits to the individual participants, however, the study may be of benefit to adolescents in that it might offer guidance on proper use of condoms to prevent unwanted pregnancy, through the study, those who needed condoms were provided and also they were directed to where they can have access to free condoms.

3.15.5 Voluntarism

The participants were free to participate, stop in the middle, or withdraw completely from participation without losing benefits of being attended to in the facility by health workers.

3.15.6 Declaration of conflict of interest

Conflict of interest in research refers to “a set of conditions in which professional judgment concerning a primary interest tend to be unduly influenced by a secondary interest hence influencing the outcome of the study” (Thompson, 2017). The research student had no conflict of interest whatsoever and thus declared it in this study.

3.16 Study limitations

In this research that involves surveys amongst people, the challenge of limited access to the respondents was common especially the adolescents who usually required a dynamic approach in order for them to be open enough and share vital information

that was required for the research. However, this was minimized through proper mobilization and sensitization. Any adolescent below the age of 18 years, were contacted through his/her parents or guardians. The risk of the parents/guardians refusing their children from participating was minimized by properly explaining the purpose of the study to them.

3.16.1 Conflicts arising from personal bias and other issues

Researchers are at times biased in views due to their cultural or religious background or perspectives like this subject of condom use. This can affect the study's legitimacy. There can also be bias toward data and results that only support the hypothesis or arguments. In order to avoid these problems, the principal investigator examined whether the way the problem was stated was in line/appropriate with the data collection. Training of research assistants (data collectors) was done to minimize personal bias

CHAPTER FOUR: RESULTS

4.0 Introduction

In this chapter findings of the research are presented, pointing out characteristics of participants, factors that enhance condom use among adolescents and factors that inhibits condom use among adolescents in Amolatar district.

4.1 Social Demographic Characteristic of Participants

One hundred and ninety-four adolescents were recruited to participate in the study including 100boys and 94 girls. There was a difference between boys and girls in terms of age. Boys were significantly older than girls (X^2= 5.2577, *P=0.022*)

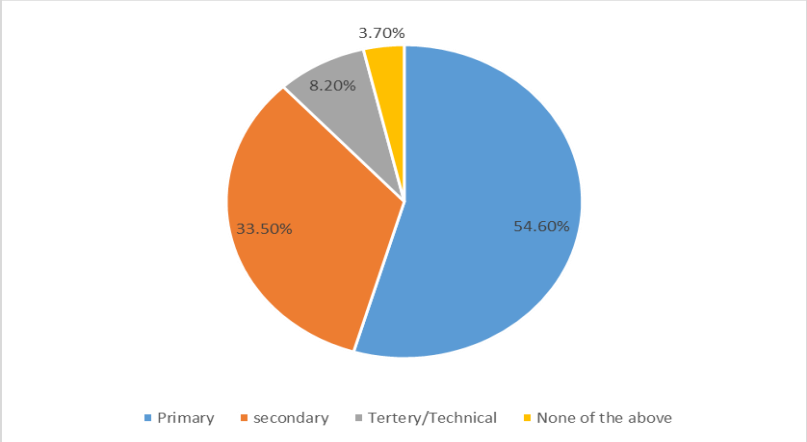

Figure 3: Level of education of Participants

Majority of the participants 106(54.6%) were in primary school (figure 3) and 7(3.7%) had had no education. Boys were more educated than girls (X^2 = 12.2232, *P= 0.007*).

In terms of religion (figure 4), 134(69.1%) were Christians, 27(13.9%) were born again, 18(9.3%) were seventh day Adventists, 13(6.7%) were Muslim and only 2(1%) had no religious affiliation.

Regarding marital status, majority of respondents 173(89.2%) both boys and girls were unmarried.

4.1.1 Knowledge about Contraceptive and sources of information

Table 1: Sources of Contraceptive Information

Major Source of contraceptive information	Frequency (n)	Percentage (%)
Radio	48	25.7
Friends	54	28.9
Health Worker	80	42.8
Parent	5	2.6
Total	**187**	**100**

The Study revealed that, 187(96.4%) of respondents heard of contraceptives. And the main source of information (table 1) was health workers in 42.8%. Parents were the least to offer information of contraceptives (2.6%) to adolescents.

Table 2: Contraceptive Methods Known by Participants

Contraceptive methods known	Frequency (n)	Percentage (%)
Oral contraceptive pills only	26	13.4
Condom only	150	77.3
Implant only	2	1.1
Injectable like Depo-Provera only	9	4.6
N/A	7	3.6
Total	**194**	**100**

The main contraceptive known by adolescents (Table 2) was condoms 150(77.3%), which was also the main contraceptive they had ever used 138/187 (73.8%) and the least used was implant 1(0.5%).

Table 3: Current Contraceptives used by Participants

Methods of contraceptive still use to date	Frequency (n)	Percentage (%)
Oral contraceptive pills	21	12.9
Condom	124	76.0
Implant	1	0.6
Injectable like Depo-Provera	5	3.1
Oral contraceptive pills and condom.	7	4.3
Condom and injectable like Depo-Provera	5	3.1
Total	**163**	**100**

One hundred and sixty-three (163) of the participants were currently using one form of contraceptive or another (table 3). The major contraceptive that was being currently used by the adolescents was condom124/163 (76%) (Table 3). In a few cases there was dual contraceptive use (condom with another contraceptive). However, when adolescents were asked of the use of condom in the last one month, 125/163(76.7%) reported using condoms the rest used other methods.

4.2 Prevalence of condom use among adolescents in Amolatar District

One hundred and twenty-five participants 125(64.4%) had used condom in the last month before the study and 69(35.6%) did not used condom. During focus group discussions both groups, i.e. male and female agreed that majority of adolescents use condoms during sexual intercourse mainly for fear of pregnancy. Regarding the type of condoms used all the groups agreed that they use male condoms (One male participant stated that "*Female condoms don't exist*".

Table 4: Consistent use of Condoms by Adolescents in last one month

Use of condom during every sexual encounter	Frequency (n)	Percentage (%)
Yes	107	85.6
No	18	14.4
Total	**125**	**100**

Those who at least used condoms in the last one month were 125, majority 107/125 (85.6%) reported using condom each of the time they had sex (table 4). However, during the focus group discussions both girls and boys said although condoms are used by most adolescents, they are not used consistently every time the adolescents have sex. The main reasons for using condoms by adolescents were stated as: prevention of contracting STDs 98(78%) and prevention of unwanted pregnancies 27(22%).

Although the numbers of respondents were few (27) in the category of non-use, the reasons for their non-use of condoms ranged from, condoms wasting time before indulging in the act, other methods are cheaper compared to condom, other methods have long lasting effect, fearing that condom may burst, difficulty to access condom due to not being easily available and also the cost and fearing that condom can cause cancer

4.2.1 Condom use by married adolescents

It was of interest to find how often the married adolescents used condoms and why they used it. Married adolescents among the study group were few (21). Thirteen used condoms in the last one month. Condoms were used mainly to prevent pregnancy (child spacing) among the married.

4.2.2 Who provide condom during sexual intercourse?

Of the 125 adolescents who had at least used condom during sex in the last one month 120(96%) reported that it was the male partners who provided condoms during sexual intercourse, 5(4%) reported female. In terms of sex, all the males among users (74) reported that male partners provided condoms during sexual intercourse. On the

other hand, 46(90.2%) of the females among users of condoms reported that male partners provided condoms and 5(9.8%) reported females.

4.2.3 Source of condoms

Out of the 125 adolescent participants who had used condom in the last one month, majority81(64.8%), of them obtained condoms from government clinics/facility, 23(18.4%) obtained from private clinic/facility, 18(14.4%) obtained condoms from community condom distributors.

4.2.4 Do adolescents discuss to use condom with partner when they are to have sexual intercourse

Majority of the adolescents surveyed 143(73.7%) negotiate with their partners whether or not to use condom when they are to have sexual intercourse, 56(26.3%) did not negotiate. During focus group discussion with the two groups of male and females, all agreed that some partners negotiate to use condom while others don't. They were asked of who initiates the discussion for using condom. In both groups, it was mainly the male partners who initiate the discussion and rarely do female partners. On the reaction of the partner when the discussion is initiated they said the reactions varied: some take it positively while others negatively. One male said "*some girls resist completely the use of condom*". This was due to belief that condom causes cancer, abdominal pain and itchiness caused by condom use.

4.2.5: Can adolescent correctly demonstrate how to use condom (observe)

It was observed that more than half of the adolescents who used condom 110(88%) correctly demonstrated how condom is used 15(12%) did not correctly demonstrate

how condom is used. Participants' thumb was used to demonstrate how correctly one can use condoms including opening the pack.

Table 5 Differences in Socio-economic Characteristics of users and non-users of Condoms among Adolescents

Variables	Chi-square	p-value
Sex	8.24	0.004***
Age	11.51	0.001***
Level of Education	19.05	0.000***
Religion	4.26	0.51
Marital Status	0.07	0.80
Knowledge of contraception	7.96	0.005**
Ease of condom access	58.38	0.000***
Affordability of condom	36.14	0.000***

A comparison of users and non-users of condom was done chi-square test for categorical variables. Table5 shows the differences between the two groups. Results show that there were differences between users and non-users of condoms. Religion and marital status were not significantly different between users and non-users of condom. Sex, age, level of education, knowledge of contraceptives, ease of access to condom and affordability of condoms were significantly different between users and non-users of condom (X^2=8.24, *P*=0.004), (X^2=11.51, *P*=0.001), (X^2=19.05, *P*=0.000), (X^2=7.96, *P*=0.005), (X^2=58.38, *P*=0.000) and (X^2=36.14, *P*=0.000) respectively.

Table 6: Factors that enhances use of Condoms among Adolescents in Amolatar

Variables	Odd Ratio	Standard Error	p-value
Sex	0.45	0.18	0.041**
Age	1.90	0.81	0.132
Level of Education	0.76	0.14	0.280
Religion	1.18	0.18	0.290
Knowledge of contraceptives	0.33	0.43	0.396
Ease of access	0.29	0.09	0.000***
Affordability	0.36	0.15	0.016**
Negotiation	0.08	0.33	0.000***

Note: 1: Significant at: *10%, **5%, ***1% levels.

A number of factors enhanced adolescents' decision to use condoms (table 6). These included, ease of access to condoms (P=0.000), and affordability of condoms by adolescents (P=0.016) which significantly enhanced condom use among adolescents in Amolatar district.

Table 7: Inhibitors of Condom use Among Adolescents in Amolatar District

Variables	Odd Ratio	Standard Error	p-value
Partner refuses	0.93	0.78	0.122
Condom may cause cancer	0.27	0. 32	0.032**
Condoms remain in a woman	0.72	0.12	0.280
Feel shy to buy condoms	1.15	0.18	0.287
Cannot afford condom	0.36	0.41	0.002***
Condom reduces sexual pleasure	0.31	0.06	0.003***
Condoms can burst in a woman	0.36	0.17	0.206
Partner is circumcised	0.89	0.36	0.211

Note: 1: Significant at: *10%, **5%, ***1% levels.

The major inhibitors of condom use (Table 7) Significant inhibitors of condom use among adolescents in Amolatar district were: belief that condom causes cancer (p=

0.032), un-affordability of condoms (cannot afford condoms) (p=0.02) and condoms reduce sexual pleasure (p=0.003). Other factors were not significant.

Table 8: Comparison of Male and female adolescents in term of condom use in the last one month of sexual intercourse

Variable	Male	Females
Age	n(%) condom use	n(%) condom use
15-16 years	11(44)	19(50)
17-19 years	63(84)	32(57)
Level of education		
Primary	38(74)	26(47)
Secondary	28(76)	23(82)
Tertiary	8(67)	2(50)
No formal education	0	0
Marital status		
Yes	11(79)	2(26)
No	63(73)	49(56)

Of the 25 male adolescent participants age 15-16 years, (table 8)11(44%) had used condoms on the other hand 19(50%) of the 38 female adolescent participants age 15-16 year had used condom. For those age 17-19 years 63(84%) of the 75 male participants had used condom while 32(57%) of the 56 female participants had used condom. It is also evident that education enhances condom use. Also more married male participants used condom than the female

CHAPTER FIVE: DISCUSSION

5.0 Introduction

This chapter discusses findings of the study. Prevalence and Factors Associated with Use of Condoms among Adolescents (Boys and Girls) in Amolatar District.

Adolescent health issues remain a major concern worldwide. In Uganda the population of adolescents stands at 12 million of the 41.5 million people. This contributes 34.8% of the total population in Uganda (UNFPA, 2018). However, in Amolatar District the adolescent population is undocumented

Little is known about the adolescents in Amolatar especially their life Styles. A significant portion of the adolescents in Amolatar are believed to be sexually active. So this study was conducted to find out about condom use among these young sexually active people.

One hundred and ninety-four adolescents (boys and girls) were recruited in the study from different parts of the district to ensure the data was representative enough and give a clear picture of use of condoms in the entire district.

The prevalence of condom use among adolescents in Amolatar district in the last one month of sexual intercourse was (64.4%) and the condoms used were male condoms. Yau and Adamu, (2020) conducted a study in Northern Thailand on contraceptive use and found a similar prevalence of contraceptive use among adolescents with majority of adolescents opting for condoms. The prevalence of condom-use among adolescent in Amolatar district is lower compared to that presented by Yau and Adamu in northern Thailand in the most recent sex 85.4% this may be due to a possible lower

contraceptive prevalence in Uganda and the level of affordability that may affect adolescents in Amolatar district. A similar study was done in Ghana by Agyeng in 2019 among female adolescent and found a lower prevalence of condom use 33.3%, compared to that in Amolatar district, the condom use prevalence among females in Amolatar district was higher51/94 (54.3%). These figures are quite high and yet the girls are passive user since they are neither the initiator nor the providers of condoms during sexual acts. During focus group discussion both groups, i.e. male and female groups all agreed that majority of adolescents use condoms during sexual intercourse. The condoms used are male o*nes. "One male even stated that "Female condoms don't exist"*. Generally, condom use prevalence in Amolatar district was high probably because the study was conducted in selected health facilities and among adolescents who had visited health facilities only and seems to have good health seeking behaviors the adolescents could have provided false information to the investigators just to impress them on condom use prevalence.

Out of the 125 participants who used condom in the last one month, majority were male 100(51.5%) adolescents. Males are confident in seeking and asking for condoms when they need sex and are in good position to use condom than females. Putra et al, (2021) in Indonesia found 27.4% condom use among adolescent boys in the last sex which is lower than among adolescent boys in Amolatar.

In terms of age, younger adolescents aged 15-16 year use less condoms, than older ones aged 17-19 years. This could be because as one grows he/she tends to be exposed sexually and begins to practice the act and may have more knowledge about condoms and why use it.

Looking at condom use against level of education, majority of adolescents that used condoms had had primary level education 64(51.2%), 51(40.8%) were in secondary, 10(8%) were in tertiary institutions and no adolescent condom user had not gone through formal education. The rate of condom use among adolescents increases with level of education (Siu *et al.,* 2021). This research found that majority of condom users were in primary probably because the survey targeted adolescents of age 15-19years. In the study areas people of this age group in most cases are still in primary and a few in secondary due to the fishing activity in the area which make them leave school in search for money. However, there is clear evidence that education is needed for one to use condom probably because with educated one is exposed to knowledge of condom, source, how to use it and also its importance.

By religion, Christians use more condoms compared to born again, seventh day Adventists, Muslim and those with no religious affiliation. This could probably be because there were more Christian participants than other religions. It could also mean that Christian teachings do not restrict the use of contraceptives including condoms compared to other religions. (Barro and Bado, 2021) found that religious leaders were not involved enough in family planning program and were reluctant to promote contraceptives use. Majority of participants were not married. The findings concur with (Nsanya et al., 2019) unmarried adolescents used more condoms because they wanted to prevent unwanted pregnancy and STIs

Consistent use of condom during sex in the last month in Amolatar was high. Logie*et al.*, (2019) findings indicate that among northern and indigenous adolescents in Northern Canada less than half reported past 3 months' consistent condom use. Their

finding is in disagreement with this study's finding where majority reported consistent use of condom. The higher rate of consistence use of condoms among adolescents in Amolatar district could have been because adolescents fear getting pregnant and fear of contracting HIV and other STDs. Another reason for the higher rate could have been that the participants provided false information to please the investigators, especially where questionnaires were administered by the research team.

Objective 2: To identify the factors that enhances condom use among adolescents in selected health facilities in Amolatar

Condom use enhancers among adolescents in Amolatar district were: sex of the adolescent, male adolescents were more likely to use condoms than their other counterparts by 0.45 times. This may hold true because males are less shy and can ask for condoms or pick them from wherever they are found. This finding agrees with a study by (Meekers et al., 2003) which he carried out in Madagascar. They found that male youths were more likely to use condoms by 2.3 times compared to female youth especially if they had a high perceived risk of STIs. Ease of access to condoms significantly enhanced use of condoms among adolescents. The finding agrees with Meekers et al., (2003) findings. Another factor that enhanced use of condoms among adolescents in Amolatar was affordability of condoms. The one who has power to buy condoms is likely to use condom consistently. Negotiation also significantly enhanced use of condoms among adolescents in Amolatar. Joint decision making enhances use of condoms among couples (Soler et al., 2000). Partners who negotiate to use condoms are most likely to use it probably because they discuss the benefits of using condoms and get to understand each other's position.

Objective 3: To establish inhibitors to condom-use among the adolescents in selected health facilities in Amolatar

Major inhibitors to condom use among adolescents in Amolatar districts were: un-affordability of condoms. This reflects the low incomes of adolescents in Amolatar and usually where most rely on parents and guardians for financial support. De Visser et al., (2003) found an opposite situation; use of condom was more among lower income earners, although this does not mean having no money to purchase. They made no mention of whether the condoms were distributed freely or not. However, in Uganda, most condom users purchase the condoms because where free condom distribution may not be favorable to the users.

Belief that using condoms causes cancer was another factor although there is no medical proof, but this rumor needs to be addressed by providing correct information and counseling. Another reason was the fear that condoms may remain in a woman private parts; this perception was also found by Mucheri et al., (2021) in Ghana among adolescents surveyed although the level was higher than in Amolatar. This percentage is higher than that found in Amolatar district. Another inhibitor of condom use is the perception that condoms reduce sexual pleasure. Similar finding was also reported by Sandy et al., (2019) in a research done in Zimbabwe. Refusal of condom by partner (9.2%), Condom causes itchiness and discomforts (Mucheri et al., 2021) the itchiness and discomfort caused by use of condom may make a sexual partner refuse the use of condom and fear to ask or buy condoms. Kusilika, (2021) found that fear of buying condoms as they feel shy to ask. This was among factors for increased HIV prevalence among adolescents in Hoima district.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents summary of the major findings, conclusion and recommendations drawn from the research findings.

6.1 Conclusion

The study assessed the prevalence and factors associated with use and non- use of condoms among adolescents in Amolatar district. Results indicated that condom use prevalence was high within sexually active adolescents in Amolatar District and stands at 64.4% among the sexually active adolescents that participated in the study. This was much higher than the national figure particularly in a rural district

i. Males were the majority of condom users, it was also found that, older adolescents of age 17-19 years use more condom than younger ones aged 15-16 year. Also among the users, there was consistent use of condoms among majority of adolescents in Amolatar and the major reasons for use were prevention of unwanted pregnancies among the unmarried adolescents and reduce risk of contracting HIV/AIDS.
ii. The major factors that significantly enhanced condom use among adolescents in Amolatar included: being a male, ease of access to condom and affordability of condoms and negotiation among partners. Also when condoms are easy to access one gives a second thought of using it than in scenarios where condoms are hard to access.
iii. Findings also indicate that major factors that hinder condom use among adolescents in Amolatar were: un-affordability of condom and minor ones

were: belief that condom causes cancer, belief that condom reduces sexual pleasure and limited knowledge to properly use condoms.

6.2 Recommendation

i. The condom use prevalence among adolescents in Amolatar district was at 64.4%, however there is need to increase it and this can be done through advocacy. This advocacy can be done by health workers, and by using media houses and diversify the avenues for distribution making access better especially among those who cannot afford but also improve on the consistent use

ii. Improved access to condom is an enhancer of condom use among adolescence in Amolatar. Adolescent access to condoms should be improved. Government and health agencies should make condoms easily accessed by adolescents by taking them closer to health facilities, landing sites and all public places. They should be placed in a private place easy to pick secretly by adolescents e.g. in toilets/latrines.

iii. Male are more likely to use condoms than females. It is therefore important for development partners, NGOs, government and other agencies to focus on providing female condoms alongside male condoms and providing basic education/training to enhance female skills and knowledge on both male and female condoms and build their confidence to acquire, negotiate and use condoms without fear or favour.

iv. Un-affordability of condoms inhibits use of condoms among adolescents in Amolatar district. It is therefore necessary for government to embark on

distribution of free condoms through ministry of health initiatives but also increase the income of the adolescents. This can be done through current government efforts like; youth livelihood programs and skilling adolescents through provision of vocational trainings.

v. Interventions that aim to encourage use of condoms among adolescents should target female adolescents, younger adolescents, lowly educated and those with limited knowledge on contraceptives because they are disadvantaged in terms of condom use.

vi. The girls need to be educated by the District Health team and empowered to use and also demand condoms from their partners before involving themselves in sexual intercourse.

vii. This research also indicates that males are more likely to use condoms than females the reasons for this are not clear. There is need to conduct a research uncovering reasons why females are disadvantaged in terms of condoms use compared to their male counter parts

viii. Dissemination and publication, to the district, young people, in meetings especially professional, finally publication in a journal

6.3 Contribution of the research

i. The study contributes to the promotion of healthy living and minimize social economic challenges including cultural perceptions that result from limited uptake of condoms by demystifying the concerns regarding condom use through counseling and health talks that will involve the cultural and other leaders.

ii. The research findings contribute to knowledge about condom use among adolescents and will find out enablers and barriers to condom use. Information generated will also help strengthen the dissemination and use of sexual and reproductive health guidelines on adolescent services and rights.

iii. It also contributes by adding knowledge to the existing literature on condom use

6.4 Limiting factors in this research

Some respondents could have provided wrong information to the investigators.

Selection bias.

6.5 Lesson Learned

i. Training research team was helpful in getting quality data.

ii. It was important to translate the questions into luo.

iii. The duration of the survey took longer than expected.

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INFORMED CONSENT

I am Odongo Jimmy, a student of Uganda Christian University. I would like to undertake this research in order to identify the prevalence of condom use as well as factors contributing to the use or non-use of condoms among adolescents in Amolatar district. I would like to request you to participate in the study by way of responding to a few questions in the questionnaire.

In this study, 194 adolescents from ages of 15-19 years will participate on a voluntary basis; having consented by way of signing or putting a thumb print in case one is unable to read or write. I also wish to assure you that the information obtained will be kept confidential and names of participants will not be revealed. For participants below 18 years, the parents will be requested to allow them participate in the study and thereafter will sign an ascent. The study will also comprise of some health workers interviewing adolescents to obtain useful information that will help in feeding and enriching the questionnaires. And the data to be collected

A copy will be given and the participant is free to choose whether to go with it or leave it behind but also free to complete the interview or not. If someone stops will not be penalized.

No benefits like transport refund or refreshments shall be provided in the course of the interviews. The risk of participating in the interview may be realized when an adolescent who is not exposed to information concerning sexual relationships-starts to indulge in sexual practices especially without using a condom, and with multiple partners.

Arising questions (if any) shall be answered and explanations given during the course of the interview. A following statement that the study involves research, an exception of the process of the research and the expected duration of the participants involvement, description of the procedures to be followed and identification of any procedures.

The following also govern the consent process:

- Prospective participants should be free to consider whether to get involved (i.e., they should not be rushed, excessive payments should not be offered, nor should other undue influence or coercion be exerted).
- Voluntarism. A participant has the liberty to freely engage in the study and also withdraw his or her participation at any point in time if they feel so.
- The informed consent document should be written in English and also translated to lango to ensure the interviewee understands. If participants are non-English-speaking, they will be given the translated document to ensure they understand what they are getting involved in and make appropriate decisions of enrolling or not enrolling in the study.
- The participants will be given a copy of consent form as a reminder of the information conveyed, only if they want it.
- Consent forms shall be retained and kept with the researcher under safe custody for at least three years following conclusion of the research project.
- Informed consent document will be kept under lock and key accessible by the researcher only or with his permission.

Privacy and confidentiality; to that there is confidentiality, the questionnaires will be numbered and the names of the different respondents will not be required or used for filling out the questionnaire. Respondents will be given the necessary privacy while they fill the questionnaires. This will be ensured by isolating them from the other participants or any other people around them before the interviews are conducted. The information gathered will strictly be kept confidential and can only be accessed by the research student and study participant.

Compensation; There will be no compensation for participants who engage in this study and this will be made known to them before they choose to be a part of the study or not.

Risks and benefits to participants; the risk of participating in this study may be realized when an adolescent who participates may be stigmatized especially the females by the male knowing they had been in a sexual relationship. No benefits like

transport refund or refreshments shall be provided in the course of the interviews for participants however the study may be of benefit to adolescents in that it will guide them on proper use of condoms to prevent unwanted pregnancy and contracting of HIV. It may also be of benefit to adolescents in that they will be directed to where they can have access to free condoms.

Research findings from this study will however help strengthen the use and dissemination of sexual reproductive health guidelines on adolescents' services and rights. It will also demystify the wrong beliefs that are held by adolescents regarding condom use and contribute to reduction of unwanted pregnancies as well as reduce contracting sexually transmitted infections (STIs) including HIV/AIDS.

Voluntary withdrawal; participation shall be on a voluntary basis and no explicit or implicit coercion whatsoever to participate. Participants are free to discontinue participation at any time without any penalty or loss of benefits to which they may be entitled-if any.

Thank you!

Participant

Signature…….

Thumb Print. If cannot write

Date-…….

Name ……..

Signature……..

Date-…….

(If the participant cannot read or write)

Data collector

Signature……. Date…….

ASSENT FORM

My name is Odongo Jimmy a student of Uganda Christian University. I would like to undertake this research in order to identify the prevalence of condom use as well as factors contributing to the use or non-use of condoms among adolescents in Amolatar district. Your parents know we are talking with you about the study. This form will seek you consent to help you decide whether or not participate in the study.

In this study, 194 adolescents from ages of 15-19 years will participate on a voluntary basis; having assented by way of signing or putting a thumb print in case one is unable to read or write.

The purpose of the research is to identify the prevalence of condom use as well as factors contributing to the use or non-use of condoms among adolescents in Amolatar district. You will be required to fill a questionnaire and there after a focus group discussion which will be done by gender. Completing the questionnaire may take you 20 minutes. There are no potential risks and no reward shall be given for participating in this study.

If you take part in the study, you will be asked fill all the questions therein filling may take 20 minutes and during focus group discussion your voice may be recorded or even video recording done. The recording will be done only with your permission.

Taking part in this study does not attract any direct benefits to the participant but indirectly by providing information to them on condom use.

Participation is purely voluntary and one will be offended if you decide against participating in this study.

You are also allowed to ask any question during the time of participation or even after the study. You will receive a copy of the form for your record.

Signing below means you have read and willing to participate in this study

Participant

Signature

Thumb Print. If cannot write

Date----------

Witness writes name of participant

Name of Witness

Signature: ……..

Thumb print (If the participant cannot read or write)

Date-…….

Data collector

Signature……. Date…….

NGEC/MIO TWERO ME BEDO I KWEDO JAMI

An olwonga ni Odongo Jimmy; atin kwan ika pwonyere me rwom amalo. Atye kede miti me nwongo ngec atutut ikom welbuli adii atio kede roc (bol/mega Mon) kede tyen kop ango amio otio gini kede onyo pe otio kede I distrik me Amolatar.

Akwayi ni ibed iyi akina jo ame angiyo tyen kop imalo no kun idok iyi apeny ame bino bedo atye. Me niang aber I kop wa imalo no, bulimia acel ipyer abongwen wie angwen ame mwaka gi cakere I apar wie abic naka I apar wie abongwen bino dok iyi apenyogo abongo dicoro.

Gin obino ye nywako I kwedotyen kop imalo no kunoketocinggionyoodioatwoncinggikacepeoromoginicoconyokwan.

Amito ni angi dang ni koporo duc ame obino leyo I kwedo jami magi pe bino kato oko bot ngatoro keken; kede dang ni pe tye nying ngatoro ame obino yaro ka naler.

Pi jo ame mwakagi pe room aparwie aboro, obino kwayo onywalgi me yeyigi nywako I ikweda man; kun okwa ojoni me yeigin ikomgi dang me bedo iye.

Otic me yot kom dang bino bedo ikapenyo buli me wek omi dang tam gi akwako pen kop man ametye I papulameapeny.

Papula ame apeny tye iye bino bedo atye me wek ngatoro keken iyi akina jo ogamo apeny magi bed agonya me wot kede onyo pe.

Jami acalo gin amata onyo cente me wot idye yo pe obin omiyo bot joameagamoapeny magi.

Adwogi mogo ape ber alubere kede gamo apeny magi room nen-aporere ka bulu moro ayam pe tye amito cakorwate I butu kede apayi mere Kun dang pe otio gini kede roc; kun dang tye amito jo apol apola.

Obino gamo apenyogo kace tye Kun oniango jo atutut I apeny magi ka penyojo magi tye awot anyim.

Apwoyo matek.

Agam apeny

Ketcingikan/Dii cingi kan……Nino dwe……

QUESTIONNAIRE

PREVALENCE AND FACTORS ASSOCIATED WITH USE OF CONDOMS AMONG ADOLESCENTS (BOYS AND GIRLS) IN AMOLATAR DISTRICT

My name is Odongo Jimmy conducting a research on the above topic. I request you to answer this questionnaire as truthful as possible. The information provided here will be for academic purpose only

Tick or circle appropriately

1. Sex of the respondent. Male…….. Female……..

2. How old are you?

a) 15-16 years

b) 17-19 years

3. What is your highest level of education?

a) Primary

b) Secondary

c) Tertiary/technical

d) Not been to school.

4. What is your religion?

a) Catholic

b) Protestant

c) Born again

Pentecostal

d) Seventh day Adventist

e) Muslim

f) Others, specify……

g) No religion affiliation

5. Are you married?

a) Yes

b) No

6. If no, are you in any sexual relationship?

a) Yes

b) No

7. Have you ever heard about contraception (methods used to prevent pregnancy?

a) Yes

b) No

8. If yes, from where?

a) Radio

b) A friend

c) Health worker

d) Parent

f) Others; specify……

9. Mention any contraceptive methods you know (methods used to prevent pregnancy).

a) Oral contraceptive pills

b) Condom (male/female……circle appropriately)

c) Implants

d) Injectable like Depo-Provera

e) Other; specify…….

10. Of the above listed methods in Number. 9 which of these methods have you ever used?

a) Oral contraceptive pills

b) Condom (male/female……circle appropriately)

c) Implants

d) Injectable like depo- Provera

f) Other; specify…….

11. Which of these methods above have you ever used?

a) Oral contraceptive pills

b) Condom (male/female……)

c) Implants

e) Injectable like depo- Provera

f) Others; specify…….

12. If your answer is not condom in Number.10 above, why do you use other methods?

……

13(i) About how many times do you have sex in a month?

a) Twice

b) Four times

c) Six and more

d) Never

13. (ii) If you at least had sex, in a month, did you ever use a condom?

No……. Yes……

14 (i) If you have ever used a condom for sexual intercourse in Number 13 (ii) above, do you use condoms each of those times you have sexual intercourse?

a) Yes

b) No

14 (ii) If NO Why not?

If you do not use condom, what do you do?.....

14 (iii) If YES who provides the condoms**?----------**

(a) Male partner

(b) Female partner

14 (IV) Where are these condoms obtained from?

a) Government clinic/facility

b) Private clinic/facility/

c) Community condom distributor

Pharmacy/drug shops

15. When you are to have sexual intercourse, do you discuss/negotiate to use a condom with your partner?

a) Yes

b) No

16. Can the adolescent correctly demonstrate how to wear/use a condom? (Observe)

a) Yes

b) No.

17 i) Is it easy to access condoms?

a) Yes

b) No

ii) Can you afford condoms……

a) Yes

b) No

18. Tell me why young people do not use condoms

19. Do condoms have any side effects or complications?

FOCUS GROUP DISCUSION GUIDE

(To be used in focus group discussions to establish enhances and inhibitors of condom use)

PREVALENCE AND FACTORS ASSOCIATED WITH USE OF CONDOMS AMONG ADOLESCENTS (BOYS AND GIRLS) IN AMOLATAR DISTRICT

1. Do Adolescents use condoms during sexual intercourse? YES……NO……..
2. If yes do you think they use them every time they have sex? YES…… NO……
3. If no, why don't they use the condom?
4. In your view, why do some people prefer using condom during sex? and what type of condoms do they prefer
5. In your own opinion, why do some dislike/ do not use condom during sexual intercourse?
6. In your opinion do you think adolescents discuss the use of condoms before having sexual intercourse?
7. If they do discuss who do you think initiates the discussion between the partners?
8. How would the other partner react?
9. If no
   Why?.....
10. Do you think condoms are readily available to the adolescent whenever they need

    If no why?.....

11. Do the adolescents have access to condoms? ……
12. Can the adolescent afford condoms

Apeny

Gwetionyogur kit amitekede

1) Agama peny, obedo; icoo/ Dako
2) Mwaka ni tye adii?
    a) 15-16
    b) 17-19
3) Rwon me kwan mene igik iye?
    a) Pramari
    b) Cinia
    c) Teknikolo nyo akato
    d) Pe tye moro keken imalu no

4) Ilego idini mene?

a) Katolika
b) Ogerica
c) Olokole/pentekoti
d) Odwenti/lego inino me abiiro
e) Ucilam
f) Men okene; acalo…….
5) Inyomere?
a) Ee
b) Pe
6) Kacepe, onyoityeirwateileb me icookededako?
    a) Ee
    b) Pe
7) Onyoiwinyo kop akwako kit me lagoronywal?
    a) Ee
    b) Pe

8) Keee, iwinyoikwene?
   a) I radiyo
   b) Bot awota
9) Tuckong yore moro me lagoronywalameingeyo.
   a) Me amwonya.
   b) Roc (bol /acoo……..onyoamon……)
   c) Me arwakaibad
   d) Me picu (me atuca)
   e) Men okene; acalo…….
10) Ikom yore ame icano i N.9 malo kano, mene anaka itio kede?
   a) Me amwonya.
   b) Roc (bol /acoo……..onyoamon…….)
   c) Me arwakaibad.
   d) Me picu (me atuca)
   e) Men okene; acalo…….
11) Yore mene, ikom en imalono ame pwod itio kede (cako amani naka I dwete adek okato)
   a) Me amwonya.
   b) Roc (bol /acoo……..onyoamon……)
   c) Me arwakaibad.
   d) Me picu (me atuca)
   e) Men okene; acalo…….
12) Ka agam ni pe obedo roc i N.10 imalo, ngo amiyo itio kede yore okene me lagoro nywal……..
13) Idwe acel, irwate iburu tyen arom oadi?

a) Iryo.
b) Ingwen
c) Tyen abicel onyo dang ikato
d) Pe arwate

13 ii) Ka ce irwate iburu I kine me dwe acel,ibin itiyo kede roc?

a) Pe……..b)Ee…….

14 i) ka itiyo kede roc Inama 13 ii) I malo no,itiyo kede en roc ni kare ducu ame irwate iburu?

a) Ee……
b) Pe……..

14 ii) kape, ngo ame itimo?

14 iii) kaitiyokede roc, ngaamepoko bot wu?

a) Icoo
b) Dako

14 iv) roc ni nwongere kwene?

a) Wudi yen a gamente?
b) Wudi yen adano?
c) Apok roc ametyeikincalo?

15) Kaceirwateiburu, ilokowunuokom tic kede roc?

a) Ee
b) Pe.

16) Buluniceonyoromongutu kite me ruku roc, (nenaber)

a) Ee
b) Pe

KITE ME PENYO APENY

1. Onyo buli tiyo kede roc ka otye rwate gini iburu? Ee…….Pe…….
2. Ka ee, onyo otiyo gini kede roc cawa ducu ka otye orwate gini iburu?

……

3. Ka ce pe, ngo omio pe otiyo gini kede roc?.....
4. Itami, ngoomiyojookenemaaro tic kede roc icawa me rwateiburu?

……

5. Itami keni, ngo omiyo jo okene pe maro tic kede roc ka orwate gini iburu?

……

6. Itami, kenibulileo kop me tic kede roc bolamepwodpeocakodoyoibuto?

……

7. Ka oleo, itamo ni nga acako kelo kop ikom roc bol me alea?

……..

8. Dano ame okele kop me roc bol me alea jolo ningo?……
9. Ka pe oleo itamo ni pingo omio pe oleo?.....
10. Itamo ni nwongo roc bol yot ka buli tye amito tic kede?

    Ka pe, pingo? .....

11. Otwero tuno ikom roc bol icawa moro keken ame omito kede? …….
12. Buli ni twero culo cente ame mite me wilo roc bol ka itamo?.....

UGANDA CHRISTIAN UNIVERSITY

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SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: 2nd May 2024

Name of Candidate: ODONGO JIMMY **Reg. No:** RS19MO7/022

Title of Dissertation: PREVALENCE AND FACTORS ASSOCIATED WITH USE OF CONDOMS AMONG ADOLESCENTS (BOYS AND GIRLS) IN SELECTED HEALTH FACILITIES INAMOLATAR DISTRICT, UGANDA

SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	Correct Typos and grammatical errors	Corrections made throughout the dissertation	As observed from cover to last page
2	State the theoretical framework for qualitative	This is stated	Pg10

	component		
3	Background should include a paragraph on Uganda's adolescent sexual behavior. Prevalence of condom use, teenage pregnancy, and STIs then Amolatar district Pg10	The paragraphs were included	Pg 4-5
4	Give operational definition for adolescents and condom use as used in this study	These are given	Pg xii
5	Qualitative part is missing	This was included especially on data collection, analysis and result. Results are mainly in quotations for qualitative data	Pgs 26 ,29, 37 and 39
6	The candidate should separate conclusion from recommendation and bullet it or number it	Conclusion and recommendation separated with conclusion labeled as **6.1** and recommendation as **6.2**	Pgs48 and 49
7	Revise the method of selection and indicate that it was a mixed method and eligibility criteria	The methods were revised and indicated as a mixed method approach with both qualitative and quantitative approaches Eligibility criteria	Pgs 21, Pg :22

SN	COMMENTS BY INTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1	Add in the ethical consideration the consent/ assent of the interviewed participants	This were part of the ethical consideration and consent and assent as appendices	Pg 60 and 63
2		The methods were revised and indicated as a mixed method approach with both qualitative and quantitative approaches Eligibility criteria also handled	Pgs 21, Pg :22
3	Specific objective could be modified	Modification of the objective was done without affecting the content of the study	Pg 7
4	Why did you choose to investigate condom use?	HIV Prevalence in Amolatar stands at 6.4% among community of Amolatar and adolescents' pregnancy at 26%. Of this almost half is unwanted pregnancy and end up as an abortion although this is not documented. These percentages are considered high, however, condom when correctly and consistently used it is safe , effective in preventing transmission of sexually transmitted diseases and unwanted pregnancies, inexpensive and widely available	Pg. 4- 5:
5	What is the national condom use rate?	26.4% adolescent girls and 41.4% adolescent boys (WHO-SRH, 2021)	Pg 6
6	Comparative condom use among girls and boys	This was done on age, level of education and marital status	Pg 41
7	In problem statement talk about HIV, pregnancy and STIs among adolescents and differences between boys and girls	This has been done and included in the section on Problem statement	Pg 6

SN	COMMENTS BY VIVA VOCE PANNEL	ACTION TAKEN	INDICATOR
1	Qualitative part is missing	This was included especially on data collection, analysis and result. Results are mainly in quotations for qualitative data	Pgs 26 ,29, 37 and 39
2	Discussion will need to be by objective	The discussion was done objective by objective starting with the first through the second to the third. considered sub-sections and also titled them from Objective 1, Clearly documented it then the relevant discussion put below it, Objective 2 and objective 3 respectively, were corrected as required.	Pg43 to 47
3	In the title you need to state study done in selected health facilities in Amolatar district, Uganda	The statement " In selected health facility include in the title"	Cover page
4	Specific objective could be modified	Modification of the objective was done without affecting the content of the study	Pg 7
5	What does the FP POLICY of Uganda say about contraception to adolescents and condoms	Adolescents shall have access to HIV prevention methods and technologies. These shall include (ABC) Abstinence, Being faithful, and correct and consistent use of Condoms, medical male circumcision, treatment and any other approved by MOH.	Pg 5
6	How was sampling done?	Health facilities were clustered, into sub-counties (on average each sub-county had two health facilities); only one health facility was selected randomly from a cluster to participate in the study. Adolescents who had visited the selected health facilities (out of a total of 14 facilities) were mobilized by the nurses, they came to the health facilities they visited, they were contacted based on the set eligibility criteria by the principle investigator and his research team and eligible ones formed a sampling frame from which participants were randomly drown using a random number table. Therefore the study was health facility based	Pgs 21 to 24
7	Inhibiting factors have significance level consideration	This has been done	Pg 41
8	Prevalence looks high	Generally, condom use prevalence in Amolatar district was high	Pg 44

		probably because. 1. The study was conducted in selected health facilities and among adolescents who had visited health facilities only and seems to have good health seeking behaviors 2. The adolescents may have wanted to impress the investigators and could have provided false information on condom use.	

Odongo Jimmy

Candidate's Name

Signature

Prof. Florence Mirembe

Supervisor's Name

Signature