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Socio-demographic and individual factors influencing female condom use among women aged 18-49 years at Mubende Regional Referral Hospital. A cross-sectional study.

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Abstract

Background: Female condoms offer unique, female-controlled dual protection against unintended pregnancy and sexually transmitted infections. This study assessed socio-demographic and individual factors influencing female condom utilization among women aged 18-49 years at Mubende Regional Referral Hospital.

Methodology: A descriptive, cross-sectional study was adopted. Using convenience sampling, 100 women aged 18-49 years attending outpatient, ANC, PNC, and FP clinics were selected. Data were collected using structured interviewer-administered questionnaires, analyzed using SPSS version 26, and presented as frequencies and percentages.

Results: Respondents were predominantly young, 90(90% aged 18-35 years, married or cohabiting, 86 (86%), and educated to at least secondary level, 75(75%). Key barriers to utilization included: Socio-demographic: Lack of male partner support, 79(79%), and unaffordability at nearby facilities, 88(88%). Individual factors: Lack of knowledge on correct usage 73(73%), low confidence in partner persuasion 55(55%), and preference for male condoms 70(70%). While 75(75% believed female condoms are effective, only 20(20% intended future use.

Conclusions: Female condom utilization is low, driven by poor knowledge, lack of male support, and unaffordability.

Recommendations: Conduct practical demonstrations, integrate couple counseling, and strengthen supply lines. The district health team must decentralize free distribution to HC II/III levels and engage community leaders.

Key words: Socio-demographic and individual factors, female condom use, Mubende regional referral hospital.
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Background

Female condoms refer to a barrier method of birth control. The FC 2 female condom is made of synthetic latex, but formerly the FC 1 female condoms were made of a thin, soft plastic called polyurethane. By acting as a barrier inside the vagina, the female condom prevents semen from entering the womb. With typical use, its effectiveness is between 75% and 82%. However, female condoms work 95% of the time when used correctly (Mokgetse & Ramukumba, 2018).

Globally, the rates of HIV infections among married women or those in committed partnerships are increasing rapidly worldwide (Jean Simon et al., 2023). Social, cultural, and health system-based barriers continue to make it challenging for young people in Sub-Saharan Africa to use contraceptives (James et al., 2022).

Low female condom use is related to the material, size, shape, and timing of insertion. HIV prevalence is 5.6% in men and 7.6% in women in East African nations, especially Kenya (Boraya et al., 2018). Despite the aforementioned data, only 0.3% of women use condoms (Shannon et al., 2025). This study aimed to determine the socio-demographic and individual factors influencing female condom utilization among women aged 18-49 years at Mubende Regional Referral Hospital.

Methodology

Study design

A descriptive cross-sectional study design was utilized to gather quantitative data from study participants due to its short duration and lack of need for patient follow-up.

Study Area

The Research study was conducted at Mubende Regional Referral Hospital, Mubende District. Mubende Regional Referral Hospital is located in the central division of Mubende Municipal Council in Buwekula County. It is located on Old Kampala, about 150Km west of Mulago National Referral Hospital and 148Km east of Fort Portal Regional Referral Hospital.

Study population

The study population included females aged 18-49 years attending the family planning Clinic of Mubende Regional Referral Hospital. This is because this age group is actively involved in giving birth or sexual activities and is vulnerable to Sexually Transmitted Infections and Diseases. This age group is also able to decide for themselves which family planning methods to use.

Inclusion Criterion

All women aged 18-49 years who had voluntarily consented, were Ugandan, could read and write English who had consented and were willing to participate in the study.

Exclusion Criterion

Participants who were very sick.

Sample size determination:

The sample size was determined using Burton's method,
N= QR/O
Where N = sample size
Q=total number of days spent on the study
R = number of respondents per day
O = number of hours on each patient; Q = 25
R=4 O=1 N=QR/O
N= (25×4) ÷1
N=100
Therefore, the sample size was 100 study participants.

Sampling Technique and rationale

The convenience sampling method was employed. This method was applied because it reduced biased participant selection and it gave each individual an equal opportunity to be part of the study.

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Sampling Procedure

Participants were selected based on ease of access and convenience. The sample chosen was based on accessibility and cooperation. Only participants who were easy to reach were selected.

Data collection Method:

A semi-structured, interviewer-guided Questionnaire approach was used, with close ended Questions to collect Qualitative data from women aged 18-49 years in Mubende Regional Referral Hospital. The Questionnaires consisted of concise multiple-choice questions, prompting respondents to select the correct answer from the provided options.

Data collection tool and rationale

Self- administered Questions were used to capture data. The questionnaire was designed to capture all the variables that answer the research questions that were used for data collection. Therefore, self- administered questions were given to the respondents because they guided the participants in answering and eliminated unnecessary information from the respondents.

Data collection procedure

An introductory letter from the Research Ethics Committee of Mildmay was used to obtain permission from the Mubende Regional Referral Hospital Authorities. On obtaining permission, there was a self-introduction to the respondents. After obtaining consent, questionnaires were administered to the participants. Those who were not able to read were helped by the Research assistants. Questionnaires were checked and kept under lock and key. Incomplete questionnaires were taken back and filled in with guidance.

Independent variable

Knowledge and awareness-related factors, and socio-demographic-related factors influencing female condom use among women aged 18-49 years in Mubende Regional Referral Hospital.

Dependent variables

Female condom use among women aged 18-49 years in Mubende Regional Referral Hospital.

Quality control and quality assurance of data

Pretesting of the study tool

A sample of 10 Mildmay Institute of Health Sciences students was assessed using the Questionnaires before actual data collection. This was then modified before the collection date so as to determine if the information collected would be reliable and valid.

Training of research Assistants:

This involved training of all those who assisted in the study before the actual data collection.

Data Analysis and Presentation:

The data was manually analyzed using statistical tally sheets and then entered into a computer using Microsoft Excel software. The findings were presented quantitatively through frequency distribution tables, pie charts, and bar graphs, accompanied by narratives to facilitate easy interpretation.

Data management

Data was managed by entering it into a computer for storage. The data was copied onto a flash drive to prevent any loss at a crucial time.

Ethical Consideration

Permission for data collection was obtained using an introductory letter from the Mild May Research Ethics Committee and a letter from the Dean, School of Clinical Officers, which was presented to the authorities of Mubende Regional Referral Hospital, who then permitted the commencement of the study. Consent was sought from the study participants through consent forms. Participants were reassured that their information would be kept private and confidential

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Results

Demographic characteristics of respondents.

Table 1 summarizes the socio-demographic profile of the participants.

The mean age was 26.465 years (n=100)

Characteristic	Category	Frequency(n)	Percentage (%)
Age group	18-25 years	55	55
	25-35 years	35	35
	36-45 years	8	8
	45-49 years	2	2
Highest level of Education	None	2	2
	Primary	34	34
	Secondary	41	41
	Tertiary	23	23
Marital status	Single	11	11
	Cohabiting	44	44
	Married	42	42
	Widowed/separated	3	3
Occupation	House wife	30	30
	Employed	25	25
	Unemployed	35	35
	Others	2	2
Religion	Moslem	15	15
	Anglican	31	31
	Catholic	43	43
	African tradition	10	10
	Others	9	9

Table 1 shows that among the respondents, 90% were 18-35 years old, indicating that the sample was dominated by young women of peak reproductive age. Most had at least Secondary education (75%), and 86% were married or cohabiting. A high proportion was unemployed (35%) or housewives (30%), suggesting economic vulnerability. Catholics formed 43% and Anglicans 31% of the sample

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Table 2: Summarizes individual related factors influencing female condom utilization among women aged 18-49 years at Mubende Regional Referral Hospital (n=100).

Characteristics	Category	Frequency(n)	Percentage (%)
Male partner support	Yes	21	21
	No	79	79
Influence of religion	Yes	37	37
	No	63	63
Cultural influence	Yes	33	33
	No	67	67
Family,friends, peer influence	Yes	31	31
	No	69	69
Affordability	Yes	12	12
	No	88	88

Table 2 reveals that only 21 (21%) reported male partner Support for female condom use, while 79 (79%) lacked it. Affordability was a critical issue, as 88 (88%) of participants reported female condoms being unaffordable at nearby facilities. Religion influenced 37 (37%) and culture 33 (33%) of respondents, though peer influence was limited at 31% (31%).

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Table 3: Summarizes individual-related factors influencing utilization of female condoms among women aged 18-49 years at Mubende Regional Referral Hospital (n=100).

Characteristics	Category	Frequency (n)	Percentage (%)
Knowledge of how to use a female condom	Yes	27	27
	No	73	73
Effectiveness of a female condom	Yes	75	75
	No	25	25
Persuasion of partner to use female condom	Very confident	15	15
	Somewhat confident	30	30
	Not confident	55	55
Preference for using a female condom over a male condom	Yes	30	30
	No	70	70
Intention to use a female condom next time they have sex	Yes	20	20
	No	80	80

Table 3 shows a large knowledge and skills gap, as only 27 27%) knew how to use a female condom, while 73 (73%) did not. Despite 75 (75% believing female condoms are effective, only 20 (20% intended to use one next time. There was low confidence in partner negotiation, as 55 (55% were not confident to persuade their partner, and only 30 (30% preferred female condoms over male condoms. This attitude-practice gap indicates that positive perception of efficacy does not translate to use without knowledge and partner support.

Discussion

Socio-demographic related factors influencing female condom utilization among women aged 18-49 years at Mubende Regional Referral Hospital.

The findings showed that 79 (79%) of the respondents lacked male partner support, which is the most critical factor. This is because in Uganda, men often control decisions around sex and contraception. This is consistent with Ting et al. 2018) in Malaysia that showed that patriarchal attitudes toward gender and sex are significant barriers to female condom use among women. Female condoms require male cooperation because they are inserted during intercourse and are visible to the partner. This result is consistent with studies from (Fasehun et al., 2022) in the Dominican Republic, El Salvador, China, Malaysia, Nicaragua, South Africa, and Uganda who reported that lack of male partner support is one of the major barriers to female condoms. The study hence revealed the need for male partner involvement in order to increase utilization of female condoms. The findings revealed that only 21 (21%) of respondents were supported by their partners to use female condoms. This study is consistent with Zhou et al. 2019) in China, which showed that most women who used female condoms were mostly being encouraged by their male partners to use them. This reveals that active male partner involvement in family planning services greatly improves female condom uptake by women of reproductive age.

On the other hand, 88 (88%) of respondents reported that female condoms are not affordable. Unlike male condoms, which are widely distributed free through MOH and NGOs, female condoms are often sold or inconsistently supplied. At 3,000-5,000 UGX per piece in private pharmacies, they are out of reach for most women, especially given that 35 (35%) of respondents were unemployed and 30% (30) were housewives This study.is consistent with Shannon et al. 2025) in Uganda that showed that women in the income category of (200,000-499000 UGX) were significantly less likely to have ever used female condoms. The study revealed that only 12 (12%) of the respondents were able to afford female condoms. This study is consistent with Shannon et al. 2025) in Uganda that showed that only women in the income category of (500000 Ugx) and above were more likely to have used female condoms. This is because women in the income category of (500000 UGX) and above are able to constantly pay the price of the female condom on a regular basis, unlike women in the (499000 UGX) and below income category, who cannot afford it but comprise the majority of the population. Therefore, the government should endeavor to supply Female condoms to all its facilities countrywide in order to increase female condom utilization among women of reproductive age.

Further, 37 (37%) said religion and 33 (33%) said culture influence their decision. Some religious doctrines discourage contraception, and cultural norms around discussing sex openly can make women uncomfortable seeking female condoms. While these are not the majority, they are significant enough to warrant targeted education with religious and cultural leaders to dispel myths and promote dual protection. This study is consistent with Kawiche (2024) in Tanzania, which showed that 49.1% of the respondents were influenced by cultural and religious restrictions. This study also revealed that 63 (63%) and 67 (67%) of respondents were not influenced by cultural or religious restrictions. This study is consistent with (Kawiche, 2024) in Tanzania, which showed that 50.9% of respondents were neutral and therefore were e not influenced by cultural restrictions to use female condoms. This therefore underscores the importance of cultural and religious influences on women to use female condoms. Therefore, more efforts are needed to sensitize and educate both cultural and religious leaders on the importance of female condom use, which would promote female condom use among women of reproductive age.

Only 31 (31%) reported peer influence, indicating that female condom use is not yet normalized in social networks. Unlike male condoms, which are commonly discussed, female condoms remain taboo. Community sensitization through peer educators could shift this over time. This study is consistent with Kyomuhangi et al. 2025) in Uganda, which

showed that 39.4% of the respondents had heard about female condoms through their peers. This included family and friends who had told them about them and taught them how to use them. This study revealed that 69 (69%) of the participants were not influenced by their peers about female condoms. This study is consistent with Kyomuhangi et al. 2025) in Uganda, which revealed that of the 76.8% of the participants who were aware of female condoms, 60.6% of the participants had not heard about female condoms through peers. This shows that more efforts need to be put into promoting female condoms on social media platforms, TV, radio, and other forms of media in order to spread and disseminate more information about female condoms to the greater public. The authorities should actively promote female condoms through alternative media platforms instead of relying on peer-to-peer communication to promote female condom utilization among women of reproductive age.

Individual-related factors influencing female condom use among women aged 18-49 years at Mubende Regional Referral Hospital.

The finding that 73 (73%) of women do not know how to use a female condom is critical. Unlike male condoms, female condoms require demonstration and practice. This gap explains why even women who know about them do not use them. Similar findings have been reported in studies in Uganda and Nigeria, where lack of practical demonstration during FP counseling is a key barrier. This points to a failure in health education at service points. This study is consistent with Ananga et al. 2017), carried out in Kenya, which showed that 51.6% did not know how to use female condoms. This study also revealed that only 27 (27%) of the respondents knew how to use female condoms. This study is consistent with Ananga et al., 2017) carried out a study in Kenya which showed that only 48.4% of the participants knew how to use female condoms. The study therefore reveals a big gap in knowledge of how to use female condoms. Most women are discouraged from using female condoms because they lack knowledge of usage. The government needs to make more efforts in teaching women how to use female condoms, especially through training of community-based health extension workers since they live within the communities of the women of reproductive age in order to promote and improve female condom utilization among women.

Findings show that 75(75%) acknowledged that female condoms are effective. This attitude-practice gap is consistent with the Health Belief Model, where perceived benefit alone does not lead to behavior change if other barriers exist. This study is consistent with Kyomuhangi et al., 2025) carried out in Uganda and showed that 76.8% of respondents were aware of female condoms and approved of their effectiveness. The study revealed that only 25 (25%) of the respondents did acknowledge of female condom effectiveness. This study is consistent with Kyomuhangi et al. 2025), carried out in Uganda, which showed that 23.2% of the respondents were not aware of female condom effectiveness. This shows a significant attitude gap and willingness to use among women. Most women are aware of the benefits of female condoms but have a negative attitude towards using them. This negative attitude toward female condoms discourages women of reproductive age from using female condoms. The government and authorities should focus on demystifying myths and misconceptions about female condoms in order to promote a positive attitude towards female condoms and hence improve female condom use among women aged 18-49 years.

Also, 55(55%) of women reported they are not confident to persuade their partner to use a female condom. Female condoms require disclosure and negotiation, which challenges gender norms in Uganda where men often control contraceptive decisions. This finding aligns with literature showing that male partner refusal and perceived discomfort with the device are major obstacles. Empowering women through gender-transformative counseling is essential. This finding is consistent with Schuyler et al. 2016), a study carried out in South Africa that showed that 75% of the participants failed to persuade their male partners to use female condoms. This study also revealed that only 45 (45%) of the participants were able to persuade their male partners to use female condoms. This study is consistent with Schuyler et al. 2016), carried out in South Africa, which showed that only 25% of the respondents were able to persuade their male partners to use female condoms. Therefore, these studies reveal that more efforts need to be put into educating, training, and empowering women in order to enable them to easily persuade their male partners to use female condoms. Empowering women to easily persuade their male partners to use female condoms would greatly improve female condom use among women aged 18- 49 years.

Only 30 (30%) preferred female condoms over male condoms. Male condoms are smaller, more familiar, cheaper, and widely promoted. The novelty, size, and perceived noise of female condoms contribute to low preference. This suggests that promotion efforts have failed to make female condoms socially acceptable and desirable. This study is consistent with Kawiche (2024), a study carried out in Tanzania, which showed that only 26.7% of the participants preferred using female condoms despite 96.6% of the participants being aware and knowledgeable about female condoms. Most participants who preferred female condoms believed it was more effective than male condoms in terms of preventing STIs and unwanted pregnancies. This study revealed that 70 (70%) of the participants did not prefer using female condoms. This is consistent with Kawiche (2024), a study carried out in Tanzania, that showed that 73.3% of the participants did not prefer using female condoms. These cited reasons such as the look, size, and appearance of female condoms, and difficult insertion techniques as the major reasons why they did not prefer female condoms. Therefore, manufacturers should work on modifying the look, size, and appearance of female condoms. The manufacturers should make female condoms easier to use in order to encourage more women of reproductive age to utilize female condoms.

80 (80%) said they do not intend to use a female condom next time. This implies that without intervention, utilization will remain low. Intention is the strongest predictor of behavior, so strategies must focus on changing this by improving knowledge, addressing partner barriers, and making the method more acceptable. This study is consistent with Kyomuhangi et al. 2025), carried out in Uganda that showed that despite 76.8% of the participants being aware of Female condoms and their effectiveness, only 89.4% of the

participants were not willing to use them the next time they were going to have sexual intercourse. This reveals that more sensitization and awareness need to be carried out in order to increase awareness and utilization among women of reproductive age. This study also revealed that only 20 (20%) of the participants were willing to use female condoms the next time they had sex. This is consistent with a study by Kyomuhangi et al. 2025) carried out in Uganda, which showed that despite 76.8% of the participants being aware of female condoms and their effectiveness, only 10. 6% of them intended to use female condoms the next time they were going to have sexual intercourse. This highlights significant gaps in attitudes associated with female condoms. Therefore, more education and female condom promotion are required to improve utilization of female condoms.

Limitations

No men were included in the study, yet men play an important role in determining their partners' choice to either use or not use female condoms.

Selection bias due to the method of sampling used (convenience sampling method). A small sample size of 100 may not be representative of the entire population.

Conclusion

Utilization of female condoms at Mubende RRH is low due to individual and socio-demographic barriers. The key gaps are poor knowledge of use, lack of male partner support, unaffordability, stock-outs, negative provider attitude, and minimal promotion. Addressing these through demonstration, male involvement, free decentralized supply, and provider training is critical if female condoms are to contribute to dual protection and female empowerment in Mubende District.

Recommendation

The hospital administration should conduct hands-on demonstrations of female condom use during ANC, Postnatal Care, Family Planning, and ART clinics to address the knowledge gap.

Integrate male partner involvement in FP counseling to improve support and women's confidence to negotiate use.

Conduct CME on non-judgmental, gender-sensitive counseling and make promotion of female condoms mandatory at every client contact. Supply chain: Strengthen forecasting and reporting to eliminate the 35% stock-out rate at MRRH.

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List of abbreviations

US FDA: United States Food and Drug Administration
UNSAID: United Nations Agency for International Development
NCCPS: National Comprehensive Condom Programming Strategy
SRH: Sexual and Reproductive Health
SSA: Sub-Saharan Africa
HIV: Human Immunodeficiency Virus
AIDS: Acquired Immuno-Deficiency Syndrome
MRRH: Mubende Regional Referral Hospital
ANC: Antenatal care
PNC: Postnatal care
STD: Sexually Transmitted Diseases

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The study was not funded.

Conflict of interest

No conflict of interest declared.

Author contributions

WM: Conceptualization, Methodology, Investigation, Writing—original draft.
HN: Data curation, Formal analysis, Visualization.
FS: Formal analysis, Visualization.
IPN: Writing review and editing
JFN: Supervision, Validation.
All authors: Approved the final version of the manuscript and agreed to be accountable for the work.

Data availability

Data are available upon request.

Informed consent

Written informed consent was obtained from all participants prior to their inclusion in the study. Participants were informed about the purpose of the study, procedures involved, potential risks and benefits, and their right to withdraw at any time without penalty.

Author biography

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