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Utilization of oral contraceptives among women aged 15-24 years attending reproductive health care at Jinja regional referral hospital. A cross-sectional study.

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Abstract

Background:

Despite global improvements in contraceptive access, uptake among adolescents and young women in sub-Saharan Africa remains low, contributing to high rates of unintended pregnancies. This study determined the factors influencing the utilization of oral contraceptive pills (OCPs) among women aged 15–24 years attending reproductive health services at Jinja Regional Referral Hospital.

Methodology:

A cross-sectional study design was used, employing quantitative methods. A sample of 305 respondents was obtained through systematic sampling, and data were collected with the help of semi-structured questionnaires. The collected data was then analyzed using Microsoft Excel, and the results were presented in the form of tables and figures.

Results:

Overall, the majority of participants were teenagers, 180 (59%), 225 (73.8%) were single, while 4 (1.3%) were married. Christianity 214 (70.2%) formed the highest number of responses. Findings revealed that while awareness of OCPs was high (90%), actual utilization remained low, with 60% of respondents reporting that they had never used OCPs, although 66.9% demonstrated knowledge of OCP side effects. Community acceptability stood at 49.8%, religious support at 45.2%, and parental disapproval at 40%. Peer influence was strong (60.7%), and fear of side effects (68.9%) was the leading reason for non-use. Misconceptions persisted, with 40% believing contraceptives cause promiscuity, although most respondents (55.1%) supported youth access without parental consent.

Conclusion:

Age, education level, and perceived community support were significant predictors of OCP utilization. While knowledge about oral contraceptives exists, socio-cultural pressures, myths, and fear of side effects remain major barriers to OCP uptake among young women.

Recommendation:

Strengthening youth-friendly services, community sensitization, and targeted education interventions is recommended to enhance OCP utilization. Ensure privacy and confidentiality in service provision to encourage young women to openly discuss contraceptive needs.

Keywords: *Oral contraceptives, Reproductive health, Contraception, Jinja Regional Referral Hospital.*
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Background

Young women aged 15–24 years face a heightened risk of unintended pregnancy, unsafe abortions, and related reproductive health complications, particularly in low- and middle-income countries (Isola, 2015). Oral contraceptives (OCs) remain among the most effective and accessible modern contraceptive methods for delaying or preventing pregnancy when used correctly and consistently (Genazzani et al., 2023). Globally, more than 16 million adolescent girls give birth every year, and an additional 5 million have abortions (WHO, 2014). Sub-Saharan Africa accounts for 50% of these births (Obba et al., 2018). As a result, the need for specially tailored adolescents' sexual health services has become more pressing. Currently, there are conflicting messages about gender sexuality; the promotion of sexual involvement on one extreme and the urging of chastity on the other makes the young women feel guilty, uncertain, or indecisive about contraception (Obba et al., 2018).

Despite their proven effectiveness, uptake of OCs among young women in sub-Saharan Africa remains low. According to recent regional studies, awareness of contraceptives is generally high; however, knowledge of proper use, side effects, and availability of oral contraceptive pills is often incomplete or inaccurate. Myths and misconceptions, including fears of infertility,

hormonal imbalance, or future health complications, continue to deter young women from adopting OCs (Jonas et al., 2022).

In Uganda, the modern contraceptive prevalence rate among adolescents and young women remains significantly lower than the national average, where 23.18% of the girls aged 15-25 experience unplanned pregnancy, with oral contraceptives used far less frequently compared to condoms and injectables (Towongo et al., 2024). Many young women rely on unreliable sources of information, such as peers, social media, or hearsay, which often reinforces misinformation about contraceptive safety (John et al., 2025). Additionally, socio-cultural norms, including religious beliefs, partner influence, parental disapproval, and stigma around sexual activity among unmarried youth, continue to shape decisions about contraceptive use (Adewale Ogundiran et al., 2024). These factors collectively contribute to persistent barriers that limit the uptake of oral contraceptives.

Jinja Regional Referral Hospital serves a diverse population of adolescents and young adults and provides essential reproductive health services. However, little is known about the extent of OC utilization among young women attending the facility or the factors influencing their decision to use or not use oral contraceptive pills. A clear understanding of these factors is necessary to design youth-friendly, effective family planning interventions that can reduce unintended pregnancies and improve reproductive health outcomes among this age group. This study, therefore, sought to determine the socio-demographic, socio-cultural, and knowledge-related factors that influence the utilization of oral contraceptives among young women aged 15–24 years attending reproductive health services at Jinja Regional Referral Hospital.

Methodology

Study design

This was a descriptive cross-sectional study employing quantitative approaches. This design was chosen because it was useful in establishing preliminary evidence for a causal relationship in this study.

Study area

The study was conducted at Jinja Regional Referral Hospital (JRRH), located in Jinja City, Eastern Uganda. JRRH is a government-owned referral hospital, located approximately 84km east of Mulago National Referral Hospital, serving a population of approximately 4.5 million in a catchment area comprising 1 city and 11 districts (Jinja City, Jinja, Iganga, Kamuli, Mayuge, Namutumba, Bugweri, Buyende, Luuka, Kaliro, Namayingo, Bugiri). The hospital also serves the neighboring districts of Mukono, Buikwe, Kayunga, Buvuma, Busia, and Tororo, among others.

Study population

The study population consisted of all young adults (15-24 years) attending the reproductive clinic at Jinja Regional Referral Hospital during the study period.

Inclusion criteria

The inclusion criteria were as follows: all females aged 15-24 years attending reproductive health at JRRH, and those who provided informed consent were added to the study.

Exclusion criteria

The study excluded any clients who were medically unstable, and currently pregnant women were excluded from the study, as well as patients who were critically ill or unable to communicate effectively during data collection.

Sample size determination

The sample size was determined using the Kish and Leslie (1965) formula for cross-sectional studies:

$$n=\frac{z^2pq}{d^2}$$

n = required sample size

Z = standard normal deviation corresponding to 95% confidence level (1.96)

P = estimated prevalence of d = desired margin of error (0.05)

From previous studies conducted in Uganda, the prevalence was estimated at 23.18% (0.2318).

(1.9)2*0.2318*(1-0.2318)

Considering a 10% non-response rate, the adjusted sample size was:

n adj = 382 + (0.1×274) = 304.03 ≈ 305

Thus, a total of 305 participants were recruited.

Sampling technique

A systematic random sampling technique was used. This approach ensured that every reproductive patient attending the clinic had an equal and known chance of being selected. It also minimizes selection bias and allows for a representative sample.

Sampling procedure

The average monthly reproductive clinic attendance was about 200 patients. The data collection ran for approximately two months, yielding an estimated 305 eligible patients. Using systematic sampling:

The sampling interval k was calculated as 400÷200 =200.

Every 2nd diabetic patient on the clinic register was selected after randomly choosing the first participant using simple random selection.

Recruitment continued until the required sample size (305 participants) was achieved.

Data collection method
Data was collected through interviewer-administered questions.

Data collection tools
Structured Questionnaire: A pre-tested, interviewer-administered questionnaire designed based on the study objectives.

Data collection procedure
Ethical approval was obtained from the research and ethics committee of Mildmay Institute of Health Sciences and JRRH. Written informed consent was obtained from all participants. The researcher and trained assistants administered the questionnaire in a private setting. Each participant's information was recorded using a unique identification number to ensure confidentiality. Data collection lasted for eight weeks.

Piloting the study
A pilot study was conducted at Mildmay General Hospital using 10% of the calculated sample size (approximately 30 participants). The purpose of the pilot was to test the clarity, validity, and
reliability of the questionnaire, assess the data collection process, and identify logistical challenges, refine and adjust the tools before actual data collection. The data collected from the pilot was not included in the final analysis.

Quality control
Data collectors were trained on research ethics and interview techniques. The principal investigator supervised data collection daily to ensure accuracy and completeness. Completed questionnaires were reviewed at the end of each day for completeness and consistency. Data was double-entered into SPSS to minimize errors.

Data analysis and interpretation
Data was entered, cleaned, and analyzed using SPSS version 25.0. Frequencies, means, and standard deviations were used to summarize. Multivariate analysis using the chi-square test (for categorical variables) and t-test (for continuous variables) was used to determine associations between independent variables and dependent factors. Statistical significance was set at $p < 0.05$, and results were presented in tables and charts for clarity.

Ethical consideration
The proposal was presented to the research and ethics committee for review and approval. Additionally, an official permission letter shall be obtained and presented to the administration of JRRH for acceptance.
In addition, written informed consent was sought from all study participants before they were enrolled in the study.

Results
Socio-demographic characteristics

Table 1: Socio-demographic profile of respondents (n = 305).

Variable	Category	Frequency (n)	Percentage (%)
Age group	15–19 yrs	180	59.0%
	20–24 yrs	125	41.0%
Education level	No formal education	11	3.6%
	Primary	87	28.5%
	Secondary	148	48.5%
	Tertiary	59	19.3%
Marital status	Single	225	73.8%
	Married/cohabiting	54	17.7%
	Divorced/separated	12	3.9%
	Widowed	4	1.3%
	In a relationship (not married)	10	3.3%
Religion	Christianity	214	70.2%
	Islam	61	20.0%
	Traditional	15	4.9%
	None/Other	15	4.9%
Employment status	Full-time employed	31	10.2%
	Part time	46	15.1%
	Student	162	53.1%
	Unemployed	47	15.4%
	Self-employed	19	6.2%
Monthly household income	Low	140	45.9%
	Middle	118	38.7%

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	High	32	10.5%
	Prefer not to say	15	4.9%
Resident type	Urban	121	39.7%
	Semi-urban	92	30.2%
	Rural	92	30.2%

Among the 305 respondents, the majority were teenagers, 180 (59%). The majority of the respondents had a Secondary 148 (48.5%) level of education. The highest number was single 225 (73.8%), whereas the widowed 4 (1.3%) made the least number of respondents. Religion, Christianity, 214 (70.2%), formed the highest number of responses. Most of the respondents were not employed; there were students making up the highest number, 162 (53.1%). Most of the respondents had a low monthly household income; this group made up the highest number of 140 (45.9%) respondents. The majority of the resided in urban 121 (39.7%).

Knowledge and Awareness

Table 2: Knowledge and Awareness of Oral Contraceptive Pills (n = 305)

Question	Response	Frequency (n)	Percentage (%)
Heard of OCPs	Yes	275	90.2%
	No	30	9.8%
Source of information	School	122	44.4%
	Health worker	92	33.5%
	Family/friends	78	28.4%
	TV/Radio	61	22.2%
	Internet/social media	47	17.1%
	Other	10	3.6%
Perceived use	Prevent pregnancy	245	89.1%
	Regulate menstruation	122	44.4%
	Treat acne	32	11.6%
	Don't know / Other	17	6.2%
Dosing Knowledge (Q12)	Daily	259	94.2%
	Weekly	6	2.2%
	Monthly	0	0%
	Don’t know	10	3.6%

Amongst 305 respondents who participated in the study, 275 (90.2%) heard of OCPs, and 122 (44.4%) confirmed that school was the source where they had heard about OCP 245 (89.1%) perceived that OCP is used for preventing pregnancy. 259 (94.2%) participants knew the daily dosing.

Table 3: Table showing the knowledge of side effects

Question	Response	Frequency (n)	Percenatge (%)
Knowledge of Side Effects	Yes	183	66.9%
	No	91	33.1%
Side effect	Irregular bleeding	92	50.3%
	Weight gain	62	33.9%
	Nausea/vomiting	45	24.6%
	Headache/dizziness	31	16.9%
	Others	16	8.7%

Amongst 305 respondents who participated in the study, 183 (66.9%) had knowledge of the side effects of OCP, and 92 (50.3%) knew irregular bleeding as a side effect.

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Socio-cultural factors

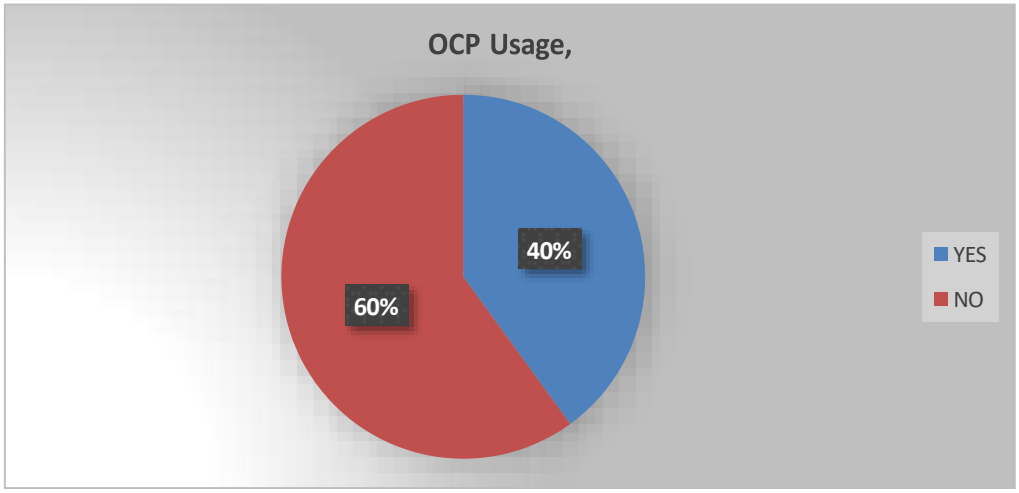
Table 4: Socio-Cultural Perceptions about OCP Use, (n = 305).

Statement	Response	Frequency (n)	Percentage (%)
Community acceptability	Yes	152	49.8%
	No	78	25.6%
	Not sure	75	24.6%
Religion supports OCP use	Yes	138	45.2%
	No	107	35.1%
	Not sure	60	19.7%
Parents approve contraceptive use	Yes	92	30.2%
	No	122	40.0%
	Don't know	60	19.7%
	Not applicable	31	10.2%
Peer influence	Yes	185	60.7%
	No	91	29.8%
	Not sure	29	9.5%
Ever discouraged from use	Yes	122	40.0%
	No	183	60.0%

According to Table 4, the community acceptability study at 152 (49.8%), whereas religious supports OCP use 138 (45.2%). Parents' disapproval of contraceptive use was 122 (40.0%), and peer influence, 185 (60.7%), strongly affected the outcome; 183 (60.0%) of the participants had never been discouraged from using OCP.

Perceived barriers and misconceptions

Figure 1: OCP usage, barriers, and beliefs (n = 305)



According to Figure 1, 60% of the respondents said they have used OCP.

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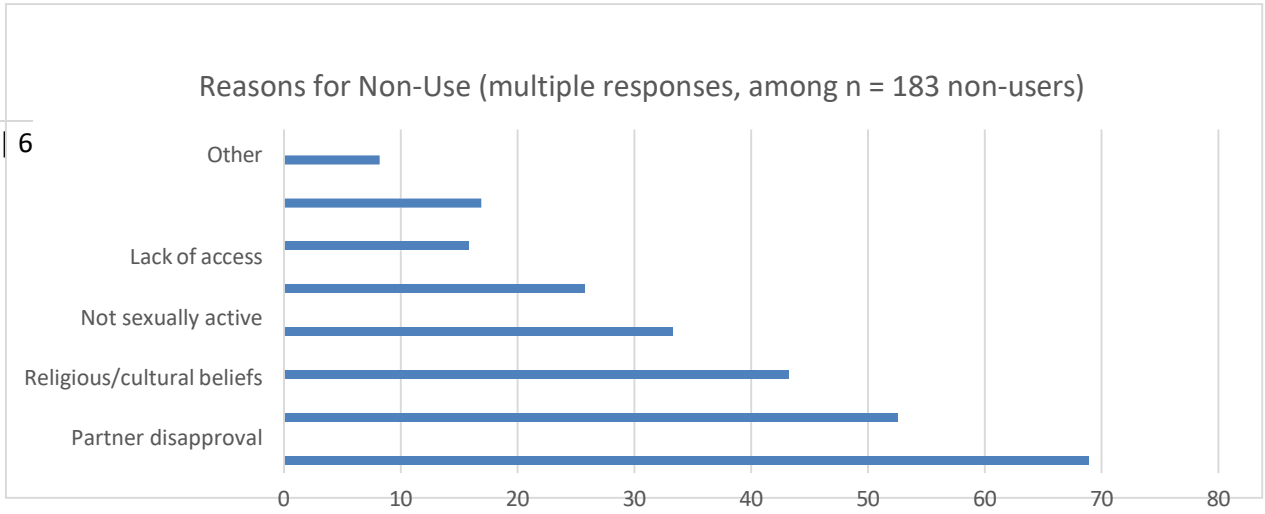
Figure 2: showing multiple reasons why people don't use OCP



The highest reason for not taking OCP was the fear of side effects, which had 126 (68.9%).

Table 5: Beliefs and misconceptions.

Belief	Response	Frequency (n)	Percentage (%)
OCPs cause infertility	Yes	92	30.2%
	No	122	40.0%
	Not sure	91	29.8%
Contraceptives encourage promiscuity	Yes	122	40.0%
	No	92	30.2%
	Not sure	91	29.8%
Young women should access contraceptives without parental consent	Yes	168	55.1%
	No	76	24.9%
	Not sure	61	20.0%

According to Table 5, 122 (40.0%) did not believe that OCP causes infertility, 122 (40%) believed that contraceptives cause promiscuity, and 168 (55.1%) believed that young women should access contraceptives without their parents' permission.

Multivariate Logistic Regression

Table 6: predictors of ever using OCP (n = 305).

Predictor	Odds Ratio	95% CI	p-value
Age (20–24 vs 15–19)	1.8	1.1–2.9	0.02
Urban residence vs rural	1.5	0.9–2.6	0.10
Secondary+ education vs primary/none	2.2	1.3–3.8	0.01
Employed vs unemployed/student	1.4	0.8–2.5	0.18
Knowledge of side effects	1.3	0.8–2.1	0.25
Community acceptability	1.9	1.1–3.2	0.02
Belief in infertility myths	0.5	0.3–0.9	0.01

According to the regression analysis, age, education, and perceived community support are strong predictors of OCP use.

Discussion

Socio-demographic factors

The majority of respondents were teenagers, single, Christian, and mainly students, with most coming from low-income households. These characteristics are consistent with other studies indicating that socioeconomic vulnerability, low income, and student status may shape contraceptive decision-making among youth (Usama, 2018; Kwame et al., 2022). Although over half of respondents had secondary education, this did not significantly increase uptake, despite evidence showing that higher education often improves contraceptive use by enhancing decision-making power and health literacy (Mutumba et al., 2018).

Knowledge and awareness of OCPs

The study found high levels of awareness, with 90% reporting prior knowledge of OCPs and 66.9% aware of possible side effects. This aligns with findings by Leelakanok et al. (2022), who reported high OCP awareness among young women across similar settings. However, fear of side effects—particularly irregular bleeding—remains a major concern. This is consistent with studies in Ethiopia and Kenya, which reported that irregular bleeding and hormonal concerns are the most common deterrents to pill use (Mardi et al., 2018; Ochako et al., 2015).

Despite substantial awareness, misconceptions persist. For instance, 40% believed that contraceptives cause promiscuity, and many considered them unsafe. These findings mirror the results of Mwaisaka et al. (2020), which documented widespread myths that contraceptives cause infertility, birth defects, or increased sexual activity. Such misconceptions continue to undermine utilization even in the presence of adequate knowledge.

Socio-cultural Influences

A central theme emerging from this study is the strong role of socio-cultural factors. Community acceptability was moderately high (49.8%), and nearly half of the respondents reported that their religion supported contraceptive use. However, parental disapproval (40%) and peer influence (60.7%) remained powerful determinants of uptake. Similar findings by D'Souza et al. (2022) and Hlongwa et al. (2020) highlight that family expectations, partner attitudes, and societal norms significantly shape young women's reproductive choices.

Although 60% of respondents reported never using OCPs, the leading reason for non-use was fear of side effects (68.9%), consistent with regional evidence (Bain et al., 2021). Misconceptions such as beliefs that OCPs cause infertility were also evident, paralleling findings in Ethiopia where myths and religious beliefs strongly influence contraceptive behavior (Shumet et al., 2024).

Perceived Barriers and Misconceptions

The presence of persistent myths and misconceptions remains a substantial barrier to utilization. Many respondents believed that contraceptives lead to infertility or promote promiscuity, misconceptions also widely documented in Kenya and Ghana (Ochako et al., 2015; Mwaisaka et al., 2020). Fear of stigma, judgment from healthcare workers, and cultural expectations further intensified these barriers, consistent with previous scoping reviews (Shumet et al., 2024).

Predictors of OCP Use

Regression analysis showed that age, education level, and perceived community support significantly predicted OCP use. Older youth (20–24 years) and those with higher education were more likely to use OCPs. This is consistent with the findings of Mutumba et al. (2018), who reported that educational attainment and community-level support strongly influence contraceptive uptake. Conversely, belief in myths, particularly those linking OCPs to infertility, was negatively associated with use, reinforcing literature from sub-Saharan Africa documenting how misinformation undermines reproductive health decisions (D'Souza et al., 2022).

Overall, the findings highlight the complex interplay of knowledge, socio-cultural norms, misconceptions, and demographic characteristics in shaping OCP utilization among young women.

Limitations

Self-reported responses may have introduced bias in the study; similarly, a clinic-based sample may overestimate contraceptive awareness, also across-sectional design cannot establish causation, and lastly, 'ever-use' does not reflect correct or continued use.

Conclusion

This study demonstrates that although awareness of oral contraceptive pills among young women at Jinja Regional Referral Hospital is high, actual utilization remains low. Knowledge alone is insufficient to guarantee uptake, as misconceptions, fear of side effects, socio-cultural disapproval, and misinformation significantly hinder consistent use.

Socio-demographic factors such as age, education, and income influence OCP utilization, with older and more educated respondents being more likely to use contraception. Addressing the multifaceted barriers highlighted in this study is essential for improving reproductive health outcomes, reducing unintended pregnancies, and advancing the well-being of young women in Uganda.

Recommendation

Strengthen health education and counseling.

Develop targeted educational programs focused on clarifying misconceptions about OCPs, especially fears related to infertility, irregular bleeding, and promiscuity.

Use youth-friendly communication approaches such as visual aids, peer educators, and simplified information materials.

Improve youth-friendly services

Train healthcare providers in adolescent-friendly service delivery to reduce judgmental attitudes and improve trust among young women.

Extend service hours and reduce long waiting times, making contraceptive services more accessible for students and young workers.

Engage parents, partners, and community leaders.

Conduct community sensitization programs to address cultural and religious misconceptions that discourage contraceptive use.

Work with parents and guardians to foster supportive attitudes toward youth contraceptive access.

Involve male partners in reproductive health education to reduce partner opposition.

Integrate contraceptive education into schools and higher institutions

Strengthen school-based reproductive health programs to provide accurate knowledge on contraceptives before young women become sexually active.

Collaborate with teachers, school nurses, and student peer leaders to deliver comprehensive sexuality education.

Enhance access and availability of OCPs

Ensure a consistent supply of a variety of contraceptive brands so young women can choose suitable options.

Strengthen pharmacy-based and community distribution channels to reduce access barriers.

Consider subsidizing OCPs or offering them free to low-income young women.

Acknowledgement

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List of abbreviations

JRRH:	Jinja Regional Referral Hospital
OCP**:**	Oral Contraceptive Pill
WHO:	World Health Organization.

Source of funding

The study was not funded.

Conflict of interest

The author declares that there was no conflict of interest.

Author contributions

DK- Investigated the study
GKM- Supervised the Study.
HN- Supervised the Study.
FS-Supervised the Study.
JFN-Supervised the Study.

Data availability

Data is available upon request.

Informed consent

There was full disclosure; full comprehension, and respondents voluntarily consented to participate in the study.

Author biography

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