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Factors Associated With Pelvic Inflammatory Disease among Women Attending the Gynecology Clinic at Kampala International University Teaching Hospital, Uganda

Petrus Baruti[1], Emmanuel Nzabandora[1] and Ezera Agwu[2]

[1]Department of Obstetrics and Gynecology of Kampala International University, Uganda
[2]Department of Microbiology, Kampala International University, Uganda

ABSTRACT

Pelvic inflammatory disease (PID) is major health problem in developed and developing country involving more young women. It is associated with high rate of female reproductive health morbidity; it can complicate with ectopic pregnancy, infertility and chronic pelvic pain. A poor response therapy increases the likelihood of these complications; this could be due to an increase in antimicrobial resistant pathogens. This was a cross-sectional study conducted among women who attended gynecology clinic at Kampala International University Teaching Hospital. Consecutive enrolment of 324 participants who consented to participate was done daily until a required sample size was realized from November 2019 to January 2020. Structured questionnaires were used to collect data on associated factors; endocervical swab was taken from patient clinically diagnosed with PID. Culturing for colony characteristics followed by Gram stain was used for provisional identity of pathogenic bacteria. Further identification was done by a set of biochemical tests. Antibacterial susceptibility pattern of isolated bacterial pathogens was determined by Kirby Bauer disc diffusion method, a rapid diagnostic test to detect Chlamydia antibody in the endocervical swab sample was also used to identify the Chlamydia trachomatis carriers among the patients. Data was analyzed using STATA VERSION 14.2. Not being educated, having two or more sexual partners, previous history of PID and induced abortion, also the previous use of contraceptives specifically the use of IUD ,were all significantly associated with Pelvic inflammatory disease (P value <0.05). Not being educated, having two or more sexual partners, previous history of PID and induced abortion, also the previous use of contraceptives specifically the use of IUD are significantly associated with PID.
Keywords: PID, women, Gynaecology, risk factors associated with PID.

INTRODUCTION

Pelvic inflammatory disease is an infection which affects the upper female reproductive tract from the internal cervical opening, the uterus, fallopian tube, ovaries and pelvic peritoneum [1,2,3,4]. Its distribution and associated factors, management and control are challenges facing the gynecologists in an effort to discharge their corporate responsibilities to the general public [5,6,7,8]. The oldest and clear description of pelvic inflammatory disease was done by Mauriceau in 1693 when he described puerperal infection with abscess in both sides of the uterus [1]. While the first description of the bacterial agent that causes pelvic inflammatory disease was after Neisser discovered *Neisseria gonorrhea* in 1879 [9,10,11,12]. This description was done by Westermark in 1886 when he demonstrated the presence of *Neisseria gonorrhea* in tubal pus and Wertheim in 1894 the first to demonstrate these organisms invading the tube [13,14,15]. Chronic pelvic inflammatory tumors unconnected with the puerperal state were described by Simpson in 1843; which described the condition as pelvic cellulitis[16,17,18,19].*Neisseria Gonorrhea* was since then known as the leading cause of pelvic inflammatory disease (PID) and its history is strongly linked to the one of

pelvic inflammatory disease. It was thought to be caused solely by an inflammation occurring in the cellular tissue of the pelvis [2,20,21,22].

Peterson [3,23,24] in his study done in South Africa showed the need of a therapeutic agent against *Neisseria gonorrhea* because of its ability to develop resistance to several antimicrobial agent therefore, multiple drug therapy may be the likely way forward in the foreseeable future. On the other hand [4], in a study done in Kenya on the detection of novel organisms associated with salpingitis, discovered that *Neisseria gonorrhea* and *Chlamydia Trachomatis* were the commonest cause of salpingitis but there were other cases with unknown cause. These underwent laparoscopic sampling and a serial of 16S DNA polymerase reaction and these patients were found with novel bacterial agents causing PID, which were identified as bacterial phytotypes most closely related to leptotrichia ssp.

Purpose of the study

To determine the factors associated with pelvic inflammatory disease among women attending gynecology clinic at Kampala International University Teaching Hospital.

RESEARCH METHODOLOGY

Study design

This was a cross sectional study. Laboratory investigations were done to achieve the prevalence, the common bacteria isolates and antibacterial susceptibility pattern in women with pelvic inflammatory disease attending gynecology clinic at Kampala international university teaching hospital. Association between PID and different factors was established.

Study area

The study was conducted at Kampala International University Teaching Hospital found in Ishaka Bushenyi Municipality at approximately 60km from Mbarara town along Mbarara Kasese highway.

Study population

The study populations were all women of reproductive age in the catchment area

Target population

All women of reproductive age attending gynecology clinic at Kampala international university teaching hospital shall be considered for inclusion in this study.

Inclusion criteria

All the women at the reproductive age attending gynecology clinic of Kampala international university teaching hospital as well as emancipated minors.

Exclusion criteria

Women on antibiotics, pregnant women, unconscious patients who cannot consent and minors were excluded from the study.

Sample size determination

Objective number 1, the sample size was determined using [5] formula with the estimated prevalence of 50%, because the of lack of current prevalence of PID in Uganda

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

Where;

n = Desired sample size

z = Standard normal deviation at 95% level of confidence; z= 1.96

p = Prevalence of pelvic inflammatory disease in Uganda, assumed at 50%, and d= Level of precision=0.05

$$n = \frac{(Z_\alpha)^2 x\, p(1-p)}{(d)^2}$$

$$n = \frac{(1.96)^2 \times 0.5(1-0.5)}{(0.05)^2}$$

N_1= **384** this is considered as an assumption of sample size**.**

Objective number 2: Musa *et al;* [6] in the study done in Mbarara Regional Referral Hospital on screening for Chlamydia *Trachomatis* among women of reproductive, found that 26% of women were carriers of *Chlamydia Trachomatis* [6].

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

$$n = \frac{(Z_\alpha)^2 x\, p(1-p)}{(d)^2}$$

Where;
n = Desired sample size
z = Standard normal deviate at 95% level of confidence; z= 1.96
p = prevalence of Chlamydia trachomatis in reproductive aged women, using a study done in Mbarara by Musa and colleagues [6]
d=Level of precision= 0.05

$$n = \frac{(1.96)^2 \text{-} 0.2(1\text{-}0.2)}{(0.05)^2}$$

N_2= 295

Specific objective 3: Mark *et al* [7] reported that women with a previous history of PID have a greatest risk of having subsequent PID, OR = 5.9**,** the proportion (p) PID among woman with previous history of PID 13.1% and among women without previous history of PID was 3.6%.
r=ratio of previous history of PID to those without previous history of PID, r=13.1:3.6, r=3.6:1=3.6
Where; =z-statistic at α=0.05, = z-statistic at β=0.84 hence statistical power = 80%. Using the formula [8].
Where:

$$n = \frac{(1+r)^2\,[Z_\alpha + Z_\beta]^2}{r\,(lnOR)^2 x\, p(1-p)}$$

$$n = \frac{(1+3.6)2 \times (1.96+0.84)2}{3.6(\ln 5.9)2 \times 0.131(1-0.131)}$$

n_3=118

Decision on the sample size

Sample size for objective number 2 was considered since this was a research done in Uganda (Mbarara Regional Referral hospital) and reflects the true Ugandan reality**.** 10% of this sample size was added to minimize non response or loss of some laboratory request form, therefore the sample size was:

N_2=324

Sampling technique

Consecutive sampling method was used to select participants who consented to be part of the study. All the women of reproductive age who met the inclusion criteria was invited to participate in the study, the participants was enrolled according to their order of arrival in gynecology clinic and this was carried out on a daily basis until the required sample size was achieved.

Data collection instruments

A pretested questionnaire was administered to each participant who consented to participate to the study in order to collect information on socio-demographic, gynecological and sexual behavior factors that related to the development of pelvic inflammatory disease in. A detailed history was taken in English, translated in local language where necessary for women who could not understand English physical examination was carried out and the endocervical sample was taken from patient with symptoms and of PID in order to achieve all the objectives.

Sample processing and analysis

Isolation

Samples collected using a sterile procedure with the endocervical swab stick was inoculated on blood agar, chocolate agar, Mac Conkey agar, Thayer Martin medium, and different biochemical tests were used. After, they were incubated both aerobically and anaerobically at 37^{o}C for 24-48hrs. Colony morphology were observed according to shape, size, elevation, margin and surface characteristics.
Rapid diagnostic test was used in order to identify the *Chlamydia trachomatis*

antibody careers within the endocervical sample of the participants, the isolation of Chlamydia which uses living cells (McCoy cell) was not done due lack of this specific media to culture *Chlamydia trachomatis,* this rapid Chlamydia test was used to determine the percentage of Chlamydia carriers among the patient with pelvic inflammatory disease.

Direct gram microscopy

A direct smear was made for Gram stain according to [9]; a drop of sterile normal saline was added on the center of a clean dried glass slide and the swab containing the sample rolled in the drop of normal saline spreading it on the glass slide in a circular motion to make a thin smear. The smear was then allowed to air dry and then heat fixed by passing it at least three times over a Bunsen flame. The slide was placed on the staining rack and flood with crystal violet solution for 60 seconds, wash with clean water and cover with lugol's Iodine and then it was allowed to act for a minute. The slide was washed in clean water and then decolorized with 50% acetone alcohol under slow running tap water until a faint pink color is observed or no more color tend to flow from the smear. The process of discoloration was not exceeding 30 seconds.

After decolorizing, it was washed in clean water and counter stain with neutral red solution. The slide was again washed in clean water; air dried and observed under the microscope with X100 objective lens (oil immersion lens).

Gram positive bacteria were observed as blue or purple color and Gram negative as red or pink color. Also, the morphology and shape of the bacteria were identified whether they are cocci, diplococcic, cocci in chains, clusters, and whether they are rods in appearance [9].

Identification of bacterial isolates

Biochemical tests

The isolates were identified using the conventional biochemical tests such as catalase, optochin, coagulase, indole, citrate utilization, urea utilization, triple sugar iron agar fermentation, MR-VP test and oxidase as described below;

Catalase test

Catalase test was carried out according to the method described by [9], to determine the ability of the isolate to produce the enzyme, catalase. A drop of 3% hydrogen peroxide was added to a loop full of the test organisms. Presence of bubbles indicated catalase activity.

Indole test

Indole test was carried out according to the method described by [9] to determine the ability of the isolate to degrade amino acid tryptophan and produce tryptophanase, enzyme were tested. 1% tryptophan broth in a test tube were inoculated with isolate and incubated at 37°C for 48 hours. After 48 hours, 1milliliter of chloroform was added to the broth. The test tube was shaken gently, and 2.1 ml of Kovac's reagent were added and again shaken gently, this was allowed to stand for 20 minutes. The formation of red coloration at the top layer, indicated positive while yellow coloration indicated negative.

Urease test

Urease test was done according to the method described by [9] to determine the ability to hydrolyze urea to produce ammonia and carbon dioxide. Test organism was inoculated into urease broth and incubated at 30°C for 72 hours. Purplish pink coloration of the medium indicates positive reaction.

Citrate utilization

This was carried out by inoculating the test organism in test tube containing Simon's citrate medium and incubated for 24 to 72 hours. The development of deep blue color after incubation indicated a positive result [9].

Triple sugar iron test

Triple sugar iron test was carried out according to the method described by [9]; the test determines the ability of the organism to ferment the three sugar component of the medium: glucose, lactose and sucrose. The medium contains a pH indicator (phenol red) and a detection system (thiosulphate and ferrous sulphate) for hydrogen sulphide (H2S).

The medium was prepared as an agar slant. The test organism was inoculated by stabbing the medium using sterilized straight wire loop and the surface of the

slope were also streaked with the test organism. The tests were incubated at 37°C for 72 hours. After incubation, gas production was determined by observing the cracking of the medium, and production of H2S was observed by the blackening of the bottom of the medium.

Coagulase test

This test was used to identify *Staphylococcus Auraus* which produces the enzyme coagulase. The rapid slide test was done by placing a drop of distilled water on each end of slide. Then a colony of the test organism (previously checked by Gram staining) was emulsified in each of the drops to make two thick suspensions.

A loopful of plasma was added to one of the suspensions and mixed gently. Formation of clumps of the organisms within 10 seconds was suggestive of a positive test while absence of these clumps indicated negative results. For suspected Staphylococcus auraus isolates which turn negative for the rapid slide test, tube test was done by emulsifying several isolated colonies of test organism in 1 ml of diluted rabbit plasma (1:5) dilution to give a milky suspension. The tubes were then incubated at 35°C in water bath for 4 hours. These were examined at intervals of 1, 2 and 4 hours for clot formation by tilting the tube through 90°**.** If the test is still negative, the tube was left at room temperature overnight and examined again for Staphylococcus auraus that produce a delayed clot [9].

Oxidase test

The test was used in identification of organisms which produce the enzyme cytochrome oxidase. A filter paper soaked with the substrate tetra methyl-p-phenylenediamine Dihydrochloride was moistened with sterile distilled water. Using a piece of stick or glass rod, a colony of the test organism was smeared on the filter paper. The development of a blue-purple color within a 10 seconds indicated positive test while absence or formation of a blue-purple color after 10 seconds was considered negative [9].

Data analysis plan

Data from questionnaires were entered in Microsoft Excel 2010, and thereafter exported to STATA 14.1. Socio-demographic, sexual behaviors and gynecologic factors were summarized as means and mediams, standard deviations and interquartile range (for continuous variables) were determined. Proportions, percentages and frequencies were used for categorical variables using STATA 14.1.

Ethical considerations

Informed consent

Informed consent and respect for participant's voluntary recruitment was observed. Informed consent for participants were obtained and signed after fully explaining the details of the study to them in English and local languages where necessary (copy attached at Appendix). Participants were not forced to enroll themselves if they don't want to, they were free to withdraw from the study any time they wish without coercion or compromise of care they are entitled to.

Risks and adverse events to study participants

Patients may undergo pain during swabbing and speculum examination, however, the process of obtaining a swab was done gently and professionally to minimize risk of pain and minimize re-infection as far as possible. Additionally, culture and sensitivity are the recommended guidelines prior to antibiotic therapy to minimize the risk of antibiotic resistance.

Approval procedure

Approval to carry out the study shall be sought from the department of obstetrics and gynecology, the faculty and post graduate directorate and finally, Research Ethics Committee of Kampala International University. This approval letter shall be presented to the hospital administration of KIU-TH. Permission shall be sought from the administration of the hospital before the study is conducted. The study will be registered with Uganda National Council for Science and Technology.

RESULTS

Table 1: Socio demographic factors

Characteristics	Frequency	%
Age (years)		
<20	31	9.6
20-29	205	63.3
30-39	71	22.0
40-49	17	5.1
Education		
None	11	3.4
Primary	99	30.6
Secondary	111	34.4
tertiary	103	31.6
Occupation		
None	127	39.2
Farmer	85	26.2
Professionals	51	15.7
Business	31	9.6
Manual laborer	30	2.3
Monthly income (UGX)		
none	10	3.1
<300000	230	71.8
300000-600000	66	26.5
>600.000	18	5.6
Marital status		
Single	86	26.5
Married	238	73.5

The above table illustrates that 63.3% of participants are aged of 20-29 years, 34.4% have secondary education, 39.2% have no occupation, 71.8% of participants have a monthly income of less than 300.000 Uganda Shillings and 73.5% are married.

Table 2: Gynecological factors

Characteristics	Frequency	%
Parity		
Zero	98	30.3
1-3	153	47.2
>3	73	22.5
Had PID before		
No	224	69.1
Yes	100	30.9
Had miscarriage before		
No	264	81.5
Yes	60	18.5
Use Contraceptive		
No	132	40.7
Yes	192	59.3
Intra Uterine Procedure		
No	281	86.7
Yes	43	13.3
Type contraception		
Condoms	38	19.8
Pills	61	31.8
Injectables	65	33.8
IUD	28	14.6
Type of miscarriage		
Spontaneous	41	68.3
Induced	19	31.7

From the above table, 47.2% of the study participants had delivered at least one to three times, 69.1% had had miscarriage of which 68.3% were spontaneous, 59.3% of the study participants had ever used contraceptive methods of which 33.6% had used injectable contraceptive methods and 86.7% had not had intrauterine procedures.

Table 3: Sexual behavior factors

Characteristics	Frequency	Percent
Number of of sexual partners		
None	20	6.2
One	253	78.0
More than one	51	15.8
Age of initiation sexual activity(year)		
< 15	25	7.7
16-20	242	74.7
>20	57	17.6
Condom Use		
Sometimes	84	25.9
Every time	38	11.8
Never	202	62.3
Smoking		
Never smoke	316	97.5
Ever smoke	8	2.5

The above table shows that, the age of initiation of sexual activity for the majority of participants was 16-20years in 74.7%, most of the study participants denied the

use of condoms with 62.3% and 97.5% were nonsmokers.

Table 4: Bivariate analysis of socio demographic factors associated with PID among women attending gynecology clinic at KIU-TH

Variable	No PID	PID	cOR(C95%CI)	P
Age(years)				
<20	24(77.4)	7(22.6)	1.8(0.70-4.48)	0.228
20-29	176(85.9)	29(14.2)	1.0	
30-39	52(73.2)	19(26.8)	2.2(1.15-4.27)	**0.017**
40-49	10(58.8)	7(41.1)	4.2(0.11-0.24)	**0.007**
Occupation				
None	100(78.40)	27(21.2)	3.1(1.04-9.59)	0.141
Farmer	66(77.7)	19(22.4)	3.38(1.08-10.59)	0.236
Professionals	47(92.1)	4(7.8)	1.0	
Business	24(77.4)	7(22.6)	3.4(0.91-12.87)	0.068
Manual laborer	25(83.3)	5(16.7)	2.35(0.57-9.54)	0.232
Monthly income				
None	9(90)	1(10)	1.0	
<500000	181(78.7)	49(21.3)	2.4(0.30-19.70)	0.404
500000-1000000	58(87.9)	8(12.1)	1.2(0.13-11.13)	0.847
>1000000	14(77.9)	4(19.1)	2.5(0.24-26-85)	0.430
Education				
None	6(54.6)	5(45.5)	4.8(1.32-18.06)	**0.017**
Primary	84(84.9)	15(15.1)	1.0(0.48-2.27)	0.906
Secondary	84(75.7)	27(24.3)	1.8(0.93-3.79)	0.075
Tertiary	88(85.4)	15(14.6)	1.0	
Marital status				
Single	65(75.6)	21(24.4)	1.5(0.85-2.81)	0.326
Ever married	197(82.8)	41(17.23)	1.0	

Independent socio-demographic factors with p-values ≤ 0.05 were considered to have a profound influence for the development of PID among patient attending gynecology clinic at KIU-TH and were considered in the multivariate model.

These included the level of education and age.

Table 5: Bivariate analysis for sexual behavior factors associated with PID among women attending gynecology clinic at KIU-TH

Variable	No PID	PID	cOR(CI 95%)	P
Number of sexual partners				
None	18(90)	2(10)	1.0	
One	214(84.6)	39(15.4)	1.6(0.36-7.35)	0.518
Two & more	30(58.9)	21(41.1)	6.3(1.31-30.09)	**0.021**
Age of initiation of sexual activity				0.089
<15	20(80)	5(20)	2.6(0.67-9.960	0.163
15-20	190(78.5)	52(21.5)	2.8(1.08-7.49)	**0.034**
>20	52(91.2)	5(8.8)	1.0	
Use of Condom				0.267
Sometimes	58(73.4)	21(26.6)	0.3(0.10-1.41)	0.132
Every time	35(92.1)	3(10.7)	1.0	
Never	169(816)	38(18.3)	0.7(0.39-0.590	0.302
Smoking				0.0669
No	256(81.0)	60(19)	1.0	
Yes	6(75)	2(25)	1.4(0.28-7.22)	0.671

The number of sexual partners and age of initiation of sexual activity show to have profound influence for the development of PID, with P< 0.05 and were considered for multivariate analysis.

Table 6: Bivariate analysis for Gynecological related factors associated with PID among women attending gynecology clinic at KIU-TH

Variable	No PID	PID	cOR (95%CI)	P
Parity				0.644
Zero	77(78.6)	21(21.4)	**1.0**	
One to three	127(83.0)	26(17)	0.7(0.39-1.42)	0.380
More than three	58(79.6)	15(20.6)	0.9(0.45-1.99)	0.889
Hx of PID				
No	215(96)	9(4.02)	**1.0**	
Yes	47(47)	53(53)	26.9(12.42-58.40)	**<0.001**
Hx of Miscarriage				
No	224(84.9)	40(15.2)	**1.0**	
Yes	38(63.3)	22(36.7)	3.24(1.73-6.040	**<0.001**
Contraceptive use				
No	119(90.1)	13(9.9)	**1.0**	
Yes	143(74.5)	49(25.5)	3.1(1.62-6.05)	
Intrauterine Procedure				
No	244(86.8)	37(13.2)	**1.0**	
yes	18(41.9)	25(58.1)	9.1(4.56-18.40)	**<0.001**
Type of Contraception				
Condom	31(81.6)	7(18.4)	1.0	
Pills	48(78.7)	13(21.3))	0.9(0.81-1.23)	0.193
Injectables	48(73.8)	17(26.1)	0.7(0.92-3.02)	0.342
IUD	16(57.1)	12(42.9))	4.2(1.70-19.42)	**0.023**
Type of miscarriage				
Spontaneous	36(87.8)	5(12.1)	**1.0**	
Induced	10(52.6)	9(47.3)	3.8(1.80-6.43)	**0.026**

Table above shows that gynecological related factors that include previous history of PID, previous miscarriage specifically induced miscarriage, contraceptive use especially having the use of intrauterine device and undergoing intrauterine procedure indicated a p-value less than 0.05 and profoundly influence PID, these factors were then considered for multivariate analysis.

Results of multivariate analysis for factors influencing Pelvic inflammatory disease

Table 7: Multivariate analysis for factors influencing PID among women attending gynecology clinic at KIU-TH

Variables	aOR (95%CI)	P
Age(years)		
<20	1.4(0.40-4.30)	0.588
20-29	1.0	
30-39	1.7(0.69-5.15)	0.235
40-49	1.1(0.26-515)	0.832
Education		
None	7.4(1.11-49.61)	0.039
Primary	0.9(0.31-2.37)	0.772
Secondary	1.1(0.46-3.00)	0.73
Tertiary	1.0	
Num of sex part		
None	1.0	
One	0.4(0.77-2.47)	0.349
Two & more	2.3(0.83-5.75)	0.049
History of PID		
No	1.0	
Yes	17.1(7.20-40.95)	0.0001
Contraceptive use		
No	1.0	
Yes	2.4(1.01-6.10)	0.046
Intrauterine Procedure		
No	1.0	
Yes	3.03(1.24-7.37)	0.014
Type of contraception		
Condom	1.0	
Pills	0.5(0.28-1.61	0.423
Injectables	0.9(0.81-2.01	0.259
IUD	3.2(1.53-6.42)	0.018
Type of miscarriage		
Spontaneous	1.0	
Induced	2.6(1.46-4.98)	0.032

In multivariate analysis the factors that were significantly and independently associated with PID were having no education, having history of PID, history of ever use contraception and specifically IUD, history of inducing a miscarriage and undergoing intrauterine procedure.

The odds of having PID were 7.4 times higher among women with without education compare to those with tertiary level of education after adjusting for other factors in the multivariate model and this were significant, OR=7.4, 95%CI:I.11-49.6 P<0.039

The odds of having PID were 17.1 times higher among women with history of PID as compare to without history of PID in multivariate model after adjusting with other factors it was significant, OR=17.1, 95% CI:7.2-40.9 P<0.001. Odds of having PID for women who have used contraceptive is 2.4 times higher than those who have not used OR=2.4 95% CI:1.06-6.10 P=0.014 , this is more observed in women who have an IUD inserted than those who have condom this is significant with; OR=3.2, 95%CI:1.53-6.42 P=0.018; the Odds of having PID is 2.6 times higher for women who have had a induced miscarriage as compare to those who have had a spontaneous miscarriage, this is also significant with OR=2.6 95%

CI:1.46-4.98 P=0.032.The odds of having PID were 2.3 times higher for women with two or more sexual partners as compare to those without sexual partners, this is significant with OR =2.3 95%CI 0.83-5.75 P=0.049.

DISCUSSION

This study established that level of education, previous history of pelvic inflammatory disease, the use of family planning methods, intrauterine procedure, and the number of sexual partners and having an induced abortion were the significant factors influencing the development of pelvic inflammatory disease among women attending the outpatient gynecology clinic at KIU Teaching Hospital.

In this study, women who reported having two or more sexual partners were 2.6 times more likely to have PID as compare to those without sexual partner, aOR=2.6 95CI0.86-5.75 P=0.049, this findings were reported by other researches. [10] in his study on prevalence and determinants of *Neisseria Gonorrhea* and *Chlamydia Trachomatis* infections in patients with pelvic inflammatory disease in Zambia observed that among all the participants, those with pelvic inflammatory disease, 98.3% of them had at least one sexual partner and 37.7% was found to have gonorrhea, while 1.7% that reported having no sexual partner no gonorrhea was isolated from their group, 16.7% of all the respondents had new sexual partners in the six months previous to the study. All the respondents who had two or three new sexual partners had PID and were found to have gonorrhea in 40.7 % [10].

Previous history of pelvic inflammatory disease was a great risk of acquiring a new episode of PID (aOR=17.1 95% CI 7.2-40.1 P<0.001), women with previous history of PID are 17 time likely to develop subsequent PID compare to without history of PID, previous history of PID is believed to impaired local immunity and increased the likelihood of acquired PID. Intracellular Chlamydia trachomatis does not cause an acute inflammatory response and little direct permanent damage results from chlamydial tubal involvement. However, cell-mediated immune mechanisms may be responsible or subsequent tissue injury. Specifically, persistent chlamydial antigens can trigger a delayed hypersensitivity reaction with continued tubal scarring and destruction [11].

The use of contraceptive is associated with increased risk of PID in this research with aOR=2.4 95%CI1.01-7.37 P=0.04). This finding has also been reported in other international journals, [12] in the study done in Sydney on assessment of risk for pelvic inflammatory disease and sexual health in urban population, they reported that contraceptive history, the use of intrauterine contraceptive device, use of condoms, and not using contraception were each associated with an increased risk of PID, however intrauterine contraceptive device use carried the great risk for PID (OR 4.5 (95% CI 2.14–9.39). this could be explain by the fact that contraceptives offer more of protection against pregnancy and need to be supplemented with a consistent use of barrier methods to also protect against STIs and other ascendant infections.

In this study, it is shown that to undergo any intrauterine procedure (curettage, HSG, IUD insertion and curettage) carries a risk of pelvic inflammatory disease (aOR =9.2 95% CI 1.70-19.42 P=0.032).

CONCLUSION

The significant risk factors were not being educated, having previous history of PID, have ever use IUD as a family planning method and undergoing any intrauterine procedure.

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