SOCIO-CULTURAL FACTORS AND THE USE OF CONTRACEPTIVES AMONG WOMEN IN LOTOME SUB COUNTY, NAPAK DISTRICT, UGANDA

BY

DENGEL CHRISTINE

BDS/38751/143/DU

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DECLARATION

This proposal is my original work and has not been presented for any degree or any other academic award in any university or institution of learning

Signature of candidate..... Date 19/05/2017

DENGEL CHRISTINE

BDS/38751/143/DU

APPROVAL

I confirm that the work presented in this research report is done under my supervision as the university examiner supervisor.

Signature ..... Date 19/5/2017

MADAM AINEMBABAZI ROSETTE

SUPERVISOR.

DEDICATION

I dedicate this piece of work to my Uncle Dr. John Robert Limlim, my brothers and sisters, , friends and all those who have contributed towards my education not forgetting my supervisor, May the Almighty God bless you all.

ACKNOLWLEDGEMENT

Above all, I thank the almighty God who has been so merciful and faithful to me from the beginning otherwise without him, I am nothing.

I would like to extend my gratitude to my parents Hon Eruu Joseph and Eruu Jema for their support throughout my life, sisters, Alpha, Betty and brothers, Omega, Kenddey, Benjamin, Solomon thank you all

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LIST OF ACRONYMS AND ABBREVIATIONS

CDC	Centre for Disease Control
CPR	Contraception Prevalence Rate
FP	Family Planning
IUD	Intra Uterine Device
MDGs	Millennium Development Goals
STDs	Sexually Transmitted Diseases
TFR	Total Fertility Rate
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNBOS	Uganda National Bureau of Statistics
USAID	United States Agency for International Development
WHO	World Health Organization
DCDO	District Community Development Officer
DHO	District Health Officer

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ABSTRACT

The study sought to find out the socio-cultural factors and the use of contraceptives among women in Lotome sub county, Napak district, Uganda, it was guided by the following objectives, to determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age, to examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age and to examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age.
This was cross-sectional, using both quantitative and qualitative approaches. Specifically a case study design was applied. Quantitative method was also used because of the small scale nature of the study. The study used a study population of 120 respondents who were chosen from women of reproductive age and directly mandated to manage use of contraceptives among women. The study targeted women of reproductive age (15-45 years), the sample size of the study was determined according Slovene's formula to get a sample size of 92 respondents the study concluded that Education has a significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value 0.04 was less than the significance level (0.05) and the correlation coefficient was notably high (0.76) rendering the effect between education and usage of contraceptives among Karamojong women of reproductive age to be a strong one. Religion has significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value (0.036) is less than the level of significance. The correlation coefficient is strong (0.864) which showed that religion has strong effect on usage of contraceptives among Karamojong women of reproductive age. In order to determine the. Culture has no significant effect on usage of contraceptives among Karamojong women of reproductive age since the p- value (0.357) is greater than the level of significance. The correlation coefficient 0.32 showed a weak effect of culture on usage of contraceptives among Karamojong women of reproductive age. The study made the following recommendation based on the findings and conclusions of the study, the following recommendations were made, in line with the specific objectives of the study. More education kills is needed on how to deliver the message about usage of contraceptives, despite the permissibility of all contraceptive methods, barriers to effective, accurate use exist. As confirmed by various experts and literature sources, a woman's ability and willingness to utilize contraception is affected by whether she identifies with orthodox, traditional, or liberal interpretations of her religion. Contraceptive behaviour is often influenced by additional factors such as suitability of the specific method to fertility control, peer influences, and cultural effects. The contraceptive attitudes and behaviours for the different religions reviewed here do not necessarily reflect the behaviours of Ugandan women. When faced with the challenges of acclimating to a new society and way of life, women may anchor more strongly to traditional religious and cultural expectations with respect to family, sexuality, and fertility. Evidence from the broader world view described here may provide insight into the cultural values and behaviours that can influence recent immigrants.

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This chapter outlined the background of the relationship between socio-cultural factors and the use of contraceptives by women of reproductive age. It also discussed the problem statement; research objectives, research questions, significance and scope of the study.

1.1 Background of the study

1.1.1 Historical background

Globally, Contraceptive use is important because it prevents pregnancy and in turn prevents Mother to Child Transmission of HIV, reduces opportunistic infection in case the mother is using a barrier method, and prevents the reduction of the mother's immunity and exposure to risks of pregnancy. In case of using barrier methods like condoms may prevent re-infection among partners which leads to development of HIV resistant strains.

In Africa, a study carried out in Lesotho on Desire for children and unmet need for contraception among women of productive age who had learned of their status had slightly lower desire for children. The study also showed that of the contraceptives use among women, 38.7% intended to have a child. This study also revealed that the unmet need for contraception was higher among the productive age (31.3%) women than among the others (44.3%).

In Uganda, according to the UDHS (2011) Uganda has a high Total Fertility Rate (TFR) at 6.2 children per woman. As large cohort of young people enter the child bearing age, their reproductive behavior will determine the growth and size of Uganda's population for decades to come. Uganda still struggles with a low contraception Prevalence Rate (CPR) of 30 per cent which is below recommended level.

This low level of contraception prevalence rate among Ugandans is mainly attributed to various factors. One of which is the cultural and social factors. First and foremost, Uganda has high illiteracy rate especially among women. This means a good number of women in reproductive age do not have the right information about contraception and its benefits in terms of population control and other health benefits.

1.1.2 Theoretical background

This study was guided by the Theory of Reasoned Action (TRA). The TRA represents a schema that helps understand how we can influence women's intentions and behaviors in regard to the use of contraception. The TRA states that a person's behavioral intention and actual behavior are determined by two main constructs: attitudes and social norms (Howard, 2009).

According to the TRA, attitudes refer to an individual's own beliefs concerning a certain behavior, weighted by an overall assessment of the outcomes resulting from performing that behavior (Sable et al., 2006). Social norms refer to "the perception of how groups or individuals important to the person (i.e., social referents) view the behavior" (Sable et al., 2006). In particular, the TRA argues that the performance of the target behavior is affected by the pressure a person might perceive from his/her referent people such as spouse, family, friends, and religious leaders (Sable et al., 2006). In accordance with the behavioral theories, social context may serve as a constraint on an individual's intentions and decision making concerning a set of behaviors, including fertility and contraception. Therefore, involving social norms in the study's framework provides an opportunity to explore how these norms might promote or inhibit a woman's intention and decision to practice contraception.

1.1.3 Conceptual background

According to Frances Raday (2003), culture refers to the society in which many people act think and live the same. Similarly, it is a group of people who share the common culture and in particular common rules of behavior. It basically refers to the way of living of a group of people. socio-cultural factors operationalized as Education, Religion and cultural norms.

According to Gordon (2011), defines Use of contraceptives as a program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control. Use of contraceptives operationlized as artificial birth control methods such as condoms, pills and injecta plan

According to Divya (2003), defines Contraceptive Prevalence rate: Is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

1.1.4 Contextual background

According to UNBOS (2014),the population of Uganda is growing at an alarming rate hitting 34.9 million people(census,2014) compared to 24 million people in 2002 marking an increase of 10.9 million people in a space of 12 years,. According to provisional results released by UNBOS, officials said the annual growth rate stands at 3.03 percent implying the population would hit a record of 35 million in 2015 and 47 million in 2025. UNBOS said the population is composed of 16.9million males and 17.9 million females.

According to UDHS (2011), the productivity rate of Uganda is 6.2 children per woman. This can result to extremely high population in the near future. The level of teenage pregnancy is also high; this is coupled with risky abortion among women of reproductive age and attempts have been made by the government of the Republic of Uganda and Non-Governmental Organizations to tackle these problems with the introduction of contraceptives.

According to TDHS, 2010 only 22% of women with no education were using modern methods of contraception as compared to 52% of women with at least some secondary education. Family planning and use of contraceptive methods also increases rapidly as the number of living children increases, picking at 41% for women with 3 to 4 children. It also increases with the wealth quintile, from 23% of women in the lowest quintile to 51% women in the highest quintile

According to the latest national survey, about one in three married women of reproductive age reported having an unmet need for family planning at the time of the survey, which translates into approximately 1.6 million women. Of these women, about 60 percent wanted to space their next birth, and the other 40 percent did not want to have any more children.(UNFPA 2010)
Women who want to avoid pregnancy, but are not using an effective method of contraception, account for a large majority of unplanned pregnancies. In Uganda, 44 percent of pregnancies are unplanned (UDHS 2006)

1.2 Statement of the Problem

Uganda's capability to meet the needs of its fast-growing population is limited by the scarcity of available resources and the current economic situation. If the total fertility rate (TFR) remains as it is now, Uganda will face a serious problem that may obstruct the future development of the country (USAID, 2006; USAID, 2010). The findings of the 2014 UBOS demonstrated that 59.4 percent of currently women of reproductive age (WRA) were contraceptive users (UBOS, 2014b). This indicates that the percentage of currently WRA who do not use contraceptives is still high (40.6%). In 2015, the percentages of women who were users of modern and traditional contraceptive methods were 40.6 and 18.8, respectively (UBOS, 2015b). Modern methods consist of Intra Uterine Devices (IUDs), injectables, oral pills, implants, female sterilization and condoms. Traditional contraceptives include withdrawal, periodic abstinence, lacational amenorrhea (LAM), and folk methods. It is noteworthy that the prevalence of traditional methods in Uganda is higher than other countries in the East Africa such as Kenya (12%), Tanzania (10%), Rwanda (8%), and Burundi (3%) (USAID, 2015). Despite the efforts made, the contraception prevalence rate lies at 30 per cent (UDHS, 2011).This was attr ibuted to various factors including socio-cultural circumstances. However, little research was conducted in this area of the impact of socio-cultural factors on the use of contraceptives especially in the community of Lotome sub county of Napak district. Therefore there was need to investigate the relationship between socio-cultural factors on contraceptives.

1.3 Purpose of the study

This study sought to establish the effect of socio-cultural factors on the use of contraceptives among Karamojong women of reproductive age in Lotome Sub County.

1.4 Specific Objectives

i. The determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age
ii. To examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age
iii. To examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

1.5 Research questions

i. What is the effect of education on the usage of contraceptives among Karamojong women of reproductive age?
ii. What is the effect of religion on the usage of contraceptives among Karamojong women of reproductive age?
iii. What is the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age?

1.6 Scope of the study

1.6.1 Geographical scope

The study was carried out in Lotome Sub County, Napak district. The area was located in the North Eastern Part of Uganda; Karamoja region. Lotome Sub County is comprised of five (5) parishes which include Kalokengel East, Kalokengel West, Nariamaregae, Lomuno and Moruongor. The Sub County had schools like St. Andrews' Senior Secondary School, Lotome Boys' primary school, Lotome Girls' primary school; Lomuno Mixed primary school among others, there was also one Health Center; Lotome Health Center III. The researcher chose this area because it was accessible.

1.6.2 The Content Scope.

The content focused on the effect of socio-cultural factors on the use of contraceptives among Karamojong women of reproductive age with special emphasis on the impact of cultural norms, religion, education, as well as access to contraception and suggesting possible measures that can enhance the use of contraceptives.

1.6.3 The Time Scope

The study was cross –sectional and started in February to May 2017

1.6.3 Theoretical scope

The study was guided by Howard's Theory of Reasoned Action (2009), which stated that behavioral intentions and actual behaviors are determined by two main constructs: attitudes and social norms.

1.7 Significance of the study

The study will help to the community of Lotome Sub County in that they will get to know the cultural barriers that hinder their use of contraceptives and the dangers involved in it.

The study will be useful to the policy makers in that they can be able to set policies and guidelines on how to use contraceptives among the women of age. The government, Nongovernmental Organizations and other stakeholders in designing policies that aims at increasing contraceptive use in Napak district.

The study will be of importance to the future researcher in that it will help them as a source of information in their research and in the different academic areas of research.

1.8 Definition of key terms

Contraceptive; according to the American heritage dictionary of English language (2000) contraception is the intentional prevention of conception or impregnation, through the use of various devices, agents, drugs, sexual practices or surgical procedures.
Contraception and fertility control generally involves both methods and devices used to prevent pregnancy.

Cultural norms; according to Frances Raday (2003), culture refers to the society in which many people act think and live the same. Similarly, it is a group of people who share the common culture and in particular common rules of behavior. It basically refers to the way of living of a group of people.

Reproductive age; this is the span of ages at which individuals are capable of becoming parents. The phrase can be applied to men and most frequently refers to women. (Divya A. Patel et al, 2003)

Artificial family planning methods

Artificial family planning is the process used to prevent pregnancy and plan for the birth of children at the most optimum time. Commonly referred to as birthcontrol, family planning can be accomplished using a variety of methods. Before you choose a method, there are a number of factors you should consider.

Artificial" Family Planning (AFP): modern methods which purpose is to prevent conception (such as hormonal, barriers, or combination), but not abortive methods.

Education level

Educational level attainment refers to the highest level of education that an individual has completed. This is distinct from the level of schooling that an individual is attending.

Religion

Religion is a cultural system of behaviors and practices, world views, sacred texts, holy places, ethics, and societal organization that relate humanity to what an anthropologist has called "an order of existence".

CHAPTER TWO
LITERATURE REVIEW

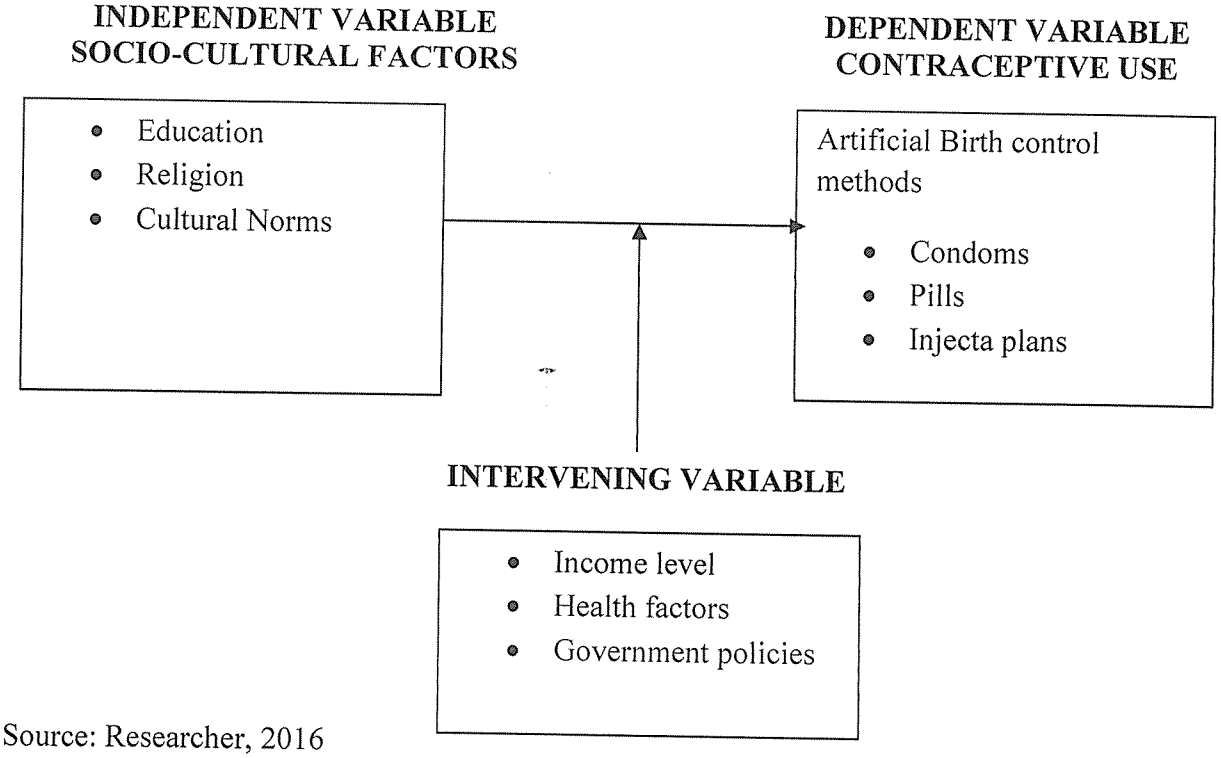
2.0 Introduction

This chapter basically reviewed the related literature on the socio-cultural factors on contraceptive use among women of reproductive age.

2.1 Conceptual framework

The conceptual framework showing the relationship between socio-cultural factors and the use of contraceptives in the study

Figure 1: showing the conceptual framework



Source: Researcher, 2016

In this study, the Independent variable was socio-cultural factors operationalized as Education, Religion and cultural norms. The dependent variable was use of contraceptives operationlized as artificial birth control methods such as condoms, pills and injecta plan. There were however other factors other than social cultural factors that affect the dependent variable (use of contraceptives) and these were intervening variables such as income level, health factors and government policies.

2.2 Theoretical framework

This study was guided by the Theory of Reasoned Action (TRA). The TRA represents a schema that helps understand how we can influence women's intentions and behaviors in regard to the use of contraception. The TRA states that a person's behavioral intention and actual behavior are determined by two main constructs: attitudes and social norms (Howard, 2009).

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2.3 Review of Related Literature

Contraceptive use has become a growing concern nowadays and hence, it has become imperative to look socio-cultural factors on contraceptive use among women of reproductive age. This can be done by looking at the literature related to the topic.

2.3.1 The effect of education on the usage of contraceptives among Karamojong women of reproductive age

Education remains the most important factor that affects contraceptive use (Rahayu et al., 2009). According to findings in Uganda, contraceptive use was higher among women with primary education than women with no education (Ojakaa, 2008). In Nigeria, it was found that higher educated women were more likely to use contraceptives thereby decreasing their fertility (Olalekan & Olufunmilayo, 2012). In addition, women are more likely to use contraceptives when they have any level of education compared to no education (Rahayu et al., 2009). Furthermore, educated women situated in urban areas usually marry at older ages and are more

likely to use contraceptives (Adetunji, 2012). In Kenya, women with higher levels of education belonging to urban areas with higher wealth quintiles were found to have a higher prevalence of modern contraceptive use compared to their counterparts (Ettarh, 2011). In another study in Malawi, women who are poor do not have high levels of education compared to the wealthy and are less likely to use contraceptives (Adebowale et al., 2013). This further adds to the importance of education.

According to a study by Nushin Mahmood (1996), a woman's education has contribution towards use of contraceptives. The study revealed that use of contraceptives increased by 0.79 for women with primary and middle education by 1.29 for secondary and higher education when compared with the "no education" category. This study shows the clear relationship between education and contraception use.

The content of contemporary sex education programs ranges from discussions aimed at helping students clarify their values or practice decision-making skills, to classes stressing abstinence almost exclusively, to forthright discussion of contraceptive use and availability. Britton, (1992) The AIDS epidemic has been an important influence on state and local educational policies. By 1989, virtually all schools included AIDS education in their curricula, sometimes together with other sex education topics and sometimes separately; AIDS education curricula are now strongly recommended or mandated in all 50 states. Silverman, (1989) Opinions are sharply divided about whether and how much schools should teach students about condoms and other contraceptive methods. Some observers believe that schools can and should influence teenagers' sexual behavior, including their contraceptive behavior, while others fear that contraceptive education encourages sexual activity among adolescents, and still others think that sex education is largely irrelevant because "nothing works."

Although several studies have documented that sex education programs result in increased knowledge about contraception and more favorable attitudes toward it, Hayes, (1992) actual changes in students' behavior due to sex education have been harder to demonstrate. A 1991 survey of the research literature summarized the evaluations of several sex education curricula with what is still the conventional wisdom on the subject: "None of the educational programs evaluated...had any measurable effects on participants' sexual activity, contraceptive use, or pregnancy rates." U. S. Congress, Office of Technology Assessment, (1992)

In contrast to this pessimistic view, a 1994 summary of the findings of 23 published, peer-reviewed studies of school-based sex and AIDS education programs reported that some of these programs "did delay the initiation of intercourse, reduce the frequency of intercourse, reduce the number of sexual partners or increase the use of condoms or other contraceptives." Kirby et al, (19194) The research presented here focuses on the last of these outcomes: whether sex education increases contraceptive use. More precisely, we investigate whether women who received formal instruction about contraception before becoming sexually active were more likely than others to use a method when they first had sexual intercourse.

Behavior at first intercourse is an informative measure of the value of sex education for several reasons. First, for most people, the initiation of sexual activity is a memorable experience, so reports about contraceptive use at that time should be relatively reliable.

Second, investigating a respondent's first opportunity to use a method following sex education should yield the most accurate, and perhaps the highest, estimates possible of the effect of contraceptive education.

Because the respondent was not sexually active previously, the potential impact of education is not contaminated by the effects of prior contraceptive behavior or by intervening sexual episodes.

Third, most young people's contraceptive behavior remains fairly consistent for at least some months following first intercourse.

For example, among teenage women interviewed in 1988 who had been sexually active for about two years, 43% reported that their contraceptive behavior had been exactly the same at first intercourse and at most recent intercourse; another 23% said they had used contraceptives on both occasions but had changed methods. Mauldon, (1995) Five out of six respondents who had used a method at first intercourse had also used one at most recent intercourse. In contrast, one-third who had used no method initially were still not using one.

Correlations in behavior between first and most recent intercourse weaken as the period between these events increases, but the results reported in this article can reasonably be thought of as reflecting behavior early in a young woman's sexual life. This is an important time; the consequences of even a few weeks or months of unprotected intercourse can be severe.

One-fifth of all premarital first pregnancies among teenagers occur in the first months after they become sexually active. Zabin, (1997)

Researchers investigating the impact of education on students' contraceptive behavior early in their sexual lives have used two types of data: retrospective reports from nationally representative samples, and data generated to evaluate various types of sex than others to use a method, Kirby et al, (1990) and one found that they were less likely to do so. Zellman, (1990)

For the remaining curricula, results are reported for all students' contraceptive use after the educational exposure. Two of these programs had no significant impact on contraceptive use, Thomas et al, (1992) while two yielded improvements in use.

Education programs aim to improve sexual health outcomes among teens. Programs can be separated into two main approaches to curriculum abstinence-only and comprehensive. Many studies have assessed the effectiveness of abstinence-only versus CSE. Abstinence-only programs, in accordance with the Health Resource and Services Administration's Maternal and Child Health Services Block Grant program (Title V Section 510), teach abstinence until marriage as the only option for teenagers. Such programs do not acknowledge that many teenagers will become sexually active and avoid all discussion of abortion. Contraceptive methods are not discussed, other than to emphasize their failure rates. Proponents of abstinence-only education argue that discussing contraception with teens can send mixed messages about sexual activity expectations. On the other hand, comprehensive programs promote abstinence yet acknowledge that many teenagers will become sexually active. Thus, the programs provide information about abstinence and contraceptive methods and include discussions about abortion, STDs, and HIV. Proponents of CSE argue that it is important not only to promote abstinence, but also to provide teens with the information and skills to protect themselves from poor sexual health outcomes if they choose to engage in sexual activity.

The large majority of literature assessing the efficacy of sex education programs supports comprehensive programs as the more effective program design. Conversely, systematic reviews of programs have found no significant evidence proving abstinenceonly education to be effective at delaying sexual initiation. A review of recent studies assessing sex education programs, led Santelli et al. to conclude that abstinence-only programs are not only ineffective but unethical

due to their withholding of medicallyaccurate information about contraception (Santelli, Ott et al. 2006).

2.3.2 The effect of religion on the usage of contraceptives among Karamojong women of reproductive age

Religion is widely known to affect people's views and acceptance of modern contraception, thus affecting the outcome of their reproductive behaviour (McQuillan, 2004). However, the extent of how much of an affect religion has in influencing the reproductive outcomes of people in developing countries remains obscure given the relatively low number of recent studies that look into these phenomenon's. Furthermore, of the studies that look at the level of influence that religion has on contraceptive use, the results vary in different sub-Saharan African countries as shown by Yeatman and Trinitapoli (2008).

Early studies show that the European transition began as a result of religious acceptability of modern contraception; the acceptance of contraceptives by the Church led a widespread decline in fertility among married women in Europe (Coale, 1986; Lesthaeghe, 1980 as cited in Addai, 1999). Lesthaeghe (1989) further argued that the use of contraceptives largely depends on the Churches stance on contraception. If contraception is positively viewed by the Church, contraceptive use increases as opposed to when it is portrayed in a negative light (Coale, 1986; Lesthaeghe, 1989; Addai, 1999).

A qualitative study of participant observation of religious services in Malawi indicate that religious leaders are neutral in that they do not encourage fertility nor promote contraceptive use (Trinitapoli, 2006). In the United States, religious engagement (attending places of worship) was found to be a good predictor of fertility behaviour (Hayford & Morgan 2008). The more religious were found to have higher fertility and lower contraceptive use (Hayford & Morgan 2008). However, in rural Malawi, attending religious services is positively associated with the use of modern contraceptives (Yeatman & Trinitapoli, 2008).

There is little to no condemnation of using birth control in most major religions. It's true that most religions promote fertility because they date back to eras when high fertility rates could mean the difference between the survival or death of a community, yet despite this, room is still made for allowing or even promoting wise family planning. Why is it, then, that conservative

Christians in modern America have started to oppose the use of contraceptives? If atheists are going to accurately and reasonably respond to these changes, it's necessary to understand what is driving them and where they are coming from.

Part of the cause may be the influence of Catholicism. Catholics and conservative evangelical Protestants have worked closely together to fight abortion and some Catholic reasons for opposing abortion, reasons which are also used against birth control, have been adopted by Protestants. Some Protestants may be following these reasons to an anti-contraception conclusion and it appears that some evangelicals are starting to use Catholic arguments against the permissibility of contraception and against Protestant tradition.

Perhaps more important, however, is the fact that support for use of contraceptives occurs in the context of "family planning." Use of contraceptives to make it easier to engage in extramarital sex (by avoiding the consequences of sex, like pregnancy) is not supported by Protestantism or any other religious tradition.

In modern America, though, contraception is legal for everyone, not just married couples, and is frequently used by unmarried sexual partners for precisely that purpose: to avoid pregnancy and/or sexually transmitted diseases.

Thus the increasing opposition to contraceptives generally may be due to a growing belief that it's more important to oppose extramarital sexual activity rather than support family planning. If making it more difficult for people to have sex outside marriage without consequences means making it more difficult for married couples to properly plan and care for their children, that appears to be a trade-off they are willing to make. It is not, however, a trade-off which non-Christians should be forced to make.

There is nothing in Islam that would condemn contraception; on the contrary, Muslim scholars investigated and developed birth control methods which were taken to Europe. Avicenna, a famous Muslim doctor, lists in one of his books 20 different substances that can be used to prevent pregnancy. Reasons why contraception is justified include preserving the quality of the family, health, economics, and even helping the woman preserve her good looks.

Protestantism is perhaps one of the most diffuse and de-centralized religious traditions in the world. There is almost nothing that isn't true of some denomination somewhere.
Opposition to contraception is increasing in conservative evangelical circles who are, curiously, relying heavily on Catholic teachings. The vast majority of Protestant denominations, theologians, and churches at least permit contraception and may even promote family planning as an important moral good.

Roman Catholicism is popularly associated with a strict anti-contraception position, but this strictness only dates to Pope Pius XI's 1930 encyclical Casti Connubii. Before this, there was more debate on birth control, but it was generally condemned like abortion. This is because sex was treated as having no value except for reproduction; therefore, hindering reproduction encouraged sinful uses of sex. Nevertheless, bans on contraception are not an infallible teaching and could change.

As fundamental human behaviors, sexuality and family formation represent legitimate areas of concern for most organized religions. Thus, the moral or ethical principles expounded by religious leaders include such issues as the appropriate age of onset of sexual activity, the regulation of non-marital sexual activity, contraception and abortion, appropriate partners, rituals for recognition of marital unions, and responsibilities and obligations for child rearing. As a country historically considered a refuge for those experiencing religious persecution, the United States is characterized by a large number of religious groups quite heterogeneous as to their principles and practices and the historical antecedents of their beliefs.

Despite the sometimes quite ancient lineage of these principles and prescriptions, the current entanglement of religious and political groups over issues of sexuality and contraception in the United States reflects a relatively recent effort of religious groups to adapt to events coming to prominence largely in this century (D'Antonio, 1994). As discussed elsewhere in this report, these events include the development of effective and reliable means of contraception, wider access to safe abortion, a broader and often conflicting array of sources of information on sexual behavior and mores including the media and sexuality education provided in public schools, and an overt recognition of and pressure to accept sexual activities and alternate family configurations not consonant with traditional religious teachings.

In addressing the current overlap of religious doctrine and political ideology, it is helpful to consider several separate dimensions, including the appropriate locus for transmission of information and values regarding sexual behavior and family function, the use of contraception both within and outside of marriage, the increased public visibility and wider availability of abortion, the extent to which individuals adhere to the official positions of their religious, and the use of political strategies to assert religious and philosophical positions.

Most organized religions transmit values through an alliance with the family, both through formal instruction during or in conjunction with religious services and through modeling of behavior by the family. This traditional mode of transmission has been complicated by the availability of alternative sources of information, especially media.

In response to persistently high rates of teenage pregnancy, and more recently the spread of HIV, efforts have been undertaken to provide information and more appropriate models of behavior through the schools. Although most organized religions support such efforts, some individuals perceive the information and values to run counter to their own religious principles. They view these efforts as encouraging premature sexual activity and sexual activity outside the bounds of formally approved unions. Hence, such efforts are perceived as undermining traditional family values.

In contrast to issues surrounding the transmission of values that generally involves custom rather than formal principles, many organized religions have formal principles dealing with contraception and abortion. Most religions encourage responsible procreation within the confines of marital unions. Most did not, however, have strong moral or ethical traditions regarding contraception and abortion until this century, and there is only a very limited scriptural background on these issues. In Judeo-Christian traditions, only one Biblical passage can be construed as dealing with contraception (and that interpretation is controversial), and the Koran does not have any clear-cut teaching on this topic. Thus, most religious traditions prior to this century reflected the teachings of religious scholars, often in response to specific questions, events, or heresies. Until this century, most Christian scholars condemned contraception and abortion, with more variability within the Jewish and Islamic traditions (D'Antonio, 1994).

In the 1930s, however, this situation changed when the mainline Protestant churches in the United States began to approve contraceptive use by married couples and then later to accept abortion. As is well known, the Roman Catholic Church formally forbids the use of any

contraceptive techniques other than "natural family planning" or the rhythm method, and any use of abortion for any reason. Other conservative religious groups also proscribe contraception and abortion, including the Lubavitcher Hasidic sect, the Church of Latter Day Saints, and several conservative fundamentalist and evangelical groups (Carlson, 1994; D'Antonio, 1994).
Regardless of the formal religious positions on sexual activity and control of fertility, substantial variation in practice occurs among those belonging to specific religious groups. The most dramatic example is the disparity between the position of the Catholic Church and most of its American members regarding contraceptive use. Despite the Church's clear stand against artificial means of birth control, most Catholic women and couples in the United States use a wide variety of contraceptive methods; 75 percent of white Catholic couples practice contraception, and among those couples, 63 percent use sterilization or oral contraceptives (Goldscheider and Mosher, 1991). Not surprisingly, the major predictor of personal practice is the degree of "religiosity," that is, the degree to which religion is seen as important and to which individuals observe other aspects of their religion (D'Antonio, 1994).

The considerable diversity of opinion among organized religions and the considerable diversity of personal practice among the membership of these religions, do not, by themselves, explain the vehemence of the current political debate on abortion and family values. The major change over the past decade has been the emphasis on conservative forms of family values and a coalescence of Catholics and the conservative elements within many Protestant denominations into politically active groups. Although certainly initiated among Roman Catholics, this movement now includes a large number of conservative Protestants who share a common vision of a threat to traditional family values. Furthermore, although the National Conference of Catholic Bishops has certainly played a seminal role in bringing its resources to political activity, evangelical Protestant groups such as the Moral Majority are equally committed and also bring substantial resources (Carlson, 1994).

Even though people and financing are important elements in attaining political power, another element also contributes to the current political climate. Blendon and colleagues (1993) report that the majority of Americans support the availability of abortion, but they do so conditionally and do not consider it their most important political issue. By contrast, those who strongly oppose abortion view it as a top priority and often vote for candidates on the basis of their expressed positions on abortion. In exploring this phenomenon more carefully, Blendon and

colleagues (1993) found that there is no evidence that groups who strongly support abortion vote with the same single-issue orientation as do those who strongly oppose abortion. They also found that the tendency to view political issues through the lens of abortion is directly related to an individual's participation in his or her religion (or to their degree of "religiosity"). One noteworthy aspect of the continuing opposition to abortion is that some of those who strongly oppose abortion are increasingly engaged in aggressive and organized political activity at all levels of government with abortion as their major, but no longer their sole, focus. This issue is addressed directly later in this chapter under the heading "Opposition to Abortion." The expansion of opposition to abortion into opposition to other aspects of reproductive health, especially contraception and family planning, is a puzzling and distressing development, inasmuch as contraception helps to reduce the need for abortion by reducing the occurrence of unintended pregnancies in the first place.

In summary, the availability of effective contraception and abortion and the broader range of sexual behavior considered acceptable in many groups in the United States present a challenge to those espousing traditional family values. Although the majority of Americans profess relatively tolerant attitudes, there is no single shared ethic about what constitutes appropriate family structures or sexual behavior. In response to what is perceived as a threatening liberalization of sexual behavior, conservative elements of many religious denominations have joined in a common cause to protect what are defined as traditional values. The political controversy, in contrast to the moral controversy, reflects the fact that these groups are willing to use the resources of their religious groups for campaigning and lobbying, and they represent single-issue constituencies voting solely on the issues of abortion and family values. Participation in such political activity is less a function of formal religious affiliation than of degree of attachment to religion or religiosity (D'Antonio, 1994).

2.3.3 The effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

While focusing on the contribution of traditional culture on the use of contraceptives among women of reproductive age, it should be noted that, a lot of literature concerning this study tend to point to the fact that traditional culture has impacted on the use of contraceptives. A study by Ankomah et al (2013) reported that in many traditional settings, young women who use

contraceptives are perceived as promiscuous. A report holds the view that if a woman uses family planning; it means "she is a loose woman, a prostitute".

Meanwhile according to a study carried out by A. Ankomah et al (2013) he discovered strong belief in the value attached to children. Children in traditional African culture are seen as a source of wealth, prestige and security and protection especially in old age. Conception is therefore regarded as abuse of cultural norms and values. Those who do this are perceived as doing evil! Ankomah et al (2013) also discovered strong believe in Traditional birth control methods. For example, one respondent is quoted as saying *"For my family; after me and my husband meet and if I don't want to get pregnant, I breathe and the entire thing (sperm) will come out."(p273)*

Contraceptives can kill through excessive bleeding. While some of the side effects are valid and well known, it should be noted that both users and non-users hold on to half-truths, misconceptions and outright conspiracy theories regarding modern contraceptives such as it "causes cancer", "it causes barrenness in women" it gives headache or causes complications during delivery. This believes are so deeply rooted that it has a negative impact on the use of contraceptives. These traditional believe exert profound impact on the use of contraceptives. This clearly documents how the traditional cultural believes can affect contraceptives use among women of reproductive age.

A variety of factors have been found to influence contraceptive use. Deardorf, Tschann, and Flores (2008) suggest there are specific sexual values that may play important roles in contraceptive use. These sexual values include level of comfort with sexual communication as well as level of sexual comfort and sexual self-acceptance. Marin (2003) found that Latino adults, particularly women, reported that communicating about sex often causes discomfort and is perceived as inappropriate and that, in turn, Latino men are expected to respect women by not discussing sex. Such lack of communication about sexual issues has the potential to lead to negative outcomes, including low rates of contraceptive use (Marin, Gomez, Tschann, & Gregorich, 1997). Sexual comfort, or a general level of comfort and positive emotional orientation toward sexuality, has been found to foster sexual communication and contraceptive use self-efficacy, which in turn predicts greater contraceptive use (Marin et al., 1997). Sexual self-acceptance is an evaluation of one's sexuality and has been positively associated with

contraceptive use among ethnically diverse youth (Tschann & Adler, 1997). Another sexual value relevant to contraceptive use is gender role beliefs. Past studies with adult Latinos suggest that gender role beliefs—including expectations for women to be chaste, virtuous, and submissive to men and men to be strong, independent, and in a position of authority—influence expression of sexuality and sexual behavior (Marin, 2003).

Attitudes regarding sex, contraception, and pregnancy in adolescents and young adults can often be influenced by parental attitudes. Perceived parental attitudes toward sex and actual parental attitudes toward sexuality are strong predictors of adolescent and young adult sexual behavior (Bersamin, Todd, Fisher, Hill, Grube, & Walker, 2008). Overall quality of parental communication may function as a protective factor with effective communication styles and positive parental relationships being associated with fewer pregnancies and more consistent contraceptive use (Bersamin et al., 2008).

Past research has shown that there are large ethnic differences in unintended pregnancy and birth rates, with Latina women having the highest rates in the nation for almost all age groups (Chandra, Martinez, Mosher, Abma, & Jones, 2005). The Latino community is growing quickly in the United States and is considered an at risk group for unintended pregnancy and high birth rates. Therefore, it is important for research to focus on ways to increase pregnancy planning and contraceptive use in this group. Investigating ethnic disparities in unintended pregnancy and birth rates as well as contraceptive use, may help policy makers and public health professionals identify high-risk groups of women and thus provide them with the means needed to achieve their reproductive goals (Finer & Henshaw, 2006).

Many potential beliefs could be at work here with Margarite and her husband. Cultural attitudes could influence her husband to believe that it is his wife's duty to bear children or that only promiscuous women use contraceptives. Religious beliefs could be the root of her husband's not wanting Margarite to use contraception. He could lack knowledge or have misinformation about contraceptives. Maybe he is afraid that contraceptives will harm Margarite or cause her to become infertile.

The direction of the discussion between Margarite and her health care provider could differ dramatically, depending on the health care provider's assumptions about underlying beliefs.

Assuming that her husband has a cultural or religious belief that Margarite does not share, a health care provider might present her with a discrete contraceptive method, such as an injectable or an intrauterine device (IUD), or provide her with emergency contraception. However, if her husband disapproves because he lacks knowledge about contraceptives or has concerns for his wife's health, it could be advantageous to involve him in a discussion to educate him about the safety and reversibility of contraception before she chooses a method.

This cultural and ethnic diversity is reflected in widely varying knowledge about and attitudes toward contraception and fertility control. For example, some immigrants arrive in the United States from countries whose systems of family planning services are arguably better organized than those here and whose range of available contraceptive methods is broader. Some bring with them rich traditions of folk medicine (such as reliance on herbal medicines and various folk remedies and use of neighborhood practitioners rather than doctors for health care) that do not always blend easily with U.S. approaches to medicine in general or contraception in particular. Some contraceptive methods available in the United States may be unfamiliar to recent immigrants, and the health care system that one must negotiate in the United States to obtain the more effective methods is certainly different, and often more complicated and inaccessible, than systems in the immigrants' countries of origin. Contraception especially may be associated with images and practices that limit its acceptability. For example, in Thailand, condom use is associated with a vigorous prostitution industry in that country, which may mean that efforts in the United States to encourage greater condom use might be resisted by recent Thai immigrants (Healthy Mothers, Healthy Babies Coalition, 1993). For illegal immigrants, the task of securing contraception may be further complicated because of their general inability to use such programs as Medicaid to help finance primary health care, including contraceptive services.

2.4 Related studies

A study in Nigeria by Clifford Obby O. (1999) found that, although most of the respondents had information about contraception (76%), only 26% were currently using one, and fewer than half (47%) reported using one. This therefore means that this study did not clearly present the effect of information about contraceptives on its use.The use of modern contraceptives differs across regions in Kenya (Ettarh, 2011). The northern and eastern regions had lower levels of contraceptive use as opposed to the central parts with the highest levels of contraceptive use. In addition, women living in slums have high parity and low contraceptive use (Ettarh, 2011).

Research shows that there exist rural-urban differentials in contraceptive use despite knowledge of contraceptive methods in Nigeria, Zambia and Indonesia (Olalekan & Olufunmilayo, 2012; White & Speizer, 2007; Rahayu et al., 2009). These studies found that rural areas have lower levels of contraceptive use as opposed to urban areas in which women are more likely to be using contraceptives (Olalekan & Olufunmilayo, 2012; White & Speizer, 2007; Rahayu et al., 2009). This study was carried out in kenya hence there is need to carry out a similar research in Uganda

According to a study that looks at wealth differentials in terms of contraceptive use in 13 sub-Saharan African countries, findings show that wealthy women are more likely to use contraceptives and meet their fertility intentions as opposed to their poorer counterparts (Creanga et al., 2009). However, this study remains optimistic in its findings that family planning programs have been implemented in most countries thus allowing poorer women to also meet their contraceptive needs hence reducing the wealth differentials among women in terms of their access to family planning methods. According to studies, it is well documented that poorer women do not make use of family planning compared to their wealthy counterparts (Creanga et al., 2009; Rahayu et al., 2009). This study was carried out in 13 sub-Saharan African countries hence there is need to carry out a similar research in Uganda

In a study conducted by Waitherero (2009), which looked at contraceptive use among young female youth (15-24 years old) in Kenya, it was surprisingly found that female youth with primary education were more likely to use contraceptives than those with secondary education and above. The study also found that levels of contraceptive use were low despite high sexual activity. Only 26% of sexually active females aged 15-19 used contraceptives while only 25% of females aged 20-24 used contraceptives (Waitherero, 2009). Bearing in mind the Kenyan government's effort to increase contraceptive prevalence since before Kenya's independence, contraceptive prevalence should be higher than it is given that contraceptive knowledge is relatively high (Akoth, 2012). This study was carried out in Kenya hence there is need to carry out a similar research in Uganda

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter presented Research design, area of study, study population, sample, sampling procedures/strategies, instruments of data collection, procedure of data collection, data analysis and processing, data presentation, ethical considerations, limitations of the study and summary.

3.1 Research design

This was cross-sectional, using both quantitative and qualitative approaches. Specifically a case study design was applied.

Quantitative method was also used because of the small scale nature of the study. Quantitative research dealt with quantities and relationships between attributes: it involved the collection and analysis of highly structured data in the positivist tradition. Besides, quantitative data was appropriate where there was already pre-existing knowledge which permitted the use of standardized data collection methods. The research design was descriptive which covered socio-cultural factors that influenced contraceptive among women of reproductive age.

3.3 Study Population

The study population was 120 respondents who were chosen from women of reproductive age and directly mandated to manage use of contraceptives among women. The study targeted women of reproductive age (15-45 years), health workers, local leaders and some few government officials who are mostly concerned with community development issues.

3.4 Sample size

The sample size of the study was determined according Slovene's table of sample determination. Under this, a target population of 120 respondents but it was zeroed down to a sample size of 92 respondents respectively as stated by Slovene's.

The Slovenes formula was used to determine the minimum sample size.

$$N = \frac{N}{1+N\,e^2}$$

Where n=number of sample

N=total population

e=level of significance 0.05

These were divided as seen in the table below;

Table 1: The sample size and sampling procedure

Sample population	Sample size	Sampling strategy
Key informants	10	Simple Random
Women of reproductive age	42	Simple Random
Health personnel	25	Purposive
Local government officials	15	Purposive
Total	92	

3.4 Sampling Procedures/Strategies

The participants in the study were selected through simple random sampling method for respondents among them key informants and women of reproductive age to have an equal chance of being selected to be part of the study.

3.4.1 Simple random

Simple random sampling was used so that each respondent has an equal chance of being selected. This makes the sample more representative. It also ensures a high degree of representativeness and ease of assembling the sample (Thampson, 2002; Levy & Lemeshow, 2008)

3.4.2 Purposive sampling

Purposive sampling was used because the method helps one to get the right respondents with specific information. This sampling procedure was used for its cost efficiency and effectiveness to collect specific information and allowed for probing for clarity (Kothari, 2004)

3.5 Sources of data

Primary sources

These were original sources from which the researcher directly collected data that had not been previously collected. Primary data sources were first hand information collected through

methods such as observation, interviewing, mailing and questionnaires. Krisna Swami (2002) gave four advantages of primary data as follows;

From the observation the researcher can study behavior as it occurs.

In particular observation, the observers understood emotional reactions of the observed group and got a deeper insight of their experience.

The observer was able to record the context which gave meaning to the observed behavior and heard statements.

Secondary data

Krishna Swami (2002) defined secondary data as sources which have been collected and compiled for another purpose. It consisted of readily available documents already compiled statistical statements and reports whose data was used by the researcher for her studies. Example included census reports and annual reports.

Secondary data consisted of published and unpublished records and reports (Krishna Swami (2002). Advantages of secondary data were;

This data was available, was secured quickly and easily

It covered wider geographical area and longer reference period without much cost

The use of secondary data broadened the data base from which scientific generalization was made. In order to get data for this study, a combination of primary and secondary data was used.

3.6 Instruments of Data collection

3.6.1 Self-Administered questionnaires

The research instrument included the Self-administered questionnaire (SAQs). SAQs were used because they were the most suitable in a survey that involved a large number of respondents (Amin, 2005). In addition, (SQAs) were very suitable for the target respondents gave their high levels of English literacy. Finally, SAQs consumed less time and money compared to other methods (Alston & Bowels, 1998)

3.62 Interview guide

Interviews were mainly used to get information from key informants. Interviews were good for probing clarity and more detailed explanation by the respondents and they kept them focused to the study topic. In addition, the interviews were used in order to collect additional data that had been left out by the questionnaires especially closed-ended ones (Amin, 2005).

3.8 Validity and Reliability

3.8.1 Validity

Validity was the ability of the research instrument to measure what it aimed or was supposed to measure. According to Arnin (2005), the research instruments were appropriate for the study objectives to be achieved. The researcher consulted and discuss validity instrument with colleagues and supervisors to limit errors as much as possible (these were judges who were experts in the field). The colleagues with the expertise were given questions so that they could rate each question on a five point rating scale which indicated strongly agree (I), agree (2), neither agree or disagree (3), disagree (4), and strongly disagree (5). The formula is

$$CVI = \frac{\text{Number of Questions Declared Valid in the Questionnaires}}{\text{Total Numbers of Questions}}$$

Where CVI was Coefficient Variable Indicators

Out of the total number of items of the questionnaire, the questions that were considered very relevant and quite relevant were rated. The content validity index for the questionnaire indicated 0.7 to confirm them valid since it was above 0.7 (Amin, 2005). This meant the items of the instrument were proved valid. The researcher finally incorporated the comments while drafting the final copy.

3.8.2 Reliability

Reliability of an instrument was the dependability or the trustworthiness of an instrument. According to Amin (2005), it was the degree to which the instrument consistently measures what it was supposed to measure. This method picked on a single pre-test group and showed the degree to which the items in the questionnaire were inter-correlated. That is, a respondent who completed the questionnaire was again politely asked to complete another fresh questionnaire (retest) after two weeks to prose the answers earlier filled for consistence or too close they relate (Amin, 2005). Internal consistence of the items in the questionnaire was established using Cronbach's formulae to compute the alpha co-efficiency of reliability.

To get the reliability, the data was entered in the computer and analyzed using the statistical package for social scientists (SPSS), which was useful for providing a Cronbach Co-efficient

Alpha test for testing reliability. After approval, 92 were given to the respondents to ensure completeness, consistency and coding of data systematically in its entirety on the same day to allow contact of respondents for further information or clarification if needed (Mugenda & Mugenda, 1999). The Formula states;

$\alpha = \frac{K1}{K-1}\left[\frac{1-\sum \sigma^2 K}{\sigma^2}\right]$

σ= Variable of the total test

$\sum \sigma^2 K$= Sum of variance of the questions in the instrument

K= No. of questions in research instrument

3.8 Procedure of Data Collection

After the approval of the proposal by the University supervisor, a general letter of introduction was got from the Head of Department of development studies and conflict resolution to introduce the researcher to the Sub County Chief permitting her to carry out the study. Then the researcher went for introduction to the respondents and piloted the area under study and gave the respondents a letter of informed consent explaining to them the purpose of the study. The researcher made appointments with the various respondents involved in the study concerning the time, date and place. Later the researcher distributed questionnaires to the respondents which contained both open and closed ended questions. Also interviews were conducted. In addition, during the study, confidentiality was highly promised and the information obtained was kept for academic purposes only.

The procedure helped to improve the usefulness, timeliness, accuracy, comparability and collection of high quality for better analysis and reporting.

3.9 Data Analysis and Processing

This was the process of bring understanding and meaning to data collected for validity and reliability (Sekaian, 2003). Data collected from the field was first of all sorted, edited, coded and entered into in the computer using SPSS. This package was useful to the researcher to present data using tables, graphics and frequency tables and further helped the researcher generate descriptive statistics such as means and standard deviations.

Qualitative data was analyzed and presented in form of texts and interviews, impressions, words, photos, symbols are examined and presented using descriptive or narrative method where the researcher presented detailed literature description of the respondents' views for the reader to make their opinions (Bell, 1993). While quantitative data was presented using a percentage distribution technique (Creswell, 1993). Closed-ended questions were recorded and then the answers to each question were checked for every questionnaire for used for calculating the percentage of participants who gave each response. For saving time and cost, they will be analyzed by generating quotations, single words and making brief phases. For individual interviews, these were used to produce data in the form of notes, a summary of individual interviews. The researcher wrote each question at the top of a separate blank page or the coded sheet to make it easy for respondents to answer using their own words to save time and money (Bell, 1993).

3.10 data Presentation

The researcher presented the data in numbers, tables, charts and percentages while giving further description of the data set, disseminated with the main variables that were covered, the classifications and breakdowns were used. This was to ensure that all the data collected covered to frame an ideal study based on the questionnaires and interviews on the study objectives.

3.11 Ethical Consideration.

In order to get good outcome from the respondents, the researcher took into consideration the following aspects;

Respect for respondents. This was done by ensuring good working support with the respondents through respecting their views, opinions, and the way they presented themselves.

Confidentiality. This was portrayed by keeping the respondents information in their identity secret. This was done so as to make the respondents gained more trust in the researcher and it prompted them to give required information.

Non-judgmental attitude. The researcher remained objective by avoiding non-judgmental attitudes towards the respondents.

3.12 Limitations of the study.

In an effort to gather information required to provide findings for the study, some problems were encountered and these included financial problems which hindered the process of collecting data

as it required transport and communication, typing, printing of questionnaires, feeding among others.

The researcher anticipated poor cooperation from respondents because some of them expect payment after interviews.

The researcher anticipated poor attention from the respondents this hindered the researcher from obtaining accurate information. This happened since some respondents were less interested in the study.

The researcher anticipated weather changes for example heavy rainfall during the time of data collection. This delayed time scheduled for data collection.

CHAPTER FOUR
PRESENTATION, ANALYSIS AND INTERRPRETATION OF DATA

4.1 Profile of respondents

In this study, the researcher described respondents profile in terms of gender, age, marital status, level of education, religion.

Table 2: Respondents Profile

Category of Respondents		Frequency	Percent (%)
Gender	Male	20	21.7
	Female	72	78.3
	Total	**92**	**100.0**
Age	15 - 29	32	34.8
	30-45	50	55.6
	Above 45	10	10.9
	Total	**92**	**100.0**
Marital status	Single	50	55.6
	Married	20	21.7
	Separated	20	21.7
	Widowed	2	2.2
	Total	**92**	**100.0**
Education Level	No formal education	5	5.3
	Primary	20	21.7
	Secondary	50	55.6
	College	5	5.3
	University	10	10.9
	Total	**92**	**100.0**
Religion	Catholic	40	43.5
	Islam	15	16.3
	Protestant	20	21.7
	Other	7	7.6
	Traditional	10	10.9
	Total	**92**	**100.0**

Source: Primary data 2017

The results in table 1 show that female were the majority respondents as represented by 72 (or 78.3%) and male were the minority 20 (or 21.7%). The findings revealed that there is relative gender balance in Vodafone Uganda when it comes to employment.

In regard to respondents' age, 50 (or 55.6%)respondents were in the age bracket of 30-45 years, 32 (or 34.8%) in the age bracket of 15 - 29 years, 10 (or10.9%) in the age bracket of above 45 years. The study indicates therefore that majority of Vodafone Uganda employees are youth.

In line with marital status, 50 (or 55.6%) respondents were single, 20 (or 21.7%) were married, 20 (or 21.7%) were separated and 2 (or 2.2%) were widowed. Therefore it's right to deduce that the majority of the respondents were single with enough time to handle organizational work effectively.

Concerning the level of education, respondents with secondary education were the majority that is 50 (or 55.6%), followed by primary holders 20 (or 21.7%), 10 (or 10.9%) were University holders, and 5 (or 5.3%) were college and non formal education holders holders. These results indicate that the education level of the majority of Vodafone employees was low as revealed by respondents mostly being secondary holders.

Lastly in regard to religion, 40 (or 43.5%) respondents were Catholics, 15 (or 16.3%) were Islam's, 20 (or 21.7%) were Protestants, 10 (or 10.9%) were traditionalists and lastly 7 (or 7.6%) belonged to other religions. This indicates that all respondents had religions where they belonged and these religions have different beliefs about contraceptives use

4.2 The determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age

The first objective was set to determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age for which the researcher intended to find out of education and the degree at which education stand when compared to usage of contraceptives among women. Effect of education was broken into aspects. In this study, all the three aspects were measured using 5 qualitative questions in which respondents were required to indicate the extent to which they agree or disagree with each statement by indicating the number that best describe their perceptions. All the five items on effect of education were likert scaled using four points ranging between 1= Strongly Disagree, 2= Disagree, 3= Agree and 4= Strongly Agree. Their responses were analyzed and described using Means as summarized in table 1 below.

Table 3: The effect of education on the usage of contraceptives among Karamojong women of reproductive age

Education on the usage of contraceptives among Karamojong women of reproductive age	Mean	Interpretation	Rank
Our culture does not allow the use of contraceptives	2.92	High	1
Contraceptives limits the number of children born which is against our culture	2.86	High	2
Socially contraceptive use, among young men and women is unacceptable	2.75	High	3
Our culture use natural ways of control birth against contraceptives	2.66	High	4
Contraceptives are inaccessible and unavailable in our local community	2.13	Low	5
Average mean	**2.67**	**High**	

Source: primary data, 2017

The means in table 2 indicate that effect of education on usage of contraceptives was rated at different levels. When you sum up all the categories, the overall average mean is (2.67) which is equivalent to agree on the rating scale used and thus basing on these results, it can be concluded that education has a positive effect on the usage of contraceptives among Karamojong women of reproductive age

Items which were highly rated among others included the fact that Our culture does not allow the use of contraceptives (Mean = 2.92), Contraceptives limits the number of children born which is against our culture (Mean = 2.86), Socially contraceptive use, among young men and women is unacceptable (Mean = 2.75) and lastly Our culture use natural ways of control birth against contraceptives (mean = 2.66)

The findings also revealed that one item was rated law which included Contraceptives are inaccessible and unavailable in our local community (mean = 2.13) meaning that respondents disagree according to the response mode.

To get a final picture effect of education on the use of Contraceptives among Karamojong women of reproductive age, the researcher computed an overall average mean for all the categories in Table 1, which came out to be (mean = 2.67), which confirms that the effect of education on the usage of contraceptives among Karamojong women of reproductive age is moderate.

4.2.1 Effect of education on the usage of contraceptives among Karamojong women of reproductive age

The researcher assessed the effect of education on the usage of contraceptives among Karamojong women of reproductive age. A null hypothesis was established: "education has a significant effect on usage of contraceptives among Karamojong women of reproductive age."To test the hypothesis, the researcher used the response of strongly agree, agree, disagree and strongly disagree as 4 to 1. The researcher then generated indices to obtain the mean response and standard deviation to show the level of agreement.

Table 4: Showing the Effect of education on the usage of contraceptives among Karamojong women of reproductive age

		Education	**usage of contraceptives among Karamojong women of reproductive age**
Education	Pearson Correlation	1	0.76
	Sig. (2-tailed)		0.04
usage of contraceptives among Karamojong women of reproductive age	Pearson Correlation	0.76	1
	Sig. (2-tailed)	0.04	

The findings from table 3 above revealed that education has a significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value 0.04 was less than the significance level (0.05) and the correlation coefficient was notably high (0.76) rendering the effect between education and usage of contraceptives among Karamojong women of reproductive age to be a strong one.

4.2.2 Regression of education on the usage of contraceptives among Karamojong women of reproductive age

Table 5: Regression of education on the usage of contraceptives among Karamojong women of reproductive age

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	0.760a	0.635	0.53	0.4499	0.735	1.541	1	2	0.04

When the factors affecting education were regressed on factors affecting usage of contraceptives among Karamojong women of reproductive age, the factors affecting education explain 63.5% of the factors affecting usage of contraceptives among Karamojong women of reproductive age. The correlation coefficient is also strong (0.76) since it is above 0.05. Therefore, education has a significant effect on usage of contraceptives among Karamojong women of reproductive age.

4.3 To examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age

The second objective was set to determine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age for which the researcher intended to find out how satisfactorily religion and the degree at which it stand when compared to usage of contraceptives among Karamojong women of reproductive age. Effect of religion was broken into aspects. In this study, all the aspects were measured using 5 qualitative questions in which respondents were required to indicate the extent to which they agree or disagree with each statement by indicating the number that best describe their perceptions. All the five items on effect of religion were likert scaled using four points ranging between 1= Strongly Disagree, 2= Disagree, 3= Agree and 4= Strongly Agree. Their responses were analyzed and described using Means as summarized in table 4 below.

Table 6: The effect of religion on the usage of contraceptives among Karamojong women of reproductive age

Religion on contraceptives use among Karamojong women of reproductive age	Mean	Interpretation	Rank
Inadequate knowledge on the use and accessibility of the contraceptives	2.92	High	2
It is against culture	2.86	High	3
Their culture prefers natural ways as compared to artificial methods	2.75	High	4
Negative attitude towards use of contraceptives	2.66	High	5
Most religions do not allow the use of contraceptives	3.55	High	1
Average mean	**2.95**	**High**	

Source: primary data, 2017

The means in table 5 indicate that effect of religion on usage of contraceptives was rated at different levels. When you sum up all the categories, the overall average mean is (2.95) which is equivalent to agree on the rating scale used and thus basing on these results, it can be concluded that religion has a positive effect on the usage of contraceptives among Karamojong women of reproductive age

Items which were highly rated among others included the fact that Most religions do not allow the use of contraceptives (Mean = 3.55), Negative attitude towards use of contraceptives (Mean = 2.66), Inadequate knowledge on the use and accessibility of the contraceptives (Mean = 2.92), It is against culture (mean = 2.86), and lastly Their culture prefers natural ways as compared to artificial methods (Mean = 2.75)

To get a final picture effect of religion on the use of Contraceptives among Karamojong women of reproductive age, the researcher computed an overall average mean for all the categories in Table 1, which came out to be (mean = 2.95), which confirms that the effect of religion on the usage of contraceptives among Karamojong women of reproductive age is moderate.

4.4.1 The effect of religion on the usage of contraceptives among Karamojong women of reproductive age.

The researcher studied the effect of religion on usage of contraceptives among Karamojong women of reproductive age. A null hypothesis: "religion has no significant effect on usage of contraceptives among Karamojong women of reproductive age.

Table 7: The effect of religion on the usage of contraceptives among Karamojong women of reproductive age.

		usage of contraceptives among Karamojong women of reproductive age	Religion
usage of contraceptives among Karamojong women of reproductive age	Pearson Correlation	1	0.864
	Sig. (2-tailed)		0.036
Religion	Pearson Correlation	0.864	1
	Sig. (2-tailed)	0.036	

Table 6.above revealed that religion has significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value (0.036) is less than the level of significance. The correlation coefficient is strong (0.864) which showed that religion has strong effect on usage of contraceptives among Karamojong women of reproductive age. In order to determine the magnitude of the effect, regression analysis was conducted.

4.4.2 Regression of religion on usage of contraceptives among Karamojong women of reproductive age.

Table 8: Regression of religion on usage of contraceptives among Karamojong women of reproductive age.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	0.864	0.747	0.621	0.49839	0.747	5.912	1	2	0.136

According to table 7 above, the factors affecting religion were regressed on factors under usage of contraceptives among Karamojong women of reproductive age. The findings revealed that factors studied under religionk explain 74.7% of the factors leading to usage of contraceptives among Karamojong women of reproductive age. The correlation coefficient 0.864 is strong and showed that religion has a significant strong effect on usage of contraceptives among Karamojong women of reproductive age.

4.5 To examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

The third objective was set to determine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age for which the researcher intended to find out how satisfactorily the effect of cultural norms and the degree at which they stand when compared to usage of contraceptives among Karamojong women of reproductive age. Effect of cultural norms was broken into aspects. In this study, all the aspects were measured using 5 qualitative questions in which respondents were required to indicate the extent to which they agree or disagree with each statement by indicating the number that best describe their perceptions. All the five items on leadership styles were likert scaled using four points ranging between 1= Strongly Disagree, 2= Disagree, 3= Agree and 4= Strongly Agree. Their responses were analyzed and described using Means as summarized in table 4 below.

Table 9: the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

Cultural norms on contraceptives use among Karamojong women of reproductive age	Mean	Interpretation	Rank
Culture does not allow Educating both men and women on the benefits of contraceptives use	2.92	High	2
Cultural perspectives do not allow availing the local people with contraceptives	2.96	High	1
Cultural norms do not agree with sensitizing the youth on the benefits of contraceptives use in the nearby future	2.88	High	3
Culture has no effect on how to carry out sex education on how, when to use contraceptives	2.76	High	4
Culture does not Promote the use of contraceptives through adverts in health facilities and homesteads	2.45	Low	5
Average mean	**2.79**	**High**	

Source: primary data, 2017

The means in table 8 indicate that effect of culture on usage of contraceptives was rated at different levels. When you sum up all the categories, the overall average mean is (2.95) which is equivalent to agree on the rating scale used and thus basing on these results, it can be concluded that culture has a positive effect on the usage of contraceptives among Karamojong women of reproductive age

Items which were highly rated among others included the fact that Culture does not allow Educating both men and women on the benefits of contraceptives use (mean =2.92), Cultural perspectives do not allow availing the local people with contraceptives (mean = 2.96), Cultural norms do not agree with sensitizing the youth on the benefits of contraceptives use in the nearby future (mean = 2.88), Culture has no effect on how to carry out sex education on how, when to use contraceptives (mean = 2.76), and lastly Culture does not Promote the use of contraceptives through adverts in health facilities and homesteads (mean = 2.45)

To get a final picture effect of culture on the usage of Contraceptives among Karamojong women of reproductive age, the researcher computed an overall average mean for all the categories in Table 1, which came out to be (mean = 2.95), which confirms that the effect of culture on the usage of contraceptives among Karamojong women of reproductive age is moderate.

4.5.1 The effect of culture on usage of Contraceptives among Karamojong women of reproductive age,

The researcher examined the effect of culture on usage of Contraceptives among Karamojong women of reproductive age,. In order to determine this effect, a null hypothesis was derived: "The culture has no significant on usage of Contraceptives among Karamojong women of reproductive age, "Therefore a hypothesis test was done using the Pearson correlation coefficient to determine the direction and magnitude of the effect.

Table 10: the effect of culture on usage of Contraceptives among Karamojong women of reproductive age,

		Usage of Contraceptives among Karamojong women of reproductive age,	**Culture**
Usage of Contraceptives among Karamojong women of reproductive age,	Pearson Correlation	1	0.32
	Sig. (2-tailed)		0.357
Culture	Pearson Correlation	0.32	1
	Sig. (2-tailed)	0.357	

The findings form table 9 above revealed that the culture have no significant effect on usage of Contraceptives among Karamojong women of reproductive age, since the p- value (0.357) is greater than the level of significance. The correlation coefficient 0.32 showed a weak effect of culture on usage of Contraceptives among Karamojong women of reproductive age,. The culture has a weak insignificant effect on usage of Contraceptives among Karamojong women of reproductive age,. Therefore there are other factors that affect usage of Contraceptives among Karamojong women of reproductive age, that should be studied

CHAPTER FIVE
SUMMERY, DISCUSSIONS, CONCLUSION AND RECOMMADATIONS

5.1 Introduction

This chapter discusses the findings from the field reported in chapter four. In addition it composed of the summery of the key findings, discussions of the findings, conclusion and recommendations which are presented objective by objective and further areas of further.

5.2 Discussion of findings

This study intended to assess the socio-cultural factors and the usage of contraceptives among women in Lotome sub county, Napak district and it was guided by three specific objectives namely: The determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age, to examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age and to examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

Data analysis that was done using SPSS's descriptive statistics it was found out that female were the majority respondents as represented by 72 (or 78.3%), in regard to respondents' age, 50 (or 55.6%)respondents were in the age bracket of 30-45 years, In line with marital status, 50 (or 55.6%) respondents were single, Concerning the level of education, respondents with secondary education were the majority that is 50 (or 55.6%), lastly in regard to religion, 40 (or 43.5%) respondents were Catholics

5.2.1 The determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age

The analysis continued to reveal that the Results from chapter four revealed that education has a significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value 0.04 was less than the significance level (0.05) and the correlation coefficient was notably high (0.76) rendering the effect between education and usage of contraceptives among Karamojong women of reproductive age to be a strong one. The findings revealed that factors studied under education explain 74.7% of the factors leading to usage of contraceptives among Karamojong women of reproductive age. The correlation coefficient 0.864 is strong and showed that education has a significant strong effect on usage of contraceptives among Karamojong women of reproductive age.

These findings were in line with those of Rahayu et al., (2009) who suggested that Education remains the most important factor that affects contraceptive use (Rahayu et al., 2009). According to findings in Uganda, contraceptive use was higher among women with primary education than women with no education (Ojakaa, 2008). In Nigeria, it was found that higher educated women were more likely to use contraceptives thereby decreasing their fertility (Olalekan & Olufunmilayo, 2012). In addition, women are more likely to use contraceptives when they have any level of education compared to no education (Rahayu et al., 2009). Furthermore, educated women situated in urban areas usually marry at older ages and are more likely to use contraceptives (Adetunji, 2012). In Kenya, women with higher levels of education belonging to urban areas with higher wealth quintiles were found to have a higher prevalence of modern contraceptive use compared to their counterparts (Ettarh, 2011). In another study in Malawi, women who are poor do not have high levels of education compared to the wealthy and are less likely to use contraceptives (Adebowale et al., 2013). This further adds to the importance of education.

According to a study by Nushin Mahmood (1996), a woman's education has contribution towards use of contraceptives. The study revealed that use of contraceptives increased by 0.79 for women with primary and middle education by 1.29 for secondary and higher education when compared with the "no education" category. This study shows the clear relationship between education and contraception use.

5.2.2 To examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age

Data processed on this second objective revealed that religion has significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value (0.036) is less than the level of significance. The correlation coefficient is strong (0.864) which showed that religion has strong effect on usage of contraceptives among Karamojong women of reproductive age. In order to determine the magnitude of the effect, regression analysis was conducted and the findings further revealed that the factors studied under religion explain 74.7% of the factors leading to usage of contraceptives among Karamojong women of reproductive age

These findings were in line with those of McQuillan, (2004), who suggested that Religion is widely known to affect people's views and acceptance of modern contraception, thus affecting

the outcome of their reproductive behaviour (McQuillan, 2004). However, the extent of how much of an affect religion has in influencing the reproductive outcomes of people in developing countries remains obscure given the relatively low number of recent studies that look into these phenomenon's. Furthermore, of the studies that look at the level of influence that religion has on contraceptive use, the results vary in different sub-Saharan African countries as shown by Yeatman and Trinitapoli (2008).

Early studies show that the European transition began as a result of religious acceptability of modern contraception; the acceptance of contraceptives by the Church led a widespread decline in fertility among married women in Europe (Coale, 1986; Lesthaeghe, 1980 as cited in Addai, 1999). Lesthaeghe (1989) further argued that the use of contraceptives largely depends on the Churches stance on contraception. If contraception is positively viewed by the Church, contraceptive use increases as opposed to when it is portrayed in a negative light (Coale, 1986; Lesthaeghe, 1989; Addai, 1999).

5.2.3 To examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

The findings from chapter four revealed that the culture has no significant effect on usage of contraceptives among Karamojong women of reproductive age since the p- value (0.357) is greater than the level of significance. The correlation coefficient 0.32 showed a weak effect of culture on usage of contraceptives among Karamojong women of reproductive age. culture has a weak insignificant effect on usage of contraceptives among Karamojong women of reproductive age. Therefore there are other factors that affect usage of contraceptives among Karamojong women of reproductive age that should be studied.

These findings were in line with those of Ankomah et al (2013) who suggested that while focusing on the contribution of traditional culture on the use of contraceptives among women of reproductive age, it should be noted that, a lot of literature concerning this study tend to point to the fact that traditional culture has impacted on the use of contraceptives. A study by Ankomah et al (2013) reported that in many traditional settings, young women who use contraceptives are perceived as promiscuous. A report holds the view that if a woman uses family planning; it means "she is a loose woman, a prostitute".

Meanwhile according to a study carried out by A. Ankomah et al (2013) he discovered strong belief in the value attached to children. Children in traditional African culture are seen as a source of wealth, prestige and security and protection especially in old age. Conception is therefore regarded as abuse of cultural norms and values. Those who do this are perceived as doing evil! Ankomah et al (2013) also discovered strong believe in Traditional birth control methods. For example, one respondent is quoted as saying *"For my family; after me and my husband meet and if I don't want to get pregnant, I breathe and the entire thing (sperm) will come out."(p273)*

5.3 Conclusions

5.3.1 The determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age

Education has a significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value 0.04 was less than the significance level (0.05) and the correlation coefficient was notably high (0.76) rendering the effect between education and usage of contraceptives among Karamojong women of reproductive age to be a strong one. The findings revealed that factors studied under education explain 74.7% of the factors leading to usage of contraceptives among Karamojong women of reproductive age. The correlation coefficient 0.864 is strong and showed that education has a significant strong effect on usage of contraceptives among Karamojong women of reproductive age.

5.3.2 To examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age

Religion has significant effect on usage of contraceptives among Karamojong women of reproductive age since the p-value (0.036) is less than the level of significance. The correlation coefficient is strong (0.864) which showed that religion has strong effect on usage of contraceptives among Karamojong women of reproductive age. In order to determine the magnitude of the effect, regression analysis was conducted and the findings further revealed that the factors studied under religion explain 74.7% of the factors leading to usage of contraceptives among Karamojong women of reproductive age

5.3.3 To examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

Culture has no significant effect on usage of contraceptives among Karamojong women of reproductive age since the p- value (0.357) is greater than the level of significance. The correlation coefficient 0.32 showed a weak effect of culture on usage of contraceptives among Karamojong women of reproductive age. culture has a weak insignificant effect on usage of contraceptives among Karamojong women of reproductive age. Therefore there are other factors that affect usage of contraceptives among Karamojong women of reproductive age that should be studied.

5.4 Recommendation

Based on the findings and conclusions of the study, the following recommendations were made, in line with the specific objectives of the study.

5.4.1 The determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age

i. More education kills is needed on how to deliver the message about usage of contraceptives, Despite the permissibility of all contraceptive methods, barriers to effective, accurate use exist. According to recent studies, ethnic Uganda women in Karamoja held many negative attitudes against oral contraceptives which became barriers to proper usage.

ii. The main concerns were fears of weight gain and infertility and cultural perceptions that women using oral contraceptives were bad or promiscuous. Of Ugandan women presenting for pregnancy termination, the most frequently used forms of contraception were condoms, coitus interruptus, and the rhythm method.

5.4.2 To examine the effect of religion on the usage of contraceptives among Karamojong women of reproductive age

i. As confirmed by various experts and literature sources, a woman's ability and willingness to utilize contraception is affected by whether she identifies with orthodox, traditional, or liberal interpretations of her religion. Contraceptive behaviour is often influenced by additional factors such as suitability of the specific method to fertility control, peer influences, and cultural effects.

ii. Such factors appear to modify the acceptance and application of various theologies. Furthermore, differences in contraceptive usage among couples are more reflective of differentials in husband-wife communication, gender roles, access to con traception, traditional values regarding appropriate family size, cultural restrictions, and social class of theological restrictions.

iii. Christian teachings vary depending upon the denomination. Roman Catholicism teaches that the primary purpose of sexual relations is procreation within marriage. Roman Catholics are therefore forbidden to use medical or physical contraceptive methods. Natural contraceptive methods such as abstinence and the rhythm method remain permissible. Although Eastern Orthodox Christianity holds a similar view of the purpose of sexual relations, most contraceptive methods are permitted. Among conservative

iv. Protestant groups, the need to procreate reflects a literal interpretation of the Bible, yet it is common for adherents to use birth control after the family is complete. Liberal Protestants, while encouraging procreation, accept that this is not the sole purpose of sexual relations. Among Protestants, no specific forms of contraception are forbidden.

v. In Orthodox Judaism, having multiple children is encouraged; however, contraception may be used for medical indications. Islam similarly encourages large families and requires parents to ensure that the basic rights of children are met.

vi. Family planning is not forbidden but is more commonly used by traditional adherents for birth spacing rather than to restrict the overall size of families. Despite this permissibility, not all adherents of Islam are aware that contraceptive use is permitted. According to Hindu doctrine, women were created to have children, particularly sons; however, there are no specific religious prohibitions against contraception. Buddhist religious dogma does not stress procreation; thus, contraception may be used. Despite the permissiveness of Hinduism and Buddhism, cultural factors often encourage large families and this may hinder contraceptive use. Chinese religious traditions, such as Confucianism and Taoism, do not prohibit birth control.

5.4.3 To examine the effect of cultural norms on the usage of contraceptives among Karamojong women of reproductive age

i. The contraceptive attitudes and behaviours for the different religions reviewed here do not necessarily reflect the behaviours of Ugandan women. When faced with the challenges of acclimating to a new society and way of life, women may anchor more strongly to traditional religious and cultural expectations with respect to family, sexuality, and fertility. Evidence from the broader world view described here may provide insight into the cultural values and behaviours that can influence recent immigrants.

ii. Finally, health care providers must be cautious that they do not attribute stereotypical religious, social, and cultural characteristics to women seeking advice about contraception. The generalizations presented in this review should enhance awareness and recognition of the environments and value systems that may influence contraception decision-making in couples of different faiths. This will increase cultural competence should be tempered by the understanding that each patient encounter is unique. The values that an individual woman holds may not be in keeping with the documented official teachings of her religion or the expected cultural norms reported by other members of the same culture.

iii. Cultural views that associate certain contraceptive methods with promiscuous behaviour, a lack of information about the safety of contraceptive methods, and lack of access because of the expense or availability of contraceptives may limit their effective utilization. Despite the importance of religion in influencing decisions, practitioners of a faith do not necessarily adhere to the prescribed doctrines of their faith. Ninety-five percent of women in Uganda will use a contraceptive method at some point during their reproductive years, despite the prohibition of modern contraception by some religions

5.5 Areas for future Research

Notwithstanding the efforts made by the researcher, she could not exhaust entirely this particular area; therefore she recommends that the future researchers should focus on the following.

Owing the fact that this study only concentrated on sociao-cultural factors and the use of contraceptives among women in Litome sub county, Napak District Uganda, there a need to conduct a similar study but purely covering the youth since they make the biggest percentage of the entire sub counties.

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APPENDIX I

QUESTIONNAIRE

Dear respondent;

I am Dengel Christine, a third year student of Kampala International University pursuing a Bachelor's degree Development Studies. I am carrying out a study on *"The socio-cultural factors and the use of contraceptives among Karamojong women of reproductive age"*

Please note that, the information given in this questionnaire is only for academic purposes and will be treated entirely confidential.

INSTRUCTION: Please tick the most appropriate option.

Section A: BIO DATA

Gender

i) Male ☐ Female ☐

ii) Age

15 - 29 ☐ 30-45 ☐ Above 45 ☐

iii) Education background

No formal education ☐ Primary ☐ Secondary ☐ college ☐ University ☐

iv) Marital status

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

v) Religion

Catholic ☐ Islam ☐ Protestant ☐ Other ☐ Traditional ☐

If other, specify:

.....

SECTION B

Objective 1: To determine the effect of education on the usage of contraceptives among Karamojong women of reproductive age.

Please answer the following questions by selecting only one of the options as highlighted below

1= strongly agree 2 =agree 3 =disagree 4=strongly disagree 5=neutral

A=agree, SA= strongly agree, D =disagree, SD=strongly disagree, N=Neutral

Education on the usage of contraceptives among Karamojong women of reproductive age	SA	A	D	SD	N
	1	2	3	4	5
Our culture does not allow the use of contraceptives					
Contraceptives limits the number of children born which is against our culture					
Socially contraceptive use, among young men and women is unacceptable					
Our culture use natural ways of control birth against contraceptives					
Contraceptives are inaccessible and unavailable in our local community					

Objective 2: To examine the effect of Religion on contraceptives use among karamojong women of reproductive age

Please answer the following questions by selecting only one of the options as highlighted below

1= strongly agree 2 =agree 3 =disagree 4=strongly disagree 5=neutral

A=agree, SA= strongly agree, D =disagree, SD=strongly disagree, N=Neutral

Religion on contraceptives use among Karamojong women of reproductive age	SA	A	D	SD	N
	1	2	3	4	5
Inadequate knowledge on the use and accessibility of the contraceptives					
It is against culture					
Their culture prefers natural ways as compared to artificial methods					
Negative attitude towards use of contraceptives					

Objective 3: To examine the effect of cultural norms on contraceptives use among karamojong women of reproductive age

Please answer the following questions by selecting only one of the options as highlighted below
1= strongly agree 2 =agree 3 =disagree 4=strongly disagree 5=neutral
A=agree, SA= strongly agree, D =disagree, SD=strongly disagree, N=Neutral

Cultural norms on contraceptives use among Karamojong women of reproductive age	SA	A	D	SD	N
	1	2	3	4	5
Educating both men and women on the benefits of contraceptives use					
Availing the local people with contraceptives					
Sensitizing the youth on the benefits of contraceptives use in the nearby future					
Carrying out sex education on how, when to use contraceptives					
Promoting the use of contraceptives through adverts in health facilities and homesteads					

Thank you for your time, May God bless you abundantly!

APPENDIX II
INTERVIEW GUIDE

What factors determine the socio- cultural factors on the usage of contraceptives among Karamojong women of reproductive age?
What have you done in order to promote the use of contraceptives?
What factors limit the use of contraceptives?
What factors favor the use of contraceptives?
What are potential barriers to contraceptives use among Karamojong women of reproductive age?
Are those barriers contributed by culture?
What are barriers affect the use of contraceptives
Do people use contraceptives in your locality?
Are you comfortable with the use of contraceptives?
What measures can be put in place to address potential barriers of contraceptives use among karamojong women of reproductive age
What do you think can be done to solve the challenges on the contraceptives use?
Has the government initiated programe encouraging the use of contraceptives?