FACTORS INFLUENCING CONTRACEPTIVE USE AMONG WOMEN IN NORTHERN UGANDA

BY

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JULY 2018
DECLARATION

I, Aturinde Elizabeth, hereby declare that this dissertation is my original work and has never been presented for any academic award in any University or education institution of higher learning.

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APPROVAL

This dissertation has been submitted to the School of Statistics and Planning for examination under my approval.

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Signature........................................................................ Date...19th: July.: 2018

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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>ICF</td>
<td>International Children Fund</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine devices</td>
</tr>
<tr>
<td>PMA</td>
<td>Performance Monitoring and Accountability</td>
</tr>
<tr>
<td>UBOS</td>
<td>Uganda Bureau of Statistics</td>
</tr>
<tr>
<td>UDHS</td>
<td>Uganda Demographic and Health Survey</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

The study set out to establish the factors associated with ever use of contraceptives among women in Northern Uganda. The study used data from the 2016 Uganda Demographic and Health Survey. Only data from the Northern region was considered and it comprised of 3546 women aged 15-49 years. Analysis was done at two levels that is univariate and bivariate.

The findings showed that there was a significant association between selected background factors age, wealth status, occupation, marital status, religion, education, region with ever used contraceptives among women in the Northern region. On the other hand, results showed that place of residence had no significant association with ever use of contraceptives.

The results showed that women with higher, secondary and primary education had ever used contraceptives at a greater percent as compared to their counterparts with no education. Thus, there is need for more emphasis on the education of women in order to increase the use of contraceptives among women in the Northern region.

More so, the researcher recommends that there is need to integrate economic empowerment aspects in family planning programs in Uganda especially targeting women from poor wealth households since wealth status is significantly associated with contraceptive use.
CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Many studies about contraceptive use have been conducted to find out how effective family planning programs can be implemented to enhance the use of contraception among the young and older women. Contraception is a birth control measure that prevents pregnancy by interfering with the normal process of ovulation, fertilization and implantation. Some of the contraceptive methods as defined by World Health Organization include Intra Uterine Device, male condoms, female condoms, sterilization, implants, injectables, vasectomy, spermicides and diaphragms and pills. The traditional methods include withdrawal method, natural rhythm, breastfeeding and abstinence. Contraceptive use has far reaching benefits for individuals, couples, households, communities and society at large including maternal and child health improvements, education advances, reduction of poverty and empowerment of women.

Globally, the prevalence rate of contraceptive usage is 63% and unmet need for family planning is 15% (Doskoch, 2013). Family planning has a direct influence on women’s health, wellbeing as well as on the consequence of each pregnancy (World Health Organization 2011). In developing countries about 818 million of sexually active women of reproductive age (15-49) want to avoid pregnancy and delay child bearing for at least two years or want to stop pregnancy and limit their family size (World Health Organization 2010). About 140 million of those women (17%) are not using any method of birth control, while 75 million (9%) are using less effective traditional method. Non-contraceptive users together (215 million women) are said to have an unmet need for modern contraception (Darroch et al., 2011).

Uganda’s current fertility rate of 5.4 children per woman has resulted in a high population growth rate which is the fastest in Africa and the third highest in the world (Birdsall, Kelley, & Sinding, 2016). The contraceptive prevalence rate among married women which has recently increased from 30% in 2011 to 39% in 2016 is still unfortunately low as compared to the neighboring East African countries that is to say Kenya 46%, Rwanda 52%, and Tanzania 34% at the time of their last surveys (Asiimwe et al., 2014). More so Uganda has a high unmet need
for family planning services of 41% thus leaving most of sexually active women not using contraception (UBOS & ICF Inc. 2018).

The demand for family planning has increased to 67% from 64% in 2011 (UBOS & ICF Inc, 2018). The percentage of the demand satisfied by modern methods has also increased from 41% in 2011 to 52% in 2016. Uganda’s target is to increase CPR to 50% by 2020 (UBOS & ICF Inc. 2018). Basing on this target contraceptive prevalence rate is still low as compared to the intended percentage.

Until 2006, the residents of Northern Uganda had lived through 20 years of conflict. This fight internally displaced approximately 1.8 million people ninety percent (Orach et al., 2015). During the after-conflict women’s access to family planning services was severely limited due to safety concerns, geographical constraints and the collapse of the health system in the region. While the situation has a bit improved, the Northern region still has a high proportion of women who cannot access the family planning services they need, hence high rate of abortion and unwanted pregnancies. In Acholi region one of the sub regions in Northern Uganda, 39% of currently married women have an unmet need for family planning compared to the national average of 28.5% (UBOS & ICF Inc. 2018). Furthermore, Karamoja has the lowest demand for family planning (27%) and use (7%) whereas unmet need is highest in West Nile 43% (UBOS & ICF Inc. 2018).

The low use of contraception in Northern Uganda has been associated with the increased rate of abortion and unwanted pregnancies. One in every five pregnant women in Northern Uganda had ever had an abortion while 50% of pregnancies were unwanted (Orach et al., 2015). This is attributed to the gender inequalities that were increased by the conflict. Men make decisions on family planning but those decisions are poorly informed and are based on cultural norms. Due to the post conflict environment, there is belief that many of the children were lost during the conflict therefore there is need to reproduce more to fill the gap thus leaving out contraceptives.

The use of contraceptives is widely considered as an important factor in controlling a country’s population growth rate and fertility. Contraceptives serve as critical tools for spacing birth and controlling family size. The benefits of a well space birth and controlled family size are so many for example improved maternal and child health, reduced induced abortion cases and improved
household welfare. Therefore, due to the fact that contraceptive use in Northern is much lower than nationally, better understanding the factors associated with contraceptive use in the Northern region is so important.

1.2 PROBLEM STATEMENT
The contraceptive prevalence rate has increased from 30% (2011) to 39% (2016), however the unmet need for any contraceptive method in Uganda remains high at 41% especially among women who are currently married, living in rural areas, and in the Northern region in particular (UBOS & ICF Inc, 2018). Northern Uganda still has the lowest Contraceptive prevalence rate (15.2%) as compared to other regions in Uganda (PMA2020 Project, Makerere University, 2014). Due to the increase in the CPR, maternal deaths have reduced from 438 in 2011 to 336 in 2016, infant mortality rate from 54 to 43 and under five mortalities from 90 in 2011 to 64 in 2016 all in relation to the increased contraceptive prevalence rate (UBOS & ICF Inc. 2018).

Doubling modest investment in family planning and maternal child health programs could result in a 70% reduction in maternal deaths and a 44% reduction in the deaths of new born with additional health societal and economic benefits (United Nations Population Fund, 2012). Therefore, contraceptive use should be increased among women in the reproductive ages so as to promote socio economic development in Northern Uganda and Uganda at large.

Several programs have been put forward to address the issue of low contraceptive use for example increased access of family planning services to the people through strengthening the use of village health teams (VHTs). Furthermore, family planning partners like Reproductive Health Uganda, are working with the government of Uganda to dedicate specific hours for health facilities to provide women with family planning, sexual and reproductive health information and services. Reproductive Health Uganda has previously had success with securing youth friendly family planning service hours in some of the districts in Uganda (UNICEF, 2014).

Despite the ongoing efforts to expand access to contraceptive use, it is still low in the rural areas of Northern Uganda. This has exposed women to unintended pregnancies, maternal and childhood deaths, morbidity or unsafe abortion. The research therefore aims at narrowing the scope from the national level to the regional level in order to hopefully find out the underlying
factors unusual in this area that have led to a low contraceptive prevalence rate in Northern Uganda.

1.3 GENERAL OBJECTIVE
To establish the factors influencing contraceptive use among women in Northern Uganda.

1.3.1 SPECIFIC OBJECTIVES
1. To examine the relationship between level of education and contraceptive use.
2. To examine the relationship between residence and contraceptive use.
3. To establish the relationship between wealth status and contraceptive use.
4. To determine the relationship between religion and contraceptive use.
5. To examine the relationship between marital status and contraceptive use.
6. To examine the relationship between occupation and contraceptive use.
7. To examine the relationship between age and contraceptive use.
8. To examine the relationship between region and contraceptive use.

1.4 HYPOTHESES
1. There is no relationship between level of education and contraceptive use.
2. There is no relationship between residence and contraceptive use.
3. There is no relationship between wealth status and contraceptive use.
4. There is no relationship between religion and contraceptive use.
5. There is no relationship between marital status and contraceptive use.
6. There is no relationship between occupation and contraceptive use.
7. There is no relationship between age and contraceptive use.
8. There is no relationship between region and contraceptive use.
1.5 CONCEPTUAL FRAMEWORK
This study presents a conceptual framework explaining how different variables both background variables, and intermediate variables influence the dependent variable contraceptive use. Back ground factors can either work through intermediate factors to influence the dependent variable or some of them can directly influence the dependent variable without passing through intermediate variables.

Women with high levels of education are more likely to be informed about the benefits of using contraceptives and make proper choices on which contraceptive method to use. Women with low education are more likely to have low self-esteem thus lacking the capacity to negotiate for safe sex from old persons hence low use of contraceptives.

Women with high levels of wealth are more likely to have the capability to purchase contraceptives because it is cost effective as compared to women with low levels of wealth. Thus, wealth status will increase the rates of accessibility to contraceptives.

Women in rural areas are in most cases poor as compared to urban dwellers thus have limited access to modern contraceptive methods as compared to the urban residents. More so, it is the rural people that have a negative perception about contraceptive methods due to the less exposure to the importance of contraceptives for example they look at condoms as only a preventive measure for STDs not considering the fact that they can help reduce chances of conception thus low contraceptive use.

Married women considering the fact that they are exposed to the risk of child bearing due to the increased chances of sexual activity. Therefore, they will use more contraceptives as compared to the unmarried women.

Women with formal employment are more empowered thus will have the power to decision making about contraceptive use as compared to unemployed women. In addition, employed women due to their daily busy schedule will need fewer children to reduce on their obligations hence using contraceptives.

Religion plays a great role in contraceptive use. Some religions for example the Catholic religion tends to discourage the use of modern contraceptive and instead advocate for the natural methods
which are less effective. This thus hinders the use of modern contraceptives among Catholic women as compared to other religions like the Protestants who are not restricted to any contraceptive method.

Women in young ages say 18-20 are so interested to conceive and give birth to children therefore this argue will reduce their need for contraception. As women tend to their thirties they opt for child spacing and limiting the number of children hence using contraceptives. Women in the ages 40-49 are approaching menopause therefore the chances of getting pregnant are so minimal thus will find no need for contraception hence low use of contraceptives in these ages.

**Figure 1.1: Conceptual framework**

<table>
<thead>
<tr>
<th>Background variables</th>
<th>Intermediate variables</th>
<th>Dependent variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Knowledge of contraceptive use</td>
<td>Contraceptive use</td>
</tr>
<tr>
<td>Wealth status</td>
<td>Number of living children</td>
<td>Yes</td>
</tr>
<tr>
<td>Residence</td>
<td>Space births</td>
<td>No</td>
</tr>
<tr>
<td>Marital status</td>
<td>Accessibility</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>Affordability</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>Availability</td>
<td></td>
</tr>
<tr>
<td>Age of women</td>
<td></td>
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</tbody>
</table>

**1.6. SIGNIFICANCE OF THE STUDY**

The target and need for contraceptive use are so key in achieving the Sustainable Development Goal 3 on child health and maternal health. Since through contraceptive use there is spacing of births and family size control thus reducing induced unsafe abortions and unwanted pregnancies
among sexually active females that would have posed a great challenge to maternal and child health.

More so the study is aimed at providing information that will be used by the policy makers to evaluate the measures that could be used to increase contraceptive use. Furthermore, understanding the key factors influencing contraceptive use is key to development of effective family planning programs.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction
This chapter presents a review of the existing literature as regards to the various methods of contraception and the determinants of family planning service uptake and contraceptives with reference to education level, marital status, wealth status, residence, religious beliefs plus age at first marriage and number of living children towards the use of contraception.

2.2 Types of contraception
There are various methods of contraception. They can be categorized into the modern methods, and the traditional methods. This study mainly focused on the modern methods of contraceptives.

The following are the modern contraceptive methods according to the Population Reference Bureau Report (Kaneda & Bietsch, 2013). Condoms are the most common method of birth control. Male condoms are dressed on a man's erect penis and physically block ejaculated sperms from entering the virginal canal (cervix, uterus) and later to the fallopian tubes for fertilization of the ova produced by ovary (Bongaarts, 2014). Modern condoms are most often made from latex, but some are made from other materials such as polyurethane, or lamb's intestine. Female condoms are also available, most often made of nitrile, latex or polyurethane. Male condoms have the advantage of not being expensive, easy to use, and have few adverse effects (Gribble & Haffey, 2008).

Surgical sterilization is available in the form of tubal ligation for women and vasectomy for men. There are no significant long-term side effects, and tubal-ligation decreases the risk of ovarian cancer (Gribble & Haffey, 2008). Short-term complications are twenty times less likely from a vasectomy than a tubal-ligation. After a vasectomy, there might be swelling and pain of the scrotum, which usually resolves in a week or two. With tubal ligation, complications occur in 1 to 2% of procedures with serious complications usually due to the anesthesia. Nonetheless, neither method offers protection from sexually transmitted infections (Fatemeh Najafi-Sharjabad et al, 2013). Vasectomy is a permanent birth control procedure where a small
An incision is made in the upper part of the man’s scrotum. The two tubes that carry sperm into the semen are cut apart and then tied off. The incision is closed with stitches. Vasectomies are often performed in a surgeon’s office. The man is awake, and the doctor will use local anesthesia to numb the area. After the procedure, the man will still produce semen, but it will be free of sperm and will not cause pregnancy.

Contraceptive sponges combine a barrier with a spermicide. Like diaphragms, they are inserted vaginally before intercourse and must be placed over the cervix to be effective. Typical failure rates during the first year depend on whether or not a woman has previously given birth, and are currently 24% in those who have and 12% in those who have not (Stanback, 2013). The sponge can be inserted up to 24 hours before intercourse and must be left in place for at least six hours afterward. Allergic reactions and more severe adverse effects such as toxic shock syndrome have been reported (Fatemeh Najafi-Sharpjabad et al, 2013).

Intrauterine devices (IUD) are small devices, often 'T'-shaped, usually containing either copper or levonorgestrel, which are inserted into the uterus. They are one form of long-acting reversible contraception, which are the most effective types of reversible birth control. Failure rates with the copper IUD is about 0.8% while the levonorgestrel IUD has a failure rate of 0.2% in the first year of use. Among types of birth control, IUDs along with birth control implants result in the greatest satisfaction among users. As of 2007, IUDs are the most widely used form of reversible contraception, with more than 180 million users worldwide (Audam, 2012).

Birth control pills of which there are two types of oral birth control pills; the combined oral contraceptive pills (which contain both progesterone and estrogen) and the progestogen-only pills (sometimes called mini pills). If either taken during pregnancy, they do not increase the risk of miscarriage nor cause birth defects. Both types of birth control pills prevent fertilization mainly by inhibiting ovulation and thickening cervical mucus. Their effectiveness depends on the user remembering to take the pills. They may also change the lining of the uterus and thus decrease implantation (Bongaarts, 2014).
2.3 Socio-economic factors and contraceptive use
This section provides the available literature on how wealth status, level of education, religion, residence, marital status, occupation and age at first marriage, affect contraceptive use among women.

2.3.1 Residence and contraceptive use
In developing countries women who reside in rural places usually have a challenge in acquiring any method of birth control measure to have a control on the number of children and this is also associated with poverty (Malacher et al, 2010). This is usually experienced in Sub-Saharan African countries for example in Kenya, Uganda, Somalia and many other countries facing such challenges with current statistics using the Demographic and Heath Survey’s Data indicating that 16%, 15% & 24% respectively (Bankole & Audam, 2011) & (Rabiu & Ahmad, 2014).

In most rural cases women tend to have many children compared to their counterparts in the urban areas who have easy accessibility and availability of any forms of contraceptives. The fertility differentials are attributed to accessibility to modern contraceptives whereas access is low in rural areas and high in urban areas. Uganda’s population is said to be growing at a higher rate of 3.0% per annum according to (UBOS, 2016). This is attributed to high birth rates mainly with the Northern and Western region having the highest.

The place of residence has a significant impact on contraceptive use whereby in different studies conducted. In the study conducted on developing countries, rates of contraceptive use among married women in rural areas are lower than in urban areas. The exception is Jamaica, where use of contraceptives in rural and urban levels are equal. In surveyed countries of Eastern Europe and Central Asia, differences in contraceptive use between rural and urban areas are quite small. As with differences in contraceptive use by level of education, differences by rural or urban residence vary among countries. In countries where contraceptive use is widespread, rural-urban differences are smaller than where contraceptive prevalence is low (Rabiu & Ahmad, 2014).
2.3.2 Wealth status and contraceptive use

Contraceptive use among the women worldwide increases with increase in wealth at household level. Wealthier women have the capability to purchase any modern contraceptives they would prefer which is cost effective in the long run. Women in this instance do have the choice to make on the number of children they would desire to have throughout their reproductive lifespan (Sileo, 2014). The women who work have more knowledge about the use of contraceptives. Wives who work outside the home have higher chances of using contraceptives than women who work within the home (housewives) and are not paid (Colleran, Jasienska, Nenko, Galbarczyk, & Mace, 2015). Working women, particularly, those who earn a salary are assumed to have greater control over household decision-making and increased awareness of the world outside home. Consequently, they have greater control over reproductive decision making than those who stay at home as housewives, especially in most developing countries. Most of them are home mothers who live in rural areas (Colleran et al., 2015).

Contraceptive use also increases as household wealth increases. There is a positive relationship between contraceptive use and wealth status in that 46% of women in the highest wealth quintile use contraceptives as compared to 15% among those in the lowest wealth quintile. Personal income or wealth is a very important determinant, which facilitates health service use by a person’s affordability of quality health services (UBOS & ICF Inc. 2012). Although there is free provision of contraceptive programs in Uganda, other related costs such as transport to the clinic and taking care of the child are the main hindrances to the use of contraceptives in Uganda (Tuller et al., 2010), hence making income an important determinant to consider.

According to studies that look at wealth variations in terms of contraceptive use, thirteen Sub-Saharan African countries results show that wealthy women have more chances of using contraceptives and achieve their desired family sizes as opposed to poorer counterparts (Creanga et al, 2009). Researchers including Rahayu et al (2009), stipulate that there is a reduced gap between the poor and the rich, as services are made available even to the poorest couples. However, it is discovered that poor women deliberately do not make use of the services compared to richer women.
2.3.3 Marital status and contraceptive use
Globally 56% of married women use modern methods of contraceptives (Margolis et al, 2013). However, in sub-Saharan Africa, only 19% of married women use modern methods of contraceptives (Bankole & Audam, 2011). This is due to the fact that sexually active unmarried women engage into sexual activity earlier, therefore they are likely to use contraceptives in order to overcome pregnancy. On the contrary the low contraceptive prevalence among the married women is attributed to the myth that marriage is associated with the onset of sexual activity. Despite the fact higher exposure to sexual activity by married women, unmarried women tend to have a higher prevalence for contraceptive use.

In sub-Saharan Africa, in almost every country, modern contraceptive use is higher among single women compared to those currently in a union (Gribble & Haffey, 2008.). This is greatly varying in terms of unmet need for contraception. According to the most recent survey in Namibia, it was discovered that the prevalence of contraceptive use among single sexually active women was relatively high at 78% and the lowest at 22% in Mali (Adetunji 2012) & (Palamuleni 2013). In Uganda, only 8.1% of married women with no living children use contraception. The percentage increases to 37.0% among women with one or two children and to 44.5% among women with three or more children (UBOS & ICF Inc. 2018).

In Sub-Saharan Africa, single women tend to use more contraceptives than the married. For example, in Namibia according to the survey carried out, 78% of the sexually active women use contraceptives compared to married women and was least in Mali at 22%. It is when women get married that they are more exposed to the risk of pregnancy (Adetunji, 2012).

According to Faniyi & Oluseye (2011) marriage is part and parcel of the African society in which early marriage and child bearing is taken as a blessing. Studies have also shown that many women in monogamous marriages tend to use contraception more than women who live in polygamous marriages (Audu et al 2008). This is because a reduced frequency of sexual intercourse for women in a union of more sexual partners discourages them from using the contraception. Similarly, these women are more likely to preserve the traditional customs and values that emphasize the advantages of large families.
2.3.4 Level of education and contraceptive use
A number of studies that have been carried out in both developed & developing countries indicate that female education is associated with a decrease in fertility (Fatemeh Najafi-Sharjabad1, 2, Sharifah Zainiyah Syed Yahya2, Hejar Abdul Rahman2 & Manaf3, 2013). (Abdulla, 2014) carried out a study in Brazil and discovered that there was rapid fertility decline in absence of a family planning effort. Brazil has contradicted studies from various countries, which shows that fertility declines following a series or periods of active family planning programs. In addition to the importance of women’s education, higher levels of school of the women in the community have a strong negative correlation with fertility (Brand & Davis, 2011).

The Demographic and Health Survey’s Data indicate that for particularly approximately 22 countries in the Sub-Saharan Africa, the education for females at community levels have strong negative impact on fertility levels (Ogbe & Okezie, 2010). Nevertheless the quantitative impact of the levels of female school and fertility haven’t been explicitly estimated properly in Uganda for the past years in terms of whether the level of school acquired by the women play an impact role in decision making on how many children a woman would love to have. (Bbaale & Mpuga, 2011). Education is a very significant factor that determines contraceptive use. Studies show that most women with at least any level of education are more likely to use contraception than those with no education level at all (Ryan & Bauman, 2016). According to research done in Uganda, it was discovered that women with primary education use contraceptives compared to those with no education level (Ojakaa, 2008).

2.3.5 Religion affiliation and contraceptive use
Religion is known worldwide to influence the use of modern contraception among people, thus affecting the reproductive behavioral outcomes in sub-Saharan Africa (Abdulla, 2014). The extent to which religion has an influence on the reproductive outcomes of people in reproductive ages in developing countries however remains obscure given that there are relatively low numbers of recent studies that look into this phenomenon.
A study was carried out and it was discovered that religion affects the use of contraceptives in Mozambique (Agadjanian, 2011). It was realized that women who are affiliated to any religion were surprisingly more likely to use contraceptives as opposed to women who were not affiliated to any religion. In addition, both Catholics and Protestants were found to be using more contraceptives compared to other religious groups like Muslims, Seventh Day’s, orthodox and others. (Agadjanian, 2011)

Religious congregations are responsible for spreading knowledge regarding contraceptives with religious leaders neither opposing nor consenting to the use of contraceptives, leaving it on neutral ground in Mozambique (Agadjanian, 2011). Roman Catholics are also at the forefront of contraceptive usage in comparison to other religious groups in Mozambique.

A research in West Africa found that the fertility of Muslims varies according to their numbers, that is, areas with high numbers of Muslims have lower fertility compared to areas where Muslims are outnumbered (Johnson-Hanks, 2006). Furthermore, Johnson-Hanks (2006) found that the differences in contraceptive use between Muslims and Christians remain inconclusive in the region. In another study in Nigeria, it was found that contraceptive use is higher among Christians than Muslims (Longwe, Huisman, & Smits, 2013.). In Uganda research indicates that one’s religion has a strong influence on family planning. Ugandans identified to be as both Catholics and Muslims cite their religions as a major reason for not using contraceptives. They desire a large family (Beyeza-Kashesy et al., 2010 & Kiene et al., 2013).

2.3.6. Age of women and contraceptive use
Age of women is highly related to contraceptive use in Uganda. A lower age at marriage means early exposure to the risks of pregnancy and child bearing. A late age at marriage means delayed pregnancy and hence low fertility levels. In addition unplanned pregnancies worsen the fertility, they often happen at a lower age before the legal age at first marriage(Carmichael, 2011). Most Ugandan women and men begin having sexual intercourse before they marry. Median age at first sex among women is 16.6 years, which is over one year before marriage (Baschieri et al., 2016). In Uganda, the median age at first marriage for women is 17.8 years. Hence, only 55 % of women ages 25-49 years are married by age 18 while 74% get married at age 20. The urban
women marry almost two years later than rural women. The median age at marriage is highest in Kampala estimated at 19.6 years and lowest in the Eastern and Western regions at an average of 17.2 years. Men enter into first marriage almost 5 years later than women; the median age at first marriage for men age 25-54 is 22.3 years.

Works from scholars like Akoth, 2012, indicate that many men prefer marrying off younger girls resulting into a high risk of conception. In Tanzania, particularly in traditional African settings, young girls are married off at a tender age, which greatly impacts on contraceptive use. They suggest that an increase in age at first marriage will increase contraceptive use, which results into fertility reduction. The study carried out in Kenya evidenced that only 26% of the sexually active females age 15-19 years used contraceptives compared to 25% of the females aged 20-24 years (Waitherero, 2009).

Fourteen percent of the currently married women aged 15-19 are said to use any method which eventually increases to 38% among 35-44 years then declines between ages 45-49 to 21 % hence clearly showing that younger women are more likely to use contraceptives than their counterparts, hence indicating a negative attitude among older women to accept contraceptives (Stephenson et al., 2007).

On the contrary, some research has it that the use of contraceptives is high among older women since they at times reached their ideal family sizes (Ahamd, 2012). Women aged 20-24 years and those in 25-29 years are more likely to use contraceptives than those 45-49 years. Contraceptive use is highest among women aged 30-44 years.

The contraceptive prevalence among currently married women is lower at younger age (15-19) and at older age (45-49). It reaches its peak among women at their late thirties. This may reflect a high desire for child bearing among young women, and a high growing interest of spacing and limiting births among women in their older age (Central Statistical Authority Ethiopia, 2005).
2.3.7 Occupation and contraceptive use

Employment is an important aspect that determines contraceptive use. Research proved that most women who have to do work away from their home stead have a higher rate of using contraceptives than those who stay home or house wives (Blackstone, Nwaozuru, & Iwelunmor, 2017). Employed women particularly those who are paid in cash only tend to have bigger control over household decision making especially on important issues like the number of children to have, when to have them and have increased awareness of the world outside home (Van Den Broeck & Maertens, 2015). According to UBOS, 2012, 49% of women were paid cash only, compared to less than 20% in 2006. Studies also emphasize that paid work promotes contraceptive use through providing alternative satisfaction for women, as they may prefer their career to child bearing.

In order to obtain contraceptive methods and services an individual may need to pay some costs which influences the type of methods a woman can use directly or indirectly. A significant proportion of modern method users in Pakistan pay for contraception. Moreover, users of modern methods also have to pay for travel costs and the opportunity cost of time spent in obtaining the method. These costs may become excessive for poor women, who may be unable to afford the use of modern contraception. In contrast, users of traditional methods don’t have to pay a monetary price, nor are there travel or time costs associated. If the effect of income on contraceptive use operates through contraceptive price and travel cost, higher household income should increase the likelihood of using a modern method. A study conducted in Kinshasa (Congo & Bongaarts, 2014) Zaire has identified that self-employed women and employees had much higher predicted probabilities of contraceptive use and women employed in the modern sector as more likely to practice contraception (Ogbe & Okezie, 2010). Women’s employment is expected to influence the number of children they desire to have and at the same time it also affects their contraceptive behavior.
CHAPTER THREE

METHODOLOGY OF THE STUDY

3.1 Introduction
This chapter presents the methodology that was used in the study, including the study variables used in the study. The section further more gives information on the data source, study population, sample size, data processing and analysis, ethical consideration and study limitations.

3.2 Data source
The study used secondary data from UDHS 2016 specifically the female dataset (UGIR), to examine the details on contraceptive use in Northern Uganda. The Uganda Bureau of statistics (UBOS) conducted the sixth Uganda demographic and health survey (UDHS) June 15 through December 18 2016, with a national representative sample of over 20,000 households from 112 districts which were divided into 15 sub-regions. All women aged 15-49 years in selected households were eligible for individual interviews. The 2016 UDHS sample was stratified and selected in two stages. The main purpose of 2016 UDHS is to provide the data needed to monitor and evaluate population health and nutritional programs on a regular basis.

3.3 Study population
The study focused on the women aged 15-49 years in Northern region. This region is one of the regions in Uganda and is majorly comprised of five main sub-regions which include West Nile, Karamoja, Acholi, Lango and Madi. Northern Uganda is one of the regions with very low levels of income which would be mainly be attributed to the political instability in this region. Northern Uganda has high birth rates which would be attributed to the extreme poverty levels. The main economic activity for women was subsistence farming followed by alcohol brewing and petty trade/business. After the war farming and trade/business still came at the top of women’s economic activities followed by formal employment and brewing alcohol.

3.4 Sample size
The study used a sample size of 4368 respondents (weighted sample,3546 respondents). This sample size was strictly got from women aged 15-49 years in the four sub-regions.
3.5 Study variables

The dependent variable in this research was contraceptive use, which was measured by the question from UDHS 2016 women’s questionnaire “Have you ever used anything or tried in any way to delay or avoid getting pregnant?” “All respondents who answered yes were grouped under those who have ever used contraceptives. All respondents who answered No were grouped under those women that have never used any method.

The independent variables were; age of women, residence, religion, employment status, level of education, marital Status, wealth index and region.

Table 3.1: Description of the study variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever used contraceptives</td>
<td>Currently using any method to avoid or delay pregnancy</td>
<td>0=No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1=Yes</td>
</tr>
<tr>
<td>Age</td>
<td>Age in 5-year groups</td>
<td>1=15-19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=20-24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3=25-29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4=30-34</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5=35-39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6=40-44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7=45-49</td>
</tr>
<tr>
<td>Residence</td>
<td>Type of place of residence</td>
<td>1=Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=Rural</td>
</tr>
<tr>
<td>Wealth status</td>
<td>Wealth index combined</td>
<td>1=Poorest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=Poorer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3=Middle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4=Richer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5=Richest</td>
</tr>
<tr>
<td>Education level</td>
<td>Highest education level</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>1=Primary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=Secondary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3=Higher</td>
</tr>
</tbody>
</table>
### 3.6 Data Processing and Analysis

Prior to analysis, the data were weighted to make it representative of the population. Before applying the weighting factor, the sample weight was divided by 1,000,000. The data was then analyzed using SPSS. This statistical software was used to the target variables that were used to analyze both univariate and bivariate in order to analyze frequencies and percentages of the different variables. Bivariate procedures in this method were used to analyze the hypotheses, relationships and cross tabulations of all variables.

#### Univariate data analysis

This was used to analyze frequencies of the different variables. The frequency tables and descriptive statistics were used to analyze and present the socio-economic characteristics of the respondents.
Bivariate data analysis

Bivariate analysis was used where by the association between the dependent variable “ever used contraceptives” and independent variables like education, religion, occupation status, wealth status, marital status, respondents age, type of residence and sub-region were investigated. In this analysis cross tabulation was used to establish the association between each of the explanatory variables and the dependent variable, thus conclusions based on the p-value for results were explained. If p-value was greater than 0.05, then there was no significant relationship between the two variables that were considered. The cross tabulation takes the form of equation;

\[ X^2 = \sum_{i=1}^{r} \sum_{j=1}^{c} \frac{(O_{ij} - E_{ij})^2}{E_{ij}} \]

Where:
- \( X^2 \) is the chi-square test
- \( O_{ij} \) is the total number of expected frequencies
- \( E_{ij} \) is the number of expected frequencies
- \( r \) - is the number of rows
- \( c \) – is the number of columns

In order to investigate the association between the variables, dependent variables were tabulated with the independent variables using cross tabulation, rejecting Ho, (null hypothesis if the p value is less than 0.05) and accept the Ho, (the null hypothesis if the p- value is greater than 0.05).

3.7 Ethical considerations

The researcher applied for access of the UDHS 2016 dataset using the DHS program website and was granted permission to access UDHS 2016 dataset. This is evidently shown by the authentication letter attached in the appendices.

3.8 Study limitations

Data is cross-sectional therefore causality cannot be inferred.
CHAPTER FOUR: FINDINGS

4.1 Introduction
This chapter provides the analysis and research findings of the data from UDHS 2016, which was used to investigate the socio-economic factors associated with contraceptive use. The first section presents the characteristics of the study population. The second section presents results from a cross tabulation which describe the associations between each independent variable and ever use of contraceptives.

4.2 Background characteristics of respondents
This section consists of the characteristics of respondents who were interviewed and these include; age of the respondents, type of place of residence, level of education, marital status, respondents’ occupation, wealth status, region and religion.

Age of respondents
Majority (25.4%) of the respondents were aged 15-19 years. A considerable number (19.1%) were in the age group 20-24 years. The rest of the respondents were distributed in other age groups and the least group (6.4%) were aged 45-49 years as indicated in figure 4.1.

Figure 4. 1: A bar graph showing percentage distribution of respondents by age
Wealth status

The biggest percentage of respondents belonged to the poorest households (50%), followed by a bigger proportion (22%) who belonged in the poorer households. However, the richest households in this region had the least number of respondents (8%) as shown in figure 4.2.

**Figure 4. 2: A bar graph showing percentage distribution of respondents by wealth status**

Type of place of residence

Looking at place of residence, most of the respondents in the Northern region resided in rural areas (85%). The least percentage of the respondents (15%) resided in the urban areas as shown in table 4.1.
**Highest education level**

Results in this study showed that the majority of the respondents (67%) had acquired primary education, (17%) had no education at all, (11%) had secondary education. Whereas only (4%) of the respondents which was the least had acquired higher education as indicated in table 4.1.

**Occupation status**

Results from the study showed that majority of the respondents in the Northern region had formal employment (54%). A considerable percentage (30 %) had informal employment whereas (16%) were not working as shown in table 4.1.

**Marital status**

Results from the study showed that majority of the respondents (62%) were married. This was followed by (24%) of the respondents who were never married. Lastly (14%) of the respondents who had been formerly married as shown in table 4.1.

**Religion**

Fifty nine percent of the respondents were Catholics while 23 percent of women were Anglicans. Nine percent of the respondents were Muslims where as eight percent belonged to other religions. A very small percentage (0.3%) did not belong to any religion as shown in table 4.1.

**Region**

According to the results in the study majority of the respondents were from West Nile 35%. Twenty nine percent were from Lango sub region whereas 26% of the respondents were from Acholi sub region. Karamoja sub region had the least number of respondents (10%) as indicated in table 4.1.
<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>610</td>
<td>17.2</td>
</tr>
<tr>
<td>Primary</td>
<td>2380</td>
<td>67.1</td>
</tr>
<tr>
<td>Secondary</td>
<td>402</td>
<td>11.3</td>
</tr>
<tr>
<td>Higher</td>
<td>155</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>532</td>
<td>15</td>
</tr>
<tr>
<td>Rural</td>
<td>3015</td>
<td>85</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karamoja</td>
<td>365</td>
<td>10.3</td>
</tr>
<tr>
<td>Lango</td>
<td>1010</td>
<td>28.5</td>
</tr>
<tr>
<td>Acholi</td>
<td>924</td>
<td>26.1</td>
</tr>
<tr>
<td>West Nile</td>
<td>1247</td>
<td>35.2</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no religion</td>
<td>12</td>
<td>0.3</td>
</tr>
<tr>
<td>Anglican</td>
<td>805</td>
<td>22.7</td>
</tr>
<tr>
<td>Catholic</td>
<td>2100</td>
<td>59.2</td>
</tr>
<tr>
<td>Muslim</td>
<td>333</td>
<td>9.4</td>
</tr>
<tr>
<td>Other</td>
<td>297</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>838</td>
<td>23.6</td>
</tr>
<tr>
<td>Married</td>
<td>2212</td>
<td>62.4</td>
</tr>
<tr>
<td>Formerly married</td>
<td>496</td>
<td>14</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Working</td>
<td>571</td>
<td>16.1</td>
</tr>
<tr>
<td>Formal employment</td>
<td>1899</td>
<td>53.6</td>
</tr>
<tr>
<td>Informal employment</td>
<td>1071</td>
<td>30.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3546</td>
<td>100</td>
</tr>
</tbody>
</table>
4.3 Contraceptive usage

Majority (55.4%) of the respondents had never used any contraceptive method to delay or avoid pregnancy. Only 44.6% of the respondents in the Northern region had ever used contraceptives as indicated in figure 4.3.

Figure 4.3: Pie chart showing percentage distribution of ever used contraceptives
4.4 Relationship between contraceptive use and background characteristics

This section looks at the relationship between the dependent variable (Ever used any method) and other independent variables age of respondents, highest level of education, marital status, wealth status, type of place of residence, region, religion, and occupation status.

Age of respondents

Table 4.2 indicates that the biggest proportion (65%) of the respondents who had ever used any method of birth control were in the age group 30-34 years, followed by those in the age group 25-29 years (63.8%), however results showed that respondents in the age group 15-19 years had the lowest percentage of use of contraceptives (12.5%). On the other hand the biggest proportion of respondents (87.7%) who were not using any method to control pregnancy were in the ages 15-19 years leaving this age group at a high risk of conceiving. Results thus showed a significant association between age of respondents and ever used any method (P=0.000).

Highest level of education

Results from the study showed that the highest proportion of the women who had ever used any method or tried to delay or avoid pregnancy had higher education level (66.2%), followed by women with secondary education (48.8%), and women with no education had the least percentage (34.2%) of ever used contraceptives. Looking at women who had never used anything, those with no education had the highest percentage (65.8%). Considering the p value there was a significant association between education level and ever used any method (p=0.000). This is clearly indicated in table 4.2.

Residence

The number of women who had ever used anything was high among women in urban areas (45.1%), as compared to women in the rural areas (44.5%). However, results showed no significance between residence and ever used any method (p=0.786) as shown in table 4.2.

Wealth status

The highest proportion of women who belonged to the middle wealth households (52.8%) had ever used any method to delay or avoid pregnancy as compared to the other households. On the
other hand, the majority of women who had never used any method belonged to the poorest wealth households (62%). Results from the study showed that wealth status of women influenced their use of contraceptives (p=0.000) as shown in table 4.2.

**Religion**

In reference to table 4.2, the highest proportion of women who had ever used contraceptives belonged to the Anglican religion (52.7%), followed by those who belonged to other religions (49.5%). The women who had no religion were found to have the highest percent of not using contraceptives (91.7%). The association between religion and ever used contraceptive was statistically significant (p=0.000).

**Marital status**

Results showed that the formerly married respondents had the biggest proportion of contraceptive users (55.8%), married respondents also had a bigger percent of contraceptive users (54.9%). Looking at women who never used any contraceptive method those never married had the highest percent (89.3%) as in reference to table 2. Thus, the association between marital status and ever used contraceptive was significant (p=0.000).

**Occupation status**

Results showed that the highest proportion of respondents who had ever used contraceptives was among women with informal employment (52.4%), followed by those with formal employment (46.6%) and finally those not working with the least percent of (23.5%). On the other hand, majority of women who did not use any contraceptive method belonged to those not working (76.5%) as opposed to those who were working. There was a significant association between occupation status and ever used contraceptives (p=0.000) as shown in table 4.2.
Table 4.2: Percentage distribution of ever used contraceptive by respondent’s background factors

<table>
<thead>
<tr>
<th>Variables</th>
<th>Ever used Contraceptives</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No (%)</td>
<td>Yes (%)</td>
<td>Total</td>
</tr>
<tr>
<td><strong>Type of place of residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>54.9</td>
<td>45.1</td>
<td>532</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>55.5</td>
<td>44.5</td>
<td>3015</td>
<td></td>
</tr>
<tr>
<td>$\chi^2 = 0.074$, df=1, p=0.786</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karamoja</td>
<td>75.3</td>
<td>24.7</td>
<td>365</td>
<td></td>
</tr>
<tr>
<td>Lango</td>
<td>44.3</td>
<td>55.7</td>
<td>1010</td>
<td></td>
</tr>
<tr>
<td>Acholi</td>
<td>50.9</td>
<td>49.1</td>
<td>925</td>
<td></td>
</tr>
<tr>
<td>West Nile</td>
<td>61.9</td>
<td>38.1</td>
<td>1248</td>
<td></td>
</tr>
<tr>
<td>$\chi^2 = 1.386$, df=3, p=0.000</td>
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<tr>
<td><strong>Religion</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>No religion</td>
<td>91.7</td>
<td>8.3</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Anglican</td>
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<td>52.7</td>
<td>805</td>
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</tr>
<tr>
<td>Catholic</td>
<td>57.4</td>
<td>42.6</td>
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<tr>
<td>Muslim</td>
<td>65.8</td>
<td>34.2</td>
<td>333</td>
<td></td>
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<tr>
<td>Other</td>
<td>50.5</td>
<td>49.5</td>
<td>297</td>
<td></td>
</tr>
<tr>
<td>$\chi^2 = 48.383$, df=4, p=0.000</td>
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<tr>
<td><strong>Wealth status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorest</td>
<td>62</td>
<td>38</td>
<td>1765</td>
<td></td>
</tr>
<tr>
<td>Poorer</td>
<td>49.8</td>
<td>50.5</td>
<td>783</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>47.2</td>
<td>52.8</td>
<td>381</td>
<td></td>
</tr>
<tr>
<td>Richer</td>
<td>47.7</td>
<td>52.3</td>
<td>350</td>
<td></td>
</tr>
<tr>
<td>Richest</td>
<td>50.4</td>
<td>49.6</td>
<td>266</td>
<td></td>
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<td>$\chi^2 = 63.213$, df=4, p=0.000</td>
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<tr>
<td>Age</td>
<td>15-19</td>
<td>20-24</td>
<td>25-29</td>
<td>30-34</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
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<tr>
<td></td>
<td>87.5</td>
<td>52.8</td>
<td>36.2</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>12.5</td>
<td>47.2</td>
<td>63.8</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>902</td>
<td>678</td>
<td>544</td>
<td>514</td>
</tr>
</tbody>
</table>

$\chi^2$=5.983, df=6, p=0.000

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<tr>
<th>Highest educational level</th>
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<th>Secondary</th>
<th>Higher</th>
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</thead>
<tbody>
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<td></td>
<td>65.8</td>
<td>54.9</td>
<td>51.2</td>
<td>33.8</td>
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<td>66.2</td>
</tr>
<tr>
<td></td>
<td>609</td>
<td>2379</td>
<td>402</td>
<td>154</td>
</tr>
</tbody>
</table>

$\chi^2$=59.164, df=3, p=0.000

<table>
<thead>
<tr>
<th>Marital Status</th>
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<th>Married</th>
<th>Formerly Married</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>89.3</td>
<td>45.1</td>
<td>44.2</td>
</tr>
<tr>
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$\chi^2$=5.089, df=2, p=0.000

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<th>Informal employment</th>
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</tr>
<tr>
<td></td>
<td>571</td>
<td>1899</td>
<td>1071</td>
</tr>
</tbody>
</table>

$\chi^2$=1.324, df=2, p=0.000
4.4 Discussion of findings

In this section we compare the findings above with the literature review in chapter two to determine whether the investigations in the research are significant for the study. Below are the comparisons of the research findings extracted from UDHS 2016 dataset and the literature review as a point of reference.

According to the above variables used in the research for example Age, level of education, marital status, wealth index, occupation status, and religion in comparison to chapter two literature the study discovered significance respectively.

Using bivariate analysis, results revealed that education and contraceptive use was significant (p=0.000). Most studies that looked at level of education in relation to contraceptive use showed that in sub Saharan Africa women with higher education level are 32 percent likely to use contraceptives as compared to women with no education (Ryan & Bauman, 2016).

Wealth status and ever used contraceptives were significantly associated with regard to the results from the bivariate analysis (p=0.000). Studies that looked at wealth variations in terms of contraceptive use showed that in African countries wealthy women had more chances of using contraceptives and achieve their desired family size as opposed to those in poorer households. Even when services are made available to the poorest women, they will deliberately not make use of the services as compared to richer women which is true in accordance with the findings in this study.

Type of place of residence and variations in contraceptive use in this study showed that the majority of the respondents were residing in rural areas (85%). This is due to the fact that most of the people in the Northern region are rural based. Different scholars suggest that residence determines contraceptive use, from the literature it was found that in most rural cases women tend to have many children as compared to their counterparts in the urban areas who have easy accessibility and availability of any forms of contraceptives (Guttmacher Institute, 2017). However, it was revealed according to the study that there was no significance association between place of residence and contraceptive usage (p=0.786).
One of the specific objectives of this study was to examine the relationship between age and contraceptive use among women. From this study age of women was found to be significantly associated with contraceptive use. Women between the ages 30-34 years had ever used contraceptives as compared to women aged between 15-24 years. This therefore means that contraceptive use is lowest among young women and it is said to peak among women in their thirties then declines among older women. Percentage of users declines at older ages of reproduction due to the fact that older women are not at a high risk of pregnancy (Palamuleni, 2013).

The results indicated that religion of respondents was significantly associated with contraceptive use. The use of contraceptives was found to be high among Anglicans, Catholics and those in other religions as compared to the Muslims and respondents with no religion. These findings are similar to the study that revealed contraceptive use being high among Christians than Muslims (Longwe, Huisman & Smits, 2013).

The results in this study revealed that there was a significant association between occupation status and ever used contraceptives. The use of contraceptives was found to increase with a better occupation status whereby women with formal and informal employment were more likely to have ever used contraceptives as compared to women who were not working. These results are similar with those of a study by (Blackstone et al., 2017) that identified that self-employed women and employees had much higher probabilities of contraceptive use as compared to those who were not working.
CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter gives a summary of the study findings, conclusions drawn from the analysis and recommendations. The first section summarizes the study design giving an overview on the analysis made from the background characteristics determining contraceptive use. The second section presents conclusions drawn from the key findings. Then the last section discusses recommendations.

5.2 Summary
Majority (25.4%) of the respondents were between the age bracket of 15 and 19 years. More so respondents were fairly distributed among the different sub-regions they belonged to, namely Acholi (26.1%), Lango (28.5%), Karamoja (10.3%), West Nile (35.2%).

Respondents belonged to different religions including Catholics, Anglicans, Moslems and others. Most of the respondents were Catholics (59.2%), and (22.7%) were Anglicans. Only 15% were from urban areas and 85% were from rural areas.

About 55.4% of the respondents had never used any method as compared to 44.6% who had ever used contraceptive methods. Most respondents had acquired a certain level of education and only a few had never gone to school.

Most respondents on average were poor, while a small percentage was rich. In addition, majority of the respondents were married (62.4%) whereas a few were never married (23.6%). About 53.6% had formal employment whereas the least 16.1% were not working.

Results indicated that region, religion, wealth status, age of respondents, education level, occupation status and marital status had a significant association with ever use of contraceptives. Whereas residence had no significant association with ever use of contraceptive methods.

5.3 Conclusion
According to the analysis of the factors influencing contraceptive use among women in Northern Uganda as carried out in chapter four, it was concluded that background factors like religion,
wealth status, age of respondents, education level, occupation status, and marital status have significant influence on contraceptive use. However, it was revealed that place of residence of a respondent had no significant association with contraceptive use.

5.4 Recommendations

Women empowerment is one of the most important measures that can be invested in to increase contraceptive use among women. This can be done through promoting girl child education. Education attainment increases knowledge and information about various methods of contraception and allows women to acquire skills and qualifications necessary for better employment. This, therefore, gives women a chance to have income that can help them access family planning services and provide better care for their families.

Occupation of women plays an important role in improving their social status thus increasing their decision-making power particularly concerning important issues like contraceptive use, when and how many children to have. This can be promoted through providing a conducive working environment at the place of work, for example promotion on merit for females and providing maternity leave. These all would encourage women to work hard in order to maintain their career.

Eliminating barriers to family planning services will reduce unmet need for contraception. The government should ensure that free or affordable public-sector contraceptive services reach all women especially those who are poor, young or live in rural areas.
REFERENCES


Performance Monitoring and Accountability 2020 (PMA2020) Project, Makerere University, S.


May 15, 2018
Aturinde Elizabeth
Makerere University
Uganda

Phone: 0776901561
Email: Lizaturinde@gmail.com
Request Date: 05/15/2018

Dear Aturinde Elizabeth:

This is to confirm that you are approved to use the following Survey Datasets for your registered research paper titled: "Factors associated with contraceptive use among women": Uganda

For restricted surveys, you must also request special permission from the Implementing Agencies. If approved, the restricted datasets will be provided to you by FTP.

To access the datasets, please login at: https://www.dhsprogram.com/data/dataset_admin/login_main.cfm. The username is the registered email address, and the password is the one selected during registration.

The IRB-approved procedures for DHS public-use datasets do not in any way allow respondents, households, or sample communities to be identified. There are no names of individuals or household addresses in the data files. The geographic identifiers only go down to the regional level (where regions are typically very large geographical areas encompassing several states/provinces). Each enumeration area (Primary Sampling Unit) has a PSU number in the data file, but the PSU numbers do not have any labels to indicate their names or locations. In surveys that collect GIS coordinates in the field, the coordinates are only for the enumeration area (EA) as a whole, and not for individual households, and the measured coordinates are randomly displaced within a large geographic area so that specific enumeration areas cannot be identified.

The DHS Data may be used only for the purpose of statistical reporting and analysis, and only for your registered research. To use the data for another purpose, a new research project must be registered. All DHS data should be treated as confidential, and no effort should be made to identify any household or individual respondent interviewed in the survey. Please reference the complete terms of use at: https://dhsprogram.com/Data/terms-of-use.cfm.

The data must not be passed on to other researchers without the written consent of DHS. Users are required to submit an electronic copy (pdf) of any reports/publications resulting from using the DHS data files to: archive@dhsprogram.com.

Sincerely,

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