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“Religion is Religion; My Life is My Life”: Religious Influences on Family Planning Decisions in Kapchorwa District, Uganda

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“Religion is Religion; My Life is My Life”: Religious Influences on Family
Planning Decisions in Kapchorwa District, Uganda

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This research is dedicated to the women and men fighting for reproductive justice around the world. Your struggle shapes the lives of women and girls everywhere, and I hope that my own work can contribute to this important tradition.

Acknowledgements

The completion of this report would not have been possible without the dedication of Madame Consolate Chemisto, and more generally, the assistance of the Reproductive Health Uganda office in Kapchorwa. I would also like to thank Darius Salimo, who tirelessly guided me in my fieldwork. Many thanks are also owed to the men and women of Kapchorwa, whose responses and insights are foundational to this research.

I am grateful to the staff at the School for International Training, who encouraged me in my work and helped me to overcome many stumbling blocks. I would also like to thank the faculty of Georgetown University's Department of Anthropology, who have always fostered my intellectual curiosity. These institutions have supported my academic interests and personal growth and have made this research possible.

Finally, I would like to extend my deepest appreciation for my cohort of fellow students at the School for International Training. Your feedback and encouragement have meant the world to me, and were invaluable to this research process.

List of Acronyms

COU	Church of Uganda
FBO	Faith-based organization
IRCU	Inter-Religious Council of Uganda
MDGs	Millennium Development Goals
NGO	Non-governmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PRA	Participatory rural appraisal
RHU	Reproductive Health Uganda
SDGs	Sustainable Development Goals
STIs	Sexually transmitted infections

Abstract

This report seeks to understand the influence that religion has on family planning decisions in Kapchorwa District, in eastern Uganda. Increased uptake of family planning has significant implications for sustainability and development in Uganda as a whole. As a district with a high unmet need for family planning, Kapchorwa serves as an important case study. Because over 99% of Uganda's population reports a religious affiliation, and because literature on family planning claims conservative spirituality as a major cause of low uptake, religion is a natural lens through which to study family planning perceptions and utilization.

Through focus groups and key informant interviews, the study analyzes the responses of 47 inhabitants of Kapchorwa and one religious leader living in Kampala. Findings show that individuals face barriers to family planning access, particularly a lack of accurate information about contraception, the spread of persistent and widely-held myths, and the disapproval of important religious institutions. Despite these obstacles, participants prioritize the spacing and limiting of children over the teachings of any religion. Significantly, religious leaders frequently acknowledge the necessity of family planning for Kapchorwa's development, and advise against the teachings of their churches in private. Recommendations include involving willing religious institutions in basic sexual health education, and encouraging religious leaders to speak their private beliefs about family planning in more public settings.

Introduction

With the second-youngest population in the world, Uganda is growing at an incredible rate and challenging established patterns of development. Infrastructure and social services are struggling to keep pace with the booming population, and it is clear that the country must prioritize family planning efforts if it is to pursue truly sustainable development policies. Uganda's fragmentation along linguistic, cultural, and ethnic lines has made it difficult for cohesive development policies to be put into place. Although Uganda is a highly diverse country, its citizens are united by religion; as of the 2014 census, 99.8% of the country's population claimed a religious affiliation (Uganda Bureau of Statistics). Although religious leaders have frequently opposed widespread contraception use, the mobilization of spiritual communities for family planning advocacy is an under-researched but potentially significant avenue for sustainable development work.

This research project will focus on the perception and utilization of different family planning methods in Kapchorwa District, in the Eastern Region of Uganda. Through predominantly qualitative research methods, it will analyze the knowledge of and beliefs about contraception present in different segments of eastern Uganda's rural population, and how those beliefs are shaped by the country's religious culture. The ultimate goal of this research is to open up new doors for family planning promotion through religious organizations in rural Uganda.

Background

Challenges to Sustainability in Uganda

The United Nations Sustainable Development Goals (SDGs), implemented in 2016 to replace the Millennium Development Goals (MDGs), provide guidelines and targets for countries

to develop sustainably over the next fifteen years. These targets focus on poverty alleviation, environmental concerns, economic inequality, and good governance and peacebuilding (United Nations Development Program). Eight of the seventeen goals relate directly or indirectly to issues of family planning and reproductive health.

As of 2014, Uganda had a population of 34.6 million people. Almost half of the population was under 14 years of age (Uganda Bureau of Statistics). With a fertility rate of 5.8 children per woman, Uganda is facing significant issues of sustainability (Uganda Bureau of Statistics). Although development efforts by both local and international non-governmental organizations (NGOs) have contributed to the lessening of Uganda's poverty over the past decade, these advances are unlikely to have lasting effects if not coupled with a serious push towards widespread family planning (Dabelko, 2011). Population growth beyond the capacity of state infrastructure will exacerbate problems of water scarcity, poor waste management, widespread malnutrition, poverty, joblessness, and landlessness, and will challenge many other sectors of Uganda's development. Much of Africa, including Uganda, is expected to find itself in a position of "water stress" by 2025, meaning there will be 1,000 cubic meters less water per person per year than what is considered adequate (Dabelko, 2011). This developing water scarcity will also put pressure on food production, which must necessarily increase to meet the demands of a growing population. Because many in Uganda already suffer from malnutrition and food insecurity, particularly in the northern and eastern regions, a rapidly-growing population will quickly become unsustainable without subsequent massive decline in the country's standard of living (Rwakakamba, 2009). For these reasons, widespread family planning is quickly becoming a necessity throughout most of sub-Saharan Africa.

Religion in Uganda

In 2014, Uganda's population was over 84% Christian (Uganda Bureau of Statistics). The most widespread denominations were Catholic, at 39.3% of the population, and Anglican¹, at 32% of the population (Uganda Bureau of Statistics). Although Uganda is a majority Christian country, other denominations are growing in popularity; 11.1% of the country is Pentecostal, and an additional 13.7% practice Islam (Uganda Bureau of Statistics). Kapchorwa District, in Eastern Uganda, varies slightly from the country's religious distribution as a whole: 26% of the population is Catholic, 39.7% is Anglican, 8.6% is Muslim, and 18% is Pentecostal. More broadly, 61% of the world's Christians and 62% of all Muslims live in the global south, illustrating the enormous influence that religious doctrine has on the politics of the developing world (Pew Research Center, 2011).

Most sects of Christianity do not condone the use of contraception, with the notable exception of Anglicanism. Since 1958, Anglicans and the Church of England have encouraged *birth choice*, or personal responsibility for reproductive decisions, over *birth control*, which in the context of international aid can be perceived as coercive or neocolonial (Harries, 1996). Catholicism and Islam, however, officially condemn the use of contraceptive measures for the purpose of preventing conception (BBC, 2009). Some religious leaders, however, are beginning to embrace the possibilities of widespread family planning. Muslim hospitals in religious Indonesia, evangelical Christian aid organizations in the U.S., and even Pope Francis have recently begun to advocate for increased availability of family planning (Levey, 2016). Because

¹ The Anglican church in Uganda is also known as the Church of Uganda, and is abbreviated in this report as COU. Members of the church are referred to in this report as "Anglicans" if they represent a broader international community of believers, or as "COU members" if they are Ugandan participants of this study.

religious doctrine has the potential to reach so many people in developing countries, it is essential that this trend towards acceptance of contraceptives be kindled by community and church leadership across Uganda.

Religion, Family Planning, and Foreign Aid

The widespread influence of religion in Uganda is not limited to indigenous practitioners. American faith-based organizations (FBOs) have played an active role in shaping sub-Saharan Africa's religious - and political - culture for the past several decades. The advent of the AIDS epidemic in 1981 opened up new pathways for the participation of religious organizations in spheres previously considered inappropriately worldly or corrupt (Gusman, 2009). As one of the countries most severely affected by AIDS, Uganda was in need of more assistance than President Museveni's newly-formed government could provide on its own. A solution was found in the outsourcing of care first to local churches, and ultimately, to international FBOs. This had the effect of institutionalizing the role of spiritual organizations as both necessary caregivers and political actors, reshaping their involvement in the public sphere and their influence over Uganda's political policies in the process (Prince, 2009).

Possibly the single most influential foreign aid program in Uganda at the beginning of the twenty-first century was President Bush's PEPFAR. The creation of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003 paved the way for American involvement in Uganda's politics in an explicitly conservative, religious context. PEPFAR is best known for its ABC program: "Abstinence, Be faithful, correct and consistent Condom use," with a particular emphasis on "A" and "B" (Cynn, 2010). By mandating that a third of the program's funding be used for abstinence-only education, "PEPFAR's ABC programs replicated US legislative

definitions of abstinence and its moralizing, heteronormative definitions of sex and sexuality. ... As a major funder of HIV/AIDS efforts in all focus countries, it continues to wield significant influence over focus countries' public health policies" (Cynn, 2010). A key example of this influence is President Museveni's ban on sexual education in public schools (Okello, 2012). Religious leaders, both indigenous and foreign, thus maintain singular control of Uganda's political and social realms, with compelling implications for the future of family planning uptake in the country.

Problem Statement

Adequate reproductive health care is essential to meeting Uganda's SDGs (United Nations Development Program). Because Uganda has one of youngest populations in the world, its growth rate is likely to increase exponentially; thus, widespread utilization of family planning is essential for keeping the population at sustainable levels. In Kapchorwa, however, contraceptive uptake is low, and women give birth on average to two more children than they had initially wanted (Hussain, 2013). This has serious implications for the ability of parents to plan for and support their families. Because religious institutions wield such political power in Uganda and directly speak to so many practitioners, institutions of faith have a tremendous amount of influence on issues concerning family life, but most literature on the subject agrees that these groups do not do enough to promote family planning to their congregations. Increased involvement of religious organizations in spreading accurate information about, and advocating for, family planning could have a remarkable impact on contraceptive uptake in Kapchorwa.

Justification

Access to and uptake of family planning are integral to the development of Uganda and the empowerment of its female citizens. By reducing the number of unplanned pregnancies, increased uptake of family planning diminishes poverty levels and make it easier for families to support the children they already have. Decreasing unwanted pregnancies also correlates with a decrease in unsafe and illegal abortions, in addition to lowering dropout rates for school-aged girls (Fox, 2016). These issues are particularly significant in Kapchorwa, where over 50% of girls below the age of 18 drop out of school to get married or care for their children (New Vision, 2008). In addition, many women in Kapchorwa continue to face obstacles emblematic of a patriarchal culture, including forced circumcision, domestic and gender-based violence, and lack of decision-making power in the home (Oduut, 2017). Improving the availability and usage of family planning methods has shown a capacity for markedly increasing women's self-perceptions and empowerment, particularly in rural areas such as Kapchorwa (Williamson, 1998).

Literature on the subject frequently cites the influence of religious communities in both developing and developed countries as one of the largest barriers to family planning uptake (Barrett, 2007). Although this may seem unsurprising, given the official positions of most Abrahamic religions, quantitative studies indicate that the correlation between an individual's faith and their family planning decisions may be smaller than expected (Kelly, 1983). It is clear that more research is necessary to accurately understand the effects of religion on family planning usage, particularly in developing countries.

Objectives

1. To understand how religious communities contribute to perceptions of different methods

of contraception among various segments of Uganda's population.

2. To evaluate the effectiveness of current family planning advocacy and education in Kapchorwa District.
3. To analyze different pathways for involvement of religious communities in such family planning campaigns going forward.

Literature Review

Although modern contraceptives are widely available throughout Uganda, many women do not utilize family planning. This is an issue that affects all demographics of women: married, unmarried, young, and old. A 2006 study estimated that over a fifth of girls aged 15-19 had already had a child; even among women in union, 60% expressed that they had wanted to wait longer to get pregnant or to not get pregnant at all (Neema, 2006). A study conducted seven years later claimed that of Uganda's 2.2 million annual pregnancies, 1.2 million are unintended (Hussain, 2013). Despite these startling statistics, "one in three married women are not using contraceptives, even though they do not want to become pregnant" (Hussain, 2013). It is clear that family planning must be more effectively utilized, and the disconnect between need and usage addressed, in order for sustainability efforts to improve in Uganda.

Previous studies suggest several reasons for the lack of contraception utilization, despite widespread availability. Significantly, many communities lack an adequate number of trained healthcare providers, who would be responsible for the dispersion of accurate information about sexual health resources (Okuonzi, 2004). Without these vital sources of information in communities, myths and misconceptions can spread rapidly, particularly if women experience the negative side effects frequently associated with contraceptive methods (Gueye, 2015). In a study

of urban Sudanese women, researchers found that “the overwhelming majority of nonusers [of contraceptive methods] ... perceive contraception as a risk to their health and fertility,” largely due to side effects associated with its use (Swar-Eldahab, 1993). A woman may experience side effects associated with hormonal birth control, discontinue the use of the method, and tell her friends of her experiences, thus increasing the likelihood that other women will perceive their risk of side effects to be higher, and decreasing their likelihood of pursuing not only the offending method, but all forms of modern family planning (Swar-Eldahab, 1993). In this way, actual side effects fuel rumors, which increase the perceived risk of the method and drive low levels of contraception uptake.

Religious communities frequently contribute to this cycle of misinformation and misconception. Studies done throughout West Africa have cited many incorrect beliefs about family planning spread by religious leaders. The most notable of these may be the *magun* curse in Nigeria, which Yoruba pastors claim can be placed on condoms to kill those involved in extramarital affairs (Gaestel, 2014). Spiritual leaders, both Christian and Muslim, may also claim that “contraception goes against the will of God,” “it is a woman’s role to bear children,” or that “contraceptives promote sexual promiscuity” (Onwuzurike, 2001). Overall, 38% of Ugandans believe that contraception is “morally unacceptable,” a statistic which the Pew Research Center claims is driven by the country’s high levels of religiosity (Lipka, 2014). Low uptake of contraception is thus directly related to misconceptions about its effects, in addition to beliefs about its morality. These myths and misconceptions are spread by women experiencing or witnessing side effects and may be supported by the teachings of religious leaders; more research is necessary, however, about the extent of this religious influence on family planning.

Methodology

Sampling

Data were primarily collected through focus groups and individual in-depth interviews. 40 community members from Kapchorwa participated in focus groups, and 6 of them were also interviewed individually. Demographic information for the focus group participants is illustrated in Table 1. Participants were selected by community organizers in partnership with the Kapchorwa branch of Reproductive Health Uganda (RHU). Participants were not selected according to religious criteria, but every participant recorded a religious affiliation, and this data was used for analysis. In total, I surveyed 8 Catholics, 19 COU members, 4 Pentecostals, and 9 Muslims. These religious groupings were divided fairly evenly across the six focus groups, and will be discussed at greater length in the Findings section below.²

Table 1. Participant Index

Focus Group #	Gender of Participants	Age Range of Participants	Number of Participants	Location of Focus Group
1	Female	22-28	7	Siron Village
2		30-50	8	Sipi Subcounty
3		56-62	6	Siron Village
4	Male	18-25	6	Kapteret Parish Parish
5		30-45	7	Sipi Subcounty
6		50-88	6	Kapteret Parish Parish

² I chose to use first person pronouns in this report because I formed personal relationships with many of the people quoted in this study. Using the third person in the research product inevitably creates a sense of distance, an “othering” which I actively attempted to minimize during the data collection process.

Interviews were also conducted with key informants in Kapchorwa and in Kampala. These key informant interviews were conducted with religious leaders, local council members, reproductive health workers, and a municipal development officer. Additionally, I attended a meeting of Kapchorwa Secondary School's Gender-Based Violence Club, where I interacted with the student members and club leader. These interviews and meetings were arranged with help from RHU Kapchorwa and the Inter-Religious Council of Uganda (IRCU). A complete list of research participants can be found in Appendix A.

Tools

Focus groups were organized using a pictorial survey (Figure 1), developed in the tradition of participatory rural appraisal (PRA). This method is intended to provide a feedback-centered approach to qualitative research, one in which a study is done *with*, rather than *on*, the population of interest (Mosse, 1994). The survey, developed with the help of RHU Kapchorwa, illustrates six different methods of family planning, both natural and artificial. Surveys were printed and handed out to focus groups. Participants were asked to describe their experiences with each method, explain what they knew about how each method worked, list any side effects they had experienced or heard about, and evaluate the general effectiveness and quality of each method. After discussing each picture, participants were asked more generally about their religious views, the teachings of their churches in regards to family planning, and whether or not they agreed with their religion's doctrine. During the focus group, each participant was asked to share their experiences and to build off of responses from other group members. Throughout the discussion, participants were encouraged to ask questions about the different methods being discussed, in order to create an environment of reciprocal learning.

Figure 1. PRA Focus Group Handout

Instructions

This survey will measure your understanding of different family planning methods. Please read over this handout. You will be asked as a group to discuss each of the methods below, and answer the following questions:

1. What do you know about each method of family planning? Do you have any questions about their uses? What are your personal experiences with each?
2. What do you think about each method? Which ones are safe? Are there side effects? Are there differences in when you would use any of the methods?



Intrauterine Device/IUD/Coil



Birth control pills



Condoms



Injectables



Moon Method



Abstinence

Following the completion of each focus group, participants were asked to choose one group member to be interviewed individually. This sampling method was chosen to reduce any undue burden on the part of the participants; although I was unable to interview some participants whose stories were particularly relevant to my research, I did not want to keep anyone from their work or ask for more time than they could easily afford to give. By asking the participants to select a respondent from amongst themselves, I was also able to gain insight into group dynamics and better understand which stories were deemed most important by group members. Individual interviews were conducted according to the sample question schedule in Appendix C, and typically lasted no longer than thirty minutes. Participants were asked to describe in more detail their family structures, both in their childhoods and in their married lives. Participants were also asked to explain the reasoning behind their family planning choices, and their experiences with both family planning and their religion's reaction to it. These interviews helped to gain valuable insight into individual decisions about family planning, and the stories behind them. Although I initially planned to survey more participants using a questionnaire format, in-depth interviews were ultimately a better fit for this study because they offer the chance to ask follow-up questions, clarify misunderstandings, and hear the individual voices of respondents. After finishing all focus groups and individual interviews, some experts were also interviewed (see appendix D for sample questions).

Data Analysis

During interviews, participant questions and responses were recorded in a notebook and transcribed into a secure file on Google Drive. All participant responses were entered into one file in order to ease data analysis. Names of focus group participants were not recorded in the file

or used in the analysis of the data. After transcription, interviews and focus group responses were re-read and coded for themes surrounding the objectives of the study: reasons for using or not using family planning, types of family planning used and their justifications, and religious and cultural opinions on various methods. Additional categories were tagged within these broad codes. Findings were then compared across sources and combined to create this report.

Ethical Considerations

Due to the personal nature of this study, it was critical that my research adhered to strict ethical guidelines. A consent form detailing the purpose of the study, its methods, and my contact information was provided to and signed by each participant. Participant rights were explained in English, as well as by a Kusabiny translator. All participants in the study were over the age of 18 and able to consent to the study. Medical professionals were nearby during interviews in the event that I felt unqualified or unable to answer a participant's questions in a way that was sensitive to the particularities of Sabine culture. Additionally, participants were reminded regularly that all interview questions were optional.

All participants were assigned an identification number in my field notes, and responses were entered under these identification numbers rather than participant names, unless they consented to having their name published in the report. Data were kept in a secure file accessible only to me. The Human Subjects Ethics form was completed to ensure commitment to ethical standards of research. Information retrieved from this research will also be used in my undergraduate honors thesis, but consent was received from each participant to use their responses in future publications (see Appendix B). No personal information was retained

following the completion of the study. All interviews were completed in private spaces and followed strict standards of confidentiality.

Positionality

As a female white American student, I expected to face many challenges in the data collection process. In particular, I was concerned about my ability to connect with my research participants, as well as about my own personal biases surrounding religious belief. Although I believed it was important to interview both men and women about their family planning choices, I was sure that men, particularly the group in the 50-88 year range, would not be interested in talking to me about their sexual health. I was surprised, in fact, by the ease with which many of my focus groups shared personal details of their lives with me. Beyond issues of positionality in the interview process, I was also very aware of the role that my experiences and biases could play in the analysis of my data. I was raised Roman Catholic in a small, very religious town in the rural American south. I did my best to refrain from inserting my own perspectives into my conclusions, but I acknowledge that doing so to some extent was likely unavoidable.

Challenges

In addition to the challenge of continuously reassessing my positionality throughout the data collection process, I faced several other obstacles during my research. The first challenge was language and translation. Because all research was conducted in rural areas, many participants did not speak English fluently. A male interpreter sat in for all interviews in case translation assistance was needed. Surprisingly, most women seemed to speak freely about intimate details of their lives, despite the presence of an unfamiliar man. It is likely, however, that patriarchal stigma may have affected the data collected from these focus groups, particularly

from the younger, unmarried women. Additionally, the language barrier prevented most participants from being able to read the informed consent form. As a result, my translator was responsible for explaining the form to focus group participants, in a process that was often tedious and very time-consuming.

Another challenge was the limited time frame of the study. Because the material discussed was so sensitive, meeting with each group multiple times would have been invaluable in building rapport and accessing a deeper quality of data. Due to budgetary and time constraints, however, I spent only a week in Kapchorwa, and conducted all interviews and focus groups over a four-day period. Participant recruitment was also difficult with such short notice for community organizers.

Perhaps the biggest challenge to my study was the lack of available information on Kapchorwa District. Few studies have been conducted about family planning or sexual health in the district, and so it was difficult to establish a frame of reference or contextualize my work within a broader body of literature. I had initially planned to analyze the changing availability of family planning in Kapchorwa over time, but even my contacts in Kapchorwa were unable to help me gain access to this information. A longer time frame for the study would also have made it possible for me to explore other avenues for developing this data, either by meeting with historians or other record keepers in Kapchorwa, or if written information truly does not exist, by reframing my study to create an oral history of family planning in the district.

Finally, I faced financial barriers in accessing the community. Although I stated in my consent forms and explained to the participants that there was no financial reward for participating in the study, several women refused to participate without assurance of

compensation. The community organizers explained to me that community members have come to expect compensation from researchers because of the large presence of NGOs in the area, all of which run funded studies. The ethical hurdles of navigating this situation were exacerbated by my positionality - as an American student participating in an expensive study-abroad program, I struggled to balance my responsibilities to my research participants with my own budgetary constraints. Overall, I believe my interviews and focus groups were successful, but could have been improved by even a basic knowledge of the local language, a longer time frame of study, and increased funding.

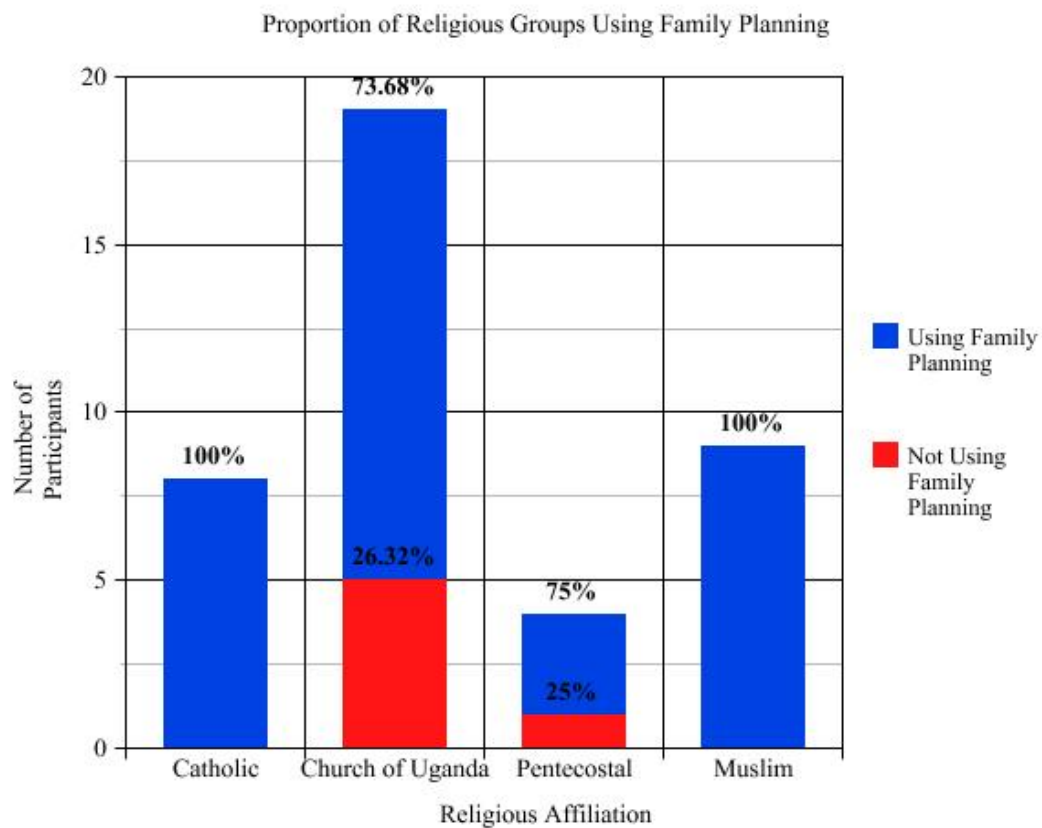
Findings

Data from this study were grouped into three categories: rates of family planning usage, justifications for particular types of family planning used, and religious and cultural opinions about family planning. Initial responses focused primarily on participants' experiences with different family planning methods. After establishing each respondent's opinion of various methods, it became possible to understand how religious background shaped these views. For this reason, the next two subsections of this report primarily describe general trends in family planning usage, with minimal consideration of the speaker's religious background. The third subsection discusses in detail the religious and cultural elements of my results, from the perspectives of both focus group participants and spiritual leaders. After analyzing these data, I spend the fourth subsection examining the results from my visit to Kapchorwa Secondary School, in order to understand the role that school systems and other sources of information play in guiding family planning decisions.

Utilization of Family Planning

The forty focus group participants represented Uganda's four most populous religions: Catholicism, the Church of Uganda (COU), Pentecostalism, and Islam. At the beginning of each focus group, religious affiliation was recorded so that it could be analyzed in conjunction with participant responses. In focus groups, participants were first asked to discuss their experiences with each pictured method of family planning, or describe any other form of family planning they knew about or used. The results, broken down by religion, are displayed in Figure 2.

Figure 2. Proportion of Religious Groups Using Family Planning



From the graph, it is clear that the vast majority of participants, regardless of religious affiliation, were using or had used at least one form of family planning.³ COU members had the lowest uptake rates of family planning possibly because this religious affiliation skewed slightly older and decidedly female, a demographic which the literature states is the least likely to use family planning because of historical barriers to access during their childbearing years (Godfrey, 2011). Nevertheless, almost three quarters of COU respondents indicated familiarity with at least one form of family planning.

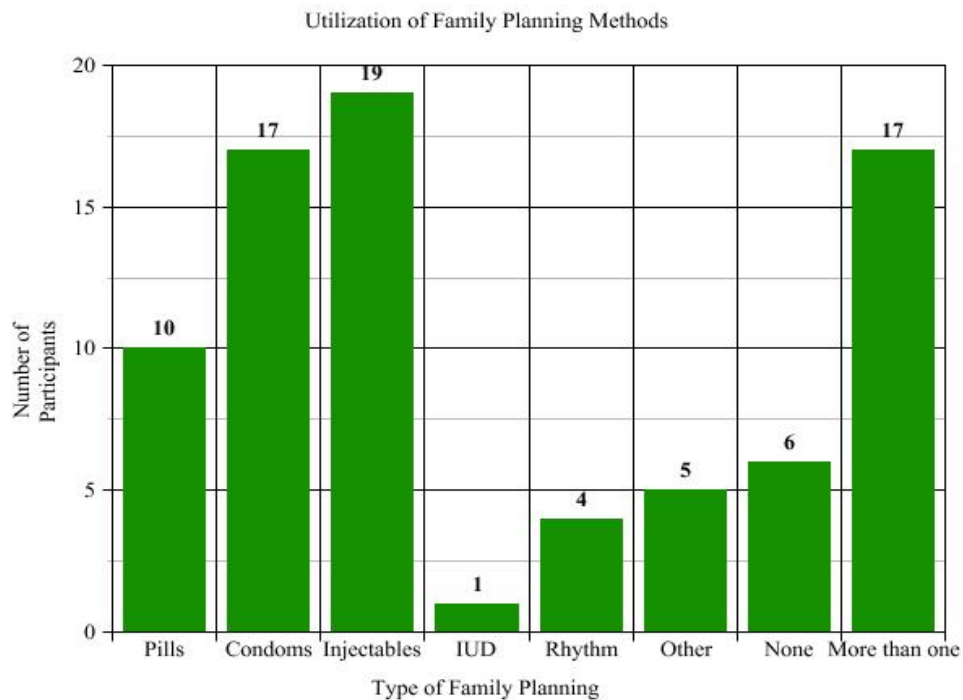
Participants differed on the type of family planning they used most frequently, although this variation did not correlate strongly with religious affiliation. Among artificial methods, almost half of all participants had used injectables, and 67.5% had used either condoms or the pill. Only one woman stated that she had used an IUD in the past, which fits into trends established by the literature on IUD knowledge and accessibility in developing countries (Department of Economic and Social Affairs, 2015). Figure 3, below, illustrates this data. Cutting across religious groups, four participants stated that they regularly used the rhythm method, either separately from or in conjunction with condom use.⁴ In fact, almost half of all respondents claimed to have used more than one type of family planning, whether simultaneously, as with

³ For this study, the definition of “family planning” was intentionally broad: it included any method intended to space or limit the number of children conceived. Thus, abstinence was considered a form of family planning if participants claimed that they were abstinent primarily to prevent conception or space their children. This coding was necessary because the goal of the study was not to follow a Western paradigmatic understanding of “modern” versus “traditional” family planning, but rather to understand the types of family planning most commonly used and the effects of religious culture on those decisions. Because there is a distinct difference between purposeful abstinence and not planning one’s children at all, abstinence was considered a method of family planning. Similarly, adherents of “traditional” or “natural” family planning methods were coded as practicing family planning.

⁴ Many respondents were not familiar with the rhythm method, but recognized the terms “moon beads” or “counting days.” “IUD” was also more frequently recognized as a “coil,” highlighting the need for local assistance in compiling research terms.

those who supplemented the rhythm method with condom use, or subsequently, due to dissatisfaction with a particular method.

Figure 3. Utilization of Family Planning Methods



Of the “other” methods discussed, one woman claimed to have had success with lactational amenorrhea; other common responses included tubal ligation, the progestin IUD/implant, and the withdrawal method. Additionally, one young woman in Focus Group #1 described a method her mother used, before she “got educated and opened her eyes to *real* family planning”:

You have a baby and you cut the cord. Dry the cord and put it in a box, like an empty matchbox. Place it among the stones in the hearth. Then you light a fire like normal. You won’t have a baby until you remove the box from the stones - one year, five years, whatever you want. That’s what my mom did.

Participants of the focus group laughed when the young woman finished telling her story, but many of them agreed that they had heard of similar practices, whether or not they believed in their effectiveness. The next section will expand upon the role of traditional family planning methods, while also describing the advantages and disadvantages of modern family planning most frequently mentioned by participants.

Justifications for Various Family Planning Methods

Almost every focus group participant, regardless of religious affiliation, agreed that family planning had had a positive effect on their lives, or more broadly, on the development of Uganda. “You can buy land, build a business, and care for your husband if you don’t have too many children,” said one middle-aged woman in Focus Group #2, emphasizing the holistic benefits that family planning can have on women’s lives. Women and men alike focused on the economic benefits of spacing and limiting children, citing the rising costs of school fees and Kapchorwa’s worsening land shortages. Many older respondents reflected on positive changes in family planning perceptions and usage over time, including this man from Focus Group #6:

People used to have many children because there was a lot of land. Seven or eight children was good, because they could be soldiers for their tribe. Ugandan culture meant having many kids, in case some of them died or turned out to be thieves or bad kids. Now, school is expensive and land is little. We need to have smaller families - maybe two [children] are enough. ... When I was young, women used traditional methods, but they were very dangerous and ruined women’s wombs. They encouraged witchcraft, so as I grew older they died out and were replaced with more modern methods.

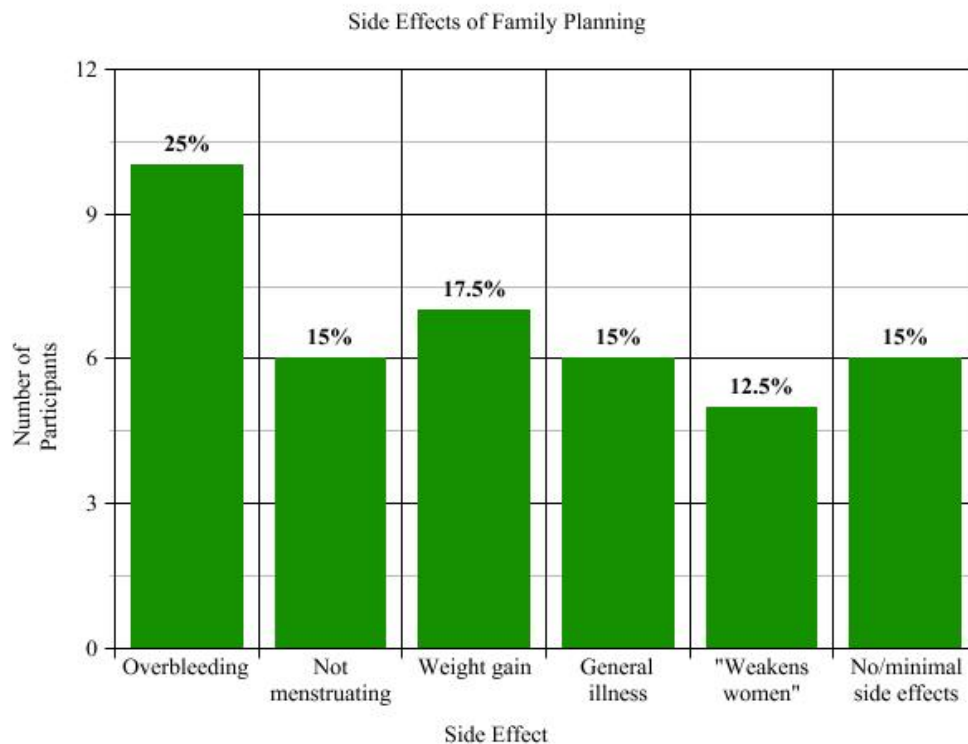
Though some still used traditional practices, many women agreed that modern family planning, whether natural or artificial, was more effective and less dangerous than the herbs or other methods previously employed.

Although most participants agreed that modern family planning was beneficial, opinions differed as to when specific methods were most appropriate. Each of the three male focus groups explained that condoms could only be used outside of the context of marriage. Over half of the men surveyed claimed that condom use was synonymous with cheating: condoms were good to use with extramarital partners, because they “prevent[ed] disease from entering the home,” but conversely, if their wives insisted on condom use, they would assume that they also had other partners. Interestingly, this also did not correlate to a specific religion, implying that extramarital affairs are common regardless of religious affiliation. Women focused on the negative health effects of using family planning with men other than one’s husband, claiming that “sleeping outside of the marriage with a coil [IUD] causes cancer” and “if your husband is cheating and you use family planning, it will cause you to get syphilis.” Although some of these misconceptions could be corrected with increased sexual education programs (as discussed in a later section), they are also indicative of broader cultural ideas concerning promiscuity and family planning, which some claim have been exacerbated by President Museveni’s abstinence-only education policies (Cynn, 2010).

Many participants were eager to describe the benefits and drawbacks to each method they had sampled. Condoms and the rhythm method proved to be the most polarizing, with many respondents advocating for both their advantages and disadvantages. Both men and women claimed that their spouses got no pleasure from sex when condoms were used, stating alternately

that “men don’t like to use condoms,” “women aren’t satisfied with a barrier,” and “there is no sweetness between partners if a condom is used.” Men in particular, however, claimed that condoms were the best method of family planning, because they prevent both sexually transmitted infections (STIs) and unintended pregnancies. Men primarily cited the rhythm method as having major drawbacks, particularly for the self-control necessary for its implementation. Many men claimed that they did not like having to abstain during a woman’s fertile time, and stated that it was sometimes difficult to keep track of “safe days” and “danger days.” Women seemed satisfied with the rhythm method, however, and praised it for being natural, rather than “like taking drugs.” Because most respondents had experience with multiple types of family planning, almost all were able to identify a favorite method that fit best with their lifestyle.

Figure 4. Side Effects of Family Planning



The majority of participants who had never used family planning, or who had utilized a method in the past but discontinued use, cited negative side effects as the biggest disadvantage of family planning as a whole. 85% of respondents claimed to have directly experienced at least one serious side effect of modern family planning, while several others said that the stories of their friends prevented them from wanting to try family planning for themselves. The most common side effects mentioned, as shown in Figure 4 above, were overbleeding (25%), weight gain (17.5%), not menstruating (15%), and general susceptibility to illness (15%).

Another side effect, mentioned only in male focus groups, was that hormonal family planning methods “weaken women.” Over a quarter of all men surveyed claimed that the side effects of modern family planning prevent women from doing work around the house, saying that “it makes our wives weak and sickly ... even to the point where it would be better just to have more children, so at least they will want to work.” The implications of this statement are important, as studies have shown that the involvement of men in family planning promotion is essential to its acceptance and continuation (Vouking, 2014). If men believe that using family planning will require them to hire additional house help to make up for the lost working capacity of their wives, they may be more likely to discourage its use, thus decreasing family planning uptake in general.

Other reasons for not using family planning were both cultural and practical. A catechist at St. Paul’s Catholic Church in Kapchorwa recognized the positive effects that smaller families could have on development, but still had questions about family planning:

Why should we emphasize family planning when there are so many deaths in the world? Road accidents, malaria, cancer, all finishing us - who will replace those

who are dying?

Another older man from Focus Group #6 had similar reservations, stating:

It is not Sabine culture to use family planning - why would we want to? We are very few in number, so we should be trying to increase. We need to produce so many more Sabine to maintain our culture. Do you not think the same things in America?

This focus on large families in order to preserve culture is supported by the literature, and by historical population trends (Pernia, 1982). Additionally, although almost every participant surveyed supported family planning for married couples, providing access to contraception for school-aged girls was a much more divisive subject. The male focus groups in particular were highly divided, with some encouraging their daughters to practice safe sex, and others convinced that the side effects of hormonal birth control were worse for their children than pregnancy. One man in Focus Group #5, participating in an animated debate between group members about the proper time for beginning family planning, made a well-received point, stating “You can’t keep girls from having sex, so at least let them be protected.” After hearing this, the men continued to argue, but ultimately agreed that it was acceptable for girls to use condoms and perhaps the pill while still in school. This exchange emphasizes the importance of community dialogue; although I had done my best to convince the men that their fears about birth control in young women were unfounded, it was the reassurance of a respected community member that changed the men’s minds.

Although most participants used family planning, individual experiences were mixed, particularly because side effects were so varied and in several cases, so debilitating. Participants

explained the cultural justifications for using certain methods and not others, depending on the situation. Most participants agreed on the significance of particular methods, and believed that predominantly married couples should have access to family planning. The next section investigates the role of religious culture in shaping these beliefs.

Religious Opinions of Family Planning

This section examines the beliefs of each religion represented in my sample. First, participants and religious leaders explain what their religion officially teaches about family planning. Next, they give their thoughts about these teachings, describe whether or not they follow them, and explain why. A discussion of public and private religious teachings follows later in the report.

Catholicism

Catholic leadership in Kapchorwa publicly reflected the official positions of the Vatican on most aspects of family planning. Father Oyengo Joseph at St. Paul's Catholic Church explained, "We encourage smaller families and the education of children as responsible parenthood, because it's easy to give birth but hard to care for a family." His catechists reiterated the importance of only having as many children as you can care for, but warned against:

... using drugs that interfere with nature and God's blessings of procreation.

Some people have too many children. That is true. But God has a plan for them

all and will provide. Just carry on, because every child who comes is God's gift.

Father Joseph emphasized the discipline required for effective use of the rhythm method, claiming that "using moon beads requires respect of and for both partners. ... Men have to learn

self-control.” He conceded that condoms were sometimes appropriate, however, particularly if one partner in a marriage was HIV positive while the other was negative. Generally, though, artificial family planning was not considered acceptable for Catholics in the ranks of the Church.

Focus group participants agreed with some of these points, but many Catholics stated that the Church was much more lenient than the leadership had suggested. Although most of the female participants believed that Catholics did not accept artificial family planning, men across all age groups claimed that the Church actively promoted injectables and condom use because “with the problems of today, what are their other options?” It did not seem to matter, however, if participants believed that their religion supported or forbade modern methods - even among those who believed that the Catholic Church said family planning was a sin, 100% of Catholic participants reported using a form of birth control in the past.

Church of Uganda

COU participants used family planning at the lowest rate of any religious group surveyed, although many participants believed that their church leadership was supportive of modern methods. Responses were highly varied, however; one woman attends a church that promotes “living a natural life” without family planning or vaccinations, while another stated that her pastor frequently tells his congregation that “family planning is the only way to prevent the next generation from becoming squished by the high population.” Several COU participants argued that “the Church of Uganda is focused on societal problems, so it is up to you to decide about your family,” which aligns with the official position of Anglican doctrine (Harries, 1996).

All participants whose pastors spoke positively about family planning reported that they felt secure in their decision to use these methods, but claimed that they would continue to use

artificial family planning even if their religion were to condemn it. Of the five COU women who did not use family planning, two were newly married and actively trying to have children, one was postmenopausal and said that she did not have access to family planning during her child-bearing years, and two said that their churches promoted natural lifestyles that did not even allow for the rhythm method. Of the women using family planning, only one stated that she exclusively used the rhythm method, primarily for religious reasons. All other women had used artificial methods at some point in their lives.

Pentecostalism

Pentecostalism as a belief system is incredibly varied, and as my study included just four Pentecostal participants, it is difficult to make meaningful claims about family planning perceptions among Pentecostals as a whole in Kapchorwa. With that acknowledged, valuable insights can still be gleaned from my work with key informants, and the openness of the Pentecostal focus group participants. I worked primarily with members of Pastor Henry Arapahi's Christ Alive Glorious Church in Kapchorwa Town, and interviewed the pastor at length about his church's opinion of family planning. Pastor Henry agreed that family planning was a positive development in many people's lives, because "due to modern economic demands, it can be too difficult to have even two or five children." In a similar vein as many other religious leaders surveyed, the pastor primarily advocated for natural family planning methods, but admitted that his wife used injectables for several years and that they worked well for her "until [they] found out she was four months pregnant - because God had willed it."

Members of Pastor Henry's church and other Pentecostal churches in the area made similar points about the "proper" Pentecostal view of family planning. A young woman in Focus

Group #1 claimed that “the Bible says to be fruitful and multiply ... God doesn’t like family planning.” An older woman in Focus Group #2 stated that “when you use family planning, it’s like you’re a murderer, because you’ve prevented sperm from reaching the egg.” This led to an intense debate among the women, who ultimately concluded that “sometimes, what we learn in Church is different from what we have to do for our families.” This statement was surprising, but the idea of separate spiritual and practical realities recurred frequently throughout the study. Indeed, although all four Pentecostal focus group members claimed that their churches did not support family planning, or only advocated for the rhythm method, three members reported that they primarily used artificial methods regardless.

Islam

In literature on family planning, Muslims are regularly cited as having one of the lowest uptake rates of any religious group (Barcelona, 1985). It was surprising, then, that 100% of Muslim men and women surveyed claimed to regularly use family planning. Kasmart Ismail, an imam in the district, discussed his own use of family planning with me as an example of how Muslim culture is changing:

I want eight children, but I can’t afford to educate them. I have three now and it is already difficult. In the past, there was a focus on big families, but now I believe that women should not get married before the age of 25 - they need to be educated and know how to manage the home. ... The Quran allows for family planning if the spouses agree, if the man allows the wife. Family planning is not so bad, but it depends on the method.

This interpretation of family planning permissibility in the Quran seems very progressive, but is perhaps growing more common. All Muslim participants stated that their mosques officially do not allow for family planning, but that they themselves, and many of their friends, utilize artificial methods. Focus Group #4 consisted primarily of young Muslim men, all of whom claimed to regularly use condoms, and who were familiar with other methods. A young mother in Focus Group #2 explained her choice to use injectables:

I use family planning even though the imam says it is wrong. We want to space our children, to have good children who we can care for well. My husband is not financially stable - we can't care for ten children, we have to modernize our family. At the end of the day, if you've produced them, you must take good care of them.

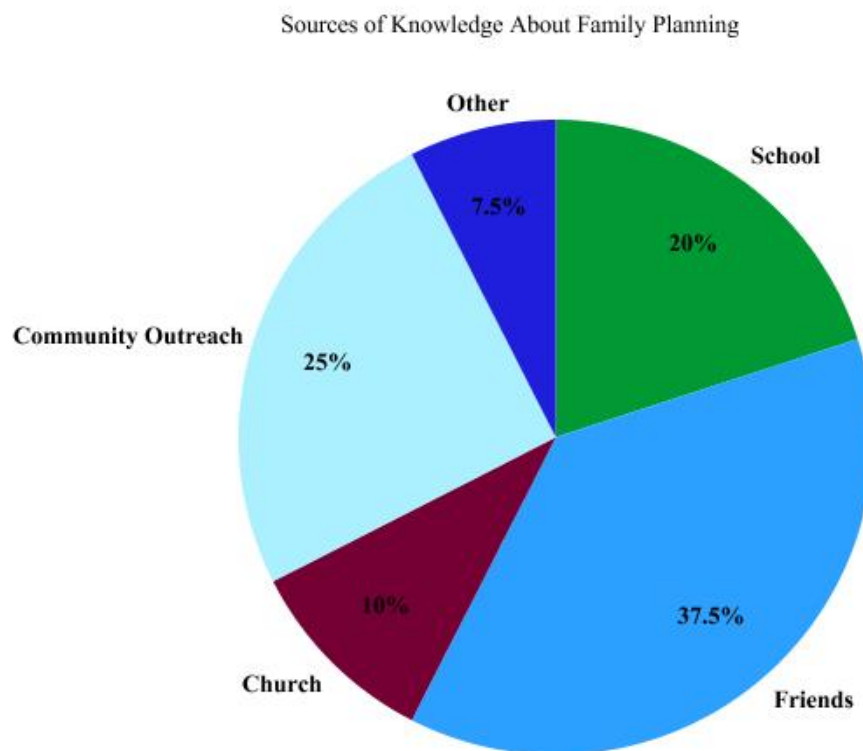
Focus group members cited increasing community sensitization and involvement of clinics and hospitals as the driving force behind rising family planning uptake. 80% of Muslim members stated that even if their mosques were to expressly forbid the use of artificial family planning methods, they would still incorporate them into their lives.

Sources of Knowledge About Family Planning

A common problem cited in family planning literature is the lack of quality sources of information in rural communities (Oye-Adeniran, 2006). For this reason, I asked each participant to list their primary source of knowledge about family planning. This information is displayed in Figure 5. A plurality of participants (37.5%) claimed that they learned the most about family planning from their friends, which is consistent with previous studies about the spread of misconceptions about contraception in developing communities (Gueye, 2015). A quarter of

participants prioritized knowledge gained from community outreach, which is promising given the increased funding that these outreach programs are receiving, but still not at the level that many community organizers would wish. A fifth of participants referenced school as their primary source of information, which is concerning given the acknowledged issues with the abstinence-only policies promoted by President Museveni (Murphy, 2006). Only 10% of participants said that they got the most information from their churches or places of worship, which could have implications for the role of religion in determining family planning usage. Other sources of information included family members and local council leaders.

Figure 5. Sources of Knowledge About Family Planning



Discussion & Recommendations

Effectiveness of Family Planning Campaigns

In the following section, I will analyze the effectiveness of Kapchorwa's family planning campaigns. I will primarily analyze campaigns stemming from two of the most influential sources of information from the last section: schools and community outreach. I will not focus in this section on the most common source of knowledge, friends. Much literature has already been written about the role of peers and family members in spreading myths and misconceptions about family planning and it is unnecessary to retread those issues here. Additionally, community outreach and sexual education in schools are the sources of knowledge that can be most easily and directly targeted for improvement by outside organizations. This section will also refrain from analyzing religious campaigns or workshops, because only 10% of participants reported getting the majority of their information from church; instead, spaces in more influential education campaigns will be identified for potential religious involvement.

Family planning community outreach in Kapchorwa, particularly flyers and billboards, are generally effective at relaying information and are highly touted by development organizations, but may have unintended effects in their evocations. Several interviewees, including key informants and religious leaders, stated that USAID-sanctioned billboards promoting Injextaplan, a common brand of injectable contraceptive, made family planning seem like a capitalist product rather than a social good (Okello, 2002). In the words of Father Gabriel, "When women go for these things, they're not told about the side effects, because these people are only interested in marketing and selling their products. See the billboard?" In this way, advertising can raise awareness of different birth control methods, while contrarily turning some

people away from potentially beneficial types of family planning; half of women surveyed who did not use Injectaplan stated that the omnipresent billboards had made them wary of the product.

Besides billboards and posters, NGOs spend most of their time and resources attempting to influence family planning in Uganda's schools. Information about family planning in Ugandan schools is limited to abstinence-only education, although outside organizations and NGOs are conditionally allowed to provide more comprehensive classes (Okello, 2012). I attended a meeting of Kapchorwa Secondary School's Gender-Based Violence Club, consisting of 28 boys and girls from S1-S4, in order to better understand the role of school programs in contributing to students' knowledge and misconceptions about contraception.

At the meeting, I asked students to write down their opinions about family planning, and any questions they had about relationships, puberty, or sex. These responses were anonymous. After receiving the questions, I read them out loud and did my best to answer them, with help from a representative of RHU Kapchorwa. Students most frequently asked about the causes of cervical cancer, the side effects of family planning in young people, normal patterns of menstruation, and "since using a condom is not 100% effective, is using more than one condom more protective and healthy?" Many questions and general comments about family planning reflected dangerous misconceptions, however. For example, three students asked "is it true that if you have sex during your period, you won't get pregnant?" while two others wondered if urinating after sex prevents pregnancy. 19 students criticized family planning for negative side effects that are not empirically proven, saying that "those pills we girls swallow cause cancer" and "family planning destroys your fallopian tubes." Only two students said that family planning

had generally positive effects, while 35% of the students surveyed claimed that family planning was entirely negative. This club meets specifically to discuss healthy relationships and issues regarding culture and family, and has hosted several NGOs and speakers to discuss family planning. The consistently negative perceptions of family planning, and the presence of so many misconceptions, is concerning, and has serious implications for future trends in family planning uptake.

Focus group participants also asked about misconceptions, many of which they claimed to have learned in school. All of the young men in Focus Group #4, who had attended various secondary schools around Kapchorwa, stated that during school lectures their headmasters had told them numerous times that “condoms caused cancer if used recklessly.” Adolescent males are the demographic most likely to have multiple partners, and thus are at a high risk for contracting STIs; consistent and correct condom use is thus essential to avoid climbing infection rates (Gusman, 2009). By actively disseminating misinformation about family planning or doing little to stop its spread, schools are doing a disservice to the students they are meant to help.

Although the secular donor consensus tends to reject religious involvement in sexual education, Uganda’s spiritual communities are perfectly positioned to improve the country’s knowledge of family planning. Most religious leaders I spoke to acknowledged that family planning is a developmental necessity, but did not prioritize educational campaigns for their congregations. Many leaders stated that they would be interested in advocating more strongly for natural family planning methods and in some cases, condom use. Some would also be willing to engage in leading sexual health lectures for adolescents, and expressed shock at the misconceptions that students reported about menstruation, pregnancy, and sexuality. Involving

religious institutions in family planning education thus might not improve awareness of artificial family planning methods, but it would provide an additional and widespread platform for the dissemination of accurate sexual health information at a basic level. Although religion and culture may constrain full representations of human sexuality, increasing the number and range of institutions willing to provide more accurate information about family planning and relationships is clearly beneficial for sexual health knowledge. Mobilizing and leveraging religious communities in this way could fill the knowledge gap currently seen in sexual health education in Kapchorwa's secondary schools.

Public and Private Religious Teachings

One issue that came up consistently in both focus groups and key informant interviews was the dichotomy between the public and the private teachings of religious leaders. Many participants reported hearing strongly negative information about artificial family planning methods in religious services, but being counseled differently when meeting with spiritual leaders individually. Even in my own interviews, religious leaders stated that they understood “the situation in families is maybe different from what the Bible says.” Father Joseph at St. Paul's Catholic Church explained that although he promotes the rhythm method among his congregation, “Kapchorwa gets very cold at night” and self-control can be difficult. A catechist at the same church claimed that “if people are using artificial methods secretly, we don't discourage it.” Similar responses among other religious leaders makes for a compelling argument: as many focus group participants claimed, the positions of religious institutions may be much less black-and-white than their official doctrine suggests.

My final interview was conducted with Madame Tegulwa Nageeba Hassan, the national coordinator for women's affairs on Uganda's Muslim Supreme Council. Madame Hassan discussed with me the challenges she continues to face in promoting family planning among religious communities. She described a meeting with a prominent imam, who had privately complimented her advocacy and confirmed its necessity, but who refused to speak to his mosque about the issues. After much cajoling, she convinced him to advocate for family planning - only natural methods and condoms, and only for married couples - at a conference of religious leaders from across Uganda. The imam was the final leader to speak on a panel about family planning, in which all previous participants had spoken negatively about the use of contraception. The imam kept his promise and publicly supported family planning in certain situations, citing the potential advances for Uganda's development as well as benefits for individual families. He received a standing ovation from the other panelists for his speech, which "publicly stated realities that many other religious leaders recognized but could not say." This story encapsulates key cultural challenges, as the perceived cost of speaking contrary to official doctrine can be too high for religious leaders to risk lending vital support to family planning advocacy. By working to dissolve the boundaries between public and private teachings, religious leaders could more adequately meet the needs of their believers while furthering Ugandan development in a significant way.

Conclusion

This study has three primary outcomes. First, religious influence on family planning decisions could be less significant than the literature suggests. Second, current family planning advocacy and sexual health education in Kapchorwa District is insufficient for an adequately

educated and empowered population. Third, religious communities have clear pathways to involvement for both improving reproductive health education among adolescents, and more closely aligning their teachings with the needs of their communities, thus making religion more relevant to the lives of their congregations.

It is clear from my research that families in Kapchorwa prioritize the limiting and spacing of their children over any potential disapproval of their churches. Frequently, however, knowledge and accessibility of family planning resources is scarce, due to misconceptions about contraception's side effects, a dearth of qualified healthcare workers, or the intentional or unintentional spread of misinformation by various institutions. Significantly, religious organizations are not to blame for the majority of these barriers; rather, systemic issues, like a government-wide focus on abstinence-only education, have made it difficult for other solutions to overpopulation and female disempowerment to come to the foreground. Scholars frequently conflate these issues or perceive sub-Saharan Africans as clinging to religious belief or an "enchanted imagination" incompatible with development; my research hopes to show that there is much more nuance and agency present in religious and sexual health decisions made in Uganda (Gifford, 2015). In reality, Ugandans and their religious organizations consciously make choices in navigating issues of development which have the potential to transform family planning advocacy and benefit ordinary families in enormous ways. Involving religious communities transparently in family planning advocacy has important implications for contraceptive uptake across the country; in Kapchorwa, this could change the lives of women and girls through education and empowerment.

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Appendices

Appendix A: Table of Interview Participants

1. 22 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
2. 28 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
3. 26 years old, female, student, Pentecostal, Siron Village, April 5th 2018
4. 26 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
5. 23 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
6. 22 years old, female, teacher, Church of Uganda, Siron Village, April 5th 2018
7. 23 years old, female, teacher, Church of Uganda, Siron Village, April 5th 2018
8. 62 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
9. 56 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
10. 60 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
11. 58 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
12. 61 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
13. 58 years old, female, farmer, Church of Uganda, Siron Village, April 5th 2018
14. 50 years old, male, Muslim, Kapteret Parish, April 5th 2018
15. 76 years old, male, Catholic, Kapteret Parish, April 5th 2018
16. 50 years old, male, Church of Uganda, Kapteret Parish, April 5th 2018
17. 55 years old, male, Catholic, Kapteret Parish, April 5th 2018
18. 55 years old, male, Muslim, Kapteret Parish, April 5th 2018
19. 88 years old, male, Muslim, Kapteret Parish, April 5th 2018
20. 20 years old, male, Muslim, Kapteret Parish, April 5th 2018
21. 25 years old, male, Catholic, Kapteret Parish, April 5th 2018
22. 20 years old, male, Muslim, Kapteret Parish, April 5th 2018
23. 24 years old, male, Catholic, Kapteret Parish, April 5th 2018
24. 18 years old, male, Muslim, Kapteret Parish, April 5th 2018
25. 18 years old, male, Muslim, Kapteret Parish, April 5th 2018
26. 40 years old, male, Catholic, Sipi Subcounty, April 6th 2018
27. 30 years old, male, Church of Uganda, Sipi Subcounty, April 6th 2018
28. 35 years old, male, Muslim, Sipi Subcounty, April 6th 2018
29. 43 years old, male, Catholic, Sipi Subcounty, April 6th 2018
30. 45 years old, male, Church of Uganda, Sipi Subcounty, April 6th 2018
31. 35 years old, male, Pentecostal, Sipi Subcounty, April 6th 2018
32. 31 years old, male, Church of Uganda, Sipi Subcounty, April 6th 2018
33. 50 years old, female, Church of Uganda, Sipi Subcounty, April 6th 2018
34. 38 years old, female, Church of Uganda, Sipi Subcounty, April 6th 2018
35. 30 years old, female, Muslim, Sipi Subcounty, April 6th 2018
36. 50 years old, female, Catholic, Sipi Subcounty, April 6th 2018

37. 30 years old, female, Church of Uganda, Sipi Subcounty, April 6th 2018
38. 48 years old, female, Pentecostal, Sipi Subcounty, April 6th 2018
39. 36 years old, female, Catholic, Sipi Subcounty, April 6th 2018
40. 41 years old, female, Pentecostal, Sipi Subcounty, April 6th 2018
41. Betty Alilo, Community Development Officer at Kapchorwa Municipal Offices, April 6th 2018
42. Chelimo Flora, Chief Nursing Officer at Kapchorwa Hospital, April 6th 2018
43. Patrick Kamutya, catechist at St. John Catholic Church in Kapchorwa, April 7th 2018
44. Father Oyengo Joseph, priest at St. John Catholic Church in Kapchorwa, April 7th 2018
45. Pastor Henry Arapahi, founder of Christ Alive Glorious Church in Kapchorwa, April 7th 2018
46. Kasmart Ismail, imam in Kapchorwa, April 7th 2018
47. 28 students from Kapchorwa Secondary School's Gender-Based Violence Club, April 7th 2018
48. Nageeba Hassan, National Coordinator for Women's Affairs at the Uganda Muslim Supreme Council, April 27th 2018

Appendix B: Informed Consent Form

Title of the Study: Religious Influences on Family Planning in Kapchorwa District, Uganda

Researcher: Sarah Mathys, School for International Training

My name is Sarah Mathys. I am a student with the SIT Development Studies program in Uganda. I would like to invite you to participate in a study I am conducting. Your participation is voluntary. Please read the information below and feel free to ask questions about anything you do not understand before deciding whether to participate. If you decide to participate, you will be asked to sign this form, and will be given a copy.

PURPOSE OF THE STUDY

The purpose of this study is to explore the influence of Uganda's religious culture on contraception knowledge and usage in Kapchorwa and Kampala. The research collected will be analyzed and presented in a formal report to be reviewed by the School for International Training.

STUDY PROCEDURES

Your participation will consist of one survey, which will take place in a focus group of five of your peers. This survey and brief discussion will take less than 90 minutes of your time, and will be audio recorded. After the focus group, you may also be selected for an in-depth interview. This will take place on a day following the focus group and will take less than 60 minutes of your time.

POTENTIAL RISKS

Risks associated with participation in this study are minimal. All information collected will be handled with the utmost care, in order to uphold high standards of confidentiality, privacy, and anonymity. Compensation for participation will be provided in the form of snacks and beverages at focus group meetings, and transportation to and from those meetings if required. There is no financial reward or cost to participating in this study.

POTENTIAL BENEFITS

You are unlikely to experience any immediate benefits from this research study. It is hoped that the study will eventually lead to more accessible and accurate information regarding reproductive health, but this is a long-term goal and one that will not directly impact you as a participant.

RIGHTS NOTICE

In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time you feel that you are at risk or exposed to unreasonable harm, you may terminate your participation in any interview or focus group. Please take some time to carefully read the statements provided below.

- a. *Privacy* - All information you present in this interview will be recorded and safeguarded. You may request at any time for any information you provide to be omitted from the

report. Additionally, if the researcher identifies information that they believe could put you at risk, it will be excluded from the report.

- b. *Anonymity* - Names will not be recorded by the researcher. Identifying information will be protected and only accessible to the researcher. If you are directly mentioned in the report, it will be with a false name, unless you request to be identified.
- c. *Confidentiality* - All names and responses will remain completely confidential and fully protected by the interviewer.

If you have questions, concerns, or complaints about your rights as a research participant or the research in general and are unable to contact the researcher, please contact the Institutional Review Board at the following:

School for International Training
Institutional Review Board
1 Kipling Road, PO Box 676
Brattleboro, VT 05302-0676 USA
irb@sit.edu
+1 802-258-3132

CONSENT

By signing below, you give the interviewer full responsibility to uphold this contract and its contents. You have read the above and understand its contents, and you acknowledge that you are 18 years of age or older.

Participant's Name (Printed)

Participant's Signature and Date

Interviewer's Name (Printed)

Interviewer's Signature and Date

If you consent to any of the following, please indicate your consent by initialing on the line.

_____ (initial) I consent to having photographs taken and published.

_____ (initial) I consent to having my name published in the report.

_____ (initial) I consent to having the information I volunteer used in future publications.

_____ (initial) I consent to having this interview audio recorded.

RESEARCHER'S CONTACT INFORMATION

If you have any questions or want to get more information about this study, please contact me at sm2983@georgetown.edu or +256 75 899 2275.

Appendix C: Sample Interview Questions - In-Depth Interviews

1. Demographic Information
 - a. Age
 - b. Education level
 - c. Career
2. Family Structure
 - a. Number of children
 - b. Number of siblings
 - c. Describe the ideal Ugandan family structure. How many children?
 - d. Describe your relationship - are you married? When did you get married/have your first child?
 - i. For women only: Is your husband living? How much support does he give you?
 - e. Did you/do you want a big family? How many kids? Why?
 - f. Do your children go to school? Have you ever struggled financially to support them? Did this have any impact on the number of children you decided to have?
3. Religion
 - a. Describe your religious practices. Are you Catholic, Anglican, or a different Christian denomination? Muslim? Or do you practice traditional religion?
 - b. How often do you attend religious services?
4. Family Planning Use
 - a. What is your opinion about family planning/contraception? What are some benefits and drawbacks? What do your friends think? What does your church teach?
 - i. For men - would you support your wife/girlfriend using family planning?
 - ii. For women - do you make decisions about family planning? your husband? the two of you together?
 - b. Do you/have you used any of the methods discussed in the focus group? Where do you get information about these methods?
 - i. Do you use other, traditional/natural methods of family planning?
 - ii. What do you think about modern methods of contraception?
 - c. Does your culture/religion affect what you believe about family planning/your decision to use family planning?

Appendix D: Sample Interview Questions - Key Informant Interviews

1. Demographic Information
 - a. Age
 - b. Education level
 - c. Career
2. Nurse
 - a. Knowledge of contraception
 - i. Tell me about your education. What degree program did you pursue? How long did you study? What did you specialize in?
 - ii. Pretend that I am a woman coming in to your clinic asking about contraception. Tell me about my options - how they work, what they do in the body, and which ones you recommend.
 - b. Perceptions of family planning
 - i. Do you think it's good to have a big family in Uganda? Why?
 - ii. Tell me about traditional methods of family planning/controlling fertility.
 - iii. What do you think about modern family planning? Is it good for Uganda? Why or why not?
 - c. Cultural and religious influences
 - i. What are some reasons women give for not wanting to use contraception?
 - ii. Do you think religion and culture have an influence on women's desire to use contraception?
3. FBO worker, Cultural Leader, Religious Leader, Political Leader
 - a. Knowledge of contraception
 - i. Look at the six types of contraception on the paper. Briefly tell me what you know about each type.
 - ii. Tell me about your experiences with family planning. Have you or your wife used any contraceptive methods?
 - b. Perceptions of family planning
 - i. Do you think it's good to have a big family in Uganda? Why?
 - ii. What do you think about family planning? Is it good for Uganda? Why or why not?
 - c. Cultural and religious influences
 - i. Are there traditional practices that you think affect how people perceive family planning?
 - ii. Would you be an advocate for family planning in your community? Why or why not?