Understanding Perceived Barriers to Contraceptive Use Through an African Feminist Lens: A Qualitative Study in Luweero, Uganda

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Abstract

Background

Gender equality and ensuring the equal rights of women and girls is the fifth United Nations Sustainable Development Goal set for 2030. Access to quality reproductive healthcare and information is a critical aspect of gender equality, including access to information about family planning and contraceptives. However, there are many barriers that impact a woman's access to contraception in rural sub-Saharan Africa, such as financial constraints, supply shortages, stigma, and misconceptions. Through and African Feminist lens, this study examines how these perceived barriers intersect with each other, and how they negatively impact women's access to family planning and their perceived value of contraceptives in Luweero, Uganda.

Methods

This qualitative study analyzed data collected from healthcare workers at one private clinic and one public clinic that offer family planning services in four focus group discussions in Luweero, Central Region, Uganda. Two focus group discussions were held in each clinic. Coded transcripts were analyzed using a reflexive methodology through an African Feminist lens.

Results

Most of the responses indicated that financial constraints experienced either by the clinic or the women significantly impact access family planning. Healthcare workers and Village Health Teams (VHTs) reported that funding constraints impact their ability to reach the clients with the resources they need in the rural areas, and clients in rural areas are often not able to afford the cost of family planning methods, especially when

considered with the hidden costs of contraception. Social barriers were also discussed, and the participants explained that barriers such as stigma, misconceptions, lack of knowledge, religiosity and cultural values impact women's motivation or ability to access contraceptive methods. Side effects also have a significant role to play in women's ability or motivation to navigate through these perceived social barriers. Participants determined that increased funding for transportation for VHTs, consistent funding for free contraception, and expanded sensitization efforts that particularly target men would be some of the most impactful methods they can adapt to address some of these barriers.

Conclusion

This study demonstrates that increasing women' access to contraception in rural Uganda requires increased state funding for sensitization efforts and subsidized contraceptive methods. Social barriers can be more deeply understood and addressed by the international development community through an African Feminist lens, which explores modern contraceptives in the Ugandan context in a more culturally, socially and historically conscientious way.

Keywords: Contraceptive use, Women's health, Sexual health, Family planning counselling, African feminism, Qualitative research

Chapter 1 Introduction

1.1 Introduction

Winding down the dirt road on the back of a boda bike through a village in Luweero, I was eager to visit Shanti birth house for the first time and introduce myself as a Canadian graduate student. Three years ago I had the opportunity to work in Uganda for six months as an intern with Global Affairs through their International Youth Internship Program, and a couple of the interns in our cohort spent their placement there. While I worked in a community library, my colleagues shared stories of their experience at the birth house with me and I became interested in Shanti's work. During this time, through my personal relationships and research I learned about Uganda's exceptionally high birth rate, one of the highest in the world at 5.8 children per woman of child bearing age (The World Bank, 2017). The question about the accessibility of reproductive healthcare has been a topic of serious debate in the international development community, especially in the Sub Saharan African context where fertility remains very high (Okonofua, 2007; Schatz & Williams, 2012; Van den Broeck, 2020). Approximately 41% of women of childbearing age in Uganda face barriers to seeking contraception, particularly for women living in rural areas (Nalwadda et al., 2010). For the most part, barriers result from a lack of community engagement and education, financial constraints and shortages of supply (Kabagenyi et al., 2016; Lutalo et al., 2018).

The United Nations Sustainable Development Goals are global development targets aimed at improving the quality of life for all. Among these goals is the objective to achieve gender equality for women and girls, which includes the right to universal

access to reproductive and sexual healthcare, such as modern contraception (OHCHR | Sexual and Reproductive Health and Rights, n.d.). Research has demonstrated that there is an unmet need for contraception among women of childbearing age in rural Uganda (Jarolimova et al., 2018; Lutalo et al., 2018; Nalwadda et al., 2010; Scott et al., 2015). Various barriers that affect women on financial, social and personal levels cause this unmet need, as well as an overall shortage of funding and resources within Uganda's healthcare system (Kabagenyi et al., 2016; Lutalo et al., 2018).

1.2 Purpose of Study

Ensuring reproductive healthcare, including contraception, is available to everyone in Uganda is critical in order to empower young women and girls, which is essential for the nation's sustainable development (Hill et al., 2013; Nabaneh, 2019; Obah-Akopoghaha, N. G., Ojakorotu, 2019). The unmet need of family planning in Uganda has prompted research to investigate the barriers women still face when seeking contraception, and the impact of community sensitization and education programs on sexual health and contraception use (Lutalo et al., 2018; Parkhurst et al., 2006; Pitorak et al., 2014; Prada et al., 2016, Uganda Bureau of Satistics, 2017). Various factors drive contraceptive use, including both the demand side (women's knowledge, age, socio-economic-status, attitude, awareness, etc.) and the supply side (provision of family planning services, healthcare facilities, distribution, etc.), but there is a dearth of research on community health care workers and their perspective on how their communities may have improved access to contraception.

Community healthcare workers and Village Health Teams (VHTs) are an essential aspect of healthcare in Sub-Saharan Africa, as they bridge the gap between

healthcare services and rural communities who might otherwise struggle to access basic care (Musoke et al., 2019; Nxumalo et al., 2013). They are individuals who are trained to deliver basic healthcare services in the areas in which they live. They are also responsible for community sensitization on various health topics such as HIV/AIDS, reproductive and maternal health, hygiene, and more (Musoke et al., 2019). Community healthcare workers can greatly improve the community's overall education, attitude and engagement with healthcare. Nevertheless certain barriers impact the ability for healthcare workers to fulfill their roles, such as inadequate funding or training, dysfunctional support networks and a lack or resources and equipment (O'Donovan et al., 2020).

The purpose of this study is to use qualitative methods to comparatively explore and understand low uptake of family planning methods through an African Feminist lens by identifying barriers to contraceptive use at a public and a private clinic. The nature of the research design allows the participants to freely discuss various barriers particularly impacting their clients. Using an African Feminist theoretical framework and a reflexive methodology, I attempt to minimize the bias of my western upbringing and privilege as a white woman in order to explore access barriers in a more culturally and historically sensitive way. This study was conducted in two clinics in Luweero, a privately funded not-for-profit clinic called Shanti birth house and Reproductive Health Uganda, which is publicly funded and operates at various branches throughout the country. Specifically, I held focus group discussions with healthcare workers at these clinics who are experienced in providing reproductive health services, including dispensing contraceptives and counselling women on family planning.

Focus group discussions with healthcare professionals from both private and public health clinics in the same district nuanced the information provided. The participants had insight on the specific reproductive healthcare services in their district and offered valuable information about the needs specific to their respective clients. Findings from this research may ultimately contribute new insight on solutions to reduce access barriers and increase the frequency and consistency of modern contraception use in rural Uganda by identifying interventions that would address one or more of these barriers. It may also improve sexual health education for young people, community engagement, and women's empowerment. Reproductive autonomy is a critical aspect of gender equality, for which there is still so much work to be done, and this study aims to contribute to this struggle in a positive way.

1.3 Research Objectives

1) To develop a broad understanding of perceived access barriers that affect women seeking modern contraception in a public and a private clinic in Luweero, Uganda;

2) To gain an understanding on why these barriers exist and persist through an African Feminist lens;

3) To explore, through healthcare professionals' experiences and perspectives, how to address these barriers and make contraception more accessible.

1.4 Thesis Structure

Chapter 2 is a literature review of reproductive and sexual healthcare in Africa and Uganda specifically. Themes include various reported barriers women face when seeking contraception, such as socio-cultural values, a lack of knowledge or education, financial barriers and supply shortages. Chapter 3 is a description of the reflexive

methodology chosen for this project, detailing the importance of researchers situating themselves in relation to the participants or context in which they are studying in order to acknowledge biases. This chapter includes my personal reflexivity statement. Chapter 4 is an analysis of African Feminisms and Womanism, the theoretical framework adopted for this thesis that centres on the African perspective and context. Chapter 5 is an overview of my research methods and tools, including data collection and analysis. Chapter 6 details the results from the data set and Chapter 7 is the Discussion. Chapter 8 is the final conclusion of this thesis.

Chapter 2 Literature Review

2.1 Access to Modern Contraception in Africa and Uganda

Contraception is a highly contested topic in African society because of the social significance of fertility and of traditional gender roles (Nahar & Mengo, 2019). Recognizing that many communities in Africa still use traditional methods of contraception such as the pull back method or herbs and teas, for the purpose of this thesis modern contraception refers to hormonal birth control such as the pill, vaginal ring, injection, implant, IUD and patch. A study that examines the public sector's role in increasing access to contraception in sub-Saharan Africa found that between the years 1990 and 2014, the use of modern contraception had gone up along with demand, while unmet need went down from 37% to 27%. Demand and satisfaction for contraception went up steadily for all countries in a cluster during this period (Ross & Agwanda, 2012). This is due in part to globalized efforts to increase access to contraception, but there is still work to be done in order to respond to the remaining unmet demand. When comparing American contraception use statistics, we see that 98% of women who had engaged in sexual relations at least once had used a male condom, 82% used the oral pill and 56% used the pull back method. This demonstrates a significant gap between contraception prevalence in developed countries versus developing countries, and this is worthy of note because contraception can reduce poverty and hunger, and prevent 32% of maternal deaths, which are significant development indicators (Nakirijja et al., 2018, p2).

Additional research from demographic health surveys of 17 sub-Saharan African countries found women who used modern contraception relied heavily on the public sector resources to access it and that public sector demand was approximately three times

higher than private demand (Ba et al., 2019). Unfortunately, government run family planning programs in many African countries are weak or non-existent, are under-resourced or lack political will, which is caused in part by religious and cultural beliefs. Furthermore, women of lower socio-economic status (SES) and in rural areas are less likely to have access to contraception because of financial and socio-cultural barriers (Ba et al., 2019). Another study found that the governments' family planning programs and subsidies directly impact the prevalence and use of modern contraception and play a significant role in addressing unmet demand. The authors found that an increase in government subsidies increased the use and prevalence of contraception in sub-Saharan African countries, effectively breaking down financial barriers to modern contraception (Bongaarts & Hardee, 2017).

The Ugandan Ministry of Health is the steward of their decentralized and mixed healthcare system of both public and private organizations. At the district level, community healthcare workers deliver health services at three types of healthcare centres (I, II, III) and general hospitals. Publically funded speciality health services are offered at semi-autonomous regional and national hospitals, which operate on a referral basis (Ssennyonjo et al., 2018, p. 2). The private sector is diverse with not-for-profit providers, for-profit providers, and traditional and complimentary practitioners. The public sector is the dominant health service provider in the country, and it is where most women go to access modern methods of contraception (Bongaarts & Hardee, 2017; Ssennyonjo et al., 2018).

Demographic health surveys of sub-Saharan African countries found that Uganda's rate of modern contraception use was at 29% despite having a policy that states

that all people of childbearing age must have access to contraception (Uganda Bureau of Statistics, 2017 p. 20). Uganda also has one of the youngest populations in the world; with a population of 40 million, 49% is less than 15 years old (Nalwadda et al., 2010). The social impact of having such a young population is exacerbated by a poverty rate of 19% in rural areas, where women face the most barriers to contraception. While there are policies in place that give women the right to access birth control, poor implementation of these policies is keeping reproductive and maternal health indicators low (Uganda Ministry of Health, 2016, p. 8). The rates of modern contraception use among youth are especially troubling, as 63% of unmarried sexually active women between 15 and 19 years old, and 43% of unmarried sexually active women between the ages of 20 and 24 years old are not using any type of birth control at all (Nalwadda et al., 2010).

Teen pregnancy is a significant concern for the argument of increased contraception accessibility. While globally, teen pregnancy is considered a serious issue, approximately 95% of adolescent pregnancies take place in developing countries. Teen pregnancy is particularly dangerous as girls 15 to 19 years old are twice as likely to die during pregnancy or childbirth complications than women in their 20s or older (Ochen et al., 2019). The rate of adolescent pregnancy in Uganda is also one of the highest in the world, with approximately 25% of women aged 13 to 19 having their first child (Ochen et al., 2019, p. 1). Teen pregnancy is the highest among girls with little education and low – income households. A 2016 report from Uganda Ministry of Health notes that Uganda is not on track to reaching their goal of 14% teen pregnancy rate by 2020. Additionally, maternal mortality in Uganda was approximately 1 in 45 in 2015, whereas the global lifetime risk for maternal mortality was approximately 1 in 180 for 2015. This report

calls for immediate action to address this high death rate, including increasing access to contraception (Uganda Ministry of Health, 2016, p.7).

2.2 Unmet Need for contraception

The overall rate of unmet need for contraception, that is women who want to either stop or delay pregnancies and cannot get access, is 31% in Uganda, despite the average in East Africa being 24% (Izugbara et al., 2018). A reduction of unmet need of contraception would reduce the occurrence of unwanted pregnancies and meet the fertility desires of women in rural areas, and would serve national population policy goals. While fertility is highly valued in Ugandan society, the context and timing of pregnancy is also significant (Cleeve et al., 2017, p. 1287).

One longitudinal study examined the unfulfilled need of contraception of 2610 women in Uganda, most of who lived in rural areas and in households with a low wealth index. The study found that there was a discrepancy between women's stated intent to use contraception (60%) and the proportion of women who initiated contraception use (30%), indicating they may face access barriers. According to this study, there is a need to develop strategies targeting women with unfulfilled need for contraceptives and for the promotion of contraception among those with no intention to use them (Lutalo et al., 2018, p.7). Addressing unmet need is consistent with human rights, is a feminist approach to women's material empowerment, and it has been determined that targeting unmet need is an effective way to achieve a reduction in fertility, in line with Uganda's national population goals (Lutalo et al., 2018). There are socio cultural factors that influence a person's decision to access contraception such as the stigma against having sex before marriage, even though 64% of youth have had a sexual encounter by the time

they are 18 (Nalwadda et al., 2010). Additionally, Uganda's investment report from 2016 recorded that only 16% of women who gave birth at a facility and 28% of women who had a miscarriage or abortion were counselled on modern contraception or family planning before they were discharged. These figures indicate huge missed opportunities to inform women about services and products available that may help them realize their fertility desires (Uganda Ministry of Health, 2016, p.8). It is worth investigating if gender inequality or stigma against young people using contraception may be a factor as to why these family planning counselling opportunities are missed at health centres. Research has shown that sociocultural factors sometimes have an impact on the level and quality of reproductive healthcare service if healthcare workers have a bias against contraception (Jonas et al., 2017).

It is also very troubling that abortion remains outlawed in Uganda and highly stigmatized, often causing desperate women to seek unsafe means of aborting their unwanted pregnancies and disparities in the rate of maternal mortality deaths from unsafe abortions (Cleeve et al., 2017). If there were a reduction in the occurrence of unwanted pregnancies, fewer women would have to seek illegal and unsafe abortions, which could in turn save lives. In 2003, there were 294,000 reported abortions performed in Uganda, most of which were unsafe, and in 2006 the Ministry of Health reported 26% of maternal deaths were from illegal abortion complications. In 2011, the maternal death rate in Uganda was 438 per 100,000, well beyond the 240 per 100,000 average for the rest of developing countries, and unsafe abortion are likely a significant factor to these deaths (Izugbara et al., 2018). A study from the 2010-2015 Strategic Plan for the Health Sector reported that deaths related to abortions made up 8% of maternal deaths (Prada et al.,

2016, p.19). While this seems like an impressive decrease in abortion related deaths since 2006, these studies do not consider the lifelong negative physical and mental outcomes or hardships that are a direct result of unsafe and illegal abortions. One sure way to reduce this number is by making birth control easily accessible to any woman who wants it, as fewer unwanted pregnancies would occur.

2.3 Socio Cultural Factors and Misconceptions about Modern Contraception

Evidence suggests that socio-cultural barriers and gender discrimination are key factors that impact women's access to contraception in the Global South (Ba et al., 2019; Kabagenyi et al., 2016; Lutalo et al., 2018; Nahar & Mengo, 2019; Nalukwago et al., 2019). An interpretive meta-synthesis of literature from a 2019 study examines the ways in which cultural and social norms and practices impact women's access to contraception in sub-Saharan Africa and Asia. An estimated 215,000,000 women in developing countries have an unmet need for modern contraception, and the highest proportion of this unmet need 21% in Africa. Some of their primary findings show that male child preference, domestic abuse, and lack of financial independence were primary societal conditions that act as barriers to contraception access in Asia and Africa, with husbands' influence on women's reproductive health identified throughout most of the studies in the analysis. For example, women often need permission to seek healthcare services and could be threatened with abuse if they pursued family planning without the informed consent of their husbands (Nahar & Mengo, 2019). The emerging themes of this analysis clearly suggest that women's lack of empowerment, especially within her husband's household, severely limits her autonomy over her reproductive health decisions and ability to access contraception. Financial dependency was also a salient reason for not

having access to healthcare facilities and services, and can keep women trapped in abusive marital relationships. The authors note that a United Nations Population Fund study found that women's autonomy in reproductive health could reduce one third of maternal deaths and 10 to 20 percent of infant mortality (Nahar & Mengo, 2019). This indicates that women's reproductive autonomy is directly linked to her general safety and freedom, because when she has limited power in the household and little to no financial resources, her reproductive autonomy is jeopardized.

There are many sociocultural factors that inhibit a Ugandan woman's access to contraceptives (Kabagenyi et al., 2016; Prata, 2007; Wado et al., 2018). These factors were explored in a qualitative study that was conducted between July and August 2012 in rural Uganda. Through focused group discussions, community members explained many reasons why they would discourage a woman of child bearing age to use contraceptives, ranging from the need to replace the dead, if there have been no or few boys born, religious prohibition or the most recent births being twins. In Ugandan culture, parents of twins are meant to have another child to follow the twins. Marital obligations also have an impact on a woman's ability to access contraception. For example, it is highly desirable for men to have a very fertile wife, and bearing many children is a sign of respect towards the husband (Kabagenyi et al., 2016).

Gender norms also have a significant impact on the prevalence of modern contraception use among young people. A cross-sectional survey conducted in 2015 explored the relationship between gender norms and adolescent behaviour towards health services in Uganda by interviewing adolescent boys and girls. One of their most significant findings was that 48 percent of the respondents had reported that they had

their sexual debut by the age of 15 or 16, with the median age being 15 (Nalukwago et al., 2019, p. 46). This demonstrates a significant need for contraception use among adolescents as the risk of unwanted pregnancy is high and can impact the ability of young women to complete their education if they bear children early. However, the study shows that most of the male and female participants were in favour of gender inequitable norms and demonstrated a correlation between these beliefs and the decision to use contraception. The power imbalance that results from gender inequality often inhibits young women's ability to negotiate safe sex, therefore putting her more at risk for unintended pregnancy or sexually transmitted infections such as HIV/AIDS (Nalukwago et al., 2019).

In addition to socio-cultural factors that inhibit contraception accessibility, there are also numerous misconceptions about modern methods of birth control, so some women choose to use traditional practices as methods of contraception such as herbs (Prata, 2007). One such myth is that modern contraception can cause permanent infertility, which is understandably a significant fear for many families that value fertility very highly, and for women who fear they may be unable to bear children and their husbands will leave them. Other misconceptions about side effects are the birth of abnormal babies, delay of returned fertility and even tumours and cancer (Bongaarts, 2010).

2.4 Contraception Outreach Programs and Supply Shortages

Education outreach programs are integral to increasing access to contraception and other safe sex practices, especially for younger people. Although HIV transmissions in Uganda have gone down thanks to intensive community sensitization programs led by

the government, recently most new HIV transmissions are in adolescents. One study investigating this phenomenon found that adolescents' knowledge about STIs was greater than safe sex practices. Upon further analysis the researchers found that while their school curriculum educates students about STIs, they found that information on safe sex practices were lacking (Wolf et al., 2017). Sexual health education that does not promote safe sex practices and information about methods of birth control do a disservice to students because they are not being given the tools and information they need to protect themselves. A lack of effective education about contraception and safe sex is a significant factor as to why contraception use among young people in Uganda is low and HIV/AIDs transmissions in young people are high.

Previous efforts have been made by the Ugandan government and the international community to improve contraceptive use in Uganda. For example, the Ugandan Ministry of Health conducted one of the largest Ugandan reproductive health outreach programs called Delivery of Improved Services for Health (DISH), in in partnership with the U.S Agency for International Development between 1994 and 1999. The goal of this initiative was to change reproductive behaviours by improving availability and quality of integrated health services. This meant strengthening support systems for the procurement, distribution and storage of contraceptives in private as well as government run clinics (Ketende et al., 2003). The study revealed that the injection was the most commonly used form of contraception at the time, but supply shortages affected delivery of this service, especially in government run facilities. Contraception stock outs are defined as the unavailability of one of more contraceptives that should be available at a facility. One of the most important lessons learned from this study about

barriers for contraceptive use was that it was critical for the supply to meet demand. Women who wish to use birth control visit a private or government run clinic often find that there is a shortage or lack of supplies at these facilities, and it is one of the most significant issues keeping them from obtaining contraception, especially following an educational outreach program which may cause a surge in demand (Ketende et al., 2003).

A qualitative study by Reproductive Health Supplies Coalition examined the ways in which contraception stock-outs impact women in Uganda seeking contraception. They found that certain methods were more susceptible to stock outs, such as the pill, the implant, and the intrauterine devices. The hormonal injection called Depo Provera and condoms were most frequently available. Stock-outs from public clinics were more common than at private clinics. Some of the most significant ways that stock-outs affect women is through unwanted and unintended pregnancies, and the additional financial strain of trying to get their preferred methods of contraception from a different clinic i.e. the travels costs, consultations, etc. (Reproductive Health Supplies Coalition, 2016). This is particularly true for rural women who may have to travel a distance to another clinic. One way that women adapt to stock-outs is by refusing to have sex with their partner or husband or by asking them to use a condom, which could result in conflict and domestic violence. These stock-outs occur partly because contraception-related indicators were not included in assessing facility performance by the Ministry of Health, and the injection was the only method they kept track of to measure supply chain performance. This means their data was either incomplete or limited and they did not include other methods in their efforts to measure supply chain performance (Reproductive Health Supplies Coalition, 2016).

Supply shortages have impacted other countries in sub-Saharan Africa as well. A study from Senegal investigates the impact of the government's response to the issue of contraception supplies shortages and stock outs at public clinics. The Senegalese government was keen to increase the availability of contraception for women of reproductive age, where 1 in 4 women are not using contraception and only 21 % of married women were using contraception (Hasselback et al., 2017). Recognizing the link between contraception use and maternal mortality, the government of Senegal committed to increasing the national modern contraception prevalence rate to 45% by 2020. Part of this plan was to strengthen the domestic supply chain; as research found that 60% of stock outs recorded in the Dakar region occurred despite stock availability at the national level, indicating problems with in-country distribution (Hasselback et al., 2017).

One of the key findings in the study was that healthcare workers could not manage the supply of contraception themselves, as they usually lacked the logistical managerial training necessary to accurately forecast, track and order contraceptives, and then travel to the regional warehouses to pick up supplies. These additional tasks also kept healthcare workers from their primary role, which is to provide healthcare services (Hasselback et al., 2017). Similar difficulties were noted in research from Tanzania, signalling that supply chain dysfunction may be a common theme in contraception accessibility in sub-Saharan Africa (Wiedenmayer et al., 2015). In response to these challenges, Senegal expanded their Informed Push Model (IPM) of distribution, which harnesses the private sector and third party contracts to aid logistics, management and distribution of public healthcare supplies. This yielded extraordinary results: in the first three regions where the program was implemented, total consumption increased by 91%

over a 35-month period. At the national level, the consumption rate increased by 48% over a 14-month period. After the implication of this program, stock outs were reported in only 1.9% of the facility visits, and it is worthy to note that of these stock outs, 14% were caused by a spike in demand following outreach programs (Hasselback et al., 2017, p. 17). First, this means outreach programs can also be effective in increasing the demand for contraception, but that contraception supplies needs to be consistently available in order for out reach programs to be impactful. Secondly, outreach programs should co-ordinate with healthcare facilities in anticipation for spikes in demand following community sensitization and contraceptive outreach programs.

2.5 Financial Burden of Modern Contraceptives

Finally, it is clear that the financial burden of contraception is one of the main barriers that women and their families face when seeking family planning methods. A study comparing two Demographic Health Surveys from 13 different African countries, ranging from 1997 and 2006, examined each country's progress in contraception accessibility for people of high and low socio-economic standing. They found that financial constrains deeply affected women of low socio-economic standing when seeking modern contraception, especially for long-term methods. They found that women in the lowest wealth quintile were less likely to use long term contraception, which is often more expensive (Creanga et al., 2011). While short-term contraception is more consistently available and affordable at public clinics, this study shows an issue of equity among different classes of women, their reproductive autonomy, and ability to fulfill their long-term fertility desires. In order to address this, the authors suggest that governments

work towards making all methods of contraception affordable in order to close the wealth gap (Creanga et al., 2011, p. 262).

A similar study also examined data from National Demographic Health Surveys from eight different countries to determine the trends and patterns surrounding long-acting reversible contraceptives (LARC), such as the intrauterine device (IUD), implants, and sterilization. The data revealed that socio economic factors had direct impacts on the uptake of long-term modern contraception in all the countries included in the study. Specifically, level of education, wealth quintile and place of residence were noted as factors inhibiting women's access to long-term contraceptives. The study concludes by recommending that the government at different levels undertake the financial cost of contraceptives particularly for under-educated, rural women living in poverty in order to increase access and use of contraception (Adedini et al., 2019, p. 16).

Approximately one quarter of Ugandans live in poverty, with greater levels of poverty found in rural areas, particularly in the northern regions of the country. While Uganda has had success in raising much of its population out of poverty, they are still very vulnerable to economic or external shocks, where for every three persons who are lifted out of poverty, two fall back in (The World Bank, 2020). This means that most of the population cannot afford emergencies such as sudden illnesses and the medical fees associated with that, let alone regular fee payments for contraceptives (Kwesiga et al., 2015). Studies show that women in the lowest wealth quintile have about twice as many children as women in the highest quintile. Intersections of poverty, education and socioeconomic status may further determine a woman's ability to afford and practice family planning. Not only are the poorest people in Uganda mostly in rural areas, but

they are also having the most children. Rural areas of Uganda can also be scarce of social services, and barriers such as a lack of transportation can further impact a family's ability to access health services or family planning (Pitorak et al., 2014). A qualitative study on the availability and cost of contraception for rural women in Uganda found that condoms and the pill were the most utilized forms of modern contraception as they cost the least. They cost between 500 and to 1,000 and 1,000 to 5,000 Ugandan shillings per package respectively. Married women were more likely to use more long-term methods such as the injection or IUD, which are the most expensive methods available. The injection plan costs 3,000 to 10,000 shillings for three months of protection while the IUD cost 50,000 to 80,000 shillings and offers up to five years of protection; a one time expense that many cannot immediately afford (Nakirijja et al., 2018, p. 3). Respondents, who consisted of 85 healthcare workers, rural women and a few men, reported that most couples agree to use contraception but they come with a cost that few families can spare. Transportation to the clinics dispensing contraception may also add to the cost of seeking family planning services. A majority of women in this study responded that health care systems were a significant barrier to contraception use. Over-populated villages that overwhelm scarce government run clinics with limited resources cause these barriers. Some of the respondents explained that the public clinics must buy contraception at an expensive price, and in turn put the cost of the contraception on the patient. One health care professional in this study called upon the government to fund reproductive healthcare programs into order to better equip grassroots clinics providing these services (Nakirijja et al., 2018, p. 14).

Qualitative research such as this exemplifies significant unaddressed barriers to contraception. As discussed earlier in this review, there are many factors that act as barriers to contraception in Uganda, such as sociocultural beliefs, gender inequality, financial barriers and supply shortages. It is critical to examine why these barriers exists and persist, and how they can be overcome in order to increase access and use of modern contraception. As seen in the research, outreach educational programs can have a positive impact on motivating women to pursue family planning counselling, but shortages of supplies and financial barriers act as health care system barriers to contraception, particularly when these outreach programs create a spike in demand. Examining the ways in which the dispensing process inhibits access to contraception in both the public and private sectors will help inform policy makers when they make decisions that will impact women's access to contraception throughout the country.

Chapter 3 Reflexive Methodology and Reflexivity Statement

3.1 Reflexive Methodology

Describing the methodology of science is critical as it details the mechanism by which the research produces knowledge, as well as locates the position of the researcher within the study (Kamau, 2013). I chose to use a reflexive methodology and theoretical framework as I was socialized differently from the participants of my study, and this affects how I analyse and interpret the data. One's socio-economic positionality should be kept closely in mind when conducting qualitative research and interpreting the narratives of a culture or society that is not their own, and over whom they have privilege (Kamau, 2013; Mauthner & Doucet, 2003; Reeves et al., 2008). Objectivity may be considered compulsory for qualitative research, but in reality the researcher herself is a research instrument fully involved in the collection and interpretation of the data. Through subjectivity, qualitative methods find contextualized insight into lived human experiences. Social scientists must therefore acknowledge the subjective and intersubjective processes that happen during fieldwork and data analysis by way of reflexivity (Day, 2012). Researchers bring inextricable biases to the specific contexts in which they conduct research, based on their lived experiences. At the same time, they attempt to record the participants' stories as they themselves see it in their context (Caretta & Vacchelli, 2015).

Although the study would not be a true ethnography I borrowed the theoretical frameworks of reflexivity as part of the study, and French feminist scholar Béatrice de Gasquet's experience puts the reason for this to light. De Gasquet explains that our values may not align with those of the community we are studying, something she encountered

while she was studying gender and religion at a feminist synagogue. She warns researchers not to occupy themselves by judging the moral genuinity of the group they are studying because of the biases the researcher herself has. During her fieldwork at the feminist synagogues, de Gasquet found herself questioning how truly feminist the synagogues were in her opinion, which kept her from focusing on the true task at hand (Gasquet, 2015). Fundamentally, de Gasquet separates, chooses, structures, and organizes her data guided by a combination of conceptual knowledge, lived experience, and impressions of the other in particular situations. In order to become aware of their own bias, researchers should take on a reflexive approach by consistently reflecting, self questioning, comparing, evaluating and verifying throughout the research project (Medico & Santiago-Delefosse, 2014, p. 352).

Dutch author and researcher Naomi van Stapele (2014) took this into consideration as a white researcher in Africa. She follows a concept of epistemology whereby knowledge is embodied; a temporal construct that is determined locally, personally and historically as a result of social relation and interaction (p. 14). During an initial interview with a grandmother in Kenya she became aware of how her positionality and approach impacted her participant's narrative and the process of intersubjective knowledge production. It can be difficult to break down the power dynamics between the researcher and the participant, particularly in this setting. The relationship and power balance between the researcher and the participant will greatly influence what information the participant gives and how it is delivered. Van Stapele (2014) recounts:

"The research setting I had initiated with my notebook in front of me had, in

> her eyes, prioritised my 'overseas' origin, my white skin and my profession over my long-term relationship with her and her family. She awarded me with an authority that she associated with white skin, and hence responded suspicious, formal and distant" (p.15).

To overcome this, van Stapele repositioned herself as the (white) friend of her participant's grandson and conducted future interviews in a more natural setting as they were used to sharing. The familiar chitchat fostered a sense of trust and intimacy that allowed the grandmother to narrate as she saw fit (van Stapele, 2014).

Situating ourselves socially in relation to participants is a crucial aspect of reflexivity, particularly when studying a marginalized or disadvantaged group (Alvesson & Skoldberg, 2009; Berger, 2013). Van Stapele acknowledged the power and privilege she held as a white western researcher and how her approach to her initial interview highlighted this to her participant, despite having built a familiar relationship with her. Her social identity factors also carrying with them certain biases that may impact the interpretation and analysis of her data, and acknowledging them is part of her reflexive process. As part of my reflexive methodology I wrote a reflexivity statement in order to reflect on my identity and life experiences that have created my own biases (Gao, 2013). Further challenges may arise from studying a context in which one is a complete outsider and have no personal experience (Birks et al., 2014). Therefore it is critical to use a theoretical framework that effectively draws from and represents the context the researcher is studying (Berger, 2013; Holloway et al., 2011). In order to aid my interpretation of the data, I will use African Feminisms and Womanism as my theoretical framework to center my focus on the Ugandan context of access to modern contraception.

3.2 Reflexivity Statement

I am a white, middle-class, cis-gendered, atheist and bisexual woman with impaired hearing. These social identity factors situate me in the socio-economic context of urban Ontario and guarantee a certain level of unearned privilege that I unwittingly carried with me throughout my childhood and adolescence. I was raised in the suburbs in a secure and loving home, and earned my secondary school diploma through a privileged French Immersion program in 2012. I chose to continue my French education at university and earned a Bachelor's degree with a double major in Social Justice and Peace Studies (SJPS) and French Language and Literature.

It is during my undergraduate degree (2012-2016) that I was first introduced to feminist theory. Since my first year, feminism became one of the most intriguing and impassioning subjects I came to study during my coursework and lectures. I took a particular interest in sexual and reproductive healthcare and rights as well as intersectionality. As I progressed into the program and learned about power and privilege and how they impact people in different ways and to varying degrees, I began to realize how privileged I was in my own life experience. I had colonial impressions of how Africa could be "saved" and developed, an understanding of poverty and the experiences of Black people that lacked depth and historical significances, and a general lack of knowledge about our own history of colonization on this land we know as Canada. My privilege as a white middle-class woman sheltered me from the reality that European colonialism, systematic racial oppression of Indigenous peoples, and the trafficking and enslavement of millions of Africans created a legacy that has characterized our world order for hundreds of years. White supremacy, from which I directly benefit, lives on

evolved. My years in the SJPS program mark the beginning of my journey to understanding how the dynamics of power and privilege permeate throughout the many forms of oppression that I already knew existed. I gained new knowledge that helped me see my privilege and learn how to break it down while also taking in new perspectives, experiences and teachings outside of the white washed and colonial curriculums our high schools students are subjected to.

I became more interested in post-colonial theories of feminism and development, gaining a new understanding of the contemporary and historical contexts of Africa, particularly the role that European imperialism plays on the economic and social development of the continent. Indeed, many development or charity initiatives carried about by internationals in African countries lack critical understandings of the contexts in which they work, as well as their own privilege as Westerners. The very presence of white internationals (such as myself) on the African continent highlights our power and privilege as we had the opportunity and the means to have travelled across the world, something our local development partners are not oblivious too. Even more critically, we bring our western concepts, ideas, and logic, attempting to apply it to the African context without consideration of whether westernized methods of development are even effective or appropriate. Understanding this allowed me to see how my privilege can be unknowingly wielded as a white saviour in Africa and how it can impact my professional and personal relationships, preparing me for my first trips to the continent.

I first went to Ghana in 2014 on what could be described as a cultural learning exchange as an extracurricular credit. After weeks of socio-cultural and self-awareness training, I lived with a host family for three months in a rural area of the country,

adopting every aspect of their lives and integrating myself in the community. I learned a higher level of empathy and humility, as well as how to adapt as a vulnerable foreigner graciously welcomed into my host family's home. These are lessons I brought with me when I first travelled to East Africa in 2016, spending six months in the border town of Busia Uganda working at a local community library as a development intern. Despite having valuable lessons from my theoretical course work and experience in Ghana, within the first few months of the internship I and the other interns realised how wrought it was with examples of the fundamental issues of international development. We worked in the country on tourist visas doing tasks locals could be hired to do, had completely inadequate socio cultural training and sensitization, and were expected to create a sustainable development project within six months of hardly knowing the communities in which we lived. This internship program, funded by the Canadian government, undermined Ugandan immigration and labour laws in order to allow young Canadian graduates such as myself to practice international development in Africa, a textbook example of neo-imperialist white saviourism in international development. However, was also while being in this library that I came across a report by the Ugandan Ministry of Health about access to contraception in Uganda. Through my own research and my personal relationships I learned more about the sexual and reproductive healthcare context in Uganda, and how there was an unmet need for contraception, particularly in rural areas. From my perspective, reproductive and sexual rights are some of the most critical issues that characterize gender inequality, and I was inspired to advocate for increased accessibility.

I decided to pursue the topic of access to reproductive and sexual healthcare in Uganda as my Master's thesis through a feminist theoretical lens. As I explored the topic of reproductive and sexual healthcare in Africa, I learned how context appropriate theories and methods were critical to the successful collection of data and implementation of sensitization programs. Feminist theory cannot be considered a monolith movement, a one size fits all solution for gender equality, because while sexism is a problem all over the world, it impacts women differently depending on where they were born, socio-economic class, culture, race, etc. The feminism I am most familiar and comfortable with is post-colonial and intersectional. Characteristically, it is queer and sex positive which is reflective of the type of cultural and historical context of the society in which I was raised. As such, sexual liberty is important to me, which means not only having accurate information and resources on sexual health, but also a celebration of queer love and free sexual and gender expression. I was raised without faith or religion, and therefore the historically conservative ideas and conventions about sex did not make a significant impression on me, despite Christianity being the most common religion in Canada. While I am respectful of other people's religions and faiths, I myself am an atheist and neither faith nor religion have any impact on my personal life or the decisions I make. Additionally, I myself have accessed contraception in Canada, a process that was relatively easy, free of cost, and did not hold as much stigma as in Uganda. This gives me a bias on what I believe good access looks like. Recognizing and reflecting on these personal assumptions about sex, religion, feminism and justice, which are products of my life experiences, has prepared me to be reflexive during the collection and analysis of my data. These personal assumptions are the biases I hold as a Western researcher in Uganda,

and I was responsible in recognizing that while I put them aside during this project, they are always present. I used a reflexive methodology to help me realize by own biases, and consistently reflect and compare multiple subjectivities throughout the data collection process. In order to keep my focus centered on the African context, I used Africana Feminisms, or Womanism as my theoretical lens.

There were times during my fieldwork where my whiteness or identity as a Canadian graduate student worked to my advantage. I sought the help of my supervisor at my university to put me in contact with some academics in Uganda who were able to help me navigate the Uganda National Council for Science and Technology (UNCST) ethics application. My identity as a white graduate student also helped me gain an audience with key stakeholders for this project, namely the directors and managers at Reproductive Health Uganda, and the founding family of the Budondo Intercultural Centre, the parent organization of Shanti birth house. I took care to not skip any formalities or exercise these privileges by making extra introductory trips to stakeholders in Budondo and Luweero and keeping close contact with them in order to build trusting and mutually beneficial relationships. My contact and communication with these stakeholders as well as with a UNCST partner representative were instrumental as they reviewed and gave feedback to my proposal, focus group guide, and ethics application, and I reported updates to them often. I was also invited to many social events and to keep in touch with many people, presumably because of my whiteness and foreignness. The particular interest people took to me in the field created some complexities, for example a young man that the Shanti staff did not know followed me from the main road and waited on the property for me to finish my focus groups so he could have a conversation with me,

prompting the staff to become suspicious of him. At times I would bring my laptop to the field or to a public work space, I made sure to cover the Pride flag sticker on the top right corner. I decided it would be best to keep it covered in case stigma against LGBTQIA+ impacted the participants' impression of me. Finally and most importantly, my very presence as a white graduate student who has come to do subjective analysis on qualitative data from the perspectives of Ugandan healthcare workers is itself a very significant exercise of privilege. While I have attempted to outline my positionality and biases in relation to the context and my participants to the best of my ability, I now understand that this is not enough. Therefore I humbly offer my work to the constructive critique of the Ugandan stakeholders, my peers and other academics, with the hope that it may still be useful and informative to increasing access to contraception in Uganda.

Chapter 4: African Feminist and Womanist Theoretical Frameworks

4.1 Theoretical Framework

I chose African Feminist critical theory, or Africana Womanism as my theoretical framework for this research project. Since I have chosen a research terrain in Uganda on an issue that concerns women's reproductive rights, a feminist framework born from the African perspective is most appropriate. As African scholars have been theorizing African women's empowerment and experience for decades, it has been disputed whether or not the white or western mainstream version of feminism is ever suitable for the African context, (Chiweshe & Macleod, 2018; Hudson-Weems, 2001; Kolawole, 2002; Ntseane, 2011; Shamase, 2017). They have developed such theories as African Feminism by Chikwenye Ogunyemi, Mary Kolawole's Womanism, Malora Ogundipe-Leslie's stiwanism (acronym of: Social Transformations Including Women in Africa), and Nnaemeka's negofeminism- feminism of negotiation. The incredibly diverse social realities in Africa make it impossible to homogenize African Feminisms, therefore it is necessary to use the plural with respect to feminism in Africa and acknowledge the varying terminologies and theories associated with African feminisms. These theories are all centered on the social and cultural constellations of African societies and are directed at changing the existing power relations between men and women (Arndt, 2002). African Feminisms or Womanism have many unique aspects; most importantly it is a discourse that takes care to delineate those concerns particular to the African situation. It also questions features of "traditional African values without [unfairly criticising] them,

understanding that these might be viewed differently to the different classes of women" (Ntseane, 2011, p. 314).

4.2 The Issue with Mainstream White Feminism

The US style of feminism that emerged in the 1960s and 1970s emphasized individualism and focused on the right to participate in the market, separate from her role at home as wife and/or mother. The separation of public and private spheres, the primacy of gender conflict as a feature of the family, and gender based assignment of reproductive labour became the three main pillars of traditional white feminist theory (Udel, 2001). In essence, it was a bourgeois revolution for middle class white women as they emerged as economic actors in their own right (Eisenstein, 2010). Criticisms of mainstream feminism, starting to emerge in the 1970s and 1980s, significantly affected how people considered the different impacts of gendered oppression on women all over the world (Mikell, 1995, p. 406; Mohanty, 1988, p. 333). Malora Ongundipe Lesie, a Marxist feminist, explained that feminism may work in the African context but that there are significant changes some of western versions of feminism would have to make, such as racism in the white feminist movement (Shamase, 2017). Mainstream white feminism is rooted in white middle class women's experiences, ignores the survival issues poorer or racialized women have, and fails to recognize that control of their destiny requires material underpinnings. For example, the white feminist perception views abortion as part of reproductive agency but fails to consider the social contexts that would be required for people to exercise their rights, or other ways the reproductive rights of racialized women are violated. Mainstream western feminism only briefly addresses obstacles that women face when trying to access abortion (Herr, 2014, p.2). Yet in fact,

the United States and Canada have a history of forcibly sterilizing Indigenous and Black women without their consent, as part of the eugenics movement that gained ground in North American during the 21st century. An American governmental investigation from 1976 found that during a four year period in the 1970s, more than 3,000 Native women were sterilized (Udel, 2001, p. 46). This history highlights how out of touch mainstream white feminists were with the reality of racialized women North America, who were and continue to be denied reproductive autonomy in a racist healthcare system that valued white babies and mothers over Black and Indigenous ones. For poor and racialized women in the United States during Second Wave Feminism, their core areas of contention were rooted in the struggle against racism, high infant mortality rates, better education, housing, and healthcare (Eisenstein, 2010).

Women of the Third World, as described by feminist scholar R.S. Herr (2014), experience diverse forms of oppression, often different from the Western experience. Additionally, when it comes to advocating for women in the Global South, white Western women may put themselves in a position of authority, assuming they know and understand the unique and diverse needs of African women, reproducing neo-colonial practices and cultural imperialism (Chiweshe & Macleod, 2018). Yet at the UN Conference on Women in Nairobi in 1985, mainstream feminists heard from Third World feminists that drinkable water, the availability of sanitary napkins, infant mortality and health problems such as fistulas were a top priority for women in developing countries (Eisenstein, 2010). African women's struggles have influenced how women organize and educate themselves for economic empowerment, education and training as well as political representation (Ntseane, 2011, p. 314). Therefore they should be empowered to

narrate their own experiences, identify what they need and lead their own movements. It is with this notion, that oppression affects women in different contexts in different ways, that we begin to realize we cannot homogenize the global feminist movement and use a wide brush to paint the reality of women outside of the Western World.

It is important to note before exploring African Feminisms that another feminist theory born in the West shares many similarities with the concepts central to African Feminisms. Native women scholars such as Ronnie Farley, Jane Katz and Stevie Wall emphasize traditional precontact female and male role models of their culture. Like African feminists, Indigenous women view their agendas as differing from those identified in mainstream white feminism, and they distinguish their "responsibilities" from white feminist notions of "rights". Native women's highly valued power and ability to procreate and nurture children, their communities, and the earth are all considered aspects of what Patricia Hill Collins calls "motherwork" (Udel, 2001,p. 43). Indigenous activists and feminists have highlighted the privilege white women have to their rights to become mothers, while Indigenous women, under eugenic policies, have their reproductive autonomy violated in a perpetuation of genocide, preventing them from engaging in their responsibilities of motherwork. Under this paradigm, Native women's procreative ability becomes a powerful tool in combating Western genocide and colonialism (Udel, 2001, p. 47). The emphasis on decolonization, the traditional value of motherhood and the complimentary traditional roles of men and women are key aspects of African Feminisms as well.

A significant difference between Western feminisms and African Feminisms is the approach to men's participation in the effort for gender equality and women's rights.

African Feminisms recognize men as partners in the struggle against gender oppression rather than as the enemy, and emphasize the complimentary relationship between men and women rather than conflict. Gender roles are seen as asymmetrical, parallel, and autonomously linked in the circle of life (Bádéjo, 1998, p. 95). Some African women feel that western feminism is designed to erode traditional African family structures. Meanwhile, African men may view the western feminist perception of gender as divisive, imported from the west to alienate African women from them (Kolawole, 2002, p. 93). Ongundipe-Leslie argues that some men discourage women from reading white feminist theories because they're a sign of colonialism and domination, as one of those other isms that impede African development and strain the relationship between men and women. A key point on African feminism that Ongundipe-Leslie argues is that it does not seek to fill masculine roles or be oppositional to man. On the other hand, while African feminism is not opposed to African culture or heritage, said culture cannot be immobilized in time to the advantage of men, as most men in African want it to be (Shamase, 2017, pp. 9211–9212).

4. 3 African Feminism

Conceptualizing gender within the parameters of African cultures allows African women to view their womanhood and African identity as integral and complimentary (Kolawole, 2002). African feminisms center traditional religious and spiritual beliefs based on African oral histories and festivals which have women at the center of social order, custodians of earth, fire and water and men as guardians of their custodial rights (Bádéjo, 1998, p. 94). The miracle of birth and motherhood, the complimentary roles men and women play in reproduction and in the continuity of humanity are recurring themes in African Feminist discourse. While culture and family structure are integral, African

Feminisms also weigh which traditional institutions are agreeable and positive for women and which ones disadvantage women to the point where their abolition is imperative. Finally, African Feminisms discuss issues surrounding gender in the context of other oppressive systems such as racism, neo-colonialism, imperialism, religious fundamentalism, socio-economic exclusion and exploitation as well as corrupt and dictatorial political systems, far exceeding the race-class-gender scheme of African American feminism (Arndt, 2002, p. 32; Nyambura, 2018, p. 428).

4.4 Africana Womanism

It is worthy to note some Africans are simply uncomfortable with the term feminism and prefer to use the term Womanism. Many African women do not subscribe to western feminisms as a way rejecting imperialistic attempts to force them to accept a foreign ideology that is indifferent to the needs of the majority (Dove, 1998; Hudson-Weems, 2001; Kolawole, 2002; Shamase, 2017, p. 9215). Africana Womanism, coined by Clenora Hudson-Waseem is distinct from Alice Walker's Womanism, and is an ideology specifically designed for African women or for the African diaspora and is grounded in African culture (Hudson-Weems, 2001). Africana Womanism seeks the genuine liberation of African women that involves probing African cultures, values, and tradition and understanding the real location of a woman. It emphasises the fact that African women have been standing up for themselves, their communities and their countries without cue from the West for millennia (Dove, 1998) . While mainstream feminism is female centered, Womanism is family centered and places a high premium on communalism. This requires an inclusive approach to gender struggles that emphasizes the unity of Black people across gender lines. By focusing on cultural contextualization, centrality of family and the importance of including men, Africana

Womanism aims to avoid the polarizing and exclusive approach of mainstream Western feminism (Dove, 1998; Kolawole, 2002, p. 97). In the African context, an inclusive approach would be more practical and effective as most policy makers in Africa are men. Including men in sensitization programming, education and healthcare efforts would be more productive in gaining grounds for African women in situations that require policy changes in favour of women (Kolawole, 2002, p. 97).

4.5 Critiques on African Feminisms

While engaging with African feminist theories for research, there are some key criticisms surrounding African feminisms that must be acknowledged. The sexual female body is barely discussed or present in African feminist critical discourse. Author Ayo A. Coly (2019) argues that the sexual African female body must be reclaimed from the colonial and neo-colonial discourses, yet the approach most African feminists have taken has been tentative. It seems as though African feminist scholars have been more occupied with restoring the moral and aesthetic dignity of the African female body that were compromised by colonial representation. A recurring topic in African feminist discourse surrounding the theme of the African female form is the cruel spectre of a South African Khoikhoi woman; named by her captors Sarah Baartman (1789-1815). Often in these discourses, the African female form turns from the colonial gaze of hypersexualization to postcolonial desexualisation. Though as Coly demonstrates, there is much to be gained socially and politically by making the exploration of female sexuality an imperative aspect of the African feminist agenda, and reclaiming it from colonial distortion and racism (Coly, 2019, p. 49). Finally, LGBTQIA+ discourses have either been completely ignored or silenced in African feminist discourses. Homophobia and transphobia, like devout Christian religiosity, was colonially imposed in Africa when for decades

education in European occupied Africa was put into the hands of the Church. The legacy of this still perpetuates a strong stigma against homosexuality and gender identity that keeps African feminisms from being as inclusive for queer Africans (Nyambura, 2018; Pindi, G.N, 2020; Shamase, 2017).

Together as a community, African women and men can mobilize to address the issue of reproductive healthcare and autonomy for women in Uganda and the rest of Africa. African feminist and womanist theories have informed this research project in order to center the theoretical lens on the African context. I adopted this theoretical lens by inviting both male and female healthcare workers at the public and the private clinics to participate in the focus group discussions, as African feminism uses a male inclusive and communal approach to issues on gender inequality. Additionally, my focus group discussion guide included questions pertaining to the empowerment and autonomy of the clients at the clinics. The focus groups also discussed issues such pertaining to power imbalances in the household, financial dependence and the political de-prioritization of reproductive healthcare.

Chapter 5 Research Methods and Tools

5.1 Qualitative Research Approach

Qualitative research provides rich and diverse perspectives, which are critical for knowledge creation in social science (Thomas, 2006). I was in Uganda for a period of 49 days from February 2nd 2020 to March 22 2020. I had planned to stay in Uganda for a bit longer, until March 31st, but due to the unfolding COVID-19 pandemic, I scrambled to get home earlier as thousands of flights were being cancelled. Thankfully this crisis did not impact my ability to gather all of my data. I conducted focus group discussions on February 19th 2020 at Shanti Birth House and on March 13th 2020 at RHU Luweero branch. This chapter will first outline the research setting and design. Following is a description of how I recruited participants and the research tools I used. I then demonstrate how I collected and analysed the data sets to draw conclusions from them.

5.2 Research Setting

Uganda was chosen for this study because it has one of the highest birthrates in the world, and research has demonstrated an unmet demand for contraception (Ariho et al., 2019). Luweero is in the central region approximately 60 km north of the capital, Kampala, with a population of over 476,000; most of the Ugandans in this district live in rural settings (Thomas Brinkhoff, 2019). During the early to mid-1980s, Luweero was severely affected by the Bush war that raged in the area, which killed thousands and led to a deterioration of their healthcare services. The government has since invested in infrastructure and the delivery of medical services; Luweero now has 3 hospitals, 9 health centres and 17 dispensaries (Uganda Travel Guide, 2015). There are two clinics that were the focus of my study, the Reproductive Health Uganda (RHU) Luweero branch, and

Shanti birth house, a Canadian founded non-profit now under local management with the Budondo Intercultural Centre. RHU is a publicly funded organization whereas Shanti is a private non-profit. Shanti and RHU provide various services to their communities, including education programs, maternal healthcare and delivery of family planning methods and education (Budondo Intercultural Centre, 2019; Reproductive Health Uganda, 2016). As the investigation involves participants from both a public and private non-profit clinic, it nuances the scope to examine these two types of development, state-led development and international development. Luweero is a prime location as it is worthy to investigate if this rural community is still affected by a resource shortage despite its proximity Kampala, which has the highest concentration of medical and healthcare resources in the country (Mujasi & Puig-Junoy, 2015).

5.3 Research Design

This is a qualitative case study using focus group discussions as the method of data collection, and a focus group discussion guide as the main research tool (Caretta & Vacchelli, 2015). As an explorative study it first focuses on the specific access barriers women in Luweero are facing when seeking contraception. Descriptive in nature, this thesis uses focus group discussions (FDGs) as the primary research method to investigate the specific context in Luweero with regard to access barriers to contraception. Focus group discussions offer a rich and inclusive approach for participants to explore topics in depth, allowing participants to discuss an issue that affects their community as a whole and to build on each other's ideas to address it (Seal et al., 1998). The first component of the FGD is discussion about perceived barriers that impact women in Luweero seeking contraception and the clinic's service delivery. The second component of the study is

investigating what the participants (healthcare providers working with contraception) recommend should be done in order to eliminate accessibility barriers. African Feminist Theory informs the design of this research as these healthcare teams have a gender inclusive opportunity to discuss communally the issue of contraception accessibility in Luweero.

5.4 Participants and Recruitment

Study participants were recruited by word of mouth and the distribution of flyers to the head offices of the organizations and directly to the clinics. While it takes time and effort, this approach has proven to be the most effective means of recruiting participants in this type of setting. Before I left for my fieldwork I emailed the Budondo Intercultural Centre, which is now the parent organization of Shanti Birth House since it was passed on from Canadian management to Ugandan. I also emailed the main office of RHU, inviting both clinics to participate in my study, and provided details in materials such as my proposal, discussion guide, and recruitment material. Both male and female healthcare workers were invited to participate who had at least three years of experience in administering or prescribing contraception to women in Luweero and are of 18 years of age.

Potential participants included doctors, nurses dispensing contraception, counsellors, or any other healthcare worker who is involved with the dispensing process of contraception at the clinics. This includes Village Health Team workers (VHTs), which as I learned in the field, are essential employees who help sensitize isolated rural communities and dispense short-term modern contraception methods to the women there. Participants were required to also be proficient in English. Former employees who meet

the participant criteria were also invited to participate, but all of the participants were current employees. These stipulations are important to ensure that participants can give legal informed consent and have enough experience in administering contraception to discuss their ideas during the focus group discussions (Smith, 2003). As compensation for the participants time and effort, I paid each person 10,000 USh and provided snacks and refreshments during the discussions. I aimed to have 6 to 8 participants per focus group discussion.

Prior to visiting Shanti for an introduction, I traveled to Budondo district to meet the founding family of the Budondo Intercultural Center and introduce myself as a foreign student. I was graciously welcomed into their home and had the honour of visiting them twice, including for a formal family function, before answering calls to go home amid the developing COVID-19 crisis. Before I initiated the focus group discussions with the participants at Shanti in Luweero, I had a meeting with two senior staff members at Shanti birth house to discuss my study in full detail as well as give them copies of the discussion guide and my recruitment material, which outlined participant criteria and compensation. I had a similar meeting with two senior staff members at the Reproductive Health Uganda headquarters before travelling to the Luweero RHU branch with one of their volunteer staff members to conduct the focus group discussions. I had intended to have an introductory meeting with the staff at the Luweero RHU clinic as well, but on the day I was meant to travel there, I was very sick on treatment for strep throat and could not travel. Despite having missed one, these introductory meetings and interactions allowed me to gain trust and earn the respect of these organizations before gathering data. They were valuable in that I met inspiring front line workers as well as

made genuine friendships and connections with the people in leadership who helped me coordinate the focus group discussions and invite the healthcare workers to participate.

5.5 Research Instruments

Four semi structured focus group discussions were held with volunteered participants from RHU Luweero and Shanti, using a guide with open-ended questions as my research instrument. The questions were used to prompt the participants to discuss topics such as different funding models, perceived barriers to contraception and their impact on clients (Yaya et al., 2019). There was one male participant group and one female participant group at each of the clinics, for a total of four focus group discussions, held in English. Focus group discussions allow participants to explore the topics at hand while building on each other's ideas in order to address the issue of contraception supplies in their community (Thomas, 2006; Van den Hoonaard, 2014). Primary research questions for the focus group discussions designed to prompt the discussion, and the informed consent documents were all prepared before I entered the field. The following are examples of some of the issues the FDGs discussed:

1. The reasons why women in the community might not use modern contraception, such as financial constraints, a lack of knowledge, stigma, etc.
2. Why access barriers to contraception exist and how they impact the clients and the clinics' operations.
3. The ways in which increased and sustainable funding can aid their service delivery and programming.

5.6 Data Collection and Procedures

Fieldwork took place between February and March 2020. During the data collection process I recorded memos noting any comments, ideas, connections and any other pertinent information that needed to be highlighted during the discussions. These notes and my field journals helped me understand the data later as my analysis began (Van Den Hoonaard, 2014, p. 116). I had four focus group discussions with a total of 27 participants. FDGs were stratified along gender lines in order to minimize the impact of gender inequality as dictated by cultural norms, which may cause some women participants to stifle their responses and listen to their male colleagues (Kitzinger, 1994). There were 10 participants in the women's group at RHU, and 6 in the men's group, while there were 8 participants in the women's group at Shanti and 3 participants in the men's group. While I did not have the minimum target of 6 participants in the men's group, as there are few male staff members at Shanti who fit the stipulations for participation, this did not impact the quality of data I collected during the discussion. This number of discussion groups offers enough data to analyse all of the key themes, as Guest, Namey, McKenna found that 90% of all themes are discoverable in 3 to 8 FGDs (Seal et al., 1998). This sample is small enough that I avoided repetitive and superfluous data, but also large enough that I was able to identify norms among the groups and subgroups of the dataset and reach data saturation (Guest et al., 2017).

Participants were asked to attend one of the four focus group discussions. I began each discussion with an explanation of who I was and the purpose of the study, as well as distribute the 10,000 USh as compensation for their time. With the participants' consent, I audio recorded the discussions as I asked each group questions about contraception accessibility in Luweero. Each focus group was held at their respective clinic, in a gazebo

at Shanti and in a performance hall at RHU, and lasted for approximately one hour. While the participants were invited to respect the anonymity of the other participants, anonymity cannot be guaranteed using a focus group discussion method (Moretti et al., 2011). At the end of each focus group, I offered biscuits and refreshments to the participants and thanked them for their cooperation and the insight they relayed to me.

5.7 Ethical Considerations

The ethical clearance approvals required for this project were obtained from the University of Ottawa's Office of Research Ethics and Integrity number S-11-19-4816 and the Ugandan National Council for Science and Technology via the TASO Research Ethics Committee (REC) reference TASOREC/093/19-UG-REC-009. Clearance from the TASO REC was obtained on the 6th of January 2020 and January 8th 2020 from the University of Ottawa. To ensure the confidentiality of the participants, personal identifiers were not included in the transcripts. Written informed consent was obtained before the start of the focus group discussions and their participation (Yaya et al., 2019).

5.8 Data Analysis

Qualitative content analysis was used in order to find themes in the dataset after the FDGs were redacted into a clean transcript edited for clarity (Azungah, 2018). By repeatedly listening to the audio-recordings of the focus group discussions, I familiarized myself with the data and took note of repeated concerns, ideas, and concepts. Upon reviewing my notes taken in the field as well as during my initial reviews of the recording, I developed a coding scheme by which I would discover a pattern of themes (Elo & Kyngäs, 2008). I used Nvivo 12 to aid me in the data analysis stage, and

incorporated my coding scheme into nodes, adding more and reorganizing them as I went through the data.

Emerging themes were noted, and pertinent ideas and quotes were organized into meaning units (Van den Hoonaard, 2014, p. 119). These units were grouped into the coding scheme in Nvivo 12 where they were compared and contrasted and I narrowed down the analysis in order to highlight the most significant themes in the dataset (Elo & Kyngäs, 2008). The responses were contrasted between the public and private clinics to find comparative themes or information pertinent to the discussion of contraception accessibility in terms of developmnt. This is an inductive content analysis methodology and allows me to analyse a large set of qualitative data in order to discover the most significant access barriers for women seeking contraception in Luweero and how these issues can be addressed (Moretti et al., 2011; Thomas, 2006).

As I read the data set and coded passages, I also took handwritten notes in my project notebook on any key ideas, connections, questions or observations I had as I analysed it (Jebb et al., 2017). I used this notebook throughout the planning stages of this project and as a reflective journal, developing my interpretation of the data through my initial perceptions and analysing them under an African Feminist lens, consistently considering where my biases are and where they come from. When I was unsure how to code a passage I analysed what meanings I saw in it and why I interpreted them that way. I also questioned my initial response to passages and developed reasoning to my interpretation and how I chose to code certain quotes and ideas. Methodologically, my journal was my tool to continuously use reflexivity throughout the process, identifying

where my social position is with relation to my research context, and reflecting on how that impacts my interpretation of the data (Probst, 2015, p. 43).

Chapter 6: Results

6.1 Funding Modern Contraception Under a Private or Public Model

Participants in the FDGs included village health teams members, registered nurses, and midwives. Financial constraints that impacted either the patients or the clinic were the most coded theme in the data set, which is consistent with results from other studies (Ali et al., 2018). A Canadian NGO originally founded Shanti birth house in 2010 and in the spring of 2019 leadership was transferred to the Budondo Intercultural Centre (BIC), under Ugandan management. Currently, Shanti is funded by a one-time grant from an international NGO, but the grant is limited and they anticipate to either face a contraception stock-out or a severely limited budget in the coming months.

> "We cannot stretch ourselves if we do not have funding for transport, if you are not funded you cannot move. So that means that if this outreach stops in May, still we will have not done much." (Female participant, Shanti)

RHU has a public funding model, and receives funds from both the federal and district level governments. However, inconsistent funding means that the operations at RHU are spread thin and programming is inconsistent.

> "It depends on the period, because right now we have the project [Wish] and we give them for free" (Male Participant, RHU)

As of yet Shanti is not self sufficient in funding their operations but BIC is, and manages to independently fund operations for a hospital in Budondo (Budondo Intercultural Centre, 2019). This means that with time Budondo might successfully develop Shanti to be financially self–sufficient. While Shanti operates on a tight budget, the staff involved with dispensing a variety of contraceptives offer many services that pertain to women's

sexual and reproductive health such as a safe place to deliver their babies with professional staff, counselling on family planning and contraceptives, pregnancy and STI tests and treatment, and referrals. The grant they received allows them to price their supplies of contraceptives methods at a flat rate of 3,000 USh for each type of method (approximately $1.12 CAD).

> Participant 2: "3,000 [Ugandan Shillings]" (Female participants, Shanti)
> Participant 5: "For three months, three packs [of contraceptive pills]" (Female Participants, Shanti)

As short-term methods Shanti offers the pill, Depo-Provera injection, and condoms, while the long-term methods they offer are the five-year implant and the IUD, all of which are sold at a flat rate of 3,000 USh, making long term methods as financially accessible as short term ones. Shanti allocates a portion of their budget to offer contraception for free at their regular out reaches in the community for sensitization and distribution of contraception.

> "Well in the community, at times there are some other funds that the clinic allocates to the community services. There is a program that receives funding at least for our services so when we go to the community it is free of charge" (Male participant, Shanti).

The participants at Shanti are concerned about the sustainability of their funding, and are actively trying to address this issue by soliciting grants from international organizations as well the Ugandan government. They explained that they applied for some government funding for their operations last year, but have not received a response to their request.

> "I think if we were involved… If we had access to the PHC funds (Public Health Care) it would really help us" (Male participant, Shanti)

As RHU is funded through the government, and while they too suffer from inconsistent programming, their funding situation is more stable and allows the healthcare workers to be more flexible in their service delivery. As short-term methods they offer the pill, Depo-Provera, and condoms, two types of implants and the IUD as long-term methods, as well as the permanent methods of tubal ligation and vasectomy.

> "Yes they [contraceptives] are on cost for private, but government facility it is free" (Female participant, RHU)

> "Ah at the branch, it depends. Sometimes 1,000 or 2,000, it depends on the method. But these days we have a project that is called the WISH project, they give us the supplies and we distribute them free of charge" (Male participant, RHU)

RHU networks closely with the nearby health centres, which include large hospital and clinics levels III and IV[1], to enhance service delivery with their clients by referring them to the health centres for permanent methods and other services. Currently, RHU has engaged a program called Wish, whereby they offer each contraception method for free; but the program is not permanent and once the budget for the program runs out, clients will have to pay a small fee of 1,000 – 2,000 USh for each type of method. At times when their subsidized supply runs out, the clients are given the date of the next community out-reach program so they may access the method of their choice for free. Or, they refer clients to the nearby health centre Katikamu III where contraceptives are given for free,

[1] Uganda's public healthcare system is divided into four levels of healthcare centers, where supplies and services are expanded incrementally the higher the level of the health center, and finally there are hospitals where clients can receive all of the services at a level IV clinic, as well as specialized clinics and consultation doctors (Richard M. Kavuma, 2009).

as per government policy. As a government run health centre, which deals with general medicine, it is mandated to serve contraceptives at a free price, whereas RHU is a government funded public organization that deals specifically with sexual and reproductive health and they do not have the same level of flexibility with their budget. However, accessing free contraception methods at Katikamu III is not a guarantee, as the subsidized supplies may run out.

> "Yes so we network with health centres, and when they come to the branch we give them for free. Though the difference is, there are those who get them outside [outreaches]. They should come with their cards [follow up appointment cards], and we charge them some little money for removal [of IUD or implant]. I'm not so specific on what amount of money, because things keep on changing depending on the year. But at the centres, where we give our services, the moment you present your card we give it for free." (Male participant, RHU)

> "Mmm it's supposed to be all but sometimes the method you are providing, they are not there, they are out of stock" (Female participant, Shanti)

6.2 Impact of Financial Barriers on Access to Modern Contraceptives

The cost of contraception impacts poor rural communities profoundly. The socio economic well being of the community in Luweero needs to be improved through measures that empower them economically, in order for more clients to be able to access healthcare in general. The contrast between the socio economic contexts of urban and rural is explained in this quote from a participant:

> "It [being unable to afford contraception] is very common in the rural areas. Because in the urban, the husbands are working and things in the urban are very expensive, but when you come this way, the little money, even if it has reduced, they are saying they cannot afford it. Because they are not working, or they

> cannot spend the 3,000 to get the contraception. But at least in the urban areas they know the cost of having those big families. And unlike in this community, they think that because they have a lot of food, they can provide enough children, so they don't even want to lose the 3,000." (Female participant, RHU)
>
> Participant 1: "Maybe they lack of money. Sometimes."
> Participant 2: "It can be up to 30 to 40 percent" (Female Participants, RHU)

The participants reported that 3,000 USh is not as significant a cost for clients living in urban areas as there are more employment opportunities and it is far more difficult to manage in urban settings with large families. Consequently, women living in urban areas tend to have fewer children. In order to address these challenges, Shanti uses out-reach programs to extend access to isolated rural communities and provide information and short-term contraceptive methods for free. During these outreaches the healthcare workers also give their clients a contact at the clinic as well as their follow up appointment, which many are unable to meet due to transportation costs. While Shanti does not have a program whereby they fund the transportation of their clients, they may fund the transportation of the VHTs in order for them to deliver short-term methods to their community. Additional costs to accessing contraception include pregnancy tests for clients who have not been on contraception for a prolonged period, STI screening and potential treatment for them and their partner, medications to manage side effects, and insertion and removal fees.

> "Well at times when they come, and then like they can't afford the method of their choice, mostly we tell them to wait for us in the community. There are times when we do the outreach, we give the methods at a free cost." (Male Participant, Shanti).

> "And there are expenses for example for the implant, when they are injecting the implant there is an extra charge for removing it." (Female participant, Shanti)

The most significant risk for a woman when she is unable to afford contraception is an unwanted or unplanned pregnancy. Participants at Shanti explained that unplanned pregnancies are an ongoing issue among young girls in the community and that they work especially to counsel and support girls who have dropped out of school as a result of pregnancy. At times, a woman may choose to abort the pregnancy but there are many financial, physical, mental, and social risks associated with undergoing an illegal abortion in Uganda.

> "Like we said schoolgirls, they are 10 girls who have dropped out of school in this community, and that number is so huge." (Female participant, Shanti)

> "Because of the unwanted pregnancy, they go to terminate the pregnancy. And the end product of that is not quite good." (Female participant, Shanti)

As a government run organization, RHU has similar challenges but they are able to manage with more flexibility as an older and larger organization. Like Shanti, the RHU healthcare team recognize how seriously impacted clients are when they are unable to access the method of their choice for financial or other reasons. As explained in the previous section, contraceptives are currently being offered free of charge because of their program Wish. However, when they are funding a different program and charging a small fee for contraceptives, there are still some clients who cannot afford to spare the 1,000 or 2,000 USh fee.

> "For sure, when that situation comes it affects the clients seriously. Because some are very poor and can't afford but we manage. Because when we meet such a client when the project is away, and she comes without money… at times we give her the service." (Male participant, RHU)

> "And also long distances, sometimes even our facility gives free services, there is need for some money for transport before you reach the facility." (Female participant, RHU)

When this happens, RHU management has the resources to ensure that the client gets the method she needs, either by networking with the nearby healthcare centres or by simply waiving the fee and giving her the method free of charge. This practice significantly reduces the way the price of the method impacts clients, especially when the question of transportation costs is answered when the healthcare workers or VHTs enter the field to reach isolated communities.

6.3 Shortage of Contraceptive Supplies

The healthcare workers at Shanti explained that there was a countrywide stock-out of Depo-Provera, a highly demanded short-term method in the form of an injection. During this time, even the international organization that was funding them were not able to secure supplies of the drug, as the shortage impacted international markets as well (Dyk, 2019). The absence of Depo-Provera affected the clients at Shanti very seriously. Confusion and suspicion arose in the community about the drug, but also about the intentions of the government and healthcare workers. One participant explained:

> "So during that time when we stocked out country wide, the women used to

> tell us ‘now you are encouraging us to go out and become pregnant’. Which was not our desire, so they went and became pregnant. Because even if someone’s interest was in Depo and did not want other methods, they didn’t switch to other methods, even though they were encouraged to. So they conceived.” (Female participant, Shanti)

Many clients who felt most comfortable with Depo-Provera were disinclined to switch to another drug, even if Shanti had another injectable by a different name. Some suspected that there was a serious issue with Depo-Provera and that the government was withholding information about it from them. When the supply was finally replenished, rumours continued to circulate the community about Depo-Provera.

> “And also, while running out of Depo worldwide, also brought a lot of misconceptions to the community. Because when that happened, that brought a lot of rumours to the community. That community was saying that there was a problem with that drug that’s why the government is stopping the drug. But it was just out of stock in the whole country. But when it came, it was expensive. So other private clinics are giving it at 7,000 - 10,000 USh. So when we give the drug at 3,000 USh some think that that is not the right drug. That was also another challenge.” (Female participant, Shanti)

RHU reported that they usually have all their methods in stock, however at the time of my focus group discussions with them, they were currently missing the five-year implant called Jadelle and were offering a 3-year implant in it’s stead. When RHU is unable to fund free contraception, clients have the option of going to Katikamu III, or any other healthcare centres levels III and IV as they all offer contraception for free. However, healthcare centres like Katikamu III face shortages in their supplies of contraception

frequently. This is due to the fact that their policy is to serve contraceptives for free, but their budget cannot accommodate the demand.

> "Today we have a stock out of Jadelle" (Male participant, RHU)

> "It is a government policy to give all services at a health facility for free, and yet the government has a limited budget for health, so they will purchase the things to use at the facility but it will not be enough" (Female participant, RHU)

The participants at RHU also speculated that the alternative to Depo-Provera, Sayana Press, is not well known or promoted enough. When Depo-Provera runs out, the staff will offer Sayana as a second choice. Like the participants at Shanti explained, clients are apprehensive to try a new product when they feel comfortable with Depo-Provera, despite the drug being the form of an injection as well. RHU suggested that promoting Sayana as an alternative to Depo-Provera might balance the demand between the two injections, and a steady supply of each would stabilize stock out issues, especially if there is ever a worldwide shortage of either drug again in the future.

> "Yes it has a high demand and two, this is my own thinking, but when someone has looked at the market [the contraceptives available] people don't know what Sayana is even though it has the same purpose." (Male participant, RHU)

6.4 Corruption and Political Influences on Modern Contraception

Political and social influencers on either side of the contraception debate can have either positive or negative impacts on the funding and social perception of family planning. Both clinics reported that political corruption is a key factor as to why there is inadequate funding to make further progress in attaining the country's targeted national total fertility rate.

> "When they know that so and so is in opposition or is not in support of this party, you do not receive any support." (Male participant, Shanti)

Participants at Shanti reported that even when funds are allocated for community development, some of it does not make it to the ground where it is needed. When they applied for government grants the previous year, they did not receive a response to their request and progress on their application has been slow.

> "But we had sent a request [for funding], but they have not answered yet." (Female participant, Shanti)

It is speculated that the reasons why community development funds do not make it to the communities that need it the most are the same reasons why applying to government grants as a private reproductive health clinic is met with a slow response or rejection. The needs of organizations applying for funding are not prioritized, and the select few groups or communities who already have a steady supply of resources are granted funding before those with more pressing needs.

> "Yes and when this fund comes into the community, it does not go to everybody, it goes to a selected few. And the actual group that needs this fund, does not get it." (Male participant, Shanti)

Under the publically funded model, RHU must order supplies on a quarterly basis and the government responses are frequently slow, sometimes impacting RHU's operations and service delivery. Socio-cultural factors and stigma also play a role in influencing law and policy makers on how to fund reproductive healthcare, including the accessibility of modern contraceptives for rural women. Some do not want to politically support family

planning for religious reasons, cultural beliefs or stigma against family planning. Additionally, most of the lawmakers in Uganda are men; therefore the importance of including men in sensitization efforts and education about family planning is of considerable magnitude.

> "And we talked about earlier on, the low participation of men, and they are mostly the law-makers so that also brings out a problem, that some men don't want family planning". (Male participant, RHU)

> "The [political] response… slowly." (Male Participant, RHU)

On the other hand, there are political figures and community leaders who are taking a positive public stance on family planning. Luweero is situated in the Buganda kingdom, where as dictated culturally, men are the ones to determine how many children their wives produce. But recently, the Queen of Buganda has spoken out about the benefits of family planning and spacing or limiting pregnancies. One participant explained:

> "Yes, though the Queen of Buganda she has come out to educate women and men. She has come out in the media, (inaudible), open forums, to sensitize men and women about family planning. And she's looking at the broader picture of it. When you think of family planning what comes to mind- the methods. Which is the smallest thing of it. But look at the resources we have, look at the health and education we have about it. So when she came out with such programs, many people gradually, especially men are now changing their minds." (Male Participant, RHU)

Watching the Queen of Buganda promote family planning had a positive impact on the population's perception of family planning, and managed to do away with some of the

stigma. This demonstrates the positive impact community leaders can have on the uptake of contraception throughout the country. Religious leaders have also promoted family planning, such as the Archbishop of the Anglican Church who is involved with RHU and helps them pass information and resources to community leaders under his influence. RHU has also had success in sensitizing political leaders in the district who were previously speaking out against family planning. Community discussions with leaders, district chairmen, health workers, educators, and religious leaders on how to deliver and promote family planning to rural communities needs to be a part of sensitization efforts.

> "Even the church, like recently we have just received the archbishop. The archbishop supports family planning. From the Anglican Church. He is a member and supports reproductive health." (Male participant, RHU)

6.5 The Impact of Side Effects from Modern Contraception

The side effects associated with modern contraception have significant psychological effects on the clients at both clinics participating in this study, impacting the operations of each clinic is similar ways. All four focus groups discussed these impacts and how as a result, side effects change clients' trust and their perceptions of contraception's value, despite receiving reliable information and being sensitized about the benefits. Some of the side effects mentioned were prolonged periods, cramping, pain from insertion or removal, lowered libido, and amenorrhea (absence of menstrual period). Fear of the side effects or the pain associated with insertion was reported as one of the most significant reasons as to why women are apprehensive about starting family planning, or why they discontinue. This severely impacts the sensitization efforts of the clinics as well as the their clients' continuity of family planning, especially when clients have knowledge and

information about the benefits of contraception, yet discontinue because of the side effects.

> "There are others who fear and don't come because of the side effects. Because the other methods that can cause bleeding. And when someone goes into that, it feels like 'ah it is inconveniencing' and they get discouraged and they discourage others." (Male participant, Shanti)

> Participant 3: "To a certain level, some people will maintain that they don't have the knowledge but the issue is about the side effects, which is the biggest of all of them because even those who have tried Jadelle, within a year or months they will come back and ask for it to be removed and when you ask why? Some hindrance bypass…"
> Participant 2: "That is lack of knowledge"
> Participant 3: "The knowledge is given, but side effects always can take away the knowledge." (Male participants, RHU)

Clients may also discourage each other if they discontinued contraception due to the impact the side effects had on them. One client turned away from modern methods of family planning to a traditional herbalist because the side effects were a significant inconvenience to her.

> "Like recently I shared with one of the ladies who was saying that at one time she used the modern methods, and she got those side effects, the continuous PV bleeding, and she was discouraged so she went to this herbalists, and then they gave out some kind of native, and apply it to her petticoat. And when she applied it there she can go ahead and have sex without a baby. And she was very happy that that is the method she is using now." (Female Participant, Shanti)

Other complications or illnesses such as fibroids or STIs are mistakenly associated with the side effects of modern methods, further exacerbating the impacts of stigma and

misinformation. Furthermore, as Depo-Provera is the most popular method, there are fewer misconceptions about the side effects of Depo than there are about other methods such as the IUD, which can cause women to perceive their options as limited, especially if Depo is out of stock. What is also convenient about Depo-Provera is that it is a short-term method and clients feel more comfortable testing the effects of contraception on their bodies for a short period of time.

> "Sometimes when people get these fibroids, even when they have not used family planning, but in case one has used family planning and gets it, they attach it to family planning." (Female participant, Shanti)

Both RHU and Shanti have considered solutions to the issue of side effects as a motivational barrier for women considering family planning. Shanti recommends that medications to stop PV bleeding or counselling on side effects should be incorporated into their dispensing process. RHU explains that if a woman has side effects and needs medication to manage them, they can refer them to one of the healthcare centres where they may access them free of charge. Counselling on the side effects and misinformation about them during the outreach programs may also prevent women from discouraging each other in the community when they experience side effects. The clinics can also engage the VHTs to support women in the community struggling with side effects, as it would give clients easier access to the clinics' services such as counselling and medication. Additionally, expanding the community's knowledge about other methods may allow women to explore the risks and benefits of each type, thus providing them with more flexibility in their options so they may choose the method that would suit them the most.

> "And maybe there are those getting side effects, so it can help when treating them (the side effects) are free. But if you charge money, they won't continue. So it means when they get a side effect like that, treatment is even free. That would encourage them to go on." (Female participant, Shanti)

> "Especially during… when a lady gets side effects you first tell the VHT and share the issue." (Male participant, RHU)

6.6 Cultural Values and Religiosity in Contrast to Modern Contraception

Cultural and religious values were reported to be a consistent reason why many women do not use modern contraceptives. As the participants explained, Luweero is situated in the Kingdom of Buganda where culturally, women are encouraged to give birth to literally all of the children in their womb, and large families are desirable. Having many children is also a way of honouring one's husband and having many children is celebrated, particularly in rural areas. These cultural beliefs impact women's motivation to begin family planning, as social norms may impact the value the community places on contraception, as high fertility is well respected and desired.

> "This place belongs to a culture name Buganda whereby men have the tendencies to determine the number of children the wife should produce, so that is one hindrance." (Male participant, RHU)

However, the participants reported that the standard of living of some of the larger families in the community are at risk because the parents are unable to provide enough for all of their children to receive basic educatation and be healthy. When the socio economic wellbeing of a family is either at risk or already suffering, it makes it more

difficult for them to respond to emergencies such as illness. At times, parents are unable to provide basic necessities for their children, despite the desire to raise a large family.

> "At least it would improve the lifestyle of the people and the community. Because people will be having the desired number of babies they can take care of and raise, be able to pay fees, even improve the nutrition status at home. If you have a good amount of money which you can afford to buy more food you can even improve the eating habits, and the nutrition at home." (Female participant, Shanti)

Participants reported that religious values from Catholic and Muslim communities also dictate that God has a plan for the number of children each woman has, and that using contraception is an affront against God's will. For example, many also believe that every child is a blessing from God on the whole family. One of the participants from RHU describes:

> "I think the Muslims think that even if you have 20 children, you can manage, or you can afford. But in reality it is quite hard according to what we see on the ground. Because you find someone who has 20 children, that person says he can manage she can manage but according to what we see, they cannot manage." (Female participant, RHU)

> "Because there was a time we went for an outreach, somewhere in the Catholic area, and they were told that they considered our system to be obscene and misleading. Then you go to an area which is mostly occupied by Muslims, their religion does not attain that. You are supposed to have as many children as you can afford or as you can manage so they don't allow it." (Female participant, RHU)

This makes it particularly difficult for healthcare workers to navigate this context when they are attempting to sensitize the community about family planning. Shanti and RHU

both reported their sensitization efforts are met with deep scepticism and often rejection in religious Catholic and Muslim communities, consistently impacting their operations and service delivery there.

6.7 Misconceptions and Stigma Surrounding Modern Contraception

Misconceptions and stigma about modern contraception were discussed in detail amongst the participants as they considered other reasons why women may not use family planning. The participant from Shanti explained that rumours about the side effects or misconceptions of family planning circulate deep into villages, posing a significant challenge for healthcare workers. Some clients worry that the contraception will cause permanent infertility, abnormal babies, cancer or even death.

> "Some say it will make you barren for life" (Female participant, Shanti)

> "Others hear that they move, so they come to us and they are like 'ah they told us when you use this method, then the capsule moves in the body and then it enters your heart and you die', so we tell them no that is rumours it doesn't move." (Male participant, RHU)

Other ailments such as STIs, fibroids or other reproductive health complications may be erroneously attributed to modern methods of contraception, and some community members may spread rumours based on their personal experiences. RHU participants also explained that suspicion and distrust of the government also fuels misconceptions, as some community members may believe that the government has ulterior motives and wishes to cause infertility in young Ugandan women and girls. The participants noted that

methods such as the IUD and implant suffer the worst reputation out of all the methods because they are more physically intrusive than many clients feel comfortable enough trying, unlike other methods like Depo-Provera, which is simply an injection which lasts three months. Depo-Provera offers a discreet, low risk, short-term method of reliable contraception; therefore it is clear why it is the most popular method used at the clinics.

> "They will use the method and go back saying they have just started a method but it is making my private parts to itch. So they combine their infections to the what? The method they chose." (Female participant, Shanti)

> Participant 5: "There are also rumours within the community that there is a hidden agenda for family planning methods" (Female participant, Shanti).
> Participant 2: "Yes that maybe the government wants to produce some infertility to their young girls and women" (Female participant, Shanti).

> "Some are also scared of the implant or IUD. Like the IUD sits in the uterus, and for that they are scared, and they are shy too. They are scared of the pain they think it is so painful." (Female participant, Shanti)

Misconceptions about modern contraception contribute to the stigma surrounding family planning, which impacts the clients and the clinics' outreach efforts in many ways. The social disapproval that stems from cultural norms and values, religiosity and misconceptions causes some clients to fear discrimination or shame unless they keep their contraceptives secret. Using family planning in secret adds risk for clients because being discovered could lead to social reprimand, exclusion or abuse. The stigma against contraception impacts the sensitization efforts of RHU and Shanti, as the participants explained:

> "And people want these things done privately because their husbands, their neighbours, don't want such things" (Female participant, Shanti)

> "They don't take it out of the house where the man can see them taking it. So you find these are all kinds of risks" (Female participant, Shanti)

> "Some of them forget to take the pill. Their husbands can come across it. There are other problems." (Female participants, Shanti)

RHU and Shanti are often barred from speaking at schools about family planning because parents and teachers believe contraception will enable young girls have their sexual debut at a young age or before marriage. Similarly, men may not wish their wives to practice family planning because they believe it may encourage their wives to be unfaithful and consequently, the outreach programs have low attendance rates, especially of men.

> "There is opportunity to go and talk to the teen girls at the schools but the parents don't want to hear this. They say they have this fear that once these children are informed about family planning, they will go crazy and go start running after men. So those are our challenges we are facing." (Male participant, RHU)

In the field, the VHTs have to navigate this stigma, and occasionally manage to discreetly deliver contraception to clients with limited mobility. At the clinics, the healthcare workers explained they become aware of certain misconceptions or stigmas when their clients ask them if something they heard in the community is true. It is critical for healthcare workers to seize this opportunity to counsel their clients sensitively on all of the facts surrounding risks, benefits, resources and choices available to them. Additionally, ensuring the dissemination of information in multiple forms of media such as radio and TV ads, and illustrative pamphlets, newspaper articles and posters is widely

available in the Lugandan language would make information more accessible the community.

> "And they don't come asking 'is it… a,b,c,d?' they come in and they tell you like 'they told me this is this and this, is it true?'" (Male Participant, Shanti)

> "And then, I don't know whether if at all we came out with other things like T-shirts, hats, umbrellas, with messages about different contraceptives. 'I'm a proud user of this', 'I enjoy using this, I've used this without any problems', if we could have a T-shirt with these types of messages on I think it would encourage more ladies to try their luck." (Male participant, RHU)

While the participants acknowledge that stigma, misconceptions and side effects lead women to discourage each other based on their experience or rumours they heard in the community, they speculate whether their peers may also have a positive influence.

6.8 Sensitization of Men on Modern Contraception

The healthcare staff and VHTs explained that more women than men attend the sensitization out reach programs in the field. Sensitization programs specifically geared towards informing and educating men have not been running at RHU since 2018. As men are typically the head of the household in Uganda, they work and control the family finances.

> "In the society that we live in, the men govern the house and if he does not have 1,000 then the method will not be there." (Female participant, Shanti)

> "That's why when it comes to financial problems in Uganda, most specially in rural areas, men are the finance controllers, they are the bread winners. So most women don't work. So if you need a service you need to ask for money to

facilitate you, even if the service is free. But you need to facilitate. So to [inaudible] financial problem, men will need to be sensitized about their role in the use of contraceptives. And among that, the financial roles as well because even if the woman is facilitated financially, [if she is also] well educated [about contraception] everything is fine." (Male participant, RHU)

The participants at RHU explained that some men might believe that taking contraception would enable their wives to have an affair. Stigmas, misconceptions, religious or cultural values all have an impact on men's perceptions of family planning, and it is not uncommon for wives to take contraception without their husbands knowing.

"They have their reasons, and some of them most specially those in rural areas, they think that when a woman takes family planning she'll go find another man out of their marriage, because a woman is not fearing to get pregnant". (Male participant, RHU)

"Yes. There are times when something is going to be costly we [men] try to hesitate. Because you have to give transport (money), then we talked about that pregnancy test, and mostly our women sometimes… I don't know how much it happens on that side but something that is for 3,000, someone can tell the husband no it is at 10,000 and they will increase the cost to the husband maybe because they want to keep something, so they increase themselves. So at times, when someone looks at it and says 'you're telling me its 3,000 and then the transport and then the test, ah don't go. You stay." (Male Participant, Shanti)

"But some of them do not know anything about family planning and they don't want to know. They won't even approach Shanti's gate. But the few who want to know, they can support their women." (Female participant, Shanti)"

"It looks so awkward when you ask a woman to join family planning and she tells you I need confirmation from my husband, yet it is you the mother carrying the

> womb. Most of the negative consequences, mothers face. They rarely appear to men, so when we are doing awareness, most especially include men also." (Female participant, Shanti)

A woman might request to be counselled on family planning at RHU without their husbands' knowledge about once a week. Issues of finances and payment complicate these clients' predicament further if they have limited financial resources at their control. For various reasons men in the community may not see family planning as a worthwhile financial investment, leaving enormous opportunity to sensitize men about the positive economic benefits of family planning. One of the participants described the mindset some community members have:

> "Okay we feel like, if it is at all free, the men at times will accept it 'ah okay, it is free, I don't have anything I can give you so you can go'. When a wife consults him about whether she should come for it or not, he asks what is needed 'nothing'? Okay you go." (Male participant, Shanti)

> "Of course, what you could put in mind is that although my colleague is talking about African men but… what I have discovered is that African men they do not want to put something in for health, most specially for those contraceptives. If it's for free they can accept it, but to pay… ah they don't like that." (Male participant, Shanti)

The participants believe that emphasizing the financial benefit of contraception may motivate men in the community to consider how family planning could benefit the physical, mental and economic health of their families. One of the participants at RHU reflected on how they used to have door-to-door sensitization outreach efforts.

> "And a lot of emphasis has been put on women, training, sensitization, media issues, but we need to come out with the same pace of sensitization of men. I remember some time back at RHU, we used to have door to door sensitization. Move to the workplace, you find two men are digging, two men are working on carpentry, (inaudible), markets, with [RHU] you crack a discussion and by the end of the day, the information is caught. So then men understand family planning." (Male participant, RHU)

Close The Gap (CTG) was another program run by RHU in recent years, which addresses the information and sensitization gap between men and women about contraceptives, however this project was discontinued and the organization went on to fund other projects. All of the focus groups discussed the impact of sensitizing men would have on the stigma, misconceptions, and lack of knowledge circulating the community, while highlighting the socio-economic and health benefits of family planning. Men should be sensitized and educated to support their spouses financially, emotionally, and physically as they explore family planning options together.

> "There was a gap between, information gap among the users. At first they started with women, but lately it was discovered that even if you sensitize women, and you don't sensitize men the impact might not come up." (Male participant, Shanti)

6.9 The Impact of Increased Funding on Clinic Operations and Service Delivery

Part of my investigation is to explore how healthcare workers and VHTs would address the various access barriers that women face seeking contraception. It is clear that access is a two-way street, whereby women in the community sometimes struggle to access the services at the clinic for various reasons, and healthcare workers have their own barriers they face when they are trying to do their job. The participants shared their insights and

ideas of how increased funding would be strategically used in order to address their barriers effectively. The participants at Shanti explained that the sustainability of their funding is the most pressing concern to their operations and connecting clients to the contraception methods they desire will become much more challenging without a new source of funding.

> "We are trying to move around for funding with NGOs. Of course if we can get, we can do better than now." (Female participant, Shanti)

Public health funds and subsidies dedicated to private not-for-profit healthcare centres would significantly help fund Shanti's long-term operation goals. Offering contraception for free would create a significant motivating factor for couples and parents exploring the possibilities offered in family planning. Addressing this concern would bring more clients to the clinic and would improve their reputation as more people use their services. Men in particular would be influenced by the free cost of contraception as they typically control the family's finances.

> "When someone comes in and they say 'ah I got a service free which is working well for me or for her' then she will try to tell others, and at least it would create publicity for us." (Male participant, Shanti)

RHU also discussed how organizing community dialogues with religious and community leaders, healthcare workers, VHTs, and educators to discuss how to best deliver information to the community would also improve the awareness of family planning in Luweero. Funding media adverts on the radio, TV, newspapers, posters, pamphlets, in the local Lugandan language would reach a wider audience where certain sensitization

efforts seldom reach. With this level of community sensitization and education efforts, the healthcare workers predict that they would see a significant increase in client volume.

> "And to have some… if at all we got some other funds to have some radio talk shows about family planning to help the community. And as well have some drives in public schools" (Male participant, RHU)

Another strategic response to creating awareness discussed was to emphasize the importance of Village Health Teams for their outreach programs and distribution operations. RHU emphasized that the VHTs were an essential aspect of their out reach operations. VHTs such as the ones used at Shanti and RHU are used throughout the country by many health centres. They bridge the gap between isolated communities and healthcare, including family planning. Additional funding for RHU would mean that the area they currently cover for outreach would be expanded and they would reach isolated communities more frequently. VHTs would also be funded to move between the clinic and the community easily, and can be part of the response to address the issue of distance between rural families and the clinics. The participants believe that closing the space between healthcare services and isolated rural communities would greatly improve the overall health of the population.

> "For me I would talk about the VHT, we have been using them, those people can go deep in the village, and they know the village mothers. So you have to be using them. That's why (inaudible)… we have to empower them, in their transport." (Female participant, RHU)

6.10 Study Strengths and Limitations.

One of this study's strengths was that it explored a broad range of perceived barriers to contraception in Luweero at both a public and a private clinic, highlighting the different financial constraints each clinic faced. This gave a nuanced examination of both funding contexts at the rural clinic level, and I saw few studies during the literature review that did this. The data is also consistent with evidence from previous studies on similar topics, such as the impacts of stigma against contraception, misconceptions about contraception, transportation costs to clinics and gender inequality. I had enough data from participants in multiple healthcare occupations, and managed to reach saturation. The demonstrated reflexive methodology credits the reliability and cultural sensitivity of the interpretation of the data by detailing researcher perspectives and biases, which is not common practice when western researchers do qualitative research in the African context, though it should be.

A limitation of this study was that I did not collect other pertinent data about the participants' characteristics that would have provided a wider contextualization of the results, such as occupation, age, and years of experience. Another limitation is that I gained a broad understanding of many different barriers, preventing me from exploring any of the barriers in deeper detail.

Chapter 7: Discussion

7.1 Perceived Barriers: Side Effects and the Socio-Cultural Context

For the purpose of this thesis, social barriers refer to a lack of knowledge and misconceptions, religiosity, cultural values, and stigma. While side effects are potential physiological reactions to hormonal contraceptives and are not exactly borne of the social context like the other barriers mentioned, they have a particular significance in this socio-cultural context and it is worth exploring how they nuance the other barriers. Side effects were reported to be a significant motivational barrier for the uptake and continuation of contraceptives. Side effects, misconceptions, and stigma have a compounding effect on each other; in essence, side effects validate stigma and fuel misconceptions. Side effects such as prolonged PV bleeding, intrusive procedures, pain, and amenorrhea are inconvenient to the clients, and significantly diminish the perceived value clients place on family planning, especially when side effects legitimize social stigmas and disinformation circulates the community. Side effects were reported to be the most significant problem RHU healthcare workers were trying to address, as it is the number one factor that discourages women from continuing family planning. For example, the troubling side effects associated with contraceptive methods coupled with the lack of knowledge surrounding family planning fuelled misconceptions about contraceptives, such as the belief that they cause fibroids.

When examining some of the misconceptions the community members have such as a fear of permanent infertility, or suspicion of the government's hidden agenda, it is clear they are reflective of sociocultural values surrounding fertility. Even the clients' preference of Depo-Provera and the relatively poor reputation of methods like the IUD or

the implant demonstrate the socio-cultural perception of contraceptives. Women are forced to navigate complex and interconnecting barriers such as stigma and disinformation surrounding these methods, and while this does not always physically bar them from accessing the clinic, the social stigma against contraception is enough to be a strong demotivating factor. Therefore it is understandable that women feel more comfortable with Depo-Provera because it is as an injection, a procedure they are well familiar with, and it has mild side effects. Most importantly, women can discreetly use the method and access the service from a local VHT in private. Additionally, the intrusive nature of the IUD and the implant are understandably unsettling for the client, especially considering the pain associated with insertion and removal. Considering the other social factors impacting a woman's decision-making process to access contraception, undergoing a painful IUD insertion procedure would discourage many. Finally, some of the clients are uncomfortable with the idea of some of the long-term side effects, such as amenorrhea. The absence of their period may cause unease for some of the clients, as menstruation is a familiar part of reproduction, and the prospect of losing that natural function of the body is daunting.

7.2 Perceived Benefits to Modern Contraception: Urban vs. Rural

There are clear and measurable benefits to the uptake of contraception such as lowering maternal and infant mortality, and improved socio-economic status of women. However there are significant perceived benefits from the urban Ugandan perspective that do not translate into benefits in the rural context. As a participant at RHU explained, urban families who work and earn more money see the economic benefits of family planning and having smaller families, particularly because of the higher cost of living in

cities and towns. Yet in the rural areas, often religious and conservative, communities hold stigma against contraception as they see it as interference with God's will or as a devaluation of fertility. This is critical to highlight as western theories and influences in international development have historically been insensitive to the socio-cultural contexts in which they operate (Chiweshe & Macleod, 2018). African Feminist and Womanist theories emphasize that traditional socio cultural values are perceived differently among different classes of women, with communities living in poorer rural areas often holding more conservative and traditional values surrounding the family and procreation. International development projects that engage with contraceptive use in sub-Saharan Africa should keep both of the following perspectives in mind while working with the community. More developed urban areas in Uganda see a higher uptake in contraception because the economic benefits of having a smaller family resonate with urban families. Yet to rural communities, the prospect of smaller families, as well as the perceived interference with God's will translate to increased stigma against modern contraception and the women who use it. The perceived benefits of family planning significantly increase the perceived value of contraceptives for urban Ugandan women, but in rural Uganda, especially in very religious communities, the nature of contraception is a quite sensitive and stigmatized topic. This is exemplified when the participants explained that clients were cautious about taking contraception and took care to ensure they used methods that were discreet such as the Depo Provera injection. When it comes to side effects, the higher rate of contraceptive use in the urban areas demonstrates that the decision to manage side effects is an easier trade-off for the prevention of pregnancy for urban Ugandan women. For women in rural areas, inconvenient side effects validate the

strong stigma against contraception as well as fuel misconceptions about exaggerated side effects.

7.3 Gender Inequality and the Importance of Gender Inclusion.

Socio-cultural values have consistently been cited as a barrier to contraceptives in Sub-Saharan Africa (Kabagenyi et al., 2016; Nahar & Mengo, 2019; Nakirijja et al., 2018; Nalukwago et al., 2019; Parkhurst et al., 2006). This thesis observes these perceived barriers under an African Feminist lens, which seeks to evaluate what aspects of African society unjustly impact women while conserving a sense of identity with African culture and tradition (Shamase, 2017). While certain cultural values may impact a woman's motivation to begin family planning, for example the desire for a large family as explained by the participants, they are not barriers in the same way that misconceptions, a lack of knowledge, and stigma can be; as it is a question of choice and autonomy. If a woman does not wish to take contraception because she wishes to continue to have children, this is not a barrier, but simply a question of personal choice. However, if she is unable to access contraception because her husband does not want her to start family planning, or the male dominated government defunds reproductive healthcare, it is a barrier born out of gender inequality. The participants explained that it was common for clients to report that they could not access contraception because her husband does not want her to use it. They also explained that in their culture, it is typically the men who decide how many children to have in the family as well as control the families' finances. The African Feminist approach to this issue is to examine how gendered power imbalances negatively impact women, and how levelling these power imbalances may empower women and benefit the community as a whole. Emphasis is

placed on the traditional harmonious connection between man and woman and their complimentary roles in life and culture. Based on the data collected, the power imbalance between men and woman in the home can create a schism between them, leading to distrust and suspicion either about what her motivations are to start contraception or the amount of money she needs to start it. A renegotiation of the financial and decision-making power in the household can remedy this and can consolidate their complimentary roles and relationship.

It is critical for village health teams to have the resources to sensitize men just as much as women. Gender inequality and men's stigma against contraception are significant factors why many of these barriers exist and persist. Gendered power imbalances exist in politics, religion, and the household, and they impact women's use of contraception in many ways. Men in influential political and religious circles can abuse their power for their own ideological benefit at the detriment of the health of the community. In the household, men benefit from holding the financial decision making powers in the family when he wants more children than his spouse desires. In fact, the hidden costs to contraception (transportation, lab fees, side effect medication, etc.) can create suspicion in the husband about what his wife is doing with the money since he does not engage in family planning with her. While the western feminist impulse is to decry the financial dependency of women and oppressive family dynamics, African Feminisms explore the issue of gender inequality in the household and society through a familial perspective, cognizant of the complementary relationship between men and women in the continuation of sustainable life. Addressing these unequal power dynamics requires cooperative and inclusive sensitization on how family planning can improve the

overall health of the community, as well as a renegotiation of financial decision-making within the household. These same principles apply to increasing the political participation of women and the general support of contraception, as government funding determines the amount and quality of the services, medicines, training, and outreach programs provided. None of the other barriers will be address or solved without political support and funding.

7.4 A Case for State-Led Development

The United Nation's Sustainable Development Goals are designed to help us achieve a global standard of living whereby every person can live sustainably and with liberty and security. International development workers, such as myself, fiercely aligned with this agenda have been engaged in development projects all over the Global South for decades, yet the African continent's socio economic and political indicators have not improved or have done so extremely slowly (Eisenstein, 2010). Development efforts aim to secure the global standard of living outlined in the SDGs, in Africa where western colonialism and capitalism have upended traditional ways of life while significantly putting the entire continent at a disadvantage in a system of neo-colonialism. Decades of structural adjustment programs[2] (SAPs) placed state governments under pressure to cut social services to education and healthcare, and prevented them from nationalizing their resources (Thomson et al., 2017). Countries subjected to SAPs, which promised

[2] Structural Adjustment Programs are loans from international financial institutions such as the World Bank and the International Monetary Fund to countries in desperate economic hardship. In return, the recipient must comply with various macroeconomic and fiscal policies that typically open their economies to neo-liberal free trade, deregulation, and privatization by multinational corporations (Thomson et al., 2017).

economic development, instead lost their ability to direct their own economies. Aid donated to African governments from the North over the last half century have amounted to over a trillion dollars, yet the aid has done nothing but sustain African countries' cycle of poverty and fuel political corruption (Moyo & Ferguson, 2010; Werlin, 2005). In the context of Uganda, such programs resulted in the mixed healthcare system we see today, where most of the funding for health organizations comes directly from patients in the form of fees. Communities like Luweero have had to assimilate into a new mode of life that is incompatible with their traditional one, as poverty, poor education and limited health services can make it difficult to have a traditionally desired large family and also be prosperous.

Consequently, NGOs and development workers, funded by international lending agencies, have stepped in to fill the gap in a wide range of services that should be the government's responsibility. Shanti birth house is an example of such development efforts, and are currently seeking international funding to sustain their operations. SAPs impoverish women and children especially; due to a reduction of free education, poor healthcare services, and family access to water is often a woman's burden. Lately international development rhetoric has been centered on the empowerment of women, almost completely substituting dialogue around strengthening education and healthcare institutions. Focus on poverty or education has been replaced by the idea that focusing on women's leadership is sufficient. However a better tool to reduce poverty and access to services is state-led development directed towards the basic needs of every person in society. The consequences of SAPs and political corruption, and international development efforts are apparent in the case of Shanti birth house and RHU. Shanti was

founded as an international non-profit health organization with the goal of filling gaps in Uganda's mixed healthcare system, and RHU, who networks with other scarcely funded public clinics, sees their limited budget create inconsistencies in programing and gaps in service delivery. Political corruption was also reported as a barrier to accessing state funding, as the government either ignored applications for funding or unfairly distributed funds, if they ever made it to the ground.

International development efforts, and their particular focus on women's leadership risks fulfilling the ongoing imperialistic relationship between the North and the South by importing mainstream white feminist ideologies that ignore the unique socio-cultural context, and material underpinnings required for empowerment. Based on the narratives of reproductive healthcare workers in Luweero, without direct state-led development planning and funding much of international development work is futile so long as the government is not willing or able to support the people. Empowering women and girls and ensuring their equal rights is the fifth goal of the SDG agenda, and includes ensuring reliable access to contraception and accurate information about family planning. Access to contraception is part of reproductive healthcare and can lower rates of maternal and natal deaths as well as improve the overall health and education of the community. Most importantly, the demonstrated unmet need for contraception demonstrates that women in Uganda want to use family planning yet are hindered by various barriers, denying their fundamental right to reproductive healthcare. The healthcare workers in Luweero have clearly outlined where the access barriers to contraception lie in their community and recognize where funding and development may improve access and quality of care. Male inclusive family planning sensitization, accessible information in

the local languages, funding for free contraception and treatment for side effects are areas identified by RHU and Shanti where government funding would significantly improve contraceptive uptake and reduce stigma. African Feminisms and Womanism should also have a more prominent presence in gender and development work in Sub-Saharan Africa in order to avoid perpetuating neo-colonial and imperialist relationships between the Global North and South. Culturally sensitive analysis must not frame traditional or cultural values as barriers, but rather consider how they impact client's perceptions of family planning, and how these perceptions may be influenced without losing traditional values or sense of cultural identity.

Chapter 8 Conclusion

Healthcare workers and VHTs in rural communities have valuable insight about the contraception dispensing process at the clinics and in the field, working hands-on with clients in delivering information and modern contraceptive methods. My thesis sought to explore how various perceived barriers impact the clients and service delivery at Shanti birth house and Reproductive Health Uganda by holding focus group discussions with healthcare workers. I found nuances and connections between key barriers such as the financial burdens, the impact of side effects, socio cultural values and religion, political corruption as well as misconceptions and stigma. One of the key underlying reasons for many of these barriers is gender inequality, because there are key actors in the contraception debate with political or social power who benefit from ignoring or exacerbating access barriers to contraception. They are the people of influence in (almost always male-dominated) political and religious circles who do not support family planning for ideological reasons, and men who wish to have more children than his spouse desires. This thesis examined these access barriers through an African Feminist lens, allowing for a more culturally sensitive analysis that found how socio-cultural factors interact with barriers to influence rural Ugandan women's perceived value on family planning. It is imperative international development efforts use theoretical frameworks that are culturally appropriate for the context in which development efforts operate and always be aware of their own western bias and perceptions. African feminisms inform the theoretical framework for this thesis and addressing gender inequality in rural Uganda, demonstrating the need for gender

inclusive sensitization, a renegotiation of the decision making power within households, and community led state funded development.

Addressing these issues requires strategic planning and funding, which both Shanti and RHU work very hard to do, however the financial barriers they face create challenges for them in the field. It is clear that as an older and publically funded organization RHU has more resources at its disposal to deliver family planning in the community, but still struggles to have consistent programming and sensitization programs for men. Shanti, which started as an international non-profit, works to fill gaps in the public services provided in rural areas by relying on international donors to subsidize their contraception and fund their services. This represents a fundamental issue within development and international development in particular. Decades of development work and aid has been poured into African countries like Uganda, yet maternal death, a key development indicator, in Africa is still among the highest in the world. This thesis made a case for a state-led development agenda that sees funding distributed fairly across sectors, as the majority of the population get their health services from governmental health organizations. Yet this is nearly impossible to execute while the state must follow SAPs, aid donated to the government is lost due to corruption, and international development organizations fail to adapt their work and research to be culturally and socially conscientious and reflexive. The participants in my study, through their hands-on experience and expertise on the cultural context of Luweero, have many ideas on how to improve access to contraception in their community, such as sensitizing men, distributing information material in the local language, free contraception and side effect treatment, and supporting VHTs. If funding manages to reach the organizations on the ground,

private or public, dedicated reproductive healthcare staff and village health teams will fill key gaps in service delivery, sensitization efforts, and subsidized contraceptives in order to serve Ugandan women with their reproductive autonomy.

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