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How can we provide access to family planning services in a culturally respectful and ethical manner in developing countries? A Ugandan Case Study

Uganda has the fifth highest fertility rate in the world, and one of the lowest family planning usage rates. While many governments and NGOs measure only physical and economic factors when assessing if a family planning services are accessible, the major barriers to access are misconceptions about contraceptive safety and cultural stigmas. Family planning usage improves health outcomes for both mother and children, and can lead to economic development. Furthermore, being able to use family planning if and when she chooses allows a woman to have greater bodily integrity and health, which ultimately increases her opportunities in life. Because of this, being unable to access family planning services is socially unjust, even in a society where some claim that the provision of family planning is culturally imperialistic. This paper aims to outline the barriers to access in Uganda, analyze the benefits of family planning, and argue for the improved access to family planning from a social justice perspective.

How can we provide access to family planning services in a culturally respectful and ethical manner in developing countries? A Ugandan Case Study

Case Study: Kasambi'ika Village, Iganga District, Uganda. Summer 2013.

In this village of about ~2000 people, a small NGO called Uganda Village Project placed a team of American and Ugandan interns to educate the community about public health concerns and coordinate the cooperation of existing local resources. One area of work was in family planning. When holding an initial focus group of 25 local villagers to discuss areas of improvement for the village, a common theme that arose was the need for more information on family planning. Many misconceptions about the dangers of FP were raised by both men and women: FP causes permanent infertility, it weakens the woman and makes her unable to work, it causes cancer, it causes deformities in later children, etc. Men in particular stated the need for male-only FP sensitization: previous NGOs in the area focused on and educated only women, leaving husbands to get (often false or incomplete) information from village rumors. Male and female interest in FP seemed high despite the negative views and low self-reported usage of FP; many in the focus group lamented the problems of having too many children and not being able to feed, clothe, and educate all of them. They stated that people used to have lots of babies to replace the ones that died, but that children are more likely to live today than in the past[1] Average family size in Kasambi'ika, however, is still high at 4-6 children; many (especially polygamist) families had 8-10 children (even per wife).

At our FP sensitization, immediately after which a nurse was available to provide FP to the female attendees for free, only 26 women attended, and 4 males (3 of whom came with their wives, 1 came alone just to learn). At this sensitization, we rapidly ran out of injectable Depo-Provera; several women left without any FP rather than having to resort to the Pill. One notable patient was a young woman with a toddler about three years old. She was 19 years old, and had already had two miscarriages. She wasn't ready to have another child because she couldn't afford it. When asked if she had a preferred method, she immediately said the "shot," explaining that, "If my husband finds out, he will beat me." Women could hide a scab from their husbands better than a pack of pills. This intentional deception of FP usage by wives was echoed multiple times throughout the two-month program. The local Health Centre complained that they usually ran out of Depo-Provera the first week after a new shipment due to high demand, but always had a surplus of the Pill. Men said they would not allow their wives to take FP because it is dangerous/it lowers their libido/it makes them spot and thus unable to have sexual intercourse. And another common reprise: Why would I want and allow my wife to have fewer children?

This case study is an illustration of common attitudes about FP in Uganda, showing that provision of FP at a low or no monetary cost is not enough for women to be able to use it. While Kasambi'ika is just one village in all of the country, the data about FP usage suggests that this is more than an isolated incident in one village. By far, the most popular type of modern contraception used in Uganda is the Depo-Provera injection, with 51.7% of users choosing this method (FP2020). While the popularity of a single type of contraception does not seem significant (even in the United States, one method, the Pill, dominates[2]), further investigation

[1] As recently as 1990, 186 infants/1000 live births would die before reaching age one (WHO). Today, as noticed by the villagers, this infant mortality rate has decreased significantly: to 60.82 deaths/1000 live births (CIA World Factbook). While an improvement, this is still the 21st highest infant mortality rate worldwide.

[2] In the United States, 62% of all women of reproductive age are currently using a contraceptive method; 27.5% of those users choose the Pill as their preferred method (Guttmacher "Contraceptive Use in the United States").

into the motivations for use of Depo-Provera and overall lack of usage of FP reveals a multi-faceted decision made by rural Ugandan women that raises complex ethical questions about FP access and usage.

Introduction

In many parts of the developing world, NGOs, private donors, and governmental organizations work to provide family planning services to women. Despite the $4.1 billion spent worldwide in 2013 on family planning services in developing countries, an estimated 877 million women have an unmet need for contraception (Singh et. al 2014).[3] Considering the billions of dollars poured into FP and development projects, it is important to analyze and understand why we are trying to provide FP services, even in communities where some people might be hostile to the idea. In Uganda, particularly rural areas, the usage of modern family planning methods is even lower than in most developing countries: only 22.6% of Ugandan women use modern contraceptives (FP2020)[4]. Meanwhile, Uganda has the fifth highest fertility rate in the world (5.97 children born/woman in 2014) (CIA World Factbook). Usage of family planning methods is a complex personal choice, but I argue in this paper that the lack of bodily autonomy and the consequences of unintended and unwanted pregnancies from lack of access to FP lead to human rights violations and detrimental effects on human capabilities that are socially unjust. To rectify this injustice, we must first examine the complex barriers to accessing FP that women face, why having access to FP is necessary for health, economic development, and individuals' capabilities and opportunities, and how exactly lack of access to FP is unjust. Then several suggestions for

[3] Unmet need is defined as those who wish to avoid pregnancy, but are currently using no method or a traditional, uneffective method of contraception (Singh et al. 2014).

[4] Compare 22.6% FP usage rate in Uganda to higher rates in neighboring countries Tanzania (34.4%) and Kenya (45.5%) and 76.4% in the United States (CIA World Factbook).

improving access while avoiding being culturally imperialistic will be proposed in a context of social responsibility for justice.

Barriers to Access of Family Planning

What is "access to family planning services"?

The term *family planning services* used in this paper includes both education about FP and the contraceptive treatments themselves. *Access* in this sense means more than the physical ability to go to a health center, pay for, and receive contraception. It is instead a more comprehensive word that signifies being able to overcome the actual costs of transportation, a doctor's visit, and the contraception; the opportunity costs of wages lost from time spent at the clinic; and the societal and ethical costs of using FP derived from stigmas attached to contraception (elaborated on more later). Too often, programs focus only on the actual cost of FP programs, leading to bewilderment about low usage rates when family planning services are offered free in many developing nations, including Uganda[5]. This skewed view of values leads to more money being spent and arguably wasted on decreasing physical barriers[6] (opening more clinics, subsidizing costs, etc.) and increasing awareness through advertising[7], when there are other, nonconcrete barriers preventing usage. This paper, however, focuses beyond the economic actual and opportunity costs of FP access, and instead concentrates mainly on the oft-ignored

[5] All basic health services, including FP, are "free" in Uganda's five-tiered public healthcare system. However, bribery of doctors is relatively common, with doctors unwilling to provide services without additional fees that many of the most vulnerable women are unable to pay.

[6] Only 7.6% of women report the reason for their nonuse as being unable to physically obtain FP (Sedgh and Hussain 2014). Being sure that medical centers are plentiful and accessible is important for health, but this shows that physical barriers are not the main reason for nonuse of FP.

[7] Radio ads and billboards that display FP facts and are funded by development agencies and reproductive health NGOS are common in Uganda, showing a concern that people are not aware of the contraceptive options available to them. However, studies show that nearly everyone in Uganda is aware of FP methods, they just choose not to use them for other reasons: only 1% of women not using FP reported the reason for their nonuse as being unaware of methods (Sedgh and Hussain 2014), and

societal and ethical costs of using FP services and how to address these barriers to use in a culturally sensitive manner.

Tension within the Self: Women's Reasons for Not Using Family Planning

In a study aiming to understand the low FP usage rate in developing countries, researchers use data from Demographic and Health Surveys in which married women list their motivations for nonuse of FP (Sedgh and Hussain 2014). In Uganda, the most common reason cited by women was concern about potential health side effects from the drugs (36.4%). Understanding how hormonal birth control prevents conception is difficult even for individuals with a college education, let alone those with only several years of primary school. Considering that only 7% of the female population of reproductive age (15-39) has completed primary school (Uganda DHS 2011), and that only 64.6% of Ugandan women are literate (CIA World Factbook), lack of education becomes a large barrier to FP usage because taking a medication to prevent the very natural phenomenon of pregnancy can seem disconcerting. Additionally, many women have valid concerns about the safety of FP. Many women hear from neighbors, friends, or radio talk shows that modern medicine, including FP, can serious side effects: half of Uganda women of reproductive age believe that contraception can cause permanent infertility, and 41% believe that intrauterine devices (IUDs) cause cancer (Mugisa 2013). Other women have even more concrete and short-term concerns: they know a woman who used FP, and she said it gave her headaches, or backaches, or changed her menstrual cycle[8]. In rural villages, the main source of information is from other community members, leading to widespread misunderstandings of and concerns about FP.

[8] 47.5% of Ugandan women who have used a modern contraceptive method in the past report suffering from side effects (Sedgh and Hussain 2014).

While there are many unfounded worries in Uganda about FP methods that have been repeatedly tested for safety and efficacy, mild side effects of various FP methods are actually quite prevalent, particularly in the first three months after first usage when the body is adjusting to the artificial hormones. Reports of headaches, bloating, weight gain, breast and/or back pain, spotting in between menstrual cycles, cramps, nausea, lighter or heavier periods, and/or mood changes are all common ("Birth Control Pills" 2013). In Uganda, however, most women are not warned about the potential side effects by their FP provider, nor are they told that symptoms usually go away after three months. Thus after starting FP, women become concerned by these unexpected side effects, and usually not only stop using FP, but tell their friends, family, and neighbors about their bad experience with FP. In comparison, American women often suffer the same side effects, but having been warned about them, they usually wait out the first three months. From that point, either side effects are gone, or they talk with their provider about switching types. The viability of switching types of FP is considerably less in Uganda, however, because most health centers have limited resources, only carrying 1-3 types of pills[9] and one dosage of an injection, which prevents providers from prescribing a type of FP that best fits their patients' needs and may contribute to high concerns about side effects.

Ugandan women also worry that FP prevents them from fulfilling their duty as a wife (Sedgh and Hussain 2014). In traditional Ugandan culture, it is desirable to have large families, and especially lots of sons. A large family connotes wealth, power, and virility of the husband (and by extension, of his wife) (Otiso 2006). The cultural practice of paying a bride price (*lobola*) reinforces this sense of obligation to her husband: in many ethnic groups, the bride's

[9] In the United States and other developed countries, there are over 130 different formulations of birth control pills that are available to women by prescription ("Birth Control Pills" 2013), allowing physicians to prescribe a more specific type that best fits the needs of their patients. This wide range of choice decreases side effects, since women respond differently to each formula of hormones.

family will receive several cows, goats, and other goods in exchange for her hand in marriage (Blanc et al. 1996). This payment is to both seal the marriage and to compensate the bride's family for the loss of her labor (Otiso 2006). This not only creates a construct in which the bride is seen as "purchased" by the husband, and thus his property, but also creates feelings of obligation towards her biological family. Inability to have children or unwillingness to have sex is reason enough for divorce in Uganda, but a wife returning home to her family requires return of the bride price to her ex-husband, decreasing the livelihood of her own family.

Furthermore, women may internally debate the costs and benefits of using FP. In the United States or another country where women have more opportunities for education and careers than women in Uganda, the opportunity cost of becoming pregnant is much higher, because pregnancy (and motherhood) impedes other goals the woman may have. Also, in most Western societies, there is a strong stigma against a teenage girl becoming pregnant and dropping out of high school. In Uganda however, only 12% of females have attended some secondary school (Uganda DHS 2011), and most women become homemakers and subsistence farmers. This perceived (and to some degree, actual) lack of opportunities beyond motherhood and wifehood lowers the opportunity cost of pregnancy compared to that of American women

Tension within the Family: Spousal Conflict

A major reason that many Ugandan women do not use FP is because their husbands disapprove. In Ugandan culture, the man is the head of the family, and he gets to make decisions for the family[10]. These decisions include health decisions[11] such as how many children to have,

[10] The Uganda DHS reports that 38% of married women participate in all major household decisions (eg: the woman's own health, making major household purchases, or visits to her family), while 21% participate in none.

and when. As seen in the opening anecdote, 15% of women often use FP secretly, knowing that their husband would not approve (Blanc et al. 1996). If found out, however, the women risk domestic violence at the hands of their husband. Domestic violence is widespread in Uganda: 62.2% of women have reported being physically, sexually, or verbally abused by their husband (Uganda DHS). One reason cited by women for this violence was FP usage (Koenig et. al 2003). However, domestic violence is so common in Uganda that it is not seen as violence or abnormal: 58% of women report wife beating as "justified" in at least one scenario[12] (Uganda DHS). Despite this view that wife beating is acceptable, domestic violence lowers a woman's bodily health and integrity, and makes her less likely to use opportunities available to her, including health care services (Uganda DHS). This familial power struggle creates a tragic choice: does the wife protect her bodily health from pregnancy risks by using FP, or does she protect her bodily health from physical violence by not using FP?

Male disapproval of FP stems from multiple reasons. Men in Kasambi'ika reported worries about the side effects, both for their wife's health and their own sexual desires. As noted, most NGOs focus mainly on educating women about FP, so men learn about FP secondhand, often hearing misinformation and rumors about the dangers of FP to a woman or her future children. From a more self-interested perspective, men reported that FP interfered with their ability to have intercourse with their wife. In Uganda, it is taboo to have sexual intercourse while a woman in menstruating, however, many FP methods can cause spotting in between menstrual periods, thus decreasing the bleeding-free days when it is acceptable to have intercourse.

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[11] 43.4% of men make their own health decisions independently of their wife; in comparison, only 23.3% of women make their own health decisions independent of their husband. 39.1% of women have their health decisions made for them by their husband (Uganda DHS).

[12] Survey participants were asked: "Is a husband justified in beating his wife if she: 1. Burns the food. 2. Argues with him. 3. Goes out without telling him. 4. Neglects the children. Or 5. Refuses to have sexual intercourse with him?" (Uganda DHS).

Another common reason that husbands do not allow their wives to use FP is because of cultural beliefs about family size. A man with many children is seen as wealthy and powerful, so men are motivated to have more children to increase social standing (Otiso 2006). However, Ugandan men usually do not help with childrearing (nor do they experience the pains and complications of childbearing). Women traditionally are responsible for cleaning the home, cooking all of the meals, growing the food for the meals, and taking care of the children: the home is the woman's domain and responsibility (Godfrey 2010). Consequently, many women wish to have fewer children because they are exhausted; however, despite his lack of participation in childrearing responsibilities, their husbands wish to contain having children, and so the use of FP is prohibited.

Husbands may also be motivated to prohibit usage of FP because of concern about social stigma. 80% of the Ugandan population lives in rural villages (CIA World Factbook), where all villagers know one another, and gossip is rampant. As explained above, women are often worried about going to the health center or pharmacy to pick up FP, because neighbors will inevitably see, and the news will probably reach her husband. Likewise, a husband may not want neighbors to see his wife obtaining FP, because of widespread beliefs that FP is only for prostitutes (Segdhen and Hussain 2014). If a man's wife is known to use FP, it could lower social standing of the family because of perceived promiscuity. A wife's usage of FP can also raise suspicions about her moral character to her husband. FP allows women to have sexual intercourse without the potential consequence of pregnancy; as a result, many husbands perceive FP as a means to have an extramarital affair, without the risk of being found out (Blanc et al. 1996). This fear of potential cuckoldry is often the source of anger and resulting violence when a man learns that his wife has been using FP without his permission.

Another source of tension in the family regarding FP usage is among wives. Polygyny is relatively common in Uganda[13], mostly among Muslims. According to the Quran, a man may take up to 4 wives. Polygamy can induce competition among wives in order to gain the attention and favors of the husband. In poor, uneducated households where women do not work outside the home, a main source of competition is children. If one wife conceives, the other(s) will likely try to conceive as well, so that they do not have fewer children than the other wives. As a result of actively trying to conceive, women in polygamous relationships have, on average, more children than women in monogamous relationships.

Tension within the Community: Religion, Culture, and Foreign Influence

A major source of tension about FP is distrust between the user and the provider. Most FP is either provided or funded by Western groups, included NGOs and governments. Because those who often are the strongest proponents of FP in Uganda are foreigners, Ugandans sometimes question the motivations of Westerners behind spreading FP usage in Uganda. One such concern that was heard in Kasambi'ika is that FP is unsafe and causes cancer, HIV, infertility, or infant deformities, a "fact" that Americans know and yet still aim to increase FP usage in Uganda. While this is not true, past Ugandan policy on FP points out the potential and even desired outcome of the state using FP to control fertility. In 1995, Uganda adopted the National Population Policy, which aimed to shape Ugandan demographics to better use limited state resources to improve life outcomes and health for fewer people; one way to decrease the rapid, unmanageable population growth was through the goal of doubling FP usage rates in the next five years (from 7% in 1995 to a goal of 15% in 2000). Usage of FP can improve health

[13] 25% of women in Uganda are in a polygynous marriage (Uganda DHS). Polygamy is less common among urban women (20%), and varies greatly among regions (ranging from 17-51%).

outcomes for individuals and a population as a whole, but care must be taken in the enactment of these policies to avoid coercion. The danger of using FP to control and limit reproduction can be observed from analyzing FP programs in Namibia in the 1970s: many women were given IUDs, tubal ligations, and even hysterectomies (during labor or other surgeries) without their knowledge, let alone their consent or choice (Turshen 1991). Because of the rocky past of FP programs in Africa, some Ugandans today mistrust foreign funding and providers, thinking that FP is a method for the United States to control populations in the developing world. Overall, misunderstanding of the motivations behind FP programs can easily spread, decreasing use of FP.

Why provide access to family planning?

Despite these tensions at the individual, familial, and cultural levels, there are numerous reasons to provide women and couples with access to FP services. Primary motivation often varies based on the specific provider: governments, NGOs, private donors, etc. Considering access to family planning is crucial in development work and in both monetary and capabilities approaches to poverty. Access to FP also improves maternal and child health. From an ethical standpoint, however, all of these benefits of FP ultimately aim to improve women's opportunities in life; fair equality of opportunity is required for a just society.

Family planning access improves health outcomes for women and children

Uganda has one of the worst maternal and infant mortality rates in the world[14]. While there are many ways to improve maternal and child health, including provision of more and better quality health services through conception to adulthood (including antenatal visits, giving birth in well-equipped health centers, vaccinations, etc.), the most cost efficient way to improve health outcomes is by improving access to FP (Singh et al. 2014). FP allows women to control their fertility in three ways, all of which influence health: to delay having children, to stop having children, and to space apart children.

Even though it is culturally taboo to talk about sex or to have premarital sex, 64% of Ugandan s are sexually active by the age of 18 (Nalwadda et al. 2010). 25% of births are to teen mothers (Nalwadda et al. 2010), but labor is particularly dangerous for teen mothers because their bodies are not fully developed yet. On average, the pelvic cavity of teens is not fully widened and developed. Consequently, complications such as obstructed labor and obstetric fistula are more common among teen mothers (Tebeu et. al 2012, *Facts for Life* 2010). This results in mortality rates being disproportionately high for teens: nearly half of all mothers who die during childbirth in Uganda each year are between the ages of 15-24 (Nalwadda et al. 2010). FP usage among teens and young women, whether married or not, allows women to wait to have children until they are physically, and also emotionally, mentally, and financially ready to have children.

FP also allows women to stop having children when they want or need to. Having more than four children is very taxing on a woman's body, especially if she is malnourished. Risk of

[14] Uganda's maternal mortality rate is 310 deaths/100,000 live births; infant mortality is 60.82 deaths/1000 live births (CIA World Factbook). By comparison, the mortality rates in the United States are much lower: 28/100,000 live births for mothers and 7/1000 live births for infants. Neighboring countries Tanzania and Kenya have better health outcomes for children, but worse outcomes for mothers (Kenya 360/100,000 mothers and 40.71/1000 infants; Tanzania 460/100,000 mothers and 43.74/1000 infants).

pregnancy complications significantly increases after the fourth child. This medical fact is echoed by empirical studies of FP: a common reason that Ugandan women cite for wanting to use FP (Sedghen and Hussain 2014) is that their last pregnancy was complicated, and they wish to avoid future health risks by becoming pregnant again, either by their own volition or a doctor's recommendation.

The most common reason that women in Uganda wish to use FP is for birth spacing. Because of traditional values placed on having large families, many women do not see FP as a means to limit the overall number of children, but rather a way to have healthy, well-spaced babies. Birth spacing allows infants to be breastfeed longer, which helps prevent childhood malnutrition. It also allows the mother to recover from pregnancy, so her next one can be healthy. The WHO recommends a minimum of 36 months between births; in contrast, most Ugandan births occur within the first 24 months after a previous birth (Uganda DHS). Using FP to space births improves the health of both mother and child. Birth spacing also allows mothers to better care for their children. As one mother in Kasambi'ika explained, she uses FP because "It is too difficult to carry two babies and a hoe." Spacing births allows infants to reach a more independent age before the next baby is born, so the mother can still tend to her agricultural duties without having to carry two young babies. This in turn benefits the dietary health of everyone in the household, since the mother's (who is often responsible for growing most of the family's food, Godfrey 2010) agricultural output is not as hindered by two infants.

Overall, FP allows the number of unwanted pregnancies to decrease at any point of a woman's reproductive history, whether it is in the beginning by delaying pregnancy, in the middle by spacing births, or at the end by limiting family size. More than half of pregnancies in Uganda are unintended; nearly a third of these end in abortion ("Abortion in Uganda"). This

leads to a very high abortion rate (54 abortions per 1000 women of reproductive age) in Uganda compared to the East African average of 36 abortions/1000 ("Abortion in Uganda"). Therefore, since access to FP can decrease the number of unintended pregnancies, access to FP can decrease the number of abortions. This decrease in abortions can significantly improve women's health considering that the majority of abortions are illegal and therefore conducted in secret. Ugandan law states that pregnancy termination is only legal is cases of "fetal anomaly, rape and incest, or if the women has HIV" ("Abortion"). More affluent women who do not fit these limited criteria can afford to pay actual doctors and nurses to perform a clandestine operation, but poor rural women who cannot afford this must resort to unsafe abortions conducted by people with no medical training, putting them at great risk of injury. Common complications from unsafe abortions include septic shock from infection, incomplete abortion, hemorrhage, and/or lacerations or perforations of the uterus ("Abortion"). In fact, 68-75% of poor rural women who had an abortion had later complications, compared with only 17% of nonpoor urban women who could go to a medical professional ("Abortion"). These complications often lead to death: the Ugandan Ministry of Health reported that about 26% of all maternal deaths were caused by abortion-related causes ("Abortion"). Arguably, the best way to prevent abortion-related injuries and deaths is to change Ugandan law regarding abortion and to better train providers when dealing with post abortion complications. However, many abortions can be avoided in the first place by providing better access to FP; therefore improved access to FP improves health.

Family planning leads to economic development that can alleviate absolute poverty

Governments of developing countries, for example, are generally most motivated by the economic benefits of FP access. Usage of family planning allows alleviation of absolute poverty (Longwe-Ngwira 2014). Absolute poverty—the lack of income sufficient to buy goods to meet basic needs—can be decreased if families limit the number of children they have by allowing better allocation of a small, limited budget. It is easier to pay for four kids rather than the traditional eight, for example. These four children will be able to eat better and will be more likely to all be able to go to school than if their family had eight kids, which in turn will help them be more economically productive as working adults. Girls especially are unlikely to attend school if a family's budget is limited due to inability to pay for supplies, books, uniforms, and school fees (Uganda DHS). By having fewer children, a family can better educate all of their children, including the girls. Girls with more education are less likely to become pregnant before marriage than their uneducated peers (Uganda DHS), and are in turn more likely to educate their daughters. Education helps individuals obtain better paying jobs and be more productive members of society. Thus there is an important economic development benefit to family planning services.

Family planning alleviates poverty from a capabilities approach

Not only can access to FP help decrease poverty in the sense of a lack of income to afford basics necessary for survival, but it can also alleviate poverty from a capabilities perspective. Amartya Sen contends that the lack of income that usually defines poverty is in fact merely an instrument to afford what truly matters in life: having the capability to have a "good" life. Nussbaum continues this perspective and creates a list of the ten central capabilities that must be provided for in order for an individual to lead a dignified life deserved by all human beings. These central capabilities include the capability to have bodily health, and the capability to have

bodily integrity (Nussbaum 2013). Access to FP is one way to allow women the capability of health and bodily integrity. As described previously, FP can improve health outcomes for women and children. Furthermore, being able to choose when to have children and how many to have is a necessary part of having bodily integrity as a human being. When considering poverty from this capabilities approach, access to FP not only improves health, but it also diminishes poverty by helping women lead more dignified lives as agents of their own bodies.

Some Ugandan women want to use family planning

On a more basic— but arguably more important— level, a major reason to provide women in Uganda with improved access to FP services is because women want to use FP. This desire to control their fertility is seen in the opening anecdote and in a plethora of data. Many women in Kasambi'ika want to be able to provide a better life for fewer children; this desire was so strong that they were willing to walk several miles each month to get birth control, and many were even willing to risk domestic violence. While the most common reason cited for FP usage in Uganda is birth spacing, some women simply wish to have smaller families. One study showed that women in Uganda generally have 6.2 children, but on average, report their desired family size as 4.5 children ("Abortion in Uganda"), showing a discrepancy of approximately two children between their wants and reality. This discrepancy is decreased as women are empowered through education and wealth: the fertility rate decreases from 6.9 children per woman with no education to 4.8 per woman who has completed secondary school; 4.0 children are born per woman in the highest wealth quintile compared to 7.9 born per woman in the lowest quintile (Uganda DHS 2011). This data shows that women, when allowed and able to make their own decisions, often choose to have fewer children, supporting the argument for expanded FP access.

Social Injustice of Lack of FP Access

From an individual to international scale, a complex network of perspectives on female autonomy and bodily integrity results in tensions surrounding the idea and usage of FP. Since most FP services in Uganda are provided/funded by Western organizations, concerns exist about the ethics of FP provision: is it culturally imperialistic? Despite these concerns, access to FP matters because the health inequalities created by lack of access are socially unjust.

Health Inequalities from Lack of Access to FP are Unjust

As previously explained, lack of access to FP results in poorer health outcomes for women and their children. In *Just Health*, Norman Daniels presents an ethical framework for determining which health inequalities are acceptable, and which are unjust using Dahlgren and Whitehead's checklist (Daniels 82). For a difference in health outcomes (that is, a health inequality) to be unjust, it must be *avoidable*, *unnecessary*, and *unfair*.

Arguably, the health inequalities faced by women in Uganda are not avoidable: all women in the world face health risks beyond those faced by men because of their reproductive capabilities. Evolution of humans into large-brained bipedal animals with small pelvises has made childbirth an extremely laborious and dangerous phenomenon (Rosenberg and Trevathan 2007). According to Daniels, if these risks are inherent to female humans and are thus unavoidable, society would just accept these risks as part of life, rather than as an injustice that must be remedied. However, modern medicine allows a large part of this risk to be alleviated:

The infant mortality rate in the United States[15] is 7/1000 live births; the maternal mortality rate is 28/100,000 live births (CIA World Factbook). Compared to Uganda's significantly higher rates[16], this shows that poor health outcomes for mother and child are in fact avoidable. While it would not be easy to improve health in Uganda to the same levels of rich, developed countries, it is feasible to at least reduce the health inequalities faced by some Ugandan women, thus making these health inequities avoidable.

Opponents to FP and reproductive rights and health programs similarly may claim that the health inequalities stemming from childbirth could be deemed necessary to society: to continue a society, people must reproduce. Despite cultural norms in Uganda, having 4-8 children is not necessary for society, even in Uganda. This is evidenced by much lower fertility rates of urban and educated women, as noted previously (Uganda DHS); despite these lower fertility rates, urban and educated Ugandan women are still "Ugandan". In fact, continuing to have large families can cause economic and social unrest due to the traditional agricultural partible inheritance system (Verschoor 2008). When a son has matured, he is given a piece of his father's land to build his home, grow his own crops, and support his family on. However, this system leads to the land grant becoming smaller and smaller with each generation (Verschoor 2008). Today, many land grants are too small to grow enough food to support a large family, necessitating that the family moves to another village and purchases land or that part or all of the family moves to the city and gives up agriculture. This remittance system of having one or two

[15] The United States actually is one of the developed countries with the worst indices of maternal and infant health. Most developed European countries have infant mortality rates of 2/1000 and maternal mortality rates under 5/100,000 (CIA World Factbook).

[16] Uganda's maternal mortality rate is 310 deaths/100,000 live births; infant mortality is 60.82 deaths/1000 live births (CIA World Factbook). Neighboring countries Tanzania and Kenya have better health outcomes for children, but worse outcomes for mothers (Kenya 360/100,000 mothers and 40.71/1000 infants; Tanzania 460/100,000 mothers and 43.74/1000 infants).

family members working in the city and sending money home to the village is fairly common throughout Uganda. While having many children is a part of traditional Ugandan culture, this act is actually causing greater departure from the traditional culture as families become unable to rely on agriculture and unable to live together. Arguing that having many children is a crucial, necessary part of Ugandan culture is refuted by this evidence. Having some children is necessary to society, but having many children is not necessary; therefore the health inequalities faced by women by having many (often unintended or unwanted) pregnancies are unnecessary.

Because these health inequalities are not faced by everyone in society (only women), they are unfair. Additionally, poor, rural women in Uganda have much higher rates of poor health outcomes resulting from pregnancies and childbirths (Uganda DHS), and higher rates of unwanted pregnancies ("Abortion"), making health inequalities among women of different social classes unfair as well.

Overall, the health inequalities faced by Ugandan women due to lack of FP meet all necessary conditions to be unjust: they are avoidable, unnecessary, and unfair.

Why do we care that these health inequalities are unjust? Health and fair equality of opportunity

Health is of special moral importance because it has both intrinsic and instrumental value. That is, not only is having good health a part of a "good" life in itself, but having good health enables an individual to partake in opportunities available to him or her (Daniels). Because of this, health justice is necessary to protect fair equality of opportunity for individuals. This holds true for Ugandan maternal health inequalities: women who face unjust health inequalities from pregnancy, labor, and/or motherhood have fewer opportunities in life than a man or even a

healthy mother. The most obvious example is maternal death during childbirth: if a mother dies, she misses out on all opportunities in life. Even uncomplicated, but unwanted pregnancies that could have been prevented by better access to FP limit a woman's opportunities to work, play, and learn because she now has another child for which she must care.

Lack of access to FP is unjust not only for married women, but for unmarried teens as well. Although there is no formal pregnancy policy in Ugandan schools, it is common practice for pregnant girls to be expelled, because school officials believe that seeing a pregnant peer will encourage immorality and promiscuity among the other students (Nalwadda et al. 2010). Becoming pregnant therefore limits her opportunities in life by preventing her from completing her education. Teen fathers do not face the same inhibition of opportunity; they are still allowed to finish their education.

Overall, the health inequalities, including unwanted pregnancy, faced by Ugandan women limit the opportunities available in life to these women, creating a social injustice that must be rectified.

Why do women have a right to fair equality of opportunity, despite traditional cultural values? (Cultural imperialism and FP)

Claiming that lack of access to FP is socially unjust relies on the normative claim that all people have a right to fair equality of opportunity. Using this rhetoric of rights—that is, saying that women, as humans, have a *right* to health and fair equality of opportunity—is commonly criticized. These critics posit that rights cannot be given to individuals without the institution of the state; that is, some argue that rights are acquired through legislation, rather than being something inherently possessed by all humans. Amartya Sen calls this criticism the *legitimacy*

critique (Sen 230). While Sen believes that rights are intrinsic, he argues that regardless of where one thinks these rights arise from, they exist and must be allowed for. Today, most nations recognize certain human rights by having signed and ratified various human rights bills. Uganda is included amongst these nations: in Article 51 of the Constitution of Uganda, the state established the Uganda Human Rights Commission as a body to monitor and advocate for human rights in Uganda. Uganda is also a member of the African Union (AU), which created the African Charter on Human and Peoples' Rights, as well as the Protocol on the Rights of Women in Africa ("Reproductive Rights" 2014). Ugandan participation in these national and international organizations and ratification of various bills shows that in Uganda, women do have certain rights. According to the Protocol of the Rights of Women, states are required to take steps to end gender discrimination and "those harmful practices which endanger the health and general well-being of women" (Article 2), which include "all behavior, attitudes, and /or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education, and physical integrity" (Article 1). Health and reproductive rights, including the right to control one's fertility (including through FP usage), are required to be "respected and promoted" according to Article 14 ("Reproductive Rights"). Regardless of whether these rights arose before or after Ugandan state ratification of this bill (although Sen, and I, believe that these rights are innate to women as humans), Ugandan women do have a *right* to health, choice in reproduction, bodily integrity, and the fair equality of opportunity that these health rights allow.

Even though Ugandan law supports the promotion of gender equality and women's rights to health, perhaps the most common concern about provision of FP is that the values behind female reproductive choice are not universal, making these FP programs culturally imperialistic. Empowering women and saying that they have "rights" can be extremely controversial in some

cultures. In many traditional societies, Uganda included, women are seen as inferior to men, who wield the power in the family, community, and state. This power inequality is seen in almost all aspects of daily life, even in something as simple as greetings. When greeting a man, a woman kneels and murmurs her response, without making eye contact, to show her respect. Many women call even their husbands "master/lord" in their local language (Godfrey 2010). FP, as we have seen from an analysis of the cultural barriers to access, involves more than just women's health, but also women's *choice*. Considering that NGOs and groups that provide and fund FP in Uganda are often Western groups, concerns that they are trying to impose Western values of female empowerment, and in the process destroy local traditional values, are justifiable. This cultural critique of the human rights approach is worth examining, but I argue that human rights reign over culture.

First of all, female equality to men is definitely not a *traditional* Western value. Since Ancient Greece (and before, but the foundation of most Western values of personal freedom began with the classic thinkers of Greece), Western women were seen as physically, mentally, and intellectually inferior to men, and were sequestered in the privacy of the home as obedient mothers and wives. Women were not allowed to vote until 1920 in the United States, and even today, gender discrimination and inequality is widespread. Thus the argument that FP groups are imposing Western values of independent women on Ugandans is erroneous; rather, FP groups are encouraging Ugandan participation in an international movement of human rights for all people (Nussbaum 2000).

Furthermore, cultures have been interacting and changing for millennia. While recent economic and social globalization does make cultural assimilation occur more rapidly, culture is not a static concept that can be destroyed by changes. Sen cites an example of changes in Indian

food. Today, an integral part of Indian cuisine is the chili pepper (Sen 243), to the point that India is the world's largest producer, consumer, and exporter of chili peppers. However, prior to just a couple hundred years ago, Indians did not even know of the existence of chili; it was not until the Portuguese brought them from the Americas in the late 1400s. While this is just a simple example of culinary evolution over time, it illustrates a larger point that cultural aspects can and do change over time. Recognizing this reveals a contradiction in the claim that FP programs are antagonistic to "traditional" Ugandan culture, which has most likely changed in some ways over time. For example, Ugandan religious values and beliefs have greatly changed in the past few decades: today, 85% of Ugandans are Christian (CIA World Factbook). This is a rather recent change: the first Christian missionaries arrived in Uganda in only 1875 (Church of Uganda), and demonstrates that Ugandan culture can and does change.

Most importantly, culture is a social construct made by the people who are a part of that society. Ugandan women are a part of Ugandan culture, and as such, they have a voice in what their culture values and believes. However, this is usually not the case; as explained previously Ugandan women often use FP in secrecy, risking domestic abuse to be able to control their reproduction. This deception shows their lack of negotiating power and voice in even their marriage, let alone their culture (Blanc et al. 1996). Sen points this out as well: "culture" is usually a construct made and maintained by those in power. However, all people, regardless of their position in society, are humans, and therefore have rights. Ugandan women are a part of Ugandan culture whether men recognize them as free agents or not; as participants, they also deserve a voice in what they value and their conception of the good life, including their views on fertility.

Because of this, saying that FP programs are an imposition of Western values that is counter to traditional Ugandan culture is not a strong argument to make. Beyond this refutation, however, there is arguably some universality of the values behind FP programs. Nussbaum argues this in the book *Women and Human Development*, saying that rights of the individual take precedence over the rights of the culture/community. That is, despite what their husbands think or their cultures dictate, women, as humans, have a right to access reproductive health services, including FP, because it enables their capabilities and allows them greater opportunities in life.

Conclusion: Mitigating Social Injustices by Revamping Uganda's Current FP Programs

As mentioned in the introduction, billions of dollars are spent each year on FP programs in the developing world, a portion of which benefits Ugandan women. Despite the extensive programming that already exists, the empirical data and the tensions analyzed above show that need for access to FP is not being fully met in Uganda, creating a social injustice. As explained, improving FP access is important for social and health justice; this can be done without being culturally imperialistic through policy and changed programming. The scope of this paper, however, permit merely several suggestions for improved access, individual NGOs and organizations will have to evaluate their programs to find potential approaches for improvement.

The main way to increase access to FP is through decreasing the social stigma of use. This can be done by increasing dialogue about FP and Ugandan values. Uganda Village Project aimed to do this, but the small scale and limited budget of the NGO limited outreach attempts. Marie Stopes International, an NGO that provides 25% of all FP services in Uganda (Uganda DHS), suggests a way of improving dialogue: including local leaders in the discussion. These leaders can and should include local priest, pastors, and imams, as well as village council members and volunteer health team members (Marie Stopes).

Another suggestion for improved access is improving FP technology and the types of FP available to women in Uganda. As mentioned previously, the most common concern about FP leading to nonuse is concern about side effects. Because only a few types of FP are available in Uganda (compared to the hundreds in the United States), women do not have their choice as personalized to their needs and body, leading to greater incidence of side effects. Some NGOs already invest in FP technology for this reason, including the Bill and Melinda Gates Foundation. Education about how FP works is also important, to decrease popular misconceptions about the dangers of FP.

Overall, the cultural barriers to access present a much more difficult situation than mere physical or economic problems reaching a health center. Despite the difficulty of improving access, the lack of access that many women in Uganda face is socially unjust and must be improved. Women will not be able to fully take advantage of opportunities available to them until access to FP allows them control over their own bodies and fertility, even though this will likely change Ugandan culture by empowering women.

References

1. "Abortion in Uganda." *Guttmacher Institute.* 2013.
2. "A Guide to Participatory Communication." 2013. *Marie Stopes Uganda*.
3. "Birth Control Pills (Oral Contrceptives)." 2013. *Drugs.com.*
4. Blanc, A.K., B. Wolff, A. J. Gage, A.C. Ezeh, S. Neema, J. Ssekamatte-Ssebuliba. "Negotiating Reproductive Outcomes in Uganda." 1996. Kampala, Uganda: *Makere University*.
5. "History." 2014. *Church of Uganda.*
6. Daniels, Norman. *Just Health: Meeting Health Needs Fairly*. New York: Cambridge University Press. 2008. 313-332. Print.
7. *Facts for Life*. 2010. United Nations Children's Fund.
8. *FP2020: Partnership in Progress*. 2014. Family Planning 2020.
9. Godfrey, A.B. "Household Gender and resource Relations: Women in the Marketing Areas of Income Generating Crops in Uganda." 2010. *EASSRR.* 26 (2).
10. Hessler, K. and A. Buchanan. "Equality, Democracy, and the Human Right to Health Care." *Medicine and Social Justice: Essays on the Distribution of Health Care*. 2012. 97-104. Print.
11. "Fact Sheet: Contraceptive Use in the United States." 2014. *The Cuttmacher Institute.*
12. Koenig, M.A., T. Lutalo, F. Zhao, F. Nalugoda, F. Wabwire-Mangen, N. Kiwanuka, J. Wagman, D. Serwadda, M. Wawer, and R. Gray. "Domestic violence in rural Uganda: evidence from a community-based study." 2003. *Bulletin of the World Health Organization*. 81 (1).
13. Longwe-Ngwira, A. *Family Planning in Sub-Saharan Africa: A Missed Opportunity for Economic Growth and Poverty Alleviation.* 2014. Policy Fellows Working Papers Series. Population Reference Bureau.
14. Mugisa, A. "Cancer myths fail family planning." 2013. *NewVision Uganda.*
15. Nalwadda et al. "Persistent high fertility in Uganda: young people recount obstacles and enabling factors to use of contraceptives." 2010.*BMC Public Health.*
16. Nussbaum, Martha. *Creating Capabilities*. United States: Harvard Publishing Press, 2013. Print
17. ---. *Women and Human Development: The Capabilities Approach*. Cambridge University Press. 2000. Print.
18. Otiso, K.M. *Culture and Customs of Uganda.* Greenwood Publishing Group, 2006.
19. "Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions." 2014. United Nations.

20. Rosenberg, K.R. and W.R. Trevathan. “An anthropological perspective on the evolutionary context of preeclampsia in humans.” 2007. *Journal of Reproductive Immunology*. 76: 91-97.
21. Sedge, G. and R. Hussain. “Reasons for Contraceptive Nonuse among Women Having Unmet Need for Contraception in Developing Countries.” 2014. *The Population Council.*
22. Sen, Amartya Kumar. *Development as Freedom*. United States: Knopf Doubleday Publishing Group, 2000. 189-204; 225-248. Print.

23. Sherwin, Susan. *The Politics of Women's Health: Exploring Agency and Autonomy:* USA: The Feminist Health Care Ethics Research Network.1998. Print.

24. Turshen, Meredeth. Women and Health in Africa. United States: Africa Research & Publications, 1991. Print.

25. Singh, S, JE Darroch, LS Ashford. *Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health*. 2014. The Guttmacher Institute, UNFPA.
26. Tebeu, P.M., J.N. Fomulu, S. Khaddaj, L.d. Bernis, T. Delvaux, and C.H. Rochat. “Risk factors for obstetric fistula: a clinical review.” 2012. *Int. Urogynecol. J.* 4: 387-394.
27. *Uganda Demographic and Health Survey.* 2011. Uganda Bureau of Statistics.
28. Verschoor, A. “Gender relations and female labour supply in East Uganda.” *Work, Female Empowerment and Economic Development*. Ed. Horrell, S., H. Johnson, and P. Mosley. 2008. 141-170.