Fertility and the Availability of Contraception in Bududa, Uganda

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Abstract

In research on fertility in developing countries, it is often assumed that lack of access to a method of affordable contraception is a significant determinant of high levels of fertility. As a result of this lack of access, actual family size exceeds desired family size. This study examines the relationship between fertility and contraception access in Bududa, an impoverished district in Uganda, which is experiencing rapid population growth. Quantitative data is combined with a series of intervals of women of childbearing age. The unexpected result is that while contraceptive use is widespread among the women in Bududa, they commonly use contraception not to reduce family size but rather to achieve optimal spacing of children in their large families. In other words, actual family size roughly equals desired family size, access to contraception primarily influences birth spacing. Instead of access to contraception, cultural and economic characteristics such as female education and compensation appear to more important determinants of fertility in Bududa, Uganda.

Project Description

This study was originally intended to test whether a woman’s desired fertility is affected by how empowered she is. Therefore, the investigation initially focused on the local perception of and barriers to family planning. Based on previous research, there seemed to be three possibilities. First, that the current high fertility rate in Bududa reflects a lack of contraceptives. In other words, the total fertility rate for women aged 16-49 (TFR) was greater than their desired total fertility rate (DTFR). Any effect on birth spacing was irrelevant. Second, it is possible that access to contraceptives affects both the gap between TFR and DFTR as well as birth spacing. Women might choose to have fewer children and increased periods between pregnancies. Finally, it is possible that TFR is equal to DTFR – women choose to have the current high
fertility rate - but think that the spacing of births is too short, which has adverse effects on maternal and child health. Therefore, if contraceptives become more available then there will be increased spacing between births with little effect on the total fertility rate.

**Introduction**

Uganda is usually seen as a country in crisis. An often-noted aspect of this crisis is the nation’s high fertility rate which has contributed to a fairly young population suffering from rising unemployment combined with widespread poverty. One solution, adopted by several of the International NGOs and donor states, is to provide more family planning options in order to reduce the high fertility rate. It is hoped that a gradual reduction in fertility will reduce the rate of growth of the country’s labor force resulting eventually in both a lower unemployment rate and reduced poverty. But, as this paper discusses, increased access to contraceptives has not had the expected impact on fertility possibly because such efforts contradict the local family culture.

In Uganda, women commonly want large families, especially in rural regions. Though the use of contraceptives is becoming increasingly more common among Ugandan women, their goal tends to be for child spacing rather than having fewer children or to stop having children altogether. So, if the intent of providing more contraceptive provisions is to bring about a lower fertility rate, it is likely not to be successful due to these cultural preferences.

One perspective is that of Geert Hofstede, a social psychologist, who is a proponent of the claim that culture influences the economy. In his academic work he identifies five cultural characteristics; the power distance index, individualism vs. collectivism, masculinity vs. femininity, the uncertainty avoidance index, long-term vs. short-term normative orientation, and indulgence vs. restraint (Hofstede 1997). These cultural characteristics of Uganda appear to have significance.
This study uses data on the fertility preferences of Ugandan women in the country’s Bududa district. With respect to Hofstede and Rarick’s Investigation of Ugandan Cultural Values and Implications for Managerial Behavior (2013), the Bududa district has a high score on the Power Distance Index (PDI), there is wide acceptance of a societal hierarchical order. Bududa society is more collective than individualistic, family and community are important. Uganda also strongly values masculine characteristics and preferences them over what is considered feminine, the society is strongly gendered. The placement on Hofstede’s Uncertainty Avoidance Index (UAI) is mixed because while this society is very conservative and religious, people’s attitude towards ambiguity is very relaxed. It is common to say that Ugandans have a very easy-going attitude, and this seems to be especially true in Bududa. Lastly, Bududa seems to have a strong culture of restraint rather than a culture of indulgence. However, there are issues of alcoholism and sexual assault that seem to contradict this perception of restraint.

These aspects give an outline of the culture of Bududa. This paper will delve into how culture affects a woman’s fertility preferences.

Literature survey

A review of the literature reveals a rough consensus with respect to fertility rates and population control across the globe. It is generally accepted that women in developing countries have higher than desired levels of fertility – tend to bear more children than optimal - and that family planning initiatives are the best way to address the situation. Most research suggests improved family planning efforts in its policy implications section. (For example, see Bongaarts, 2008; Buyinza and Hisali, 2014; and Meier, 2005.)

Economic studies of fertility rates attempt to determine which factors determine reproductive behavior. These studies are useful if they can identify the most effective means to
change fertility rates have clear policy implications. A common theme is that women in the
developing world either do not use or do not have the option to use contraceptives. This literature
tends to focus on the barriers to accessing contraceptives especially among women in rural
regions. These barriers include low access, women’s inequality, inadequate knowledge, and
moral barriers.

The study of fertility control is not without controversy. In his study on the politics of
fertility control Donald P. Warwick (1994) stated that if a research project on family planning
does not yield the results desired by the sponsors of the research, it will not be published.
Research on fertility control is thus affected by whether the research is sponsored by parties that
are in favor of population limitation or skeptical about it. The politics of fertility is mostly driven
by lobbyists that benefit from, work for, or own companies that manufacture contraceptives, or
are morally against contraceptives. That said, most published studies are skewed towards the
need for population growth limitation. Warwick points out the danger that such political
considerations may distort our understanding of the determinants of fertility.

While most economic literature on this subject suggests that the best way to combat high
fertility is to push for public support of family planning policy (Meier, 2005, pp. 248) there is
still some disagreement on the exact mechanism by which additional family planning actually
brings about a change in total fertility rate. For example, Günther and Harttgen (2014) argue that
contraceptive availability is an unambiguous determinate of the fertility rate. Their study was a
quantitative analysis of DHS surveys to compare the total fertility rate (TFR) to the desired
fertility rate (DTFR), the wanted total fertility rate (WTFR) and a measure of unwanted fertility
(uTFR). This study also included a test of the relationship between family planning efforts (FPE)
and total fertility rate (TFR). The study attempted to identify whether fertility desire or family
planning efforts had a stronger effect on total fertility rate. The study indicated that women in
sub-Saharan Africa – unlike women in developed countries - are unable to translate their desired
fertility into their actual fertility. In other words, family planning efforts did not significantly
alter fertility rates. While the results of the Günther and Harttgen study are mainly in agreement
with this paper there are some differences discussed below.

Nonetheless, this study notes that family planning efforts are more effective on a familial
scale rather than on a macroeconomic scale. In other words, family planning can have benefits
for families independent from its impact of limiting population growth (Meier, 2005, pp. 247).

One of the strongest determinants of fertility rates is female education. Specifically, the
more women who achieve secondary education or higher , the lower the total fertility rate. For
example, Buyinza and Hisali’s study illustrates that women’s education and social-economic
factors can explain reproductive behavior (2014). They used quantitative methods to see if there
is a significant relationship between women’s education, usage of family planning and fertility.
This is useful for this research project because it identifies significant correlations with
demographic variables and fertility.

In their study, DeRose and Ezeh (2010) discuss how the situation in which a woman
lives, her autonomous decision making and the external patterns of decision making, affect her
overall usage of contraception. This study highlights how husbands tend to dominate joint
decision making within a family. Community-level decision making is also an important factor
regarding contraceptive use. First, DeRose and Ezeh asked women about how family decisions
are made in their community; by the husband, the wife or jointly. Then they created an index as a
point of reference for female involvement in decision making. This is a useful insight for this
paper because it showcases how male dominance and peer pressure from the community affect a woman’s usage of contraception.

Bongaarts’s research shows the fertility decline is slowing in sub-Saharan African countries (2010). Bongaarts tested whether this trend is exceptional in comparison to other developing countries. He argues that, since the cost of living in sub-Saharan Africa is relatively low, the cost of raising children remains low. Other factors also play a role in reduction in fertility decline, such as the benefits of having offspring in subsistence economies. The results indicate continued population growth in sub-Saharan Africa, which is already a major concern for many scholars. This study will expand further on why there is little fertility decline in sub-Saharan Africa.

An article by R. Turner (1991) investigates modern versus traditional contraceptive usage in Uganda. The conclusion is that women in Uganda in the 1990’s were more familiar with traditional rather than modern methods. This article is almost thirty years old and it is a common misconception that this is still the case today. This outdated rationale is still used as a point of argument of why fertility rates remain high and that family planning should be improved to address this. This research project investigates if this is true or not rather than just assuming this is the case.

In a study by Abiona (2017) the impact of economic shocks on contraceptive usage is tested. This study focuses on a lack of rainfall. The analysis utilized a quantitative comparison of rainfall shocks and UNPS surveys as indicators of contraceptive use. Abiona argues village residents in Uganda tend to demand contraceptives to delay pregnancy when there is a lack of rainfall. In villages where agriculture is the main industry, during normal times families desire to have large families. However, a lack of rainfall that negatively affects the harvest causes
families to want to have fewer children. This research is useful for this research project because it expands the pool for potential determinants for total fertility rate.

Some researchers see economic development as a way to combat high fertility. In a study of Uganda’s economy, Hausmann (2014) argues that challenges of population growth should be addressed through the development of tradable industries such as oil and through increased construction. This study utilizes an analysis of the efficiency frontier for the potential paths of diversification for Uganda’s economy. Hausmann’s work uses a mixed methods approach and provides information about Uganda’s economy.

This study also has benefited from later research by the author. After performing interviews and surveys in 2017 and 2018 in Bududa, Uganda, the author carried out a similar project in Amman, Jordan on fertility preferences and expectations. In that project that author found similar results to what was found in Bududa, specifically a high desired fertility rate. The main difference between the Uganda and Jordan results was in how many children a woman expects she will have. The project in Jordan further validated the author’s experience in studying fertility preferences.

Data

Method

For this project the researcher surveyed 150 women, aged 16-49, living within the Bududa district of Uganda. The surveys were collected in five randomly selected sub-counties out of a total 16, by coding them and choosing from them using an online algorithm. The randomly selected sub-counties were Bududa Town Council, Bukigai, Bulucheke, Nabweya and Nakatsi. The researcher administered 30 surveys in each sub-county.
The purpose of the survey was to study how a woman’s desired fertility rate is affected by other aspects of her life. It included questions on a woman’s desired fertility rate and variables intended to identify female empowerment, to see if there is any correlation between them. Desired fertility was collected by asking how many children a woman would have if she could choose. The variables of empowerment included: whether she uses a method of family planning; if she has a cellphone; her level of education; if she is a member of a microfinance savings group; and if she is employed. Below is a list of women’s desired fertility rates and the corresponding percentages of the sample. The desired fertility rate was high, as can be seen in Table 1, 78% of the women sampled desired 4-6 children.

*Both the interview guide and the survey can be found in the appendix*

<table>
<thead>
<tr>
<th>Desired Fertility Rate</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>.67</td>
</tr>
<tr>
<td>2</td>
<td>6.67</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>46.67</td>
</tr>
<tr>
<td>5</td>
<td>9.33</td>
</tr>
<tr>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>7</td>
<td>1.33</td>
</tr>
<tr>
<td>8</td>
<td>2.67</td>
</tr>
<tr>
<td>9</td>
<td>1.33</td>
</tr>
<tr>
<td>10</td>
<td>.67</td>
</tr>
<tr>
<td>12</td>
<td>.67</td>
</tr>
</tbody>
</table>
Some important information about this sample is that over 60% of the respondents were a member of a microfinance group. Around 57% of them had their own cell phone. Only about 35% of them were employed. Almost 70% of the respondents were married. Additionally, about 50% of them had received at least a secondary education. Lastly, around 74% of the respondents actively use contraceptives or a family planning method.

After already collecting 35 surveys, the survey was altered in order to collect additional control variables. The variables added were age, marital status and which number wife in a polygamous marriage. The wife who was married first would be considered number one. Since only about 13% of respondents responded as being in a polygamous marriage, this did not largely affect the research results. Age and whether a woman is either married or single were useful points of comparison, however these variables are more predictable.

The information from the survey was coded into STATA 15. Desired fertility was used as a continuous variable. Whether or not a woman was a member of a microfinance group (VSLA) was used as a dummy variable. The span of time that she was in the microfinance group was
collected, however it was omitted because it did not act as a useful point of analysis. Whether or not a woman is employed was also used as a dummy variable. The span of employment was also collected; however, it was omitted because it did not act as a useful point of analysis. A woman’s education level was collected in the levels of none, primary, secondary, and university. It was later sorted into a dummy variable of whether or not a woman has received secondary or post-secondary education.

Where a woman obtained family planning methods was collected with the options being a government clinic, a private clinic a pharmacy or other. Table 2 shows the responses indicating that a high number of women get family planning services for free at Government Clinics but a substantial amount are still paying for their services at the pharmacy or private clinics.

<table>
<thead>
<tr>
<th>Family Planning Method Provider</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Clinic</td>
<td>61.66</td>
</tr>
<tr>
<td>Private Clinic</td>
<td>31.48</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1.85</td>
</tr>
<tr>
<td>Other</td>
<td>5.56</td>
</tr>
</tbody>
</table>

The classification of the person that told the respondent about the importance of family planning was collected. It is shown in Table 3. Marital status was collected and separated into a dummy variable of if she is married or not at the time of the survey. Lastly, her age was recorded as a continuous variable and later separated into a string variable of whether she is “older or younger.” This was separated from 16-24 and 25-49.
Table 3

<table>
<thead>
<tr>
<th>Family Planning Educator</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>73.50</td>
</tr>
<tr>
<td>Husband</td>
<td>3.42</td>
</tr>
<tr>
<td>Another Family Member</td>
<td>5.13</td>
</tr>
<tr>
<td>Friend</td>
<td>5.13</td>
</tr>
<tr>
<td>Other</td>
<td>12.82</td>
</tr>
</tbody>
</table>

Whether or not a woman uses family planning was used as a dummy variable. The type of family planning was collected, with the main responses, about three-fourths being implant or injection.

Table 4

<table>
<thead>
<tr>
<th>Family Planning Type</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection</td>
<td>55.24</td>
</tr>
<tr>
<td>Implant</td>
<td>20</td>
</tr>
<tr>
<td>Oral</td>
<td>11.43</td>
</tr>
<tr>
<td>Permanent Surgery</td>
<td>5.71</td>
</tr>
<tr>
<td>Condoms (Alone)</td>
<td>5.71</td>
</tr>
<tr>
<td>Lactation</td>
<td>2.86</td>
</tr>
<tr>
<td>IUD</td>
<td>1.9</td>
</tr>
<tr>
<td>Rhythm (Calendar)</td>
<td>.95</td>
</tr>
<tr>
<td>Other</td>
<td>.95</td>
</tr>
</tbody>
</table>

Snowball sampling, in which participants recruit other participants for the study, was used to conduct qualitative interviews with community members and healthcare workers. The data reached saturation for the qualitative portion at 25 community member interviews and 12
healthcare worker interviews. With guidance from professionals, the author reasoned there was not enough variance in the responses of the participants to add new information to the study.

The researcher collected the informed consent of each individual that participated in the study before the interview or survey began. There were no issues of participants withdrawing consent thereafter. Clarification was asked for when necessary. Lastly, the translator asked the question in different ways to avoid misunderstandings and in order to avoid losing information in translation.

Discussion on Data

Combining quantitative and qualitative strategies allowed the researcher to better understand the region of Bududa. This paper will focus on the quantitative data, and reference some of the agreements or disagreements encountered in the interviews.

The responses for the dependent variable alone were quite intriguing – as seen in Table 1, 83.3% of women responded they wanted 4 or more children. The most common response was 4 children, at a percentage of 46.67%. As noted above, 78% of the respondents desired 4-6 children. The least common responses were one child and 12 children, with a percentage of .67% each.

One important finding is, in the impoverished and rural region in Eastern Uganda known as Bududa, most of the women actively use family planning. Around 74% of respondents in the survey answered yes to the question concerning use of family planning. Of this group, 20% of women use the implant contraceptive method, and 55% use the injection method. It is likely more women use injections because of the lower cost, ease of use, and the fact it is less invasive and more focused on short term contraception. This gives the women more flexibility in family planning.
A downside of injections is the possibility of adverse side effects, such as prolonged bleeding and discomfort, which can scare some women away from using contraception. This fact was brought up as a major concern in the interviews. In fact, women who use injections without the consent of their husbands face these side effects with little to no support.

Another fact is women in Bududa mainly obtain family planning methods from health clinics. Around 62% of the women obtained contraceptives from public clinics, which provide these methods free of charge. Nearly 32% of the women that use contraceptives get them from private clinics for a cost. Public clinics are frequently low on stock due to high demand.

Something that was discovered from the interviews is that community members in Bududa are much more open to family planning methods than was expected. The difference is in their motivation for using it, however. In the West, many tend to use contraceptives to avoid getting pregnant. In Bududa, nearly all the women interviewed wanted to use contraceptives for child spacing. *Their goal was not to avoid pregnancy, but to delay it.* Their perception of family planning was focused on the effects it would have on the family rather than the benefits it offers for an individual. With this in mind, initiatives to lower fertility rates in regions like Bududa will not be successful if more contraceptives are donated or provided. It is not a matter of women not using it, it is because they use it for a different reason

**Analysis**

In this analysis two hypotheses (H1 and H2) are presented and tested.

**H1: High fertility rate reflects lack to contraceptives**

**H1 Testing**

The original goal of the study was to investigate the perceptions and barriers to the implementation of family planning in Bududa, Uganda. Originally the method was to test
whether a correlation existed between women’s empowerment and desired fertility rate. If a correlation existed that showed “empowerment” was related to a lower fertility rate, then the results would suggest empowering women was one way to lower fertility.

The hypothesis (H1) was tested using a series of multiple regressions using variables that represent women's empowerment and desired fertility rate.

This study used a series of regression tests for desired fertility (Y) as the dependent variable, and considered if a woman is in a microfinance Village Saving and Loan Association (V), if she has a cellphone (C), whether or not she is employed (E), if she attended secondary school or higher (S), if she uses a family planning method (FP), if she is married (M), and if she belongs to the age group 16-24 (younger) or 25-49 (older) (A). A woman would be considered more empowered if she was in a microfinance group, if she has access to a cell phone, if she received an education, and if she uses family planning. The variables that considered age and marital status were control variables that did not seek to comment on empowerment.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microfinance</td>
<td>.40</td>
</tr>
<tr>
<td>Cellphone</td>
<td>-.21</td>
</tr>
<tr>
<td>Employed</td>
<td>-.39</td>
</tr>
<tr>
<td>Family Planning</td>
<td>-.04</td>
</tr>
<tr>
<td>Education</td>
<td>-.40</td>
</tr>
<tr>
<td>Marital Status *</td>
<td>.60</td>
</tr>
<tr>
<td>Age **</td>
<td>.82</td>
</tr>
</tbody>
</table>

*= 10% confidence, **=5% confidence, ***=1% confidence
In this regression series each variable was put through a t-test. The two variables with the least significance were removed in each series. The results show that the most significant variable of the series was age, whether a woman was grouped into the older (25-49 years old) or the younger (16-24) group.

The results show that, as a woman’s age increases, there is a 3.3% increase in her desired fertility. This outcome is statistically sound. However, its economic significance is limited. Age was also not considered an empowerment variable. The variable of whether or not a woman uses family planning was removed from the regression series after the first test. It did not have the relationship it would be expected to, signified by a positive correlation coefficient.

Primarily, the data showed a large desired total fertility rate (DTFR) among respondents in the sample. Since the regression analysis showed there was no significant relationship between DTFR and contraceptive use, it can be concluded that high fertility does not represent a lack of access to contraceptives. Consequently, H1 is rejected.

H2: TFR > DTFR; spacing of births is not a significant determinant.

H2 Testing

This study did not find any statistically significant correlations of a lower desired fertility rate with any variables that showcase empowerment. This lack of significance is of utmost importance because it provides reasons for discussion about the women of Bududa and what their preferences are.

In carrying out the study, the researcher encountered other important factors which should be considered, the main one being cultural norms. A cultural norm is a societal preference, and not necessarily something altered by outside variables. The cultural norm considered here is having a large family. During the research process there was a notably higher
desired fertility rate than expected. The desire for spacing children was strongly emphasized. As a result, the main research question shifted to: Has the availability of contraceptives affected either TFR or birth spacing in Bududa, Uganda?

Finding a large desired fertility rate is notable, considering the beliefs of those involved in the population control and family planning initiatives conversation globally. This study accounts for a very high rate of family planning or contraceptive usage (74%) amongst the women in Bududa alongside a high desired fertility rate (an average of 4.5 children per woman). It would be expected that contraceptive use would correlate with a lower desired fertility rate, and that correlation is present in most developed countries. Bududa, Uganda does not follow this pattern. This use of contraception for child spacing rather than to limit the number of children they bear raises issues of both policy and culture.

Currently, the total fertility rate, 5.5 children per woman is higher than the desired total fertility rate collected in this sample, 4.5 children per woman. The difference is only about 1 child, but the total fertility rate has decreased over time. Furthermore, children are usually raised by their mothers or women in their extended family. This conclusion was made considering the results of interviews and analysis using Hofstede’s characteristics of culture. The interviews showed children are viewed as an investment or desired expenditure in society because they provide an opportunity for the family to gain more revenue or provide labor for family subsistence.

The next consideration is whether or not contraceptives are actually available. During the research process, the availability of contraceptives was discussed at length. Contraceptives are provided to the local population at no cost to them through government clinics and NGOs,
though in some situations they run out of stock. Contraceptives can also be purchased at private clinics or pharmacies.

Lastly, it was expected that there would be substantial cultural and moral restrictions on contraceptive use. The interviews showed this expectation was not necessarily true. There has been a shift in cultural attitudes, making the population more open to contraceptive use. It is probable that this is due to globalization and the influence of western humanitarian missions that promote contraceptive use. The interviews showed that some men do reject the use of contraceptives, but this is slowly changing. Some women even use contraceptives without the consent of their husbands. Overall, the majority of the sample supported the use of contraceptives. Therefore, the claim that there are barriers to contraceptive use because of lack of availability or cultural barriers is not supported by the evidence.

The last point to consider is whether the presence of contraceptives has shifted the total fertility rate towards the desired fertility rate. This chart on the next page shows that modern contraceptive use in Uganda increased from the late 1980s to the 2000s.

As contraceptive use increased, the fertility rate also declined. In the graph on the next page the fertility rate drops from more than 7 children per woman to 5.5 children per woman. Since then the fertility rate has not changed much, but there is a general pattern of decline. It can be speculated that it is approaching the desired fertility rate.

The reason the decline in fertility rate has not dropped lower than desired fertility is because of the spacing of children. This analysis shows that H2 can be rejected. Therefore, spacing births is a significant determinant.
Figure 2
Contraceptive Use Trends amongst Married and unmarried Sexually Active Women (pp. 25)

Figure 3
Trends in Fertility Rate (The World Bank)
Further analysis following H2 shows that in Bududa, Uganda TFR is approaching DTFR but spacing of births is too short causing adverse effects on maternal and child health. Therefore, if the availability of contraceptives increases then there will be increased spacing between births.

The TFR is currently higher than DTFR but it is approaching it. Women are having around 1 more child than they desire to have. The analyses from the prior hypotheses have shown that contraceptives are available.

Lastly, it is necessary to consider whether the availability of contraceptives has caused an increase in spacing between births. From the 1970-1990s the TFR was around 7.1 and it dropped to 5.5 between 1990 and 2017 (World Bank).

Bududa’s desired fertility rate remains high despite increased contraceptive use. Women in Bududa use contraceptives or family planning methods to space their children and their fertility rate remains the same in the long run. This brings into question whether family planning initiatives consider the cultural preferences of the communities in which they are present. And since women do benefit from spacing out their children, contraceptive provision remains important. It is flawed reasoning to see a lower fertility rate as the sole metric of success for family planning initiatives.

The results of this study seem consistent with the results of other researchers. For example, Günther and Harttgen (2014) explored whether women’s demand for children was related to their number of children. Their conclusion was that women in African countries are not able to translate their birth preferences into birth outcomes (pp. 55). This offers useful insight because women in developing countries like Uganda do not have access to the same resources as women in the Western world. Bongaarts (2008) explored the phenomenon of stall in fertility
decline in sub-Saharan Africa. It is probable that there are stalls in fertility decline because fertility rates in sub-Saharan Africa are approaching desired fertility. The researcher explored a stall in fertility decline in the project in Jordan and concluded that fertility preferences and expectations were the reason for the stall.

Limitations

This project is limited because it is a case study. The sample was large enough to make a quantitative assertion about the population of Bududa, however it is still considered small. It is also limited since it was collected in one district of Uganda. It would be useful to continue this research on a larger scale. Since the researcher knew the limits of the project before it began, a mixed methods approach was the best way to extract the most information.

Recommendations

The results of the project have implications on how family planning initiatives should be carried out around the world. Before any project begins, it is necessary to understand the culture of the community it will take place in. More often than not, international initiatives to lower fertility rates promote ideals of the West which may contradict the indigenous cultures. This is not to say that communities do not benefit from contraceptive provision. The measurement of success should be on a family or individual level rather than on a demographic scale.

Conclusion

Uganda, already struggling with high unemployment and poverty, is facing an economic and cultural crisis. As stated earlier, with a fertility rate of nearly 5.5 children per woman and a large number of young people (about 50% of the population is 18 years old or younger), the country must address its rapidly rising population rate. Implementing additional family planning methods, however, will not adequately address the problem in the absence of a proper
understanding of the preferences of Ugandan women. Notable barriers to female empowerment, such as the accepted dominant roles of Ugandan men, affect the likelihood that increased use of contraception will successfully decrease the population rate. It is important to consider the degree in which Ugandan women value motherhood. They have a much higher desired fertility rate than women in the Western world. Most family planning initiatives in Uganda fail because they are based on Western world ideological beliefs towards the importance of contraceptive use to avoid pregnancy. These initiatives lack an understanding of Ugandan regional cultures and preferences. It is a cultural norm to want a large family. But contraceptives are not as taboo as the literature suggests. Women do use contraception, but for improved birth spacing rather than fertility reduction.

A woman’s desire to have more children is affected by a number of factors: the number of children she already has, her age, her marital status, how “empowered” she feels, and cultural norms within her community. This study explores these various factors and argues that women in rural Uganda do have access to, and knowledge of, modern contraceptive methods. Additionally, their level of “empowerment” does not affect their desired fertility rate. The sample in this study shows desired fertility rate changes as women grow older and choose to have more children.

Many initiatives offered by the developed world continue to focus on lowering fertility rates, despite an apparent lack of success. Improvement will not be realized unless there are new strategies offered to combat high fertility rates that consider how culture is related to the economy. Keeping this in mind, fertility rate evaluation needs to change. When considering family size over time, child spacing should be a factor in determining total fertility rate. The goal should not be to bring fertility rates to replacement rate, but rather to the rate of desired fertility.
This study demonstrates that this consideration is actually what is happening over time in Bududa. Above all, women should be given autonomy in their fertility choices.

Acknowledgements

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References


Appendix

Interview Guide (community members)

1. What is your age?
2. Note M/F
3. What is family planning to you?
4. Do you think family planning methods are commonly used in the community? Why or why not?
5. What family planning methods are most commonly used in the community?
6. Why are some people in the community against using family planning methods?
7. Have perceptions of family planning in the community changed over time?
8. In your community, what is the ideal family size?
9. Where can people in the community receive education on family planning?
10. Do you think most people in the community know where to get family planning interventions if they want them?
11. Do you think men and women in the community have different viewpoints on family planning?
12. (Women only) Are women in the community aware of their fertility patterns?

Interview Guide (healthcare workers)

1. Do you think family planning is important to promote in this community? Why?
2. How open is the community that you work into modern methods of family planning?
3. How does your clinic/organization pay for family planning methods to distribute to the community? Are there adequate supplies of family planning methods?
4. How supportive is the administration in your organization of family planning?
5. How often do you meet with clients/patients related to family planning?
6. What challenges do people in the community face when trying to access family planning?
7. How often do you meet with a place patient due to an unplanned pregnancy?
8. Does your organization/clinic educate communities on how to plan a family?
9. What needs to change to make family planning methods more widespread in the community?

Survey

1. If you could choose, how many children would you have? __________
2. Are you in a microfinance group (Village Saving Loan Association)?
   ○ Yes
   ○ No
3. If yes, how many years have you been a member of the microfinance group?
   ○ Less than 1 year
   ○ 1-2 years
   ○ 3-4 years
   ○ 5+ years
4. Do you have your own cell phone?
   ○ Yes
   ○ No
5. Are you employed outside the home?
   ○ Yes
   ○ No
6. If yes, what is your employment and how long have you worked outside the home?
   __________________________
   ○ Less than 1 year
   ○ 1-2 years
   ○ 3-4 years
   ○ 5+ years
7. What is your education level?
   ○ None
   ○ Primary
   ○ Secondary
   ○ University
8. Do you use any type of family planning method?
   ○ Yes
   ○ No
9. If yes, what type?____________________
10. If yes, where do you obtain family planning methods?
    ○ Government clinic
    ○ Private clinic
    ○ Pharmacy
    ○ Other:____________________
11. If yes, where did you first hear about the importance of family planning?
○ From my husband
○ From another family member (please specify):____________________
○ From a friend
○ From a doctor or community health worker (CHE)
○ Other:_____________________

12. What is your marital status?
○ Single
○ Monogamous Marriage
○ Polygamous Marriage
○ Widowed
○ Separated

13. If polygamous?
○ First wife
○ Second wife
○ Third wife
○ Fourth wife
○ Fifth wife or above

14. How old are you? __________

**Regression Series**

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