“I only want six children”

– A qualitative study in rural Uganda of the women’s perspectives on how many children they want and how their experiences are reflected by traditional and new structures

Informants in Luwero District. Photos; Sofie Hjorth Schausen

By Dina Sloth Illeris (58988) and Sofie Hjorth Schausen (42903)
Master thesis in Health Promotion and International Development, Roskilde University,
Supervised by Dina Danielsen 01.06.2018

Abstract

In Uganda the average number of children a woman has is 5.4 (UBOS 2016) and this relatively high fertility rate combined with improvements in reproductive health such as a decline in child and maternal mortality and other changes in the public health, has led to intense population growth (UBOS 2016; World Bank 2018). The aim of this study is to investigate the perspectives of women, in rural Uganda, on the number of children they want in the light of cultural traditions, economic structures, access to modern family planning methods and gender power relations in the families.
To investigate the women's perspectives, we conducted semi-structured interviews, in Luwero district, Central Uganda. We conducted 22 individual interviews with women, men and health professionals, and 12 focus groups with women and men in different age-groups. All interviews were recorded and transcribed.
In the analysis of the data we apply a combination of three different theoretical approaches. To investigate how the women's perspective are related to different structures we apply the concepts of capital, habitus, the field and symbolic violence, put forward by Pierre Bourdieu. To understand how these relations are connected to the women's health we apply the concepts of health, health determinants and empowerment based on Glenn Laveracks definitions, and to understand how the relations between men and women are renegotiated, due to changing structures in the society, we build on the feminist approach of Gender and Development.
We find that, as the traditional structures are defining the field, the desire for large families is embedded in the habitus of both the women and men in the rural communities. Nevertheless, we find that the young women, due to changing economic structures, want to have less children than the generations before. The women generally emphasize that they only want to have as many children as they can provide without the help of a man as they find that the men often leave their responsibilities as providers for the family. Though access to modern family planning methods is increasing, we find several barriers to the use of it including; the men's perspectives, myths, distribution of methods with many side effects as well as limited access for young girls below the age of 18. At last we find that even though many of the women in the rural areas are gaining financial empowerment the decision-making power still primarily lies with the men, including the decision about the number of children a woman should bear.

Resumé

I Uganda er det gennemsnitlige antal børn en kvinde får 5,4 (UBOS 2016), og denne relativt høje fertilitetsrate kombineret med forbedringer i reproduktiv sundhed, som nedgang i børne- og mødredødelighed og andre fremskridt i folkesundheden har ført til intensiv befolkningsvækst (UBOS 2016; Worldbank 2018). Formålet med dette studie er at undersøge kvindernes perspektiver i forhold til hvor mange børn de ønsker, i lyset af kulturelle traditioner, økonomiske strukturer, adgang til moderne prævention og kønsrelationer i familierne.

For at indsamle information om kvindernes perspektiver gennemførte vi semistrukturerede interviews med 22 kvinder, mænd og sundhedsprofessionelle og 12 fokusgrupper med kvinder og mænd i forskellige aldersgrupper i landdistriktet Luwero i det central e Uganda. Alle interviews blev optaget og transskriberet.

I analysen af den empiriske data kombinerer vi tre forskellige teoretiske tilgange. For at undersøge, hvordan kvindernes perspektiver relateret sig til forskellige strukturer, anvender vi Pierre Bourdieus begreber; kapital, habitus, feltet og symbolsk vold. For at forstå, hvordan disse relationer er forbundet med kvindernes sundhed, anvender vi begreberne sundhed, sundhedsdeterminanter og empowerment baseret på Glenn Laveracks definitioner og til at m forstå, hvordan magtforholdet mellem mænd og kvinder bliver genforhandlet på grund af ændrede samfundsstrukturer, bygger vi på den feministiske tilgang, Gender and Development.

Vi finder at, fordi de traditionelle samfundsstrukturer er definerende for feltet, er ønsket om store familier indlejret i både kvinders og mænds habitus. Dog finder vi at de yngre kvinder, på grund af ændrede økonomiske strukturer, planlægger at få færre børn end generationerne før. Kvinderne understreger generelt, at de kun ønsker at få så mange børn som de kan forsørge, uden hjælp fra en mand, da mændene ofte forlader deres ansvar som forsørgere. Selv om adgangen til prævention er forbedret, finder vi adskillige hindringer for brugen, herunder; mændenes perspektiver, myter, udbredelse af metoder med mange bivirkninger samt begrænset adgang for unge piger under 18 år. Endelig finder vi, at selv om mange af kvinderne i landdistrikterne forbedrer deres økonomiske situation, er det primært stadig mændene der træffer beslutninger i familien, også omkring hvor mange børn, kvinden skal have.

Table of Content

Focus Group of Young girls. Photo: Sofie Hjorth Schausen

Abbreviations

DFPA	Danish Family Planning Association. (In danish: Sex og Samfund)
RHU	Reproductive Health Uganda
UBOS	Uganda Bureau of Statistics
UMoH	Uganda Ministry of Health
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRAP	Women's Reproductive Rights Advocacy Project

Concepts

Autonomy: *"The right or condition of self-government"* (Oxford Dictionaries 2018).

Bargaining power: In this thesis, the concept of bargaining power is to be understood as a person's relative ability to exert influence over another person, in a situation of negotiation (Oxford Dictionaries 2018).

Commercialisation: "*The process of managing or running something principally for financial gain"* (Oxford Dictionaries 2018).

Culture: In this thesis the concept of culture is understood as the sum of beliefs, values and practices in a community, a geographic area or within a group of people who share a common context. This definition is inspired by the work of Mohan Dutta (Dutta 2008. p. 7).

Poverty: The concept of poverty has been defined in a number of different ways (Alkira et al 2016). In our report it is simply to be understood as not having the resources needed to attain the basic material needs in a person's live, like food, closing and shelter. This definition is inspired by UNESCO's definition of absolute poverty (UNESCO 2018).

Producing children: In Uganda, the term used about having children is *producing.* Not only is this the word used by all our informants, but also in official documents from for instance The Uganda Bureau of Statistics (UBOS 2016 and UMoH 2017 (a)). As this study is by no means a discourse analysis, and we do not possess the necessary language skills to analyze the use of terms in Uganda, we will not reflect further on this. However, whilst the term seemed peculiar to us in the beginning of our fieldwork, we grew used to it, and as it is the term used in our field, we will also use it in this report.

Reproductive Health: In this thesis we lean against UN and WHO's definition of good reproductive health as: *"A state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex*

life, the capability to reproduce, and the freedom to decide if, when, and how often to do so" (UNFPA 2018).

Introduction

> *"In Uganda it is very rare to find a lady that produces only 3 kids and stops. (...) But for us as Ugandans - producing is not a problem. So, we grow up knowing we have to produce many - as many as possible. It is like that. The grannies, they also produced many children, so we took it as we also have to produce many. Like the great great grandfathers. (...) We used to have 20 or 10. But now we will have 6. So, 6 is a small number even."*
> (Alice Nassonko, 55-year-old woman in a village in the Luwero district of central Uganda)

This study is a qualitative study based on individual and focus group interviews with women, men and health professionals in the rural Luwero district of central Uganda. We investigate the women's perspectives on the number of children, they want in the light of cultural traditions, economic structures, access to modern family planning methods and gender power relations in the families.

Motivation to Conduct the Study

In Uganda the average number of children a woman has is 5.4 (UBOS 2016). This relatively high fertility rate combined with improvements in reproductive health such as a decline in child and maternal mortality and other changes in the society has led to intense population growth in Uganda (UBOS 2016; World Bank 2018). Rapid population growth entails a number of adverse effects on societies and health of populations including poverty, hunger and malnutrition, public health problems like maternal and child mortality (Bongaarts 2016; UN 2017; Kibirige 1997). Though the fertility rate is still high compared to the global average, it has declined over the past decades (UBOS 2016).
The main goal of health promotion is to empower people by increasing their ability to take control over their own health (Laverack 2004). According to values embedded in the Ottawa Charter, this is best done by combining a top-down approach with a bottom-up approach, where any intervention is based on the perspectives of the people in the communities (ibid).

As health promoters we want to investigate the high fertility rate, by analyzing the perspectives of Ugandan women, in regards to the number of children they want and how it is affected by traditional and new structures.

The Women's Perspective

According to the Indian professor of communication Mohan Dutta (2008), health promoters must place the culture and the perspectives of the people, whose health they wish to promote at the center, when developing health promoting interventions. He argues, that the dominant paradigm in health communication, is biomedical thinking and efficiency as a goal for health promotion, but that health communicators must understand the meanings and experiences of health in marginalized context, in order to succeed in their communication (Dutta 2008). Following this line of thought, it becomes relevant to investigate what the women in Uganda consider important in their lives and how they experience their own health. However, the women in Uganda do not make their fertility choices in a setting where they are completely free to make the choices they wish. As any other group of people, they are tangled up in socio-environmental conditions and health determinants that impact their health, and their ability to make choices (Laverack 2004). Especially the patriarchal gender structures in Uganda have a large impact on the women's ability to make choices (Tuyizere 2007; Beyeza-Kashesya et al 2010; Sileo et al 2017; Kabagenyi et al 2014; Tamale 2016; Morgan et al 2017).

As the men in rural Uganda traditionally hold the power to make decisions in the families, they will in many cases be the ones to decide how many children a woman should have, and whether she should be allowed to use contraceptives (Sileo et al 2017; Kabagenyi et al 2014). Thus, the women's power to control the important health and life decision of how many children they want is in many cases limited. As health promoters we apply a holistic understanding of health, in line with the WHO definition that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", and thus good health is in many ways determined by a person's ability to take control over one's life and one's living conditions (Laverack 2004, p. 19). Thus, the gender relations in Uganda might profoundly affect the women's ability to achieve good health.

Patriarchal Gender Structures in Uganda

The Ugandan professor and doctor of philosophy in education Alice Peace Tuyizere has studied the gender relations in Uganda and other developing countries. She argues in, *"Gender and*

Development: The Role of Religion and Culture", that the Ugandan society is extremely patriarchal and male dominated as the roles assigned to men and women, are predetermined and different as socialization assigns different values to girls and boys. Women play an important role in holding the families together by attending to the domestic responsibilities of housework and childcare, and at the same time they socialize the children and pass values on to girls, that consign them to a position of subordination (Tuyizere 2007).

At the same time, a number of cultural traditions like the clan system places the men as heads of families and landowners. The tradition of dowry payment (bride price) is harmful to the women's autonomy and health and put them in a position of over working (Tuyizere 2007;Tamale 2016; Morgan et al 2017; Beyeza-Kashesya et al 2010). However, the family relations and the traditional systems are greatly challenged by prevailing problems associated with unemployment and economic deterioration, which continue to impoverish many households, and disrupt the relations between men and women (Tuyizere 2007).

Gender and Development

Over the past 50 years or so, and especially since the women's conference in Mexico 1975, a growing number of feminist scholars have concerned themselves with the patriarchal and male dominated systems, which dominate many developing countries, and with how the women in these societies can be empowered (Young 1993; Kabeer 1994; Miller and Razavi 1995). A group of these feminist scholars have developed an approach, which they refer to as Gender and Development, the so-called GAD-approach, which advocates that when changes are happening in developing countries, it is important to be aware of, how it affects the relations between the genders. They argue, that when women get financially empowered, for instance through development programs providing microfinance for women, it does not necessarily strengthen the women's autonomy and their bargaining power towards the men. In fact, the pre-existing gender relations and roles get messed up, and a re-negotiation of power begins - and it might not fall out in favor of the women (ibid). In the light of this perspective we find it relevant to investigate, what is going on in the relations between the genders in rural Uganda, as studies show, that the women are indeed experiencing increased financial empowerment in these regions (Amialya, 2017; Sileo et al 2017).

Changing Economic Structures

During the last decades Uganda has been undergoing radical economic changes, which can be relevant to the perceptions of the women and affect the number of children they want. The economic situation for the people in the rural areas in Uganda is suffering from decades of conflicts and bad governance as well as economic crises and inflation which is contributing to increased poverty (Nabuguzi 1993). Along with the fast growth of the population, land grabbing is resolving in land scarcity, threatening the livelihoods of the people in the rural areas who mainly depend on farming (Carmody and Taylor 2017). Though the education level has improved the access to formal jobs is limited, as the slow growing private sector is not absorbing the graduates (ibid). As the country's economy is depending on export of raw materials, which are not creating jobs for the many, the possibilities for people to escape poverty is limited. In addition, the import of manufactured commodities is delaying the possibilities for development of the industrial sector, which could reduce unemployment (Byekwaso 2010).

Access to Modern Family Planning Methods

One of core structures affecting the women's capabilities to take control of their lives, is the access to modern family planning methods. Though the access to contraceptives has increased in Uganda, there are still several barriers for the women to use the methods (UBOS 2016). One of them being distribution of bad quality methods with high levels of side effects, and the fact that the methods are not adapted to the locals setting in developing countries (Sen and Grown 1988). When investigating the perspectives of the women on the number of children, they will have it is therefore relevant to understand how access and barriers to contraception are related to those.

Research Question

In order to investigate the women's perspectives on the number of children, they want in the light of the traditional and new structures described above, we put forward the following question:

How are the women in rural Uganda’s perspectives on the number of children they want related to cultural traditions, economic structures, access to modern family planning methods and gender power relations in the families?

When referring to cultural traditions in the research question, we will especially consider the clan system, the polygamous system and the patriarchal structures in Uganda. By economic structures we refer to poverty, commercialization, increased living expenses, unemployment and land scarcity. Family planning methods refer to different kinds of contraceptives used in rural Uganda and gender power relations in the family refer to who has the power to make decisions about important issues in the women's lives.

Delimitations

The field of reproductive health in Uganda is complex and involves a number of different aspects. As our thesis has a specific aim of illuminating the perspectives of the women in regards to the number of children, they wish to have and how they are affected by a specific set of structures, we have decided to delimit ourselves from some issues which could also have been included.

It could have been relevant to include analysis about how the high prevalence of HIV and other sexually transmitted diseases in Uganda (UMoH, 2017 (b)), affect the women's perspectives, the gender relations and the use of family planning methods. Nevertheless, this was not the prime focus of our work, and as our informants barely touched upon this issue, we choose to delimit from it.

Another factor which could have been relevant to include is the issue of abortion, as it is closely connected to the topic of family planning (UNFPA 2013), and it would have been relevant to include the women's thoughts and experiences of this issue. However, as abortion is illegal and highly controversial in Uganda, we were advised by the local project leader of WRAP, Agatha Nanfuka Sherura not to ask questions about this issue. We chose to follow her advice due to our safety, but also due to reflections about how it might negatively affect our informant's confidentiality and perhaps their safety.

Scientific Approach

In the following, we will present our scientific approach to the field we investigate.

As the aim of this thesis is to investigate the women's perspectives on the number of children they want and their experiences of the structures affecting them, we will first and foremost adapt a phenomenological approach. The phenomenological approach allows us to be aware of our pre-assumptions, but set them aside, and ask and listen openly with the aim to understand our informants experiences (Brinkmann and Tanggaard 2015 p. 217-218). Through the intentionality of phenomenology, we can investigate the different phenomena, and describe the meaning of those through the experiences presented by our informants. The intentionality of the phenomenology means that the consciousness is always directed against something, which makes it possible to study phenomena through subjective experiences (Brinkmann and Tanggaard 2015 p. 219). In phenomenology the lifeworld is the reality, we can experience and which we take for granted when we make decisions, communicate and act in our daily lives (ibid). Therefore, from a phenomenological perspective, it is crucial to take the starting point in the "real world" to describe the phenomena as they are (ibid). In this thesis we will take starting point in the experiences of our informants and strive to understand how the structures of consciousness are experienced from the first-person point of view. The phenomenological approach allows us, to investigate the women's perspectives and the underlying reasons for their wishes in regards to the number of children they want.

However, the phenomenological approach, entailing the first-person perspective, does not fully allow us to investigate the structures affecting the women's perspectives. Such as cultural traditions, economic structures and access to modern family planning methods. We therefore combine with a structuralist approach, which implies that one strives to uncover the underlying structures that shape the way humans feel, think and perceive and what they do (Sonne-Ragans 2012). By applying a structuralist perspective, we can investigate the different phenomena and the meaning of those more objectively by focusing on how the structures create the reality of the subject field, as structuralism entails the ontological perspective that the social reality is created by the structures (Thisted 2018). Structuralism implies that human culture can best be understood by investigating human relationships to the overarching system of structures (Sonne-Ragans 2012). Therefore, the structuralist perspective allows us to research how different structures in Uganda affect the women and their preferences and choices.

About Uganda

In order to provide the reader with relevant knowledge about the context our study is conducted in, the following will present some facts about the demography, culture and religions in Uganda, and how the policy towards family planning has been changing. A few statistics about reproductive health in Uganda as well as a fact box about contraceptive methods used will also be provided. Further we will describe how changing economic structures are affecting the people in the rural areas.

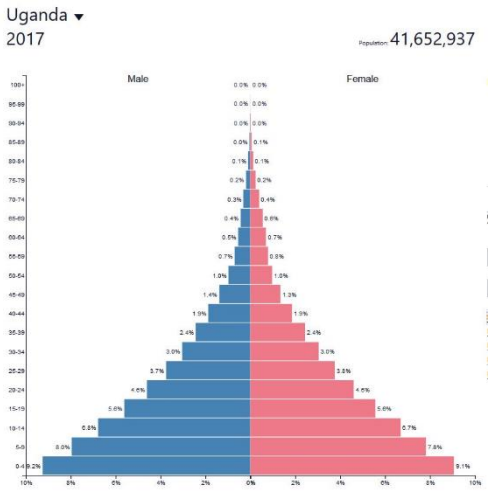
Short Introduction to the Country

Uganda is a landlocked country in East Africa bordering Kenya, South Sudan, Democratic Republic of the Congo, Rwanda, and Tanzania. It is a former British colony and achieved independence in 1962. Since then a number of civil- and clan-wars and unrest have marked the country, including the dictatorship of General Idi Amin, who conducted mass killings in the country in the 1970's and the brutal civil war against the Lord's Resistance Army lead by Joseph Kony in the 1980's and 1990's. In 1986 the current president Yoweri Museveni took office, and for the past 2 decades the country has witnessed a relatively peaceful time (Reid 2017).

Map of Uganda highlighted in Africa. Source: https://commons.wikimedia.org

Population

The total population of Uganda is just over 41.5 millions and has been rapidly growing from about 9.5 millions in 1970 (World Bank 2018). This immense population growth has resulted in a very youthful population with almost 48 percent of the population being under 15 years of age (UMoH 2017(a)) as shown in “figure 1”.



Age pyramid of Uganda 2017. Source: https://www.frberg-hf.dk

Culture and Religion

Uganda has a diverse culture in terms of traditions, language and religion as the population is divided into about 50 different clans and a number of ethnic groups. The official language is English, but a number of other languages are spoken around the country. 85% of the population consists of Christians, half catholic and half protestant. About 14% are Muslims and the rest follow traditional religions (UBOS 2014).

The vast majority of the population, about 80% live in rural areas (ibid). 74% of Ugandans in rural areas and 29% in urban areas, practice subsistence farming, meaning they are growing crops and raising livestock sufficient only for own use, without any surplus for trade (UMoH 2017(a)).

Policy Towards Family Planning

There have been strong political forces working against the spread of family planning methods in Uganda. For decades the president Yoweri Museveni, remained convinced that a large population was the key to economic success, based on the argument that China's economic success could be explained by its large population. Thus, he advocated for population growth in Uganda and encouraged women to have as many children as possible (Wakabi 2006). However, activists and global institutions calling for a reduction in fertility rates put pressure on the president and in 2012, at the London Family Planning Summit, he appeared to have changed his mind, and thus he allocated funding for family planning (UNFPA 2018(b)). In 2014 he backed the *Harnessing Demographic Dividend to Achieve Uganda's Vision 2040*, a policy which strongly advocated for family planning and education as the means for economic growth (UNPA 2014).

A Few Facts on Reproductive Health Statistics

- The fertility rate is 5.4 birth per woman and has declined from 7.4 in 1988 (UBOS 2016).
- The under-5 mortality rate is 64 deaths per 1,000 live births and has declined from 177 in 1988 (UBOS 2016).
- The maternal mortality ratio is 336 deaths per 100,000 live births and has declined from 529 in 1995 (UBOS 2016; World Bank 2018)
- 25 percent of Ugandan girls aged 15-19 is either pregnant or have already given birth (UBOS 2016).
- 35% of married women use a modern contraceptive method and this figure has increased from 8% in 1995.

Fact box About Methods of Contraceptives:

Injectables: Also known as the Depo-Provera, is a hormonal injectable administered by a health professional. It prevents pregnancy for 3 months at the time by stopping ovulation. This method has a large number of side effects due to the high concentration of hormones (Planned Parenthood 2018). It is by far the most used method in Uganda (UBOS 2016).

Implants: Is a small rod, about the size of a matchstick, which is inserted just under the skin on the upper arm by a health professional. It prevents pregnancy for up to 4 years by releasing hormones.

It also carries a number of side effects, but less than the injectables (Planned Parenthood 2018). The implant is the second most used method in Uganda (UBOS 2016).

IUD's: The Intrauterine Device is a small T shaped device which is inserted into the uterus and prevents pregnancy until it is removed. There are 2 types: the copper IUD usually has the side effect of increased menstrual bleeding, while the hormonal IUD usually decreases or stops menstrual bleeding (Planned Parenthood 2018). This method is used by only 1-2 % of women in Uganda (UBOS 2016).

The third and fourth mostly used methods of contraception in Uganda is the female sterilization and the male condom.

Changing Economic Structures

In the following we will describe some of the economic changes that Uganda has been undergoing during the last decades, and how they have contributed to poverty faced by the people in the rural areas.

Land-grabbing

As most people in the rural areas in Uganda derive their livelihood from farming, land is essentially important (Carmody and Taylor 2016). The land in Uganda is inherently fixed in terms of amount at location, however it has, since the 2000's attracted increasing attention from international investors (ibid). The international interest in the land has increased its value and therefore it has been giving a greater interest by domestic economic and political elites (ibid). Whilst those have been benefiting from the increased value, the poor farmers have been suffering from the consequences through dispossession as the land has been taking without consent of its previous long-term users (ibid). In 2011, 15.000 people in Uganda, were displaced, in favor of a British company, New Forest. This was done in order to make timber plantations as a part of United Nations Reduction of Emissions from Deforestation and forest Degradation program (REDD+). Sadly, the population displacement involved extreme violence and fatalities (Carmody and Taylor 2016). Just as under the British colonist empire the people are now displaced in the name of economic accumulation, to expand

state territories and in addition to decrease the ecological effects of the expanding global markets (ibid).

Inflation and Economic Crises

In the 1970´s a collapse of Uganda's economic infrastructure lead to a disruption of commercial life. Alongside a collapse of the East African Community in 1977 lead to disruption of transport, telecommunication and complimentary financial and industrial planning (Nabuguzi 1993). In addition, the terror under Amin's regime contributed to a flight of qualified people (ibid). The economic crisis was characterized by high levels of unemployment, lack of essential goods, drastic drop in production of traditional crops. As money were printed to finance political budgets, the Ugandan shilling was overvalued in comparison to convertible currencies (Nabuguzi 1993). In the beginning of the 1980´s the economic crisis was amplified by the international economic crises which caused a dramatic change in trade disfavoring primary products, high interest rates and sharp rise in oil prices (Nabuguzi 1993). In addition, the rural areas in the Luwero triangle suffered from the guerilla war between 1981 and 1986 (ibid).

Education, Unemployment and Increasing Poverty

Recently the educational level has improved as a result of the liberalization of the education sector. The increased access to tertiary education has been characterized by introduction of private sponsored programs in public institutions and licensing of private institutions (Nuwagaba 2012). In addition, many families have been struggling economically to get their children into tertiary educations. The problem is the relevance of the acquired training. The unemployment level has been raising as a result of the slow growth of the private sector, which is not able to employ the available graduates (Nuwagaba 2012).

Though the statistics show economic growth in Uganda, they are misleading as they do not show the countries capacity to produce goods for its own consumption. In addition to this, the World Bank has observed that aid covers 80% of all investments. The majority of Ugandans do not have the opportunity to earn enough to improve their lives, as the economic growth does not come from internal productions, which would create jobs and make it possible for the many to improve their livelihoods in sustainable and meaningful ways.

In addition, the quality of the growth should be taken into concern as the domestic export is still depending on primary products which are vulnerable to fluctuations. As an example, the decline in coffee prices has had terrible consequences for the lives of the coffee growers. Furthermore, as Uganda continues to import manufactured goods it loses the opportunity to develop the industrial sector (Byekwaso 2010).

Literature Review

The objective of the following section is to place our study in relation to the current scholarly literature, to explore the state of the art within the field of reproductive health in Uganda and illuminate the reproductive situation of women in Uganda. When conducting the literature review it became clear, that this field has received intensive scholarly attention, and thus the body of literature is immense. We have conducted a thorough review of the existing debates and studies about the subject, in an attempt to identify gaps in the existing knowledge and clearly describe how our study can contribute to the current knowledge by filling such a gap. Due to the vast amount of literature it has been necessary to limit the following review strictly to debates and articles of direct relevance to the objectives of this study.

In order to systematize and structure the collected literature the following topics have been identified:

- Fertility motivation and cultural habits
- Access to and knowledge about family planning
- Power relations between the genders
- Teenagers reproductive health

The literature has been sought by using the following search words: Reproductive Health, Fertility, Family Planning, Gender Relations, Gender Equality and Uganda. Furthermore, we have to a large extend found relevant literature by looking into the references in the relevant article that we found.

Fertility Motivation and Cultural Habits

In 2010 Beyeza-Kashesya et al. conducted a qualitative study of young people's views on their reproduction in rural Uganda, using interviews and Focus Group discussions to explore their perceptions and thereby uncover reasons for the persisting high fertility rate in Uganda. They found that the young people's views were still strongly influenced by the patriarchal cultural and religious norms and that a major incentive to have many children was to secure the lineage and expand the clan. Thus, in order to fulfill his duty to the clan, a man would have to father at least one boy, but preferably a number of them. Girls were considered of less value, but still important as they represented a possible income by bringing in a bridal price or "dowry", when reaching the age of marriage. Furthermore, the young people in this study identified joblessness and poverty as a breeding ground for an environment, where many children could be born, due to the fact that people had nothing to do and thus used sex as a pastime. Another incentive to have a large number of children was religious believes, that God will decide on the number of children and that the religion in general directed them to have many children. However, this believe might to a larger extend have roots in the cultural norms rather than the religious as the respondents were a mix of Muslims, Catholics and protestants.
The Ugandan culture carries a tradition of polygamy, and most respondents in this study agreed that if a woman did not produce any boys, it would be natural for the husband to have children with another woman as well, even if this lead to high-risk sexual behavior because the rates of HIV and other STI's are high in Uganda (Beyeza-Kashesya et al. 2010).

Our study in many ways resembles the objectives of this study, however we had strong reason to believe that some of these traditional cultural trends have changed since 2010, and that these changes would be worthwhile investigating. First of all, a number of initiatives have been implemented to strengthen family planning information and service provision for women in Uganda and secondly the fertility rate seems to be declining in a more rapid pace than before (UMoH 2007-2015; UMoH 2015; UBOS 2016). Indeed the present study will build on the findings of Beyeza-Kashesya et al. (2010), but we have identified a number of changing trends and added a focus on the power relations between the genders, as will be specified in the analysis.

Access to and Knowledge About Family Planning

In 2016 The Uganda Bureau of Statistics released their 6th Uganda Demographic and Health Survey (UDHS), which they have been conducting on a regular basis since 1988 in collaboration with USAID, UNICEF and UNFPA (UBOS 2016). In this quantitative survey information was collected on fertility levels, marriage, sexual activity, fertility preferences, breastfeeding practices, and awareness and use of family planning methods, by trained field staff, who visited a total of 20.000 households in all districts of Uganda (ibid). According to this survey, 35% of married women and 47% of unmarried sexually active women were using a modern contraceptive method. However, 28% of married women and 32% of sexually active unmarried women had an unmet need for FP services. The unmet need for family planning services is defined as women who want to postpone their next birth for 2 or more years, or who want to stop childbearing altogether, but are not using a contraceptive method. The rate of unmet need for FP has been declining since 2006, where 38% of married women had an unmet need (ibid).

A number of scholars suggest that men's involvement in women's decisions regarding their use of family planning, is crucial due to the fact that men are often the final decision-makers in the family. However, in many cases the men in Uganda are not as knowledgeable, nor do they involve themselves in matters of reproductive health and family planning (Sileo et al. 2017; Kabagenyi et al. 2014). For those reasons it is suggested that reproductive health interventions focus on male involvement in women's reproductive health. In 2014 Kabagenyi et al. identified a number of barriers to men's involvement in contraceptive uptake in rural Uganda, including perceptions that reproductive health was a woman's domain, preference for large family sizes and concerns that women's use of contraceptives would lead to extramarital sexual relations. Likewise, Sileo et al. (2017) investigated strategies to get men more involved in women's reproductive health in Uganda and found that limited knowledge and misinformation about contraceptives, like stories about condoms getting lost in the body and side effects like cancer, infertility and birth defects were major barriers to men's approval of use of family planning methods. This study was based on focus group discussions and like Kabagenyi et al., it was also a common perception that use of contraceptives would lead to extramarital affairs. About half of the respondents did not jointly discuss the number of children they wanted with their partners.

Power Relations Between the Genders

The traditional culture in Uganda is based on a patriarchal structure, with gendered social norms and a strict division of labor. Men are seen as the sole providers whilst women are responsible for housework, including childcare, cooking and working in the field. Men are traditionally the decision-makers of households, and women are supposed to be subordinate and obedient (Tuyizere 2007; Tamale 2016; Morgan et al. 2017; Sileo 2017).
Morgan et al. (2017) found that these gendered power relations affected women's reproductive health and their access to maternal health care, as they limited women's access to resources and their ability to make decisions regarding their own health. In this qualitative study, the women would claim that men were often not fulfilling their responsibilities, by providing resources for transport and other expenses related to pregnancy and childbirth and criticizing them for having a negative attitude towards fatherhood. The men on their part would justify their behavior by referring to issues of poverty, joblessness and general lack of financial capability, which they felt the women did not understand. Thus, as poverty and unemployment affect the men's ability to provide for their families it also affects the power relations between the genders. In our study we go further into analyzing these power relations, as we found that a number of the women were financially empowering themselves, and we analyze how this change affects the pre-existing power structures.

In a 2017 mixed-method study of the shifting gender norms and food security, Amialya et al. found that household inequalities between the genders contributed to food insecurity for girls and women in rural Ugandan. The study paints a picture of women who are increasingly economically independent, but who are at the same time overburdened by household responsibilities. A majority of the female respondents in this study explained that they were reliant on the income they could make on their farming in order to provide food and school fees for their children, as they could not rely on their men to spend the money on the family (Amialya et al. 2017). In our study we reveal a similar picture, but unlike Amialya et al. we go further into how this affects the relations between the genders, and analyze how new and traditional structures affect the gender relations.

Another problem which is commonly linked with the power relations between genders is domestic or sexual violence (Tamale 2016; Morgan et al. 2017) and in fact more than one in five Ugandan women have been subjected to this (UBOS 2016). Ogland et al. (2014) found that women's risk of experiencing domestic violence was tied to issues of poverty, as Ugandan women in households

with greater wealth were at lower risk of experiencing lifetime physical violence. Furthermore, they found that gender power relations were connected to sexual and domestic violence, as women with higher education than their husbands and women who possessed egalitarian decision-making were in fact at higher risk of experiencing violence, due to the fact that they contested patriarchy and challenged the male partner's authority. A number of scholars who have studied domestic violence in Uganda found, that both men and women often view beating of a female partner as justifiable in some circumstances (Morgan et al. 2017; Ogland et al. 2014; Koenig 2003).

Another reproductive health factor, which also seems to be affected by the gender relations in Uganda is the HIV prevalence. According to the Uganda Population-Based HIV Impact Assessment (UPHIA), which is a household-based national survey, including almost 13.000 households, the prevalence of HIV among adults in Uganda is 7.6% among females and 4.7% among males (UMoH, 2017 (b)).
Different studies show that Ugandan men in general are reluctant to be tested for HIV, in many cases due to fear of testing positive and then they will rather not know (Sileo et al. 2017; Rudrum et al. 2015; Kabagenyi et al. 2014). Rudrum et al. found that although most women had a positive view on couples testing for HIV, they were in many cases not able to convince their partners to go, due to their lack of decision making-power. In their qualitative study they also found that fidelity was a major issue among the respondents - even within the context of some men having multiple wives, and that this was under scrutiny when being screened for HIV (Rudrum et al. 2015).

Teenagers Reproductive Health

Adolescent pregnancy and childbirth is associated with highly increased risks of both morbidity and mortality to both the mothers and the newborns and with adverse social consequences due to loss of opportunities and education for the mothers (UNFPA 2013; Wolf et al. 2017; UBOS 2016). With the Sub-Saharan countries amounting for the highest rates of adolescent pregnancy in the world (UNFPA 2013), Uganda amounts for the sad figure of 25% of adolescents age 15-19 having begun childbearing (UBOS 2016). In the North Central region, where the field work for our study was conducted the figure was at an even higher rate of 30% (ibid). The proportion of teenagers who have started childbearing decreased with increasing level of education (ibid).

A number of studies highlights the need for better information provided to the youth about sexuality, contraceptives and sexually transmitted infections (STI) (Biddlecom et al. 2007; Wolf et al. 2017; Muhwezi et al. 2015). In a qualitative study among secondary school students Muhwezi et al. (2015), found that most adolescents only in rare occasions discussed issues like sex and dating with their parents, and when it happened it would usually be with the mothers and focus tended to be on STI's. Muhwezi et al. stress the importance of improved parent-adolescent communication in promoting healthy sexual behaviors among adolescents as this is associated with reduced levels of risk-taking among adolescents. Whilst parents were in many cases ill-prepared for the task of educating their children about sexual matters, it was commonly left to so called Singas or aunties in Uganda (Ninsiima et al. 2018).

Wolf et al. (2017) found that Ugandan adolescents had a great lack of knowledge about reproductive health and that implementation of reproductive health education in schools, performed by an outside party could help to close this knowledge gap.

In 2007, Biddlecom et al. found that less than 60% of sexually active adolescents in Uganda had ever used a contraceptive method, and that condoms were the far most common method for them to use. Furthermore, they identified a number of barriers facing the adolescents in the attempt to obtain information about and access to contraceptives, including feeling afraid or embarrassed, not knowing where to go or how to get there and the costs. They also found that the teenagers lacked knowledge about STI's due to some of the same barriers.

The Relevance of Our Study

By going through the available literature on the subject of Ugandan women's reproductive health, their cultural and traditional roles and their motivations regarding reproduction, a complex and comprehensive picture has revealed itself. However, no studies have in recent time focused on how the women's perspectives on the number of children they want is related to cultural traditions and economic structures. Nor have any studies to our knowledge attempted to bridge the connections between the women's motivations for reproduction, their access to family planning methods and how the power relations to the men are changing, as they gain financial empowerment. Thus, we attempt to pursue filling this gap in the current knowledge with our research.

Methods for Data Collection and Analysis

In this part we will describe our way into the field, how we have gathered the empirical data and some reflections about factors that could affect our data collection. At last we will describe how we have analyzed the empirical data and shortly present the theoretical concepts we have used.

Our Way into the Field

As we wanted to investigate the Ugandan women's perspectives we needed a way in to get to talk to the women in the rural areas. We became aware of the WRAP project, which was conducted in collaboration between DFPA (in Danish "Sex og Samfund") and RHU (a Ugandan NGO, working with reproductive health). The project aimed to increase the demand for family planning and to build local capacity to influence national policy processes for the promotion of family planning (WRAP 2014). We contacted DFPA, who put us in contact with the national project leader of WRAP in Uganda. She in turn connected us to the local project leader, of the rural Luwero branch of the project, Agatha Nanfuka Sherura. Mrs. Sherura has been of tremendous help, by setting up all interviews according to our wishes and by acquiring a skilled interpreter and means of transportation to the rural villages.

Methods for Data Collection and Analysis

As it is often the case for phenomenological research, our work has been inspired by hermeneutics, by aiming to extract meaning from our empirical data through interpretation. In order to generate in-dept interpretations of the phenomena we sought to uncover, we used the hermeneutic cycle. Thus, in our process of analyzing the data we have been going back and forward between the whole and the detail and between our interpretations and understandings, as this circular principle of interpreting is at the basis of hermeneutic methodology (Thisted 2018). In the following we describe the way we have conducted data, how we analysed the data and at last reflect on which aspect could have affected our result.

Using Semi-structured Individual- and Group-interviews and a Diversity of Informants

As we were interested in investigating the perspectives of the Ugandan women on their reproductive health choices, we have chosen a qualitative method for our data collection, which can

be useful when attempting to interpret processes of meaning or describing a phenomenon in context (Silverman 2014; Kvale and Brinkmann 2014).

We chose to conduct semi-structured interviews, as a tool for investigating the respondent's views and follow up on the information they put forward, while still remaining within the chosen topics and making sure to stay on track with the research problem (ibid). Furthermore, we conducted a number of focus group interviews, as this method allowed us to gain a sense of the dynamics and debates between the respondents and a way to have the perceptions of individuals challenged by their peers (Silverman 2014; Harboe 2010).

As a way to "get behind the front-stage" we chose to set up a number of different interviews with different informants, and especially the interviews with midwives and other health professionals helped us to gain knowledge of a different angle on the women's perspectives, as they knew the culture and the women in depth, but also had kind of an outsiders view to add on the local women's reproductive choices. All questions in our interview guides were formulated as open questions. As an example, we would not ask: "Why do you want so many children?" but rather "What is a good number of children to have?" and "Why would you like to have that number of children?". In this way we hoped to allow the women to express their own perspectives on a matter.

Individual Interview with Ugandan Woman and Translator. Photo: Dina Sloth Illeris

Data Collection

In order to reach an overall understanding of the field we were approaching, we started out by interviewing key-staff on the WRAP project, namely the national and local project leaders and later the in-charge midwife. As those people were dealing with some of the issues of our interest, on a everyday basis, they had valuable knowledge which made it easier for us to approach our informants in the rural areas. The main body of the data consists of the individual- and focus group interviews with the local women and men off the rural villages and the interviews with local health staff on three different health centers that we visited. Most of the villages we visited were enrolled in the WRAP project, and thus the women had recently been sensitized about family planning. In order to investigate the view of women, who had not been enrolled in the WRAP project, we later visited a village outside of the project area, where we conducted a number of interviews. It turned out that people in this village had also to some extent been sensitized about family planning, but that they knew less about it and had a poorer access.

Already on our first day conducting focus group interviews, it became clear, that when we had groups of mixed ages, the young women would not say much, so we started constructing focus groups of only young women, which certainly enriched us with very different perspectives that will be analyzed further in the report. Also, it was evident that the gender-power relations have an essential influence on the number of children a woman has, and that the women and men have very different perspectives on reproductive choices. We therefore conducted interviews with men alone and focus groups of men as well as focus groups of mixed gender, which lead to some very lively discussions between the genders.

In total, we conducted 22 individual interviews and 12 focus group interviews, and the details of the collected empirical data are presented in the table below.

Overview of the Collected Empirical Data	
RHU Staff	Individual interviews in English with: National Project Leader of WRAP Local Project Leader of WRAP, Luwero Branch
Individual or 2-person Interviews. (No. 1-15)	7 individual interviews with women from different villages

	4 individual or 2-person interviews with men. All "Male Role Models" enrolled in the WRAP project. One of the interviews turned into a focus group interview. 4 individual or 2-person interviews with "Pressure Group Members", women enrolled in the WRAP project
Focus Group Interviews (FG 1-2) Generally consisting of around 8-20 informants	2 Focus groups of mixed gender 3 Focus groups of women of mixed ages 5 Focus groups of young women. Age 15-27 2 Smaller Focus groups of respectively 2 and 4 local men
Health Staff (HP 1-7) From 3 different local health centers of very different capacity and from the RHU clinic in Luwero	3 Interviews with midwifes from local health centers 1 Interview with a nurse at a local health center 1 Interview with the in-charge doctor at local health center 1 Interview with the in-charge midwife at the RHU Luwero Branch 1 Interview with a clinical officer at the RHU Luwero Branch

When analyzing the different interviews in the study, references to the individual interviews will be numbered as No 1-15, the focus group interviews will be numbered as FG 1-12, and the interviews with health staff will be numbered as HP 1-7.

Due to a technical problem interview No. 5 with a 32-year-old mother of 4 was not recorded properly and will not be used as we could not transcript it. However, we kept it in the data to keep the order. Interview No. 11 is different from the others, as it started out as an individual interview with a 58-year-old man, but later, as we were sitting under a tree in the middle of the village, other people joined and we allowed them, turning it into a focus group of mixed gender and age. Again, we chose to file the interview in the original category of individual interviews, to keep the order in our data.

Factors Affecting Our Results

In the following we will describe how a number of conditions have affected our data collection, including accessing the field through an NGO with certain objectives, using an interpreter in the interviews, our appearance as white, educated women and the influence of our professional backgrounds.

Because our way into the field has been through an NGO with the aim to increase the use of contraceptives in rural Uganda, some informants might have seen us as representatives of this

message. Thus, the fact that it was RHU who was the connection between us and the informants, might have biased their answers towards a more contraceptive positive direction and a decrease in the number of children they would say they wanted.
However, a positive effect of our way into the field being through RHU have been that many of our informants had access to family planning and therefore could provide more in-depth knowledge about other barriers to the use of contraceptives, as well as how gender related power structures affected the use of family planning methods.

During our fieldwork we had an obvious challenge in our lack of local language skills, as most of the local people spoke Luganda and only to a smaller extend understood English. This meant that when interviewing the local people, we were dependent on a translator. As English is the official language of Uganda all educated people, like RHU- and health staff spoke English at a high level. Through the organization RHU we got in contact a young woman, who served as our translator. She grew up in Luwero and was currently volunteering at RHU Luwero Branch. She possessed a diploma degree in art and her language skills in both Luganda and English were excellent. Furthermore, she had received training about family planning by RHU, thus her vocabulary regarding matters of reproductive health was complete and this certainly came in handy, as she was also able to explain both clinical as well as cultural customs and understandings to us.
However, using a translator might have influenced the interview situation and the answers we got, in various ways that, due to cultural differences, are difficult for us to recognize.

Another factor that could have been affecting the answers of our informants is our appearance as white women, with professional backgrounds as midwife and biologist. This might have led to certain expectations or precautions, which could have had an influence on the answers we got. But again, how and if it has affected the data is unknown.

Our Professional Backgrounds

Sofie Hjorth Schausen has a background as a biologist, with years of professional experience in conducting radio about science. This background came in handy, as she was already experienced in constructing interview guides and performing interviews.
Dina Sloth Illeris has a background as a midwife, with 9 years of experience from a maternity ward in Denmark. This background was useful, as it made us able to fully understand matters of obstetric

or clinical relevance and it served as an icebreaker, when conducting interviews with health professionals. Furthermore, it served as a way to make it obvious to the local people, why we would be interested in asking about their reproductive health, as they were all acquainted with the profession of a midwife, while the notion of master students might seem more intangible.

Data Analysis

In the following we will explain how we have coded and analyzed our data, and shortly present our theoretical concepts, which will be unfolded further in the theory section.

Transcription and Coding

The process of analyzing our empirical data started already during the fieldwork, as we would discuss our findings along the way and in some cases alter or add to our interview guides. All interviews were recorded on audio, and notes were taking during the interviews. After returning from the field we transcribed all interviews with the local people and the health professionals in order to assure the reliability of our research. The two interviews with the national and local project leader of the WRAP project were recorded and listened through, but not transcribed, as we will not directly use them in the analysis. They served more as a way for us to understand the setting of our fieldwork.

After transcribing the interviews, we identified and color-coded seven different themes, in order to get an overview of our results:

1. Access to family planning, Use, Knowledge. Side effects.
2. Women's perspective on number of children – culture, responsibility, changes young/older.
3. Men's perspective on number of children and FP – Changes, culture.
4. Teenage pregnancy – access and knowledge – culture
5. Cultural traditions
6. Economy – poverty, Land scarcity, Commercialization.
7. Gender related power structures – Gender equality, empowerment of women (Economical, knowledge, rights). Des-empowerment of men, irresponsibility.

Using the color-coded transcripts, we made a working paper with all the main findings we could identify in the interviews and structured them under 4 themes related to our research question. In

order to achieve depth in our analysis, we formulated sub questions to the empirical data, using our theoretical concepts.
The method of coding, structuring and asking sub-questions related to the theoretical concepts was largely inspired by David Silverman's work on "Interpreting Qualitative Data" and Steinar Kvale and Svend Brinkmann's "Seven phases of an interview study" (Silverman 2014; Kvale and Brinkmann 2014), although we did not follow any of these step-by-step.

Theoretical Concepts

To investigate the women's perspectives, we apply the French sociologists Bourdieu's concepts of capital, habitus, the field and symbolic violence (Priur and Sestoft 2007). These concepts are applied in order to analyze the women's bodily incorporated dispositions, determining their views upon their reproductive health and fertility choices and how their interactions with the men in the community affect them.
To reach a deeper understanding of how the field, habitus and the gender related symbolic violence affect the health of the women in a holistic sense and how this affect their perspectives, we further include the concepts of health, empowerment and health determinants as they are put forward by Professor in Health Promotion, Glenn Laverack (2004).
In order to analyze the gender relations, we furthermore apply the theory of Gender And Development, put forward by a number of feminist scholars. This theoretical approach provides us with a framework which enables us to analyze how changes in the social relations between the genders affect the women as the traditional systems and gender roles develop.

Structure of the Analysis

The 4 themes we identified will serve as the 4 parts of our analysis. Below, the themes and the sub questions are listed:

1. The women's dreams and wishes for how many children they want

- How is the habitus determining the women's perspectives on the number of children they want?
- How does changing health determinants like poverty and commercialization interact with the habitus?
- How does motherhood affect the health of a woman in the broader sense?

2. The men's perspectives on the number of children they want, and how it influences the women's possibilities for having the number they want.

- How are the women's ability to choose how many children they want affected by the men?
- How are the different structures connected to men' s habitus, reflected in the number of children they want?

3. **Access and barriers to the use of family planning methods.**

- How can the increasing access to FP, be seen as an important health determinant?
- How is the bad quality of methods, limiting the use, connected to lack of adaptation to the society, gender power relations and the attitudes of the health professionals?
- How is the habitus of the people a barrier to access and knowledge of family planning for the young girls?

4. Changes in the social relations between the genders

- How are the women getting economically empowered, and how does this affect their power relations to the men?
- How is the economic empowerment affecting the decision-making power?
- How does the increased access to family planning affect the gender relations?

Theoretical Approach

In this section we will elaborate on the theoretical concepts we apply, why we have chosen them and how we will use them in our analysis. The section is divided into 3 main parts, as we have chosen to apply 3 different theoretical apparatuses. In the first part we will elaborate on the concepts of capital, habitus, the field and symbolic violence as put forward by Pierre Bourdieu (Bourdieu and Wacquant 1996; Bourdieu 1986). In the second part we elaborate on the concepts of health, empowerment and health determinants as put forward by Glenn Laverack (2004) and in the last part we will elaborate the theoretical approach of Gender and Development (GAD) as put forward by a number of feminist scholars (Miller and Razavi 1995).

The Construction and Reconstruction of the People's Perspectives.

In order to deeply analyze how the women's perspectives in regards to the no of children they want are affected by the different structures, we will apply the concepts of capital, habitus, the field and symbolic violence launched by Pierre Bourdieu. The concept of habitus opens a door to investigate how the bodily incorporated dispositions determining the women's views on their reproductive health and fertility are shaped. The concept of the field allows us to analyze how structures in the society affect the women's views. To understand the perspectives on reproductive health and fertility it is necessary to understand the mechanisms that determine the attitudes and behaviors within the society.

Capital

We will apply Bourdieu's concept of capital when analyzing the habitus of our informants as well as the gender related symbolic violence.

Bourdieu defines capital as accumulation of work which, when archived, makes the holder capable of acquiring power and material wealth (Bourdieu 1986: 247-55). Capital shall be understood as different kinds of resources in the society (Bourdieu 1986:241). Bourdieu differentiates between three kinds of capital; economic-, social- and cultural capital. The different kinds of capital are valued differently depending on the field it is operating within. Economic capital can be seen as the access to money and material values. Social capital is the value one possesses through social network and membership of certain groups. Cultural capital refers to formation and literacy competencies which are essential for actors' success in certain societies (Bourdieu 1986:243-249). The ones, in a social field like rural communities in Uganda, who possess most of the highest valued forms of capital, will possess the most power.

In the analyses we will apply the concept of capital, when analyzing the dynamic between the habitus of wanting many children as well as the reproduction, and the field of reproduction in the communities in rural Uganda as well as how the gender power relations are reproduced.

Habitus

Bourdieu uses the concept of habitus to connect the concepts of the field and capital. He defines habitus as systems of values and norms, cultural habits or systems for perceptions, which individuals or groups orientate themselves to. Habitus is the embodied cognitive structures, which are a foundation for people's practices, opinions and decisions (Bourdieu & Wacquant 1992. Further Bourdieu defines a person's habitus as a set of durable and bodily incorporated dispositions that

regulate how one classifies and interprets the world, evaluates persons and objects in the world and how one acts (Aakvaag et al. 2012: 193). The dispositions constitute the core of the personality and are located in the pre-reflexive level of habitus responses which Bourdieu defines as a practical sense (ibid). Because of our habitus we 'just know' what to do without having to think too much about it (Aakvaag et al. 2012 :193). According to Bourdieu our habitus is a product of the social environment we grew up in, meaning that people who grew up in similar socialites acquire similar habitus (ibid). Furthermore, habitus is class specific, so the way people are disposed to behave is a product of their position in the social space (ibid). By applying the concept of habitus, it is possible the analyze the local's perspectives in rural Uganda, in relation to the structures of the communities.

The Field

It is central to the sociology of Pierre Bourdieu, that the society consist of a number of small social fields. Each field consist of a network of social relations between positions of actors, maintained by the division of power and capital recognized in the specific field (Bourdieu 1994:53). To get access to a field a person must possess specific qualifications and characteristics. A goal of Bourdieu's sociological research is to understand which specific forms of capital has value in a certain field (Bourdieu & Wacquant 1992).

Each field is dominated by certain rules, values and interest. The rules about what is right and wrong are called the doxa of the field. Those rules maintain recruitment to the field through socialization of new arrivals in accordance to the doxa (Bourdieu 1994: 137). The doxa will never be complete though and there will be a consistent power-struggle to define which rules and values are important in a certain field (Bourdieu 1994: 56). Bourdieu applies his concept of economic, cultural and social capital, to explain how uneven access to material, social and cultural resources create and reproduce certain power relation in the social fields.

In the analysis of this thesis we will apply the concept of the field to analyze the structures affecting the social arena of reproduction in rural Uganda and the power-struggles between the different positions defining the rules, values and interest. And how they are affecting the men's and women's choices and perspectives on the number of children they would like to have.

Habitus and the Field -A Dynamic Interaction

Habitus is not a fixed way of being, but it is formed in interaction with the specific social field (McNay, 1999). According to Bourdieu habitus is creative and inventive within the limits of its structures (Bourdieu and Wacquant 1992: 94-138). He emphasized that habitus is not simply inherited but made, as the history is turned into nature (ibid). In the analysis of this thesis, we will look at how the desires for producing children are related to the different structures of the society and the cultural practices.

Bourdieu describes the dynamic relation between habitus and the field as learning the rules of the game (Bourdieu and Wacquant, 1992: 94-138). The habitus reproduces social structures by producing individuals with the dispositions needed to make them work (IbidBourdieu argues that fields of action produce a specific habitus in participants and views this specific habitus as a mechanism through which the field is reproduced (Bourdieu 1990). Thus, the field shape individuals' habitus, which reproduce the field as habitus is both structuring and structured by the field. Thus, habitus is an internalization of external structures in the individual (Bourdieu & Wacquant 1996, 29-30, 106-107). In the analysis of how the local's perspectives are related to different structures in the society we will elaborate on this dynamic relation between habitus and the field.

Symbolic Violence

One of the internalized structures, structuring and structured by the habitus, is the symbolic violence. The non-physical violence is exercised with silent acceptance of both the dominating part and the dominated part, as both parties are unconscious about the dominance. (Bourdieu and Wacquant1992: 140-173). The dominated part does not recognize the symbolic violence as violence but accepts the conditions. The unreflective accept is happening, because the agents experience the relations as natural and therefore do not question them. This experience is due to that the dominating part is internalizing the structures, determining the world around both agents (Bourdieu & Wacquant 1992).

We will use the concept of symbolic violence in order to analyze the gender power relations and the decision-power in the families on reproductive matters, which are tightly connected to the health of

the women in rural Uganda. Further we will analyze how structures of the society and the habitus of the men and women reproduce the dominance.

A Health Promotion Perspective

In the following we will elaborate on the concepts of health, empowerment and health determinants and how they are applied in our analysis.
The concept of health will be applied as we will analyze how the women's health is affected by their empowerment and what they consider to be important in order to achieve a good live and to gain power in their relations to the men.
Some of the key elements in health promotion are the notions of empowerment, which can be seen as the goal of health promotion and health determinants, which can be seen as the socio-environmental conditions that create the possibilities for people to be empowered (Laverack 2004: 1-25). In this thesis we will analyze how the women in rural Uganda are gaining empowerment in the form of ability to control the number of children they have, as some of the health determinants have changed. Especially access to contraception and the women's ability to make an independent income are determinants which have positively affected the women, whilst other determinants like poverty and low social status have affected the women's situations negatively.

The Concept of Health

In the following we will elaborate on how the concept of health is understood in our work and how we will apply the concept in our analysis.

The concept of health has been interpreted in many different ways and is still an arena for heartfelt debates among scholars and practitioners (Laverack 2004: 16). In our work we will apply a holistic understanding of health inspired by WHO's definition: *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (Laverack 2004: 19). Our focus will not be on the physical health and absence of disease, but on the social well-being and the ability to live a meaningful and rich life. Laverack and other health promoters argue that when people are asked to elaborate on what makes them feel healthy they tend to focus on factors like having a sense of purpose in life, having good social relationships, happiness, being loved and experiencing control over one's life and one's living conditions (Laverack 2004: 17-19). It is

exactly this broad sense of health as the ability to take control over and live a good life that will lay the foundation of our understanding of health.

Empowerment

Laverack (2004) argues that empowerment is the key element of the health promotion which has raised with the Ottawa Charter from 1986. In the charter health promotion is defined as the process of enabling people to gain increased control over their lives and to improve their health (Laverack 2004: xii).
When promoting health in rural Ugandan communities, economic empowerment and increasing possibilities for the men and women to control the number of children they want, is essential. In our study we investigate how the women's economic empowerment and access to family planning methods and control of the number of children they want is related to the gender power structures in the families. Health promotion can serve as a mean to transform the power relationships, and thus enable people or groups of people to gain control and to achieve their goals (ibid). Throughout our analysis we will investigate how the women in rural Uganda are struggling to empower themselves both by controlling the number of children they have, by gaining economic independence and by attempting to re-negotiate their power relations to the men.

Health determinants

Whereas the dominant approach to health is in many cases a biomedical one, focusing on physical health or a behavioral one focusing on the individual's lifestyle, health promoters in general argue that focus should be turned to the socio-environmental conditions determining people's health (Laverack 2004: 20-26). These conditions are defined as health determinants and consists of structural issues such as poverty, housing, low social status, lack of power or discrimination (ibid). In the following we will elaborate on the concept of health determinants as understood in the field of health promotion and how we will use the concept to analyze how socio-environmental conditions affect the women in rural Uganda, and how they influence the choices the women make in regards to the number of children they want.

Laverack describes health determinants as the risk conditions which people live and work under and which are deeply structured by political and economic practices, but also by dominant discourses and ideologies in a society. Thus, these determinants can be of a societal nature, like when groups

of people experience poverty, low social status, dangerous or stressful work or a polluted environment or they can be of a psychosocial nature like low self-esteem, isolation, lack of social support or loss of meaning or purpose in life. In general, people who experience any of the negative health determinants or risk conditions are less likely to report feelings of healthiness or happiness because they lack the control over their own lives which strengthen a person's health (ibid).

In our study we have identified a number of social and economic structures, which determine the women's health and their ability to take control over their own bodies by deciding the number of children they want. By applying the concepts of health, empowerment and health determinants as interpreted in the field of health promotion, we are enabled to analyze how the women's health is affected, both by their power relations to the men, by the traditional and new structures and by the number of children they have.

Changing Gender-power Relations

During our fieldwork it became clear to us, that the women's perspectives on how many children they wanted were strongly connected to their relations to the men. In fact, we came to the conclusion, that it would not make sense to investigate the women's perspectives on this issue, without including the gender relations, as the men were often the decision-makers in matters related to reproduction. We therefore chose to apply the social constructivist framework of the Gender and Development (GAD) approach, which specifically focuses on the dimensions of social relations that create the differences and positions of men and women in developing contexts (Miller and Razavi 1995). This approach opens up the possibility to illuminate the power relations between the men and women and the advantages and downsides to the changes, that are happening within the families and communities. Furthermore, it allows us to study how the gender relations affect the women's reproductive health choices in the light of the changes in the society such as the increased access to family planning and structural economic changes.

The GAD approach is developed by a number of feminist scholars and builds upon the approaches of Women in Development (WID) and Women and Development (WAD) (ibid), and we therefore find it relevant to briefly explain these approaches and the historic development of the GAD approach. Thus before we dig into unfolding the specifics of GAD we will outline the WID and WAD and how the three approaches relate to each other.

Historic Development of GAD

In the 1970's feminist scholars began focusing on the Women in Development (WID) as they emphasized that women's work in the homes and in agriculture should be acknowledged. These scholars were mainly of economic background and questioned the existing theories about the trickle-down effects of economic growth in developing countries, as they argued that women did not gain any advantages from economic growth because their work was most often not recognized and unpaid (ibid). However, in the late 1970's this approach was criticized for associating increased female status only with the woman's income potential.

As a reaction to this, the Women and Development (WAD) approach gained momentum. The main idea was, that women should be actively involved in development programs as this would help them to break free from the patriarchal hegemony, they were tangled up in (Young 1997). However, whilst this approach might in theory be useful, it was later criticized because many of the women-only programs seemed to fail due to their small scale and the marginalized status of the enrolled women (Miller and Razavi 1995; Young 1997).

In the midst of this critique of the WAD programs, the GAD approach grew strong during the 1990's. This approach argues that in order to make real changes for oppressed women in the developing world one must focus on the power-relations between the genders and the division of work and roles (ibid).

We will unfold and illuminate the GAD approach through the work of the four feminist scholars Kate Young, Naila Kabeer, Shahrashoub Razavi and Carol Miller, which have all been influential pioneers in the development of the approach.

Social Relations in the Center

The GAD approach has a strong emphasis on the social relations between men and women in developing settings, as it is perceived that it is through the gender relations, that men are given power over women, economic resources, and greater capacity to pursue their interests (Miller and Razavi 1995). GAD-scholars realize that battling women's subordination will not be successfully done merely by re-allocating economic resources to women and allowing them access to goods and

services like health care and family planning, but that it must also involve a redistribution of power within the families. As an example, Young (1997) points out that there is not a direct relationship between a women's independent income and her power in household decision-making.

Thus, rather than downplaying the political dimension of gender, it is essential, that the gender power relations are placed at the very core of the fight for equality. Whilst it is still considered to be important to financially empower women, it is not taken for granted that this process will necessarily lead to women's equality or autonomy. In fact, the redistribution of resources is perceived as a zero-sum game, implying that if the women gain a proportion of resources or power, this must necessarily also entail that men will lose this (Kabeer 1994). However, it is the hope, that in the long run all will benefit from a more gender equal society (Miller and Razavi 1995).

This focus on social relations between the genders allows us to analyze how the changes in the gender relations in our fieldwork affect the women's autonomy and decision-making power. Thus, we can illuminate how our informants experience advantages and downsides to the increased access to family planning and the growing financial empowerment of the women.

Gendered Division of Labor

When studying the gender relations in Uganda, as in many other developing countries, the gendered division of labor proves essential as a form of social separation (Tuyizere 2007). When applying the GAD approach of placing the social relations in the center of the analysis, this division of labor is not necessarily considered as a suppression of women, but rather assigning women and men to different responsibilities, making it possible to engage in relationships of cooperation and exchange between the genders (Young 1993). However, Kabeer (1992) points out that this interdependency caused by the division of labor is far from symmetrical and is often the source of conflict between the genders as well as co-operation. Any intervention in the division of labor will upset pre-existing systems of exchange, and sometimes with negative consequences (Miller and Razavi 1995).

The Bargaining of Security and Autonomy

According to the GAD scholars, a battle of power is deeply embedded in the social relations between the genders and this entails a constant process of negotiation and re-negotiation between men and women. Thus, for those who wish to improve women's status or empower them, a central

aim must be to provide them with a stronger bargaining power in this process of negotiation (Miller and Razavi 1995). Kabeer (1992) points out that the bargaining of power between men and women often involves a trade-off between autonomy and security for women, as they will in many cases value their security and the security of their children higher than their autonomy. Thus, they might often accept a loss of power in order to secure the stability of the family by keeping the traditional roles with the man as the patriarch, who holds the final decision-making power. For health promoters and other agents who wish to empower women, it is therefore important to understand and respect how women perceive their interests, and the risks and costs embedded in the power relations between the genders. The changes of power relations must be generated by those whose interests it shall serve, and thus empowerment cannot be given but must be self-generated (Kabeer 1994). As gendered negotiations of power over resources and decision-making stands out as a central part of the changes happening in the rural Ugandan communities, and thus applying the GAD approach will help illuminate and analyze our findings on the issue.

Analysis

The following analysis is divided into four themes, based on the findings in our empirical data. In all themes we strive to answer the research question, but from different angles. The themes are: The women's dreams and wishes for how many children they want, the men's perspectives on the number of children they want, and how it influences the women's possibilities for having the number they want, access and barriers to the use of family planning methods and changes in the social relations between the genders.

The Women's Dreams and Wishes for How Many Children They Want

Because we wanted to investigate how many children the women wanted, one of our standard questions in all individual and focus groups interviews were how many children they wanted to have, and why. In this first section of the analysis we will analyze how the women's wishes and dreams in regards to the number of children they want, are connected to their habitus and how they act in the field. This part of the analysis is divided into 3 main sections: The first is about the habitus of wanting large numbers of children. The second is about how the women feel they need to limit their number of children due to economic constraints and changes in the structures

determining their health and the field they act in and the third is about how having children affect their ability to live what they consider a good life.

"I want as many children as I can provide for"

In this first part of this section we will show that the women in our fieldwork have a strong habitus of wanting large numbers of children. The analysis will be based on the concept of habitus as put forward by Bourdieu, in the light of the statements the women we interviewed expressed.

When asking the women how many children they wanted, it quickly became clear, that most of them wanted as many children as they felt they could provide for, in terms of food, closing and school fees. Most of the women gave a number of between 4 and 6 children and the standard answer, when asked *"why this number?"* was *"it is how many I can provide for"* (FG 1-12 and No. 1-4, 7, 9, 13, 14). When we attempted to go deeper and asked beyond this question it seemed that most of the women wanted to have a larger number of children, if they had no economic limits (FG 1, 4, 6, 7, 10 and No. 2, 3, 8, 10). This trend showed up in most of our interviews, and was vividly exemplified, by the following citations from a focus group of young girls:

"So, if there were no economic issues how many children would you like?"
All are talking and laughing a lot...
"16"
"20"
"10"
"Are you not worried that it would be hard work and hard for your bodies?"
"Provided we eat well, it is not a problem to produce many."
"Provided we have everything, we can give the children everything, we don't see any reasons for not having as many as we want."
"If I would get the chance of getting married to Obama right now - I would have 10." (FG 6)

Though, one must take into concern that the young girls had not yet experienced the struggles which can be connected to giving birth to large numbers of children, this example is one of many in our data, which show that the women had a desire for having many children (FG 1, 4, 6, 7, 10 and No. 2, 3, 8, 10). However, most of the women we interviewed did not clearly know why they had

this desire but explained it with words like *"That is what my heart is saying."* (No. 2, 3) or *"I had planned to have 6 children. God told me 6."* (No. 4). These kinds of expressions show that the dreams and wishes in regards to the number of children the women wanted, lie deeper than what can be accounted for by a conscious decision. They can be understood as an expression of the woman's habitus, or their sets of durable and bodily incorporated dispositions that regulate how they classified and interpreted the world and how they acted. Because of a person's habitus, she will act in a certain way which seems sensible in the given setting, not because she necessarily makes a rational decision, but rather because her habitus entails this behavior (Larsen 2010) - she will *"feel it in her heart"*. According to Bourdieu our habitus is a product of the social environment we grow up in, implying that people who grow up in similar cultural settings will have similar habitus (Aakvaag et al. 2012). The cultural setting of the women in the area of our field work, seemed to support a habitus, entailing a strong desire for having many children. An elderly woman in one of the villages explained it like this:

"In Uganda it is very rare to find a lady that produces only 3 kids and stops. (...) But for us as Ugandans - producing is not a problem. So, we grow up knowing we have to produce many - as many as possible. It is like that. The grannies, they also produced many children, so we took it as we also have to produce many. Like the great great grandfathers. So, people from different countries tell us to have less. So now we have declined - we used to have 20 or 10. But now we will have 6. So, 6 is a small number even." (FG 1)

This example shows, how having a large number of children is deeply rooted in habitus of the people in rural Uganda - they simply *"Grow up knowing they have to produce many children"*. The tradition of having many children is essential in the reproductive field in rural Uganda and due the tradition the habitus is reproduced. Bourdieu argues that fields of action produces a specific habitus in participants and views this specific habitus as a mechanism through which the field is reproduced (Bourdieu 1990). However, he also argues that habitus is not a fixed way of being, but it is formed in interaction with the specific social field. Thus, habitus is not simply inherited but constantly made and remade in interaction with the field (McNay 1999; Larsen 2010;). As some structures in rural Uganda have changed, the people are adjusting to the new realities surrounding them. As we saw, the women no longer wished to produce as many children as they could - they were adjusting to new structures - and thus they planned for fewer children (FG 1-12 and No. 1, 2, 3, 4, 7, 9, 10).

"Children nowadays are so expensive"

In this section we will analyze how the women experience that the economic structures in the field they act within have changed and made it more expensive to raise children. In our empirical data it is clear that the women felt they needed to limit their number of children due to economic constraints and we will base the following analysis on their statements about the cost of providing for their children.

In our field work we have identified a number of new structures and health determinants, which have affected the women's fertility choices. Especially the changes in the economic situations like commercialization of crops and the need to pay school fees affected their choices, as the women experienced that it had become much more expensive to raise children (FG 1, 3, 5, 6, 10 and No. 8, 10, 11), as expressed by this woman in a focus group interview: *"Children nowadays are so expensive compared to early days, in terms of feeding and schooling."* (FG 5)
These growing expenses of raising children are connected to poverty and must, in the eyes of a health promoter, be seen as a health determining factor. The lack of money to pay for the expenses of having children, limits the women's power to freely follow their wishes in regards to how many children, they want and thereby to take control over important decisions in their lives.

Suffering Caused by Poverty

As mentioned, the standard answer to the question of why a woman wanted the number of children she did, was that it was how many she could provide for. Some had experienced cases of families, that were unable to provide for the large number of children that they had produced, and they had seen the suffering this had brought on these families (FG 1, 3 and No. 6, 11). Some had felt it on their own bodies, by growing up in families with many siblings and scarcity of food and money (FG 1). An older lady in one of the focus groups explained it like this, on behalf of one of her younger female friend, who said she wanted 2 children:

"I want to clarify why this young girl gave the number of only 2 children total. After what she has been through, with her parents having a much to large number of children, she had to first during the holiday look for work to make school fees for next term. So, after that suffering of having to look for money for school fees and for eating, that is why she doesn't want her child to have to

experience the same things as she has experienced, so that is why she gave the number 2. And me, as an aged woman I would wish to have had only 3 children." (FG 1)

In another focus group the women discussed how having a large number of children affected the families economically and mentioned different examples:

"Many children are hard to take care of because if they get sick it is expensive to get medicine for all of them. And to pay school fees."
"The mattresses are so expensive so they are sleeping bad, 2-3 on one mattress."
"It is not clean in the house. Sanitation in the houses is a problem with a large number of children."
(FG 3)

These examples show how the women's choices, in regards to the number of children they wanted, were clearly affected by their economical capability, and thus by the changes in the structures affecting the field they acted in.

Commercialization of Crops

One of the important structural changes, and a health determining factor, that might have led to the women's experiences of children being more expensive, was the growing commercialization of crops. Whereas they used to share their outcome more in the communities, people would now prefer to sell the little extra crops they could produce, in order to pay for their daily necessities. The women did not directly mention this as one of the reason for the growing costs related to raising children, but it was very clearly explained by a 40-year-old farmer and teacher in secondary school:

"In the past you could just go to any tree to eat the fruits free of charge, but now they are getting commercialized. The people sell the flower to the middlemen. So, in the time of harvest, the community cannot enjoy free. For us, we could go anywhere in this community and eat jackfruit and like, but today, if you enter someone's garden, you are trespassing, So, it is changing. Individualism is coming up and open sharing is declining." (No. 6)

This structural change, has made it more expensive to have a large number of children, as a family now have to rely on their own farming to feed their children, and no longer can depend on the

shared crops in the community. Although the women did not address the issue of commercialization themselves, it was likely to affect their habitus of producing many children, as it affected their capability to feed their children. Thus, the growing commercialization of crops becomes a health determinant, as it affects the women's ability to feed a large number of children. Thus, the women tend to limit the number they have. To have control over these kinds of important decisions and to be able to fulfill your dreams is essential to good health in the holistic understanding (Laverack 2004).

School Fees

Another economic structure that clearly affected the women's reproductive choices was the expenses of school fees. As times have changed it has become much more important for the children to receive schooling and education, and thus school fees have to be payed and this was a factor mentioned by many of our informants (FG 1, 3, 5, 6, 7, 10 and No. 3, 8, 10, 12, 13, 15). The commercialization had brought about a need for an income and inflation made living expenses even more costly (FG 9 and No. 8, 10). Thus, education seemed more important in order to get a job, whereas most people traditionally used to work with farming and did not have a need or an opportunity for schooling. Again, the 40-year-old teacher explained it clearly: *"When I grew up there were no schools. So, the children could not go to school. Before everyone lived from own production."* (No. 6).

Many of our informants expressed an increased need to make an income, but some experienced problems of unemployment (FG 10 and No. 9, 10). As it was simply put by a young girl, in a focus group of young girls: *"Because poverty has increased and there are no jobs. Even when you are educated you cannot get a job."* (FG 9)

However, there were disagreements on whether education was really an important factor, in order to make an income, as exemplified by this short argument between two young girls in a focus group:

The first girl: *"You cannot work without being educated."*

The second girl: *"The richest men in the village have very little education, so you can work without having education."* (FG 6)

Although the women might disagree on whether education was important in order to make a living, it was clear, that it was an economic concern to most of them because of expenses for school fees for their children (FG 1, 3, 5, 6, 7, 10 and No. 3, 8, 10, 12, 15).

Over all these different changes in the socio-economic structures, caused by poverty, commercialization and the growing expenses for school fees seemed to have affected the lives of the people we interviewed, and to be a source of changes in the reproductive choices the women made. The conditions surrounding motherhood had changed and especially the health determining factor of poverty seemed to have a greater influence on their ability to take control over their own life than it used to. In general, the young women wanted less children than the women in the generations before them had had (FG 2, 4, 6 and No. 9, 10) and this could be understood as an effort by the younger girls to take more control over their own situation by decreasing the number of children they had to provide for.

"To Be a Woman You Have to Have a Child"

In this section we will look at how the perspectives of the women in regards to the number of children, they want are related to the traditional structures. To investigate this relation, we look into how the women's health and capital is determining their perspectives. We will look at how having children affects the women's ability to live what they consider as a good life, and how their choices are affected by the traditional structures surrounding motherhood. We asked many of our informants what they felt was important for a woman in order to have a good life, and it was clear, that having children was of the utmost importance. The notion of "a good live" is closely related to health when understood in the holistic sense that is applied in this work. We will analyze how the social well-being, sense of purpose in life and strong social relations, which a woman could gain by having children might lead to empowerment which is by Laverack (2004) defined as the main goal of health promotion.

"A woman without children will live a miserable life"

When we asked the women what they found important for a woman in order to live a good life, many of them mentioned the material things they needed (FG 1, 6, 9, 10 and No. 10), and as we have analyzed above, their lack of economic capability was in many ways a limiting health determinant and a factor of great importance to the women. However, it was very clear, that most of

them felt that having children was an even greater factor of importance and in fact they felt that without children it would not be possible to have a good life (FG 1, 6, 9, 10 and No. 10 and HP 6). As expressed by a young girl in a focus group: *"A woman without children will live a miserable life."* Another girl in the same focus group suggested that if a woman did not have any children she could adopt (FG 4). These statements show that having children was so important for a woman, that if she did not have any, her life was ruined.

When asked why having children was so important some of the women pointed to the fact that having a number of children prevented loneliness for a women (FG 6, 9), and that the children would find joy and happiness in having siblings to share their ideas with (FG 4, 8). An example of this thinking was expressed by a young girl in a focus group, when we asked whether it was more important to them to have a relationship with love or to have children she replied:

"To a large extent children. Because when you give birth to children your man can become hard and leave for another woman, so you have your children and you can talk to them and share your ideas." (FG 9)

Other women explained about the joys of having siblings: *"According to African tradition you should not have only like 2 children because they will be so few to have the same idea."* (FG 8) and *"If you give birth to only 1 child, then he would be bored."* (FG 4).

Avoiding loneliness can be considered an important part of being able to take control over one's own health, in the sense of social well-being, and can thus be empowering for a woman. The process of empowering people and enabling them to increase control over and improve their health is at the very core of health promotion as it was defined in the Ottawa charter (Laverack 2004). Thus, in order to promote health for women in rural Uganda it becomes important to understand just how essential having children is to a woman's life.

"Who Ever has a Child is a Good Women."

Another very important reason for a woman to have children, is that motherhood empower her in terms of her status in the community. Tuyizere describes that in a patriarchal society like Uganda motherhood is of high importance for the status of a women. A woman is still a girl until she

becomes a mother, no matter her age. The mother is a symbol of live and the children honor the mother more than the father (Tuyizere 2007, p 48). Some of the women we interviewed confirmed this line of thinking by explaining that having children turned a girl into a woman, and thus changed her status in the community (FG 6, 10) as this example from a focus group of young girls shows:

"Whoever has a child is a good women."
"And if she does not have a child?"
"To call a family you have to have a child. As long as you have no children, no matter your age, you are still a girl. As soon as you have a child, you are a woman." (FG 6)

In another focus group the participants likewise agreed that a woman could not have a good life if she had no children. A woman said: *"But if she has one she can have a good life"* but a man disagreed and said: *"women who has no children it is not good for them. Even one is not enough. She should have at least 4."* (FG 10)

From these examples we can see, that motherhood is what defines a woman. Without children she is simply not a real woman, and she is considered of less importance, like a child. As health is closely connected to feelings of wholeness and a belonging in a community as well as good social relationships (Laverack 2004), one could easily imagine how not having children in rural Uganda can seriously harm a woman's health and her social status. Thus, having a child is of crucial importance to a woman, but for most having a much larger number would be better as it secures the position as a mother stronger. A number of our informants also mentioned that having a small number of children left a woman in a fragile position, because the children might die, and she would be left childless (FG 4, 6, 8). A young woman explained it with the following calculation:

"For those who say they want 4 - they can produce 4 but if two die they will remain with 2. So for me, if I produce 6 and 2 die, I will still remain with 4. I want at least 4." (FG 6)

This kind of rational calculation combined with understanding of just how crucial it is for a woman to have children, can be part of the explanation as to why the women wished to have as many children as possible. Furthermore, it shows us how the women take the risk of losing some children into consideration, when they make their choice of how many children they want.

As there is no doubt, that motherhood is an absolute necessity in the life of a woman in Uganda, motherhood is of great importance to her sense of purpose in life and therefore her health. Having children is an essential form of social capital for the women because it enhances her status in the community and this form of capital have a very strong value in the field of reproduction in rural Uganda. In this sense, social capital is to be understood as the resources one possesses through social networks and membership of the community, as defined by Bourdieu (1986).
Building on the analysis above we argue that the traditional importance of motherhood is essential in the field of reproduction in rural Uganda and is shaping the habitus of the women which is determining their strong desires for children.

Sub Conclusion

In this section we have analyzed how the women's wishes for how many children they wanted are embedded in their habitus, and that this habitus commended them to have large numbers of children. We have shown how having at least one child, but preferably more is essential to the health of a woman, as motherhood in itself defines a woman and she will have much less purpose in life and risk loneliness without children. However, our findings have shown, that a number of health determinants and structures like commercialization of crops and the need to pay school fees limited the woman, as they are not able to economically provide for as many children as they want. These new structures have changed the field which the women act in and we argue that these changes in the field make the women decrease the number of children they have and can eventually bring changes to the habitus.

The Men's Perspectives on the Number of Children They want, and How it Influence the Women's Possibilities for Having the Number They Want

When investigating the women's perspectives on the number of children they want in patriarchal societies like rural Ugandan communities (Tuyizere 2007) it is highly relevant to look at the men's perspectives and desires as well, since it is traditionally the men who make decisions in the families (Tuyizere 2007). As the Ugandan professor, Alice Tuyizere puts it; *"In the context of religion and culture men wish to control female sexuality and reproduction"* (Tuyizere 2007, p 15). In the following we will analyze how the social structures and traditions entail the decision power of men,

and how this can determine the number of children a woman gets. Secondly, we will analyze how the polygamous structure supports the men's possibilities to have many children. Further we will analyze how the traditional structures are determining the men's habitus and desire for having many children. At last we will analyze how the changing economic structures are affecting their desires for producing high numbers of children.

"The Men are the Ones Taking Care of the Decisions Including the Number of Children."

In the following we will analyze how the men's decision power is rooted in the social structures and how this influences the number of children a woman gets.

When a man and a woman get married, the man pays a bride price to the woman's parents, mainly her father (Tuyizere 2007), and then she moves to his land where she is traditionally *"expected to fulfill the role as mother, housewife, family worker and agricultural laborer"* (Tuyizere 2007, p 49). One could say that she is bought to produce children for the man and his family. As one of our male informants put is; *"Here we pay bridge price. So, if the man has paid, in return he expects children."* (No 6). So, the women is expected to give birth to children and in that sense she has limited control over her own reproduction. Following the Ottawa charter, it is fundamental to health promotion to increase people's control over their lives and health (Lavarack 2004), therefor it is essential to understand the forces controlling the women's reproduction in order to improve their health. Due to the traditional gender power relations in Uganda, a man's desire for having many children is an essential force in determining the number of children a woman has.

Even though a lot of our informants said that a man and a woman decide together how many children they want (No. 1,13), it became clear in many of the interviews, that the men were the ones with the last word (FG 10 and No. 7, 10, 13). In a mixed focus group interview the women's answer to the question, *"who decides on the number of children?"* was; *"It is supposed to be a couple, but men end up making the decision. It ends up being the man, because he is the head of the family. The one who makes the money."* (FG 10). To a 33-year-old man, it was very clear that the decisions should be made by the men: *"The men are the ones taking care of the decisions including the number of children."* (No. 7).

A 58-year-old man explained that he and the wife decide together how many children they would have, but if his wife said that she would only want 6, then he would not accept (No. 13). This shows

that he has the last word. Another younger man, who joined the interview also said that he and his wife decided together and if they didn't agree they would sit down and talk again to discuss. If his wife would have problems with giving birth he would be satisfied with 3 children (No. 13). Even though this man was willing to compromise with the number of children he wanted, it was still dependent on whether his wife was physically not capable of giving birth to many.

Grounded in our empirical data we argue, that men often were the decision makers in the families, which was seen to be part of the habitus of both men and women. Due to the unequal power relation between men and women, women were not able to take full control of their own lives and health, as the number of children a woman has is essential to her life and health. Large numbers of children can increase poverty in a family, and the many deliveries and pregnancies can be exhausting for the body and even lead to obstetric complications like postpartum hemorrhage which can cause health problems or even death in rural Uganda (HP 2, 4). That the men were dominating the health of the women can be seen as symbolic violence, as defined by Bourdieu (Bourdieu and Wacquant 1992). Bourdieu defines symbolic violence as non-physical violence exercised with silent acceptance of both parts (ibid). According to Bourdieu, the experience of the symbolic violence as a natural condition, i due to that the dominating part is internalizing the structures, which are determining the world around both agents (Bourdieu and Wacquant 1992). Thus, the dominated part does not question the practice (ibid). As can be deduced from the interviews with both men and women, the men holding the decision power is accepted as a natural condition for both genders. The structures defining the decision power are constructed through cultural practices. As evident in our data, the cultural practice of the men paying bride price, to pay a for the wife as a reproductive agent, is a way to maintain the domination. The women do not own their own land (Tuyizere 2007) and do not have other options, then to get married on the conditions of the husband holding the decision-making power, determining the number of children, she will have. The analysis above shows how the domination is internalized in the habitus of both men and women and is reproduced through cultural practices related to reproduction in rural Uganda.

"The Men in General Want More Children Than the Women and From Different Women."

In the following we analyze how having many children, was integrated in the traditions and community structures, which were determining the habitus of the men. Secondly, we will analyze

how the men's wishes to have many children were affecting the women's possibilities to decide on the number of children they want, and how the polygamous structure is favoring the men's domination.

It was a general consensus among our female informants that men wanted more children than women (FG 1, 4, 8, 10, 12) and this was verified by several of our male informants (FG 10 and No. 6). Because the men were the ones with the decision-making power, they were often pushing their wives to have more children than they wanted (HP 7). As a midwife expressed it; *"We have a saying that; "a man can have as many children as he wants"... So, for them they don't care. They can even have many women..."* (HP 7). Another midwife told us; *"Yes the men want more children than the women and that's why they become polygamist and get many children which they are not prepared to take care of."* (HP 4).

Those quotes describe that the men's desires for having many children often resulted in polygamous marriages. Some women did not know how many children their husband had or wanted, because he had children with different wives (No. 3,4). Some said that if the man wanted more children than the wife, he would *"produce children from another women"* (FG 8, 12). Many of our female informants have been talking about polygamy as a causing factor for the men to leave their responsibility for the children of the first wife, which was a reason for the women to want to have less children (FG 12 and No. 4). As one woman described it; *"After producing 8 children with one woman they leave her to produce with another, so it is the women facing all the problems with having many children."* (No. 4).
In a focus group some young girls told us that they would like to have 3-4 children. When we asked if the men wanted more children than that. They answered;

"Yes, they want more than that."
"So what do you do about that?"
"He will take another wife"
"How do you feel about that?"
"We don't like it, but there is nothing we can do about it."
"We get jealous."
"We can even fight about it, with the other women."

"The men focus more on the new woman than on us, so that causes jealousy."
"What about your children - would he focus less on your children than the new wife?"
"He will forget all about the children of the first wife." (FG 12)

This dialog indicates how the man, because of polygamy, can choose to have many children even if his wife did not want to have that many. Because of the polygamous structure, the women were put in a dilemma: If they didn't want to give the man the number of children he wanted, he might take another wife and he might leave his responsibility for the children with the first wife. Even if he did not leave his responsibility, they would still have to share the attention, money and land with another wife.

The decision-making power of men are supported by the polygamous structure. Even though it seemed that women were suffering from the polygamous structure because it leads to jealousy and competition between the women and made the men leave their responsibilities of the children from the first wife, many of the women said that polygamy was okay (FG 4 and No. 12). This indicates that the women are silently accepting the structure of polygamy even if it can be seen a way for men to dominate women. Thus, it can be argued that the polygamous structure is supporting the practice of symbolic violence. The women do not question the domination because they recognize the polygamous structure as a natural condition even if it is suppressing their capability to make decisions about their own lives. The polygamous structure is favoring the man's power position in the society by making it possible to have more children than the women. As will be elaborated on later, having many children traditionally strengthen a person's economic and social capital. According to Bourdieu (1994), the ones in the society, who owns most symbolic capital will possess most esteem and power. Thus, the polygamous structure is supporting an unequal distribution of capital and thereby strengthening men's power position and domination of the women.
How it can favor the man's economic and social capital to have many children and with different women was expressed by a woman;

"If a man produces from 2 different women, the one could be more clever than the ones from the other… so they want to have a variety. He will check out the economic situation of the women. One

might be more rich than the other and then she can pay school fees for her children. Some men want many children because of prestige." (No. 12)

This point of view was supported in a focus group interview. A woman said; *"Men have a saying that if a man produces with one women maybe that woman's children are dumb, so they produce with another - maybe her children are better."* (FG 8).

The power a man has in the community is traditionally increasing with to the number of children he has, which will be elaborated on in the following part where we will describe and analyze how the traditional structures in the society are determining the men's desires for having many children.

"The Tradition of the Man was to Expand Their Families."

Due to Ugandan traditions, the sons share their father's land and when they marry, their wives move to their land and produce children to their clan (Tuyizere 2007). It is the son's responsibility to make sure the clan is expanding to gain power in the community. The wives are never fully integrated into their husband's clan, which means that they don't inherit their husband's properties, including his land, if he dies (ibid). The children as well belong to their father's line (Tuyizere 2007, p 47). *"For this reason, wives in patrilineal marriages have no children of their own but produce to extend the lineage of the man's clan, and when divorced, they go back to their birth families."* (Tuyizere 2007, p 47). The tradition of men being responsible for expanding their clan was still a determining factor for the men's desires for having many children, which was confirmed by some of the men we spoke to and a lot of the women (FG 5, 7, 8, 12 and No. 4, 13 and HP 2, 3, 4, 7). When three young men were asked if they felt that it was their duty to produce children to expand the clan they all agreed;

"Yes, it is."
"So even if it makes you suffer to have all these children, you will still get them to expand the clan?"
"Yes. The chicks eat the skin of a rooster" (FG 7).

Thus, men and women had very different reasons for wanting many children. Whilst the women gained status by having children mainly because motherhood was what defined a woman, men

gained status by expanding the clan. The same group of young men explained that it was a problem for the family, if they only had two children, because then it was difficult to know what was going on in the community and represent the family if there were important meetings (FG 7). This supports the point that it gives a family power to be many, so the family always have at least one person involved in everything in the community. An important difference between the men's and the women's situation, in regard to having children, was that it seemed that the men needed more children to gain status, whilst as reflected upon earlier, just one child was enough to turn a girl into a woman. In the first section of the analysis, we showed that the element of status is closely connected to the health of a woman. The same applies for a man as it can increase his feeling of control over his life, his sense of purpose in life, and experience of belonging in the community and his social relations in general (Laverack 2004).

According to Bourdieu, when capital is recognized in a specific field it becomes symbolic capital (Bourdieu 1994). The habitus of the men in the rural Uganda is still highly influenced by the traditional structures, as having many children, and thereby expanding the clan, is recognized and exchanged to symbolic capital in the field of rural communities in Uganda. Symbolic capital improves the holder's capability of acquiring power and material wealth (Bourdieu 1986:241). For a man expanding the clan means expanding the power of the family.

The increased status one gains from having many children is reserved for the man's clan, as the woman always produce children for another clan. Thus, one could argue that the clan structure is supporting uneven distribution of capital between men and women and consolidating the gender related symbolic violence.

"So, if Those Children go to School and Get Married They Bring Gifts (...)"

As shown in the previous part of the analysis, women expressed that it had become more expensive to have children and that economy was a limiting factor for having as many children as they wanted. When talking to the men, some of them had a different perspective on this as they considered having children a possible source of income. When asking a mixed focus group if it was expensive to have children one man said; *"In Africa it is not a problem, because children do not cost a lot of money…"* (FG 10). Some of our male informants described it as economically

beneficial to have many children. A 38-year-old farmer said that he would prefer 10 children, 7 girls and 3 boys;

"Boys have to share the land so it is not god to have too many. 3 are enough to expand the clan. The girls go off and get married and produce for other clans. I want many girls to get bride price from their husbands. If they are coming to meet the parents they cannot come empty handed." (No. 13)

This statement indicates that the boys have value because they expand the clan and thereby improve the father's status and power in the society and the girls have an economic value because of the bride prices. When he was asked if it was expensive to raise the children, he said that it was not (No. 13). A 58 years old farmer with 2 wives verified these economic benefits and that it improved a man's status to have many children, when explaining why he was happy to have 15 children; *"So if those children go to school and marry they bring gifts, which makes me proud."* (No. 13). As we can see, the bride prices for the daughters are an important income for the parents (especially the fathers) and it had become even more important with new changes in the economic structures in the communities, as another man explained about the bride price;

"It has been commercialized. It used to be in order to your ability. But because of what has happened to the community and the neighboring community, you cannot bring something small. It is a shame to the community. People meet and decides to live together, and you cannot bring small things…It is very expansive. But it depends on the girl's family and culture. It can be hens and cows. The community will be invited to the introduction ceremony so you will compare. So, it is becoming more and more expansive. In the past it was done secretly, but today it is being done openly. If you can't afford, you negotiate with your partner and you start working and living together. But you are not formally a part of the family and you are not getting the blessing from the family. Not legally married. So, you will get some strong questions. I have not paid it yet. What I wish we have not attended. We have planned but we have not reached. The community helps you, but only until a limit." (No. 6)

This indicates that changes in the economic structures in the communities are making it more economic beneficial to have children for some men.

Bourdieu (Bourdieu 1986:243-249) defines economic capital as the access to money and material values. In the field of rural communities in Uganda, economic capital is of high value. When we asked many of the male informants what made a live good for a man, the simple answer would be; *"Money"* (FG 9,10). When we asked if children or love was important too, the answer would be that if a man had money he would get it all (ibid). This indicates that the economic capital would improve a man's symbolic capital significantly and thereby expand his power in the community. Because economic capital is of such high value, the economic benefits of having children can be argued to have a large influence on the habitus of the men.

Clearly, poverty was a health determinant of great importance in the communities in rural Uganda, and thus the economic effects of having children was of high importance to the health of the parents as well as the children. As the GAD scholars emphasize, in gender segregated societies like rural Uganda, men and women have very different roles and duties of labor. This also means, that when structures change, it will affect the genders very differently (Kabeer 1994; Miller and Razavi 1995; Young 1997). Thus, it is possible, that having a large number of children could increase the level of poverty for the women and at the same time decrease it for men. However, as we will reflect on below, the younger men seemed to have a different view on this, as they also experienced that having many children could cause poverty.

"The Young Men in Village Tell That They Would Like to Have 4 Children, Because of the Hard Economic Situation."

Though the traditions are still determining the men's desires for having many children the times seem to be changing as the younger generation of men preferred to have less children due to the changing economic situation (FG 11 and No. 6, 7, 8, 9).

A 40-year-old school teacher told about the traditional men in Uganda; *"... In Uganda the men had no limits in number of children. A man should produce as much as possible. The tradition of the man was to expand their families. It was prestigious to have many children. Of what quality..? It was about quantity."* (No 6). He said that there were still men in the society who wanted as many children as possible, and he gave an example of an elderly man, who wanted 3 football teams before he was satisfied, which he had almost reached. However, he talked as if this tradition belonged to the past and that the times were changing (No 6). When we asked him if the younger generation of

men wanted less children his answer was; *"Of Course, of course… The younger men they want less. Even the ones who are illiterate, they prefer good schools for their children and when they go to good school it is a bit expensive."* (No 6)

In another village, a 58-year-old man told that his wife and him did not know about family planning when they had their 7 children, and that they had suffered a lot raising them. He thought that 2 or 3 would have been a good number of children to have (No 11). He told that a lot of men in the village today would like to have 4 children and he advocated for smaller numbers; *"There are many literates, those who are born in late 1990 and 2000, in the community so they see the economic problems, so it is easy for them to be convinced. But the ones born before are illiterates and more difficult."* (No. 11). This was verified by a young man who joined the interview and said that the economic situation was forcing them to have less children. He only wanted one and then he wanted to become rich before having more (No 11). When the young men in the village were asked if the economic situation was the only reason for not having a lot of children most said yes, but some said that it was also bad for the wives (No. 11).
This indicates that the choices and perspectives on reproduction are changing among the men too, due to the changing economic structures in the society. Nevertheless, the whole group agreed that neither men nor women could have a good life without children (No. 11), which indicates that having children is still an essential need for the individuals in the community.

How the habitus determining the men's reproductive choices is affected by both the traditional and the changing economic environment was indicated in a mixed focus group interview. When we asked the men if they wanted many children, one answered; *"Yes to some extent but not this big number like 40" "Why not 40?" "Our fathers had much land, but today because of population growth, we have only little land."* (FG 8).
Although land scarcity was only mentioned by few of our male informant and none of the female, it can be seen as a general reason for having less children.

Many of our young male informants did agree with the women that people should have as many children as they could take care of economically: *"It depends on their economic situation. If they have money they can have more children."* (FG 7). The tendency that the younger generation wanted less children can be seen as a rational decision and a way that the habitus interacts with the

field. Bourdieu describes the dynamic relation between *habitus* and *the field* as *Learning the rules of the game* (Bourdieu and Wacquant, 1992). It can be argued that not having unlimited numbers of children but "as many as one can provide for" within the given structures, is a way of *"Learning the rules of the game".* Thus, the habitus of having as many children as one can provide for is reproducing social structures of power and status being related to the number of children one has.

Our data shows that the men's desires for many children did not only differ between young and elderly men but is also dependent on how much the man valued education. A midwife explained it like this;

"For some - they can't manage so many but they just want to count the numbers so others will see that they have a big family. Those are the ones who do not consider educations. For the ones who do consider education you will find that they have less numbers of children, that they can manage and take to school." (HP 2)

This can indicate a conflict between different positions within the field of reproduction in rural Uganda. For some it is prestigious to have many children, and for others it is important to be able to pay for their education in order for them to make money in the future. One could say that there is a conflict between the value and prestige connected to a quantity of children and the quality of children (children who get an education). If education becomes more important in the rural areas of Uganda, men's desires for having a large quantity of children could decrease as the desire for "quality" children, which they are capable of providing an education for would increase. The habitus of the men is interacting with the field in the way that paying for children's education becomes important as, due to the changing economic structures, the family will do better with fewer, but educated children. Another issue which opposes the development that education has become more important is the high unemployment and the fact that you, according to one of our informants, have to pay money to get a governmental job (No. 6). A woman in a focus group interview (FG 6) said that the richest man in the community has the best job, indicating that education doesn't matter in order to get a job, it is what is in your pocket.

Sub Conclusion

The men's position as decision makers in the family disempower the women because they are not able to decide how many children they want, which is crucial to their health in multiple ways. The traditional clan structure influencing the habitus of the men, affects them to want many children, and being the decision makers in the families, they push the women to have more children than they want. The men's domination of the women can be identified as symbolic violence supported and reproduced through the traditional gender power relations, polygamy, and uneven distribution of economic and social capital, and this consolidates the men's domination of the women.
Even though some men experience it as economically beneficial to have many children, a lot of men agree with women that the changing economic structures are making children more expensive. Finally, the desire for having many children seems to depend upon how much the man would value education.

Access and Barriers to the Use of Family Planning Methods

The access to family planning methods is crucial when enabling women to limit the number of children they will have and therefore it is an essential determining factor for the women's changing perspectives on the number of children they want.
The focus on contraceptive distribution in third world countries, to decrease the fertility rate, has been massive since the 1970's (Sen and Grown 1987). Even though the access to contraception is expanding there are still several barriers that can be identified to the use of, especially quality methods. In the following we will analyze the empowering influence of family planning methods and some of the barriers to the use of it. The knowledge about- and access to family planning methods are unevenly distributed in rural Uganda (UBOS 2016). The aim of this part of the analysis is to analyze how the barriers to use of contraception are embedded in the habitus of the people and the gender power relations, how the use of methods with many side effects are important to the health of the women and therefore a barrier to the use of contraception and how the barriers affect the process of empowerment.

This part of the analysis will be divided in 3 parts. In the first part we will analyze how the increased access to family planning is empowering the women to take control of their life by decreasing the number of children they will have. In the second part we will analyze how myths, quality of used contraceptives and gender power structures can be seen as barriers to use of family planning methods. The last part will be focusing on the access to family planning methods for

teenagers, and how habitus and health determinants can be seen as a barrier to access and therefore a cause of the many teenage pregnancies threatening the health of the young girls.

"Back Then I Did Not Know Anything About Family Planning, Because it Did Not Even Exist."

As elaborated in the literature review, the unmet need for modern contraceptive methods has significantly decreased during the last decades (UBOS 2016) and thus, the women of Uganda have both gained increased knowledge about contraceptives and experienced increased access to family planning methods. Indeed, these new gains have empowered them to make choices about their fertility, which were not possible in earlier times. As a woman in a focus group interview explained;

"Family Planning has done a lot in our lives. When I was giving birth to many children, I did not know anything about family planning. After I got to know, I stopped producing children. So, I think family planning is a good thing." (FG 5)

This quote is an example of how the access to family planning methods really can increase a woman's capability to take control of her live, which following the Ottawa Charter, is the essence of health promotion (Laverack 2004). Empowerment entails the process of enabling people to gain increased control over, and to improve their lives (Laverack 2004) and thus a tool such as modern contraceptives, which enables the women to take charge of how many children they want, can prove to be very empowering. As empowerment is a core value in health promoting work (ibid), providing women with contraceptives certainly makes good sense to a health promoter. However, in order to the real empowerment to happen, the women must take in these new tools and use them in ways that they find profitable.

In most of the villages we visited RHU, which was our connection to get in contact with the villagers, had been spreading knowledge about contraceptives for years, and people had good access to it. Especially in one of the villages we visited, the people were very positive toward the use of contraception and they all agreed in the focus group interview that; *"In this community there are no one who does not know about family planning."* and that *"People's attitudes have changed positively toward family planning."* (FG 3). However, when we went to the neighboring village, where RHU had not been working, we found that both knowledge about and access to family

planning methods were much more limited. As expressed by a mother of 10 children, who had her first child when she was 16 years old: *"If I would have known about family planning methods, I would have liked to have only 5. I have never learned about family planning."* (No. 15). And by a young mother of 2, who had her first child 5 years ago, when she was 17 years old: *"Back then I did not know anything about family planning, because I did not know it even existed."* (FG 12). In this village, the women also explained, that it was hard to get access to contraception, because transportation to facilities was so expensive (FG 12). However, it was our overall impression, supported by our interviews with both health professionals (HP 1, 2, 5) and villagers (No. 1-4 8, 9, 11, 12, 14), that family planning methods in general had become much more available during the past decade.

Although family planning methods, have become much more available to the women in rural Uganda, not all have embraced the new methods as a tool to limit their number of children, as explained by a midwife at a health center:

"They are very aware of family planning, but there are those who don't want to use them at all. They say let me deliver 9 and then they can sterilize me. So, they are not lacking knowledge, because even at village level information is given." (HP 2)

However, many of the women we interviewed expressed how empowering it had been for them to be able to use modern family planning methods as a means to space their children, even if they wanted to produce a large number. This was explained by an elderly women in a focus group interview:

"Family planning methods are important because it gives a gap between the children - that is child spacing. For example, that lady – if at all her child hasn't joined school, she hasn't given birth to another child. When that child joins school, then she thinks of producing another child. That is why family planning is important - it helps us to do child-spacing." (FG 1)

Spacing the children was an issue which were addressed by several of our informants (FG 1, No, 6, 11, 13) The women found it empowering to be able to control the space between the children,

because they were able to wait to have their next child, until they were sure they could provide for the children they already had (No. 6, 13).

Still knowledge about and access to family planning methods are very unevenly distributed geographically in rural Uganda (UBOS 2016). The increasing access is empowering the women in the sense, that it gives them the possibility to space the children and to limit the number in order to only have the ones they can provide for. This makes access to contraceptives a very important health determinant as it improves the women's possibilities for escaping poverty, by limiting the frequency and the number of children they are having. By having less children, then they can afford to send them to school, feed, and provide with necessary medical services, is not only the women's health increased, but indeed also the health of their children.
Unfortunately access to the methods is not the only barrier to the use of them. In the following, several other barriers which we identified in the field study will be analyzed.

"We Love it So Much But it is Treating Us Bad"

Because most of our interviews were conducted in areas with good access to family planning methods we could identify several other barriers to the use of the contraceptives. The most significant barriers we identified were myths about negative consequences of using family planning methods, experiences of bad side effects and the men's attitudes.

Some of the most common myths about contraceptives we heard were: it causes cancer (FG 12 and No. 7, 9 and HP 6, 7), it can lead to infertility (No. 10), the implants can get lost i body (No. 10 and HP 1), it makes women lose their appetite for sex (No. 9, 10) and it makes women unfaithful (No. 10). Even though a lot of the myths did not seem to have a medical explanation, some of them might have roots in what people actually experienced, as they were using methods with severe side effects. The most used method was Depo (UBOS 2016), an injection preventing pregnancies for three months, which had a number of side effect, some of them being an even bigger health risk in a rural setting with a high level of poverty (Sen and Grown 1987). In the following we will analyze how methods with many side effects, like Depo, are a barrier to the empowering influence of contraceptives in a setting like rural Uganda. Further we will identify some of the reasons for Depo being the most used contraceptive.

The most common side effects (10 out of 100) to Depo is; bleeding disorders, weight change, abdominal pain, fluid accumulation in the body, decline in bone mineral density, headache, and nervousness (Promedicin 2018). Already back in the 1980s international development scholars were critical to the family planning methods launched in developing countries, such as Depo, which was of very poor quality with active substances which were banned in western countries as dangerous to health (Sen and Grown 1987). In our field studies we saw that Depo was the most used method (No. 4, 10, 11, 15 and HP 1, 3, 6), which is supported by Ugandan Bureau of Statistics (UBOS 2016). This shows that quality of family planning in Uganda is still very poor. In the Third World, condition of sanitation, health care and female nutrition are poor and the side effects of contraceptive methods can be very serious and even lead to infertility in these settings (Sen and Grown 1987). This supports some of the local myths, that we heard about family planning methods. One of them being that they can cause infertility. As highlighted in a previous part of the analysis, fertility is crucial to a women's life in rural Uganda. Because the importance of having children is deeply rooted in the habitus of both the men and the women, the fear of becoming infertile must be seen as a threat to a woman's social and economic status.

A woman told us that she had tried to use Depo, but she bled a lot, so she stopped (No. 15). Bleeding can cause serious problems to undernourished women as it increases the risk of iron deficiency anemia (Sen and Grown 1987). This woman had 10 children and her farming was providing for the whole family, which meant that she needed to work hard. Tiredness caused by increased iron deficiency anemia is not what she needs. She was then trying to avoid more pregnancies by not having sex 14 days after the first day of her period (No. 15). Another women told that most of the women in her village said that family planning methods; *"...treats us really bad with side effects. But we still use. The most common side effects are much bleeding for some days - prolonged bleeding."* (No 3). This was confirmed by a group of young girls who said that they loved family planning but it was treating them so bad; *"I bleed for a month. I used Depo. I am still using, but it will soon expire. I stopped bleeding after the one month."*
"I used it but it treated me bad. I used Depo and implant." (FG 12)

Thus, access to family planning methods is essential when empowering women and have a crucial influence on their perspectives in relation to the number of children they want. The quality of the methods and side effects they are associated with, has to be taken into concern. That Depo is the

most used family planning method can be seen as an important barrier to the empowerment of women, because of its health threatening side effects. The health promoting effect of increased access to family planning methods like Depo is connected to several disadvantages for the health of the women using it. And those disadvantages are affecting the women's perspectives on the number of children they will have.
In the following we will analyze some of the reasons for Depo being so popular compared to other available methods.

"She Just Comes In. We Educate Her and She Gets the Injection."

There are several reasons for Depo being the most used method. One being the attitudes of the men. As described above, the men generally wanted more children than the women and they were also the ones with the decision-making power in the family. Because of the men's desires for having many children and because of the believe in myths like, it can lead to infertility, makes a woman cheat or loss her appetite for sex, they were often against their wives using family planning methods (No. 4, 6, 11, 12 and HP 2, 7). This made Depo very convenient for many women compared to other available methods, because they could use it secretly without their husbands knowing, which was the case for several of our informants (HP 2, 4). The implants, which were the second most popular method (UBOS 2016) could be detected because they were right under the skin on the woman's arm, so her husband could feel it (HP 2, 4). The IUD was not a popular method as it was followed by a lot of myths (HP 1, 3, 4, 7) and birth control pills were hardly used and a nurse explained that it was because the women forgot to take them every day (HP 6).

Other reason for the use of Depo we identified as, easy accessibility (No. 9, 12 and HP 6), and the attitudes of the health professional providing the services, which will be analyzed in the following. Many of the health professionals we interviewed saw Depo as the best method. When we asked a midwife why, her answer was;
"Because it is easy. She just come in. We educate her and she gets the injection."
"What about the side effects of Depo?"
"No, it is okay. If you teach them about the side effects, the side effects are bearable." (HP 4).
This interview shows, that the health educator does not see the side effect of Depo as an important problem, which can be a reason why the method is used so much.

Though the resistance to use of contraceptives seemed to decline (No. 6, 8, 9, 11, 14) there was still a lot of rumors about the bad side effect, and some of the rumors did speak the truth. If the resistance to contraceptives is to be removed, the methods must be better adapted to the social and health environments in which they are used (Sen and Grown 1987).

"Those Who Think That School Takes Their Time and They Just Want to Enjoy Their Lives in Their Own Land, They Find Themselves Pregnant."

When investigating the women's perspectives on the number of children they want and how it is related to access to family planning methods it is relevant to look into the conditions for access to contraception, not only for the grown women, but also the young girls, as teenage pregnancies has a crucial influence on a woman's life. Our informants generally said that teenage pregnancies were a bad thing (FG 2, 9, 10 and No. 14). Still in average one out of four girls in Uganda get pregnant in their teenage years (UBOS 2016). Knowledge about and access to family planning methods are keys to avoid teenage pregnancies, but as we will argue, teenagers have a limited access to family planning methods. In the following it will be analyzed how the limited access is connected to negative perspectives on teenagers engaging in sexual activity, rooted deeply in the habitus of both men and women, as well as the health professionals providing the services.

"I Was Not Expecting to Get Pregnant at That Time."

That the teenagers lack knowledge about family planning methods was a reason for teenage pregnancies, can be seen in some of our interviews (FG 7, 12 and No. 15). One women who got pregnant when she was 15 years old explained to us; "*I was not expecting to get pregnant at that time. I did not know what would cause pregnancy. I did not have any information… I was just green."* (No. 1).

In addition to lack of knowledge and access to family planning, we identified poverty as a reason for teenage pregnancies. A midwife explained that some girls from poor families with many children were told, by their parents, to find their own way of getting food, and they ended up pregnant (HP 2). In a focus group interview with young girls (FG 12) we identified at least 4 who had become pregnant as teenagers. When we ask why they became pregnant as teenagers, one girl said that the reason was, that she was orphaned (FG 12). This indicates that when being orphaned engaging in sex is a why to get by. This indicates that the health determinant of poverty, in some

cases, can lead teenage girls to situations, where prostitution becomes a part of their way of providing for themselves, and this can lead to pregnancy. Poverty can be seen as an effect of the changing economic structures, which is pushing some girls into engaging in sex in an early age and thereby ending up pregnant. Additionally, the traditional structures motivating some families to have a large number of children, which they cannot take care of are resulting in teenage girls getting pregnant, because the parents tell their daughters to find their own way of getting food.

Several of our informants agreed that if young girls would not abstain, and insisted on engaging in sexual activities, the contraceptive solution should be condoms, though there seemed to be several issues connected to the use of condoms, even if the girls had access and knew how they should be used, as expressed in a focus group interview with young girls:

"Some men don't want to use them. Some are scared."
"Some men don't know how to use condoms."
"Some boys put holes in the condoms because they want to have life sex."
"Some put it on the other side than it should be."
"Some are raped."
"Some boyfriends are resistant to condoms. Remember that it is the boy in control so if he refuses to use them... he just does it, just like that."
"The decision-making is in the hands of the sugar daddy."
"If you don't control yourself in the movement you can easily forget." (FG 9).

These quotes specify some of the most important issues when counting on condoms as contraceptives for young girls. Because of the traditional gender power relations, the boy was the one in control, so he had the power to refuse to use the condom.

In the above we identified lack of knowledge and access to family planning as well as poverty and traditional gender power relations as reasons for teenage pregnancies however, many of our informants seemed to blame the girls for the pregnancies as they did not abstain from sexual activity. In the following we will analyze the habitus of the people in our fieldwork entailed negative attitude towards teenage girls having sex.

"The Parents Counsel Them But They Don't Listen."

Many of our informants agreed that 18 was the right age to engage in sexual activity (FG 2, 4, and No. 9). This moral perspective can be seen as a health strategy in a society without family planning methods, because sex will lead to pregnancies and a teenage pregnancy is crucial to a girl's health since her body might not be capable of giving birth yet, which was confirmed by a local midwife (HP 2) and other informants (FG 9). In addition, the high occurrence of HIV makes it rather dangerous to engage in sex with different partners. When we asked the locals, what were the reasons for teenage pregnancies many would blame the girls for not listening.

Two elderly men gave the following reasons;

"Parents drop their responsibility of the children, by letting them go out."
"The parents counsel them, but they don't listen."
"Most of the girls are alcoholics and they end up getting used while being drunk, by young and elderly men. They become alcoholic because of adolescence and because they don't listen to their parents."
"If they reach the age of 18 the parents cannot make decision for their child."
(No. 13)

By giving those reasons, they blamed the young girls as well as bad parenting for the teenage pregnancies. Another man put it like this; "*I think it is adolescence, they became pregnant, because they receive a lot of power and they become uncontrollable. They feel they are on the top."* (No. 11). A woman pointed to the young girls being ignorant and irresponsible whilst teaching them about abstinence was the way to avoid the pregnancies;" We *do have many teenage pregnancies, because they don't listen."*(No. 9)

Another reason expressed was the desires for material gods (No. 12). A woman who was teaching her community about family planning expressed it like this; *They over admire, like see someone having a screen touch phone. So, they expect such things to come from boyfriends."* (No. 7). Some said that it was because the girls dropped out of school and then did not have any other opportunity than to get married (HP 3) or just wanted to enjoy themselves without wasting their time in school and then found themselves pregnant (HP 2). Another reason mentioned by a nurse, was; *"Peer group. They have a friend who is having a boyfriend so they also want to try."* (HP 6). When our

informants mentioned the reasons for teenage pregnancies it was obvious that the fault was on the girl. They saw her as a bad girl because she engaged in sex.

The morale that sex before the age of 18 is wrong, is seen as deeply integrated in the habitus of the people in rural Uganda, and even in the habitus of the women, who had become pregnant as teenagers themselves. In a village, a mother of 10 told us that she had her first child when she was 16, and she had never learned about family planning (No. 15). Despite her experiences with teenage pregnancy she told us that she did not teach her children about family planning methods but counselled them to abstain (No 15).
The negative attitude toward young girls engaging in sexual activities, which is embedded in the habitus of the men and women, can be seen as a barrier to access to family planning, which will be elaborated on in the following part.

"..The Shopkeepers are Told to Only Sell to People Above 18."
The barriers to the access to family planning methods for the teenagers were reinforced by the law as well as by the service providers. A man explained that the young people would have difficulties buying condoms;

"Because the shopkeepers are told to only sell to people above 18. But if they have money they might sell them secretly, but they are not doing it openly. But most of these boys have not started getting money… It is almost 0.25 dollar, but that is not easy to get as a child in the rural area. There is a risk for a child, who starts having sex but don't have money, of getting HIV." (No. 6)

Two elderly women who were teaching community members about family planning said that the teenagers knew about the methods, but they were scared to ask for the methods and they didn't have money to buy them (No. 12). When we asked young girls in a focus group if family planning methods were less accessible for teenagers, the answer was; *"At times we are scared to ask for different methods at the hospitals because they would ask us about our age, …"* (FG 2)

A woman, said that she taught the very young girls about contraception if they approached her, though her attitude towards them using it was not positive;

"When they approach I ask why they want to use family planning and tell them that it is not good to start having sex at that early age and that family planning does not prevent them from getting STDs. If they insist on engaging in sex I advise them to use condoms." (No. 8)

When we asked a woman, who was also teaching the community about family planning, if the young girls at age 15-16 could get Depo, her answer was; *"We health educate them to abstain. I think it is best to abstain until 18 years and give birth at 24 years."* (No. 9). This shows that it can take some courage of a young girl to get knowledge and access to family planning methods, because engagement in sex before the age of 18 is seen as wrong. And the same attitude can be recognized when talking to health professionals who explained, that when the young girls asked for family planning they would first of all be told to abstain (HP 7). When asking a nurse why the young girls didn't use family planning her answer was;

"They come late and they don't ask the nurse about getting family planning because they are ashamed about that they let them self into sex, so they keep it secret."
"Are there anywhere they can get condoms without anyone knowing?"
"We have condoms here but they don't come, but we don't have condom automate." (HP 6)

In general, the health professionals did not see lack of knowledge or access to family planning as the main causes for teenage pregnancies (HP 2, 6, 7). Based on the interviews with health professionals and the local women distributing family planning methods, the general picture was that it is not well seen for girls below 18 to have sex and therefore search for contraception. As can be written in quotes above, the young girls are ashamed and come too late. If they come for a contraceptive method the service provider will first of all tell them to abstain. Thus, we identify the attitude of the health professionals and other service providers as a barrier for the teenagers to get access to contraceptives. This attitude is seen to be deeply embedded in habitus of our informants. This habitus is reproducing a field where teenage sex is unaccepted which can be seen to be a reason for the high occurrence of teenage pregnancies.
Though, it is a way to protect the health of the young girls to morally prevent them from having sex, when seeing it in the light of the fact that 1 out of 4 girls get pregnant as teenagers, the limiting affects this moral has on the access to family planning methods for the young girls must be taken into account. In order to empower the young girls to take control of their own lives, access to

contraception is crucial, not only from 18 years of age, but from the age, when they start having sex, is essential. Especially for the girls from poor families who are forced into different kinds of prostitution in order to survive, access to family planning is a very important health determinant.

Sub Conclusion

Access to family planning is a way of empowering the women to take control of their own lives. However, increasing the women's access and knowledge is not enough to spread the use of family planning. Lack of access to quality methods, the attitudes of the health professionals as well as the fact that men, being the heads of the families, often are opposing their wives using family planning methods, leads to use of methods with severe side effects. In order to increase the use of family planning methods it is crucial to integrate methods adapted to the environment and cultural settings. The bad attitudes to teenage girls using contraception is another barrier to access which, as well as lack of knowledge and poverty, is leading to teenage pregnancies. Getting pregnant as a teenager can be a threat to the young girl's health and future life, teenagers access to contraceptives is therefore crucial.

Changes in the Social Relations Between the Genders

In this part of the analysis we will investigate how the social relations between the genders have changed as the women are gaining financial empowerment and how the economic structure affects the women's perspectives. The analysis will mainly be based on the GAD approach, where focus is not on the women's roles or the men's roles alone, but on how their relations interact and how changes affect both genders positions in different ways (Miller and Razavi 1995).
The analysis is divided into the following themes: The women's growing financial empowerment and independence, how the women experience, that the men leave their responsibilities, the changes in decision-making, power relations and the consequences of the women's secret use of contraception.

"I Think They Will Think About it When it is Too Late, When the Women Have Overpowered Them."

In the following we will analyze how the women seemed to have gained economic empowerment, and how they utilized these new gains in terms of growing independence from the men.

During our interviews with the women it became clear, that although it was the traditional role of the men to provide for the families (Tuyizere 2007), most of the women had found a way to make sure they could be financially independent of their men (FG 8, 12 and No. 3, 4, 8, 9, 10 and HP 4, 7). Many of the women we talked to in the villages were farmers (No. 4-7, 11-14), but had also found a way to make a small income (FG 8 and No. 3, 4, 8). Some of the women had small businesses, like selling clothes in the marked (No. 3), hairdressing (No. 10) or selling alcohol (No. 15), and one of them was teaching (No. 9). Of course, the health professionals we interviewed had jobs. In a number of the villages we went to, RHU had organized the women in groups to spread knowledge about family planning, but the women also used these groups to join their savings and to make businesses together, like catering service or making handicrafts (FG 1 and 8). This trend clearly showed, that the women were getting financially empowered. However, our material might be biased by the fact that most of the villages we visited had been enrolled in the WRAP project, and thus women in other villages might be less financially empowered as they had not been summoned in women's groups.

Many of the women explained, that they only wanted to have the number of children that they would be able to provide for themselves, without any financial help from their husbands (FG 8, 12 and No. 4, 10 and HP 7). Thus, there was no doubt that the women were striving for financial independency and that they were well on their way to reaching it. A woman in a village explained that she had joined a women's group to save money with the other women, and that she would like 6 children, but for now had decided to have only 4;

"I can take care of them even if my husband leaves me"
"What do you want to with your savings?"
"After getting the money, I want to start up a business with pigs." (No. 10)

Surely in the eyes of the feminist scholars who concern themselves with the GAD approach, this growing financial independency of the women in rural Uganda is a positive trend, and to health promoters wishing to empower the women to gain control over their lives the development of economic empowerment is worth striving for (Miller and Razavi 1995; Laverack 2004). However, as the GAD-scholars point out, no development to a community of women will happen without

affecting the social relations between the genders, and thus the men will also be strongly affected by this growing financial independency of the women (Kabeer 1994; Miller and Razavi 1995; Young 1997). Kabeer refers to the redistribution of resources between the genders as a zero-sum game, implying that when the women gain a proportion power, this must necessarily also entail that men will lose this (Kabeer 1994). Thus, as the women were financially empowering themselves in rural Uganda, the men might be losing some of their power although, according to a midwife, they might not yet be much aware of this;

"They (red. the men) look at them (red. the women) and say, "they are women - I don't care what they are doing" They don't care!... I think they will think about it when it is too late, when the women have overpowered them. As time comes, they will find that the women are very far from them. I think they will come and say; "ehh.. you left us behind", but then also the women they would not care - they would say; "well we don't have a problem around us. We take care of our families".

A female nurse in a rural health center explained the growing empowerment of the women like this:

"It is good because she will care for the children. And the children get much more from their mothers, because she is with them all the time, so if the mother is empowered, she will educate her children and if they are sick she will take them to the hospital, even catering for food. She can do that if she is empowered."
"So, she does not really need the man anymore?"
"No. Only for getting pregnant. That's all... It takes 5 minutes."

These statements about the growing empowerment of the women came from well-educated health professionals, who worked in the area of our fieldwork, but who also seemed to have a bit of an "outside" view on what was happening. Having formal jobs, they were in a different position than the women from the villages, who mainly lived of farming. The village women themselves did not talk about a trend of overtaking the men and leaving them behind, but rather of a number of issues they seemed to be having with the men. Especially, the fact that the men were not living up to their responsibilities seemed to be a concern to most of the women. This confirms what Young (1997) points out, that redistribution of resources does not necessarily bring about gender equality and an

independent income does not necessarily strengthen a woman's position within the family. In the following section of the analysis we will focus on some of the downsides to the women's financial empowerment.

The Irresponsible Men and the Undisciplined Women

In Uganda, as in many other African countries, labor and roles are strictly divided between the sexes. Whilst women are engaged in agriculture, cooking, childbearing, caring for children and other domestic tasks, men are responsible for participating in public affairs and earning an income to provide for the family (Tuyizere 2007, pp. 126).
In this section we will look at the interactions between men and women in relation to traditional roles and labor division, in the light of the changes that relates to the women's growing economic empowerment. As the GAD scholars point out, there is never just one side to the story, when a gender is empowered in some way, then the social relations will shift and rearrange, entailing a constant process of negotiation and re-negotiation between the genders (Miller and Razavi 1995). Thus, we will analyze how the women experience that the men leave their responsibilities and the men experience that the women become undisciplined.

Throughout our fieldwork it was striking how many women mentioned that they could no longer rely on the men to fulfill their gender role by living up to their responsibilities of providing for the family (FG 1, 3, 4, 6, 8, 10, 12 and No. 4, 12 and HP 3, 4, 6, 7). An example of this was expressed by a 28-year-old woman who made her living from farming;
"The men don't mind because they drop the responsibility. They don't know their roles." (No. 4). In a focus group interview it was expressed like this by a woman, when asked why she wanted 4 children which she considered a small number;

"Because men are no longer responsible"
"Does anyone else share the opinion, that you cannot count on that the men would take responsibilities?"
The women discuss. Translation:
"Yes, all men are like that" (FG 8)

These examples show how the women experienced that they were left alone with the responsibilities, because the men did not live up to their role as providers. As is often the case with social relations, the causal effects are not clear (Miller and Razavi 1995). There were different opinions about, whether the women were empowering themselves as a result of the men leaving their responsibilities, or whether it was the other way around - that the men left their responsibilities because the women were making their own money. Whilst the above statements indicate that the women took charge over their own situations because they could no longer count on the men, other women expressed it like this: *"Nowadays women are working. Some men are not happy about that, so they leave the economic responsibilities with them since they are working"* (No. 12) A nurse expresses it like this:

"...you know men, when they see a woman is working, they leave everything for the woman. (...) Yes, they do leave the responsibility. If the woman is empowered and has a job, the man does leave the responsibility - "You have money - cater for your children"" (HP 6)

Whilst the women we interviewed agreed that the men nowadays were not fulfilling their responsibilities, this was perceived very differently by the men. In fact, a number of the men expressed that the younger generation of men were more responsible than the older, which was a reason for them to want less children (No. 6, 9, 11). Instead, some of the men complained that it was the women, who did not know their roles in the family and that they were undisciplined (FG 8 and No. 12). A man in a focus group of mixed gender expresses it like this:

"Nowadays women are undisciplined. The second thing to do, is to move to another wife who is disciplined."
"How are they undisciplined?"
"Her behavior."
"How is her behavior undisciplined?"
"If a man is working and he comes late, the women will lock him out. She doesn't give him food. After being denied food he ends up eating elsewhere and comes home, only for sleep. Or if a woman gives birth to children, she stops caring for the husband and only care for the children." (FG 8)

The quotes clearly show that the women and the men had completely different perceptions of what was happening in their communities. As Kabeer (1992) points out, this division of labor entails an interdependency between the genders which is far from symmetrical, and which will often serve as the source of conflict between the genders, like the ones shown above, where the women perceive the men as irresponsible and the men perceive the women as undisciplined.

The quotes also show that the division of labor and roles might be challenged by the changes in the distribution of financial resources, as the women were gaining empowerment. As mentioned earlier, the school fees were an economic issue, which came up in many of our interviews (FG 1, 3, 5, 6, 7, 10 and No. 3, 8, 10, 12, 13, 15) and it was mentioned by a number of the women, that it was supposed to be the men, who provided for the school fees, but that it was more often the women who did it (FG 1, 3, 6, 10 and No. 10, 12 and HP 6, 7). When this issue came up in a group interview a woman stated: *"Men normally pay for school fees, but when it comes to feeding and dressing it is the women. And not all men pay for school fees."* This statement leads to a talk about how the women had to give birth, raise children, give them food and clothing and on top of that pay for school fees, and the conclusion was simple: *"it is not fair"* (FG 10). The women also explained that these things lead to misunderstandings and arguing at home. The fact that the women had in many cases taken over the responsibilities for paying school fees, is an example of an intervention in the pre-existing system of gendered division of responsibilities which lead to re-negotiations of the gender roles and thus of the distribution of power. As the GAD-scholars describe, this kind of re-negotiation of the gender roles is often unequal, as the men, in most cases, possess a stronger bargaining power than the women (Miller and Razavi 1995). Kabeer (1992) points out that the bargaining of power between men and women often involves a trade-off between autonomy and security for women, and they will, in many cases, value their security and the security of their children higher than their autonomy. The patrilineal kinship links the children to the father and this means that the children belong to the fathers and in case of divorce, they stay with the father's clan (Tuyizere 2007). Thus, if a woman was to decide that she would not accept the unfairness in the relationship to the man, her only choice might be to give up her children and her home. This was exemplified by a mother of 10 who explained about her husband;

"He is just not perfect. All married couples have some problems. (...) I think he spends money on women."

"Have you considered divorce?"
"As I have many children there is no way I can leave the children alone. So I would not leave them." (No. 15)

Through this section of the analysis we have seen that the empowerment of the women affects the relations between the genders and that it does have some downsides as well as some advantages for the women. In the following section we will analyze how the changes in economic empowerment affect the power relations between the genders, and thus the women's autonomy to make decisions concerning their own reproductive health.

Power Relations and Decision Making

As we have touched upon earlier in the analysis, the power to make decisions in a family, traditionally lies with the men (Tuyizere 2007). However, as the women were getting more financially empowered, it seems reasonable to investigate, whether they were also gaining power to make more decisions, especially regarding their own bodies and their reproductive health. As Young (1997) argues, there is not a direct relation between economic empowerment of a woman and her power to make decisions in the family. In the following we will reflect on how the power relations between the genders were affected by the growing economic empowerment of the women.

"If She is Poor, Then Why Should She Make Decisions. The Poor Don't Make Decisions."

As we have shown earlier, most of our informants agree that the power to make decisions about how many children a couple should have, often lay with the man (FG 10 and No. 1, 7, 10, 13). However, our data also shows that this power might be affected when the woman made her own income, though in some cases it did not. As this following section of a focus group with young men shows, income did affect the power to make decisions:

"Can the women make decision too?"
"Yes, she can"
"What kind of decision can she make?"
"About the school fees"
"If a woman does not make money, can she still make decisions?"

"If she is poor, then why should she make decisions. The poor don't make decisions. She can decide on the schools to go to. The food. These small small things"
"What about the number of children?"
"As I told, I can produce from only one women, so she cannot decide this." (FG 11)

These statements show that money do affect the power to make decisions and could indicate that if the woman is making money, she would get to make decisions to. However, in accordance with what the GAD scholars advocate (Young 1997; Kabeer 1994) in many cases, the decision-making power remains with the man regardless of the distribution of income. In fact, some of our informants stated, that even if the woman had money she did not have the power to make decision about the number of children a couple should have, if her husband disagreed (FG 10 and No.11). This is supported by the following example from a focus group of mixed gender;

"...the man ends up making the decisions, because he is the head, the one who makes the money."
"What if it is the women who makes the money?"
"The decision making is still staying with the man, because if a woman goes for a sterilization the doctor says that he needs the signature of the husband." (FG 10).

This quote indicates that it is not only due to the culture and the traditions, that it is the man who decides on the number of children a couple should have, but also to some degree the legal system. However, our data also show that some of the women, namely the health professionals, seemed to have empowered themselves to make most decisions themselves.

"I Am the One Who Plan for the Family. I Decide How Many Children"
During our fieldwork we found an important distinction between the position of the women in the villages and the health professional women. The health professionals who had actual jobs where economically independent of their husbands, could independently decide how many children they wanted and were not very concerned about if their husbands had other wives (HP 2, 3, 6). This was expressed by a nurse:

(...) "Does your husband go to other women?"
*"I am less concerned. That is his own. "(*HP 6)

And by a young midwife who had 2 children:

"Does your husband have other wives?"
"I don't know"
"Do you think it is okay?
"Yes. If he wants more children than the two I want. The only opportunity he has is to produce from another woman." (HP 3)

The health professionals were, like the women in the villages, facing a situation, where they could not count on the men to be what they considered responsible, and in some cases, they did not even know if their husbands had other wives and children (HP 2, 3 and 6). However, as they seemed to stand stronger they were in a position to care less about the men.

As elaborated on above, the women in the villages were generally much more dependent on their husbands who were still the decision-makers in the families even though they would have some independent income. Many of those women had 6 children or more (No 1, 4, 8, 12, 14, 15). This can, as elaborated on in the previous, indicate that the men had decided on the number of children they had, and secondly that to those women having children was a way to increase their status in the community and thus their social capital, which improves their power position in the society. Though the women in the villages were generally uneducated and have no formal jobs (No. 4-7, 11-15 and HP 6), in that sense they can be seen to have low cultural and economic capital. In contrast, the women working as health professionals where both educated and employed, which means that they have more both economic, cultural and social capital. Those women were not depending on their husbands as they did not even seem to know or care, where he went and if he had other women (HP 2, 3) and they generally had less children; 1 or 2 (HP 2, 3, 4, 6). They were empowered to decide how many children they wanted and able to educate their children and take them to hospital if they would get sick (HP 6). This shows that if the women get education and actual jobs, they can become empowered to take control of their own life, which also makes them have fewer children. Thus, the capital of a women does have an essential influence on the number of children, she will have, and makes her capable of escaping the gender related domination in this regard.

"Family Planning - We Use it Secretly"

As we have shown, the decision making about the number of children a woman should bear still lie with her husband for most of the women in the villages. However, the women had their own way of reclaiming the power over this decision. They simply used contraception in secret from their men (FG 1, 2, 5 and HP 1, 2, 4). In the following, we will analyze how the secret use of family planning empowered the women, but at the same time had some downsides.

The following quotes from 2 different focus group interviews with women of different ages showed that the women used family planning methods in secret;

"So, family planning, we need it so much as women - even if the men are not accepting it, we have to look for it to have a good life." (FG 1) and *"Family planning - we use it secretly"* (FG 5).

Some of the health professionals we interviewed confirmed this trend (HP 1, 2, 4), and also explained that the secret use of contraception could sometimes lead to quarrels within the families and even domestic violence. This was expressed by a male clinical officer, who worked with providing family planning methods:

"Some men have come, after his woman had got an implant and told me to remove this thing. It is very common in the North and in East that the husband cut the woman's arm to remove the implant. Sometimes the women get a method without their men knowing and then when he finds out it can cause domestic violence. That way some women find the injectables convenient." (HP 1)

A midwife in a different health center addressed the same issue; *"The problem with the implant is, that today all men know it, so when they touch they will feel it. And then she will come back, and they will fight about it every day."* (HP 4). Thus, whilst the secret use of contraception could empower the women to make their own choices about how many children they wanted and when, it could also cause problems for them. An issue that came up in a number of our interviews was the fact, that when a woman chose to limit her number of children to less than the number her husband wanted, he would in many cases find another woman to have children with (FG 2, 4, 6 and 12 and HP 3). This issue came up in a focus group of young women after a talk about how many children the women and men wanted:

"For those who are married, are your husbands against the use of family planning?"
"The husbands are not aware - and if the husbands ask we deny."
"Do you think that the men will accept that you only want 4 children?"
(Talking and laughing)
"If a man doesn't accept, let him go and produce with another woman."
(FG 2)

As we have reflected on earlier, the polygamous structure enhanced the man's domination of the woman, as he could choose to take another wife, if the first wife did not give him the number of children he wanted. By using contraception secretly, the woman often ends up in a dilemma where she gains control of the number of children she will have, but at the same time she might be facing conflicts in the family, or her husband might choose to take another wife.

This ambivalence in the women's feelings about the secret use of contraception and the consequences it brought about, once again show that empowerment often comes at a price and that interventions that upset the pre-existing systems between the genders sometimes have negative consequences as argued by the GAD scholars (Miller and Razavi 1995).
Thus, as the financial empowerment of the women entailed the downside of men dropping their responsibilities, in the perception of the women, it also seemed that the bodily empowerment of being able to use contraception secretly also entailed a downside for the women.

Though the secret use of family planning is common among the women, our data also shows that many men we talked to where positive towards family planning and felt empowered by the possibility to limit the number of children they would have (FG 11 and No. 6, 7, 11, 13) and several of the women we talked to said, that their husband where supporting them in using family planning (No. 1, 3, 8). This indicates that when the men are positive toward the use of contraceptives they too are getting empowered by the decreasing accessibility to the methods, by being able to limit the number of children and thereby being able to take better care of the children they have.

Sub Conclusion

In this section of the analysis we have reflected on how the growing economic empowerment of the women in rural Uganda affected their power relations with the men. We found a trend towards the

women getting economic empowered to pay for school fees and other necessities and thus had become less dependent on the men, but there is also a downside to this empowerment, as the women experience that the men leave their responsibilities as providers for the family. In accordance with what the GAD scholars argue, we have found that the growing economic empowerment of the women, does not necessarily bring about changes in the power relations when it comes to decision making, and that the changes in the pre-existing gender roles causes a conflict and re-negotiation of power relations. The causal relation between the growing economic empowerment of the women, and the men leaving their responsibilities is unclear.
We also identified a distinction between the empowerment of the women in the villages and the health professional women, who seem to have a greater power over their own lives.
Furthermore, we found that the women use contraception secretly from the men as a means to take control over the number of children, and thus strengthen their reproductive health and empowered themselves. This secret use of contraception however leads to unintended consequences, as the men will in some case find out and get upset and, in some cases, he will find another woman to have more children with.
Though the men are still in some cases a barrier to the women's use of contraceptives, many men are positive toward family planning methods and do support their wives using them.

Discussion

In the following part we will discuss our findings and our methods as well as our theoretical approach and reflect on how our research contributes to the current debates in the field of reproductive health in Uganda.

A Critical View on Our Results

In this section we will engage in a critical discussion of our different findings.

The Women’s Habitus of Wanting Many Children

One of our main findings in the analysis is that the women in our fieldwork have a strong habitus of wanting many children and that they limit the number of children they have, mainly because of economic concerns. The reasons we identified for this habitus were both that the women, due to the

environment they grew up in, “felt in their hearts” that they wanted many children and that motherhood strengthened their status in the community as well as their health. Some scholars argue that poor health and poverty lie the foundations for population growth as these factors provide the impetus to have many children (Kibirige 1997). This view can be argued on the basis of the demographic transition theory which states that in societies, characterized by high birth rates, death rates also tend to be high and as a result, population growth will be slow. With improvements in access to basic health care, death rates decline followed by rapid population growth. However, as these societies develop further, the benefits of a smaller family become apparent and the fertility rates and population growth typically declines (ibid). Kibirige (1997) argues that the African situation has posed a paradox. Before the 1950 Africa was characterized by a slow population growth as a result of high birth and death rates. Improvements in health have led to a decline in mortality and high population growth. The paradox is that the improved health has not been followed by improvement in other living condition. Poverty has therefore continued and maintained the need for a large family and has thereby amplified the problem of the rapid population growth as well as causing a deterioration of the health condition. As most people in the rural areas of Uganda still depend on manual farming, without basic agricultural equipment and often have to travel far to collect water and fair wood, the socio-economic situation continuously benefits large families. Thus, children are still seen as a necessary source of labor (Kibirige 1997: 253). In a society with no social security of private investment, the children are the only support for the old aged and the only source of self-worth in the absence of wealth and luxuries (ibid). Having many children is also a way to increase the chances of one child having success and dragging the rest of the family out of poverty. At last producing many children is a way to secure the survival of some (ibid).

Our study can to some extend support this theory, as a number of the people we interviewed stated that it was wise to produce a large number of children, because they knew from experience that some of the children might die. In addition, some of our male informants talked about the economic benefits in having many girls because of the bride prices, and that they expected their children to bring gifts when they grew up. On the other hand, our data show that the women would want to have more children if they had the health and the economic means to provide for them whilst the demographic transition theory predicts that they would have fewer. There is no way of knowing whether they would change their minds and start seeing the benefits of a smaller family if the socio-economic situation changed and they became less poor, as the demographic transition theory predicts. The health professionals we interviewed, who had a stronger cultural and economic capital

due to their education and job, did indeed have a preference for lower numbers of children than the women in the villages. This might be an indicator, that the women's preferences for large numbers of children might change if they continue to financially empower themselves or if their access to education and jobs would increase.

Access to Family Planning Methods

Through the analysis we have argued that the low quality of family planning method, Depo, as well as lack of knowledge and access to the methods for the teenage girls are barriers for the women to use the methods even though they are locally accessible. On the other hand, it can be argued that the access to Depo is very empowering for the women as it gives them the opportunity of using a contraceptive without their husbands knowing. Another advantage of Depo is that it is very easy to inject which means that the local women in the villages can learn to give the injections, which makes it possible to make it accessible in the very rural areas.
When it comes to the teenager's limited access to and knowledge about family planning methods, one could argue that using other contraceptives than condoms, as a teenager in the rural areas of Uganda, is dangerous because of the high occurrence of HIV and other STDs. On the other hand, the high occurrence of teenage pregnancies does expose an unmet need for contraceptives for the young girls. The occurrence of teenage pregnancies is seen to be highly related to poverty, as the young girls from poor families are in a position where engaging in sex is a solution to other health treats like hunger or abuse at home, as we have shown in our analysis. This supports the prediction in the demographic transition theory, in the way that if the girl's socio-economic situation would change, they would be less likely to be forced into prostitution leading to teenage pregnancies and other health issues.

Changing Gender Power Relations

Throughout our analysis, we argue that the women in our fieldwork are in a process of financial empowerment, and that this strongly affects their relations to the men. Based on the GAD approach and on our data, we also argue, that the financial empowerment of the women leads to re-negotiations in the power relations between the genders, and this does in many cases not fall out in the favor of the women. Our results show, that the women, despite financial empowerment, in many cases, have not gained decision power which is still held by the men, even when it comes to the

reproductive health of the women. However, our findings on this topic is a momentary picture of what is going on, and we have no way of knowing whether the financial empowerment of the women might in the long run fall out in favor of gender equality and stronger autonomy of the women. The fact that the health professional women, we interviewed had a stronger autonomy and were able to make more decisions about their own health, supports the idea, that financial empowerment of the women will lead to more gender equality.

Our Contribution to the Current Debates

In the following we will discuss our findings in relation to the scholarly literature in the field, which we presented in our literature review and other sections of the study. We will do so, in order to identify how our study contributes to the current debates and knowledge about women's reproductive health and fertility choices in Uganda.

The Debate on Fertility Motivation

In 2010 Beyeza-Kashesya et al. found that the young people's views were still strongly influenced by the patriarchal cultural, and that they wanted many children. Likewise, we found, that the Ugandan people's perspectives were strongly influenced by the traditional cultural structures, but our study also indicates that changes had happened in the 8 years which have passed, as we found a clear trend that the younger people wanted less children than the generations before them. In Beyeza-Kashesya et al.'s study, the young people identified joblessness and poverty as a breeding ground for an environment where many children could be born because people used sex as a pastime. In our study, we also found that health determinants as unemployment and poverty affected the number of children people had, but for very different reasons, and with a different outcome. Our results show that these structural factors made the women, and to some extend the men, limit their number of children because they experienced that they could no longer provide for large numbers of children.

The Debate on Male Involvement in Women's Reproductive Health

In our study we found that the women would to a large extend use contraceptives in secret from their men, and that this empowered them to take control over how many children they had. On the other hand, it caused a number of problems in their relations to the men, and in many cases, it leads

to domestic quarrels or to a situation, where the man would produce children with other women. A number of scholars have problematized the fact that men in Uganda are not as knowledgeable as the women in matters of reproductive health and family planning, and that they do not involve themselves in these issues (Sileo et al. 2017; Kabagenyi et al. 2014). These scholars suggest that interventions should focus on male involvement in women's reproductive health and strive to inform the men and preferably make them participate when the women go to clinics or other reproductive health facilities (ibid). Our study supports that male involvement in women's reproductive health could have the advantages of limiting misinformation and enlighten the men in the matters of family planning (Kabagenyi et al. 2014). We found that many of the women had to use contraceptive methods with many side effects in order to keep it secret from their husbands who were against the use of family planning methods, and that one of the reasons for this is the men's lack of knowledge. As we also found that the men who had knowledge about contraceptives were supporting their wives using them, our study shows that involvement of the men in contraceptive use is key to increasing the women's access.

In addition, we have identified a number of issues between the gender's, which might be better resolved if the men were more involved in the women's reproductive health. Especially the fact that men and women did, in many cases, have very different views on the expenses of parenthood and on whether the other gender was living up to their responsibilities. Perhaps, these issues could easier be resolved, if the couples involved themselves more in each other's situations. Our findings about how men and women had very different views on a number of issues related to reproductive health confirm the results of Morgan et al. (2017). They found that the women felt that the men were often not fulfilling their responsibilities, by providing resources and criticized them for having a negative attitude towards fatherhood and that the men would explain their behavior by referring to issues of poverty and joblessness which they felt the women did not understand.

The Debate on Distribution of Contraceptives

As recognized by the World Bank in 1984, to decrease the fertility rate, it is necessary to; educate parents (especially women), raise rural incomes, increase women's employment, legal and social status and reduce infant and child mortality (Sen and Grown 1987). Bongaarts (2016) supports this view by arguing that the reproductive health programs which have proven to be most successful

were carried out in settings where the socio-economic situations have also been improving, especially a rise in education for girls and women have proven to correlate with declines in fertility rates (Bongaarts 2016). However, he also argues that the main policy response towards the issue of high fertility rates has been focused on improved health education and availability of contraceptives and not on socio-economic structures (ibid). Our study shows that, 31 years after the World Bank identified the importance of focus on socio-economic structures, the women in the rural Uganda still have limited possibilities for escaping poverty and taking control of their own live. Though many of the women we interviewed were earning money on small businesses, only few were working in the formal sector and many of them expressed concern about having more children than they could provide for and had issues of paying school fees.

It was addressed by Sen and Grown in 1987 that, despite the recognition of the link between women's autonomy over their lives and fertility control, agencies were still treating the women in an instrumental manner in population programs. This could be seen in the limited understanding of the mixed responses to family planning programs by the third world women (Sen and Grown 1987). This is in line with our findings as we identified skepticism towards the family planning methods as a limiting factor to the use. This underpins the need for a more culture-centered approach, where the women's experiences of their reproductive health are taking into concern when developing new interventions for family planning distribution (Dutta 2008).

Methodological Considerations

In the following we will discuss our methodological approach to the field and our choices of theory.

Reflections on Our Method

By conducting semi structured interviews we allowed ourselves to be open to our findings and to ask in-dept questions, when an informant touched upon an important issue. This method proved to be very useful as we did indeed find a number of issues which were of great importance to the women, and which influenced their perspectives of how many children they wanted, which we were not aware of, before we started our data collection.
Nevertheless, by conducting data through interviews, our findings reflect the way our informants want to appear (Silverman 2014; Kvale and Brinkmann 2014). This can be a bias to getting a representative understanding of their perspectives in regards to the number of children they want.

In order to overcome this issue, it could also have proven useful to conduct a more ethnographic long-term observational study (Silverman 2014), but we did not have the time or resources available for this kind of research in the present study. However, though we only spent 14 days in the field, our cultural understanding developed significantly, as we were lucky to be surrounded by people, who were pleased to talk about their culture and the issues they were facing. Among those people where our two drivers, the people working at RHU and our translator.
During our fieldwork we constantly developed our interview guides and our approach to the field as we learned more and became more confident about which issues were most relevant to our investigation. Especially, the importance of the gender relations stood out, and we therefore started asking questions to uncover this and interviewing men as well.

Reflections on Our Scientific Approach

We chose to approach the field from a combined perspective of phenomenology in combination with structuralism, and this cocktail of perspectives has allowed us to investigate the perspectives of the women from a first person's point of view and how those perspectives interact with structures of the society and the gender-power relations. We could have chosen to have a critical theoretical perspective which would have giving us access to a more critical analysis of the structures shaping the lives of the women, and the number of children they were having. Through a critical approach we could have focused on relating the analysis to a broader societal and cultural perspectives (Brinkmann and Tanggaard 2015: 374), which could have led to a valuable critical analysis of how international economic structures along with traditional structures affects the fertility rate and the women's reproductive situation in rural Uganda. However, the more phenomenological approach we have chosen is contributing to relevant knowledge about the perspectives of women in rural Uganda, which is essential knowledge in order to develop successful health promotion intervention targeting this group.

Reflections on Our Theoretical Concepts

In our work we chose to apply a number of different concepts put forward and interpreted by a number of different scholars. This choice allowed us to approach our data from different angles and to illuminate different aspects in our analysis. However, it also entailed that we have not been able to fully integrate all aspects of the theories put forward by each of the scholars. Bourdieu's work for

instance is very comprehensive, and we have only elaborated on the specific concepts which we found of particular relevance in order to analyze our data and answer our research question. Another approach we could have chosen was to include less different concepts and go more into debt with for instance the theoretical apparatus put forward by Bourdieu, Laverack or by the GAD scholars. However, as we were going through our data, and made our decisions about how to analyze them, we found that using different scientific and theoretical approaches allowed us to unfold a more nuanced picture of the field we had approached.

The concepts we have chosen to apply have been investigated and put forward by western scholars in western settings, and this has caused for reflections about their relevance in our non-western field. Clearly, we found it highly relevant to apply them in our work, although we wish to state our humbleness as to the possibility, that our western views might have distorted some of our findings. In the process for searching for relevant literature we looked for African scholars, and preferable women, who had put forward theoretical concepts of relevance to our research question. However, we had to acknowledge, that it was not possible to find, although concepts put forward by such scholars might have provided us with a tool for a more accurate analysis of the perspectives of the Ugandan women. When we surrendered to the fact that the most relevant scholars were all western, it felt like a defeat, as it highlighted the problem that most research, even in developing countries, is conducted through a western perspective.

Use of our Results, Validity and Generalization

As it is an explicit goal and hope to us that our research can be helpful in the planning and conduction of future reproductive health promoting initiatives, we have from the beginning of this work planned to make our results available to professionals working with these issues. We have therefore agreed to share the thesis with DFPA and RHU, and they are expecting to receive our results, and hopefully be able to make use of them. Furthermore, we plan to conduct a podcast about our findings, as it can serve as a different and perhaps more easily digestible way of communicating our work and a way to get the knowledge represented in the thesis out into mainstream media.

In order to make our work relevant in relation to current academic debates we have aimed for a high proportion of transparency throughout the report. It has been important to us to maintain a high validity, by insuring that the reader easily can follow what we have done, how we have done it, and

how it relates to the research problem we have been investigating. Furthermore, we have transcribed the interviews to be able to systematically build our analysis on our conducted data.
Although our fieldwork has been carried out in a specific district of Uganda, many of the issues regarding gender roles, reproductive health, fertility rates, poverty and access to family planning are similar in many other developing settings and we therefore expect that some of our findings can be generalized and thus we hope that health promoters in other parts of the developing world might also find inspiration for their work. However, as with most qualitative research, the findings are not directly generalizable to other cases (Silverman 2014), as the context of health promoting work is never totally alike in different settings.

Conclusion

Our data and analysis show that the women in rural Uganda have a habitus which entails a strong desire for having many children, and that motherhood defines a woman and strengthens her health and status in the community. However, a number of health determinants and economic structures such as poverty and growing expenses in relations to raising children, make the women limit the number of children.
Furthermore, we have found that the relationship to the men are of immense importance to the women's perspectives on the number of children they have, as the traditional gender structures places the men as decision makers. The men generally want more children than the women, because of their responsibility to produce children for the clan, in order to expand their power position in the community. Furthermore, they do in some cases conceive children as a potential source of income due to the tradition of bride prices. Thus, the men put pressure on the women to have many children. The pressure is embedded in traditional structures such as bride prices, polygamy and uneven distribution of power and materials good, which is maintaining gender related symbolic violence. However, it is a clear tendency, that the younger generation of both men and women want fewer children than the generations before them, due to economic constraints and this could be part of the explanation to the declining the fertility rate.

The women generally expressed that they would want more children if they had the economic means to provide for them. This does to some extend contradict the demographic transition theory, which projects that as societies go through socio-economic improvements, the benefits of a smaller family become apparent, and the fertility rates typically declines (Kibirige 1997). However, the

health professional women we interviewed, who had an income due to their education and jobs, chose to have less children than the women in the villages, which might indicate that women who are more empowered will have less children.

We also found that the increased access to family planning methods in rural Uganda empower the women to make choices about their own health, by enabling them to control the number of children they have. However, due to male domination, limited access to quality methods, myths as well as the attitudes of the health professionals and other service providers, the women often use methods with many side effects (Depo), which are health threatening in the rural setting. Thus, we have identified the lack of quality contraceptive methods adapted to the environmental and cultural setting as a barrier for the women to decrease the number of children they will have. Though Depo has many side effects is also has the advantages of being easy to inject and therefore possible to access even in very rural areas, as well as making it possible for the women to use a contraceptive secretly.

Because teenage pregnancies are such a widespread problem in rural Uganda (UBOS 2016) it is crucial to the women's perspectives in regards to the number of children they want.
We found that teenage girls have limited access to and knowledge about contraception in comparison to the grown women and that one of the reasons for this is negative attitudes towards engagement in sexual activity before the age of 18. These negative attitudes are embedded in the habitus of both men, women and health professionals, and even the women who had themselves been teenage mothers and they cause a barrier to knowledge about and use of contraceptives. Thus, we argue that attitudes can be a reason for the many teenage pregnancies. Furthermore, we identified poverty as another reason for teenage pregnancies, as young girls from poor families with high numbers of children, that the parents cannot take care of, are forced into different types of prostitution, which in combination with the limited access to contraceptives, can lead to pregnancies. Thus, it can be argued that changing the socio-economic structures supporting that families produce more children than they can take care of, would lead to a decline teenage pregnancies.

Another important finding in our study is that the women are in many cases financially empowering themselves by creating an income. This financial empowerment does not necessarily increase their

decision-making power in the relation to the men. In fact, the women experience, that the men are leaving their responsibilities as providers for the family, when the women earn money and that they in many cases also leave them to live with other women. Thus, financial empowerment of women does not always lead to gender equality and is far from without downsides for the women in rural Uganda. In order to gain control over the important decision of how many children they will have, the women often use contraception secretly from their men, but this also causes issues in the gender relations and in some cases leads to domestic quarrels or even violence. In relation to decision-making power, we have identified a distinction between the empowerment of the women in the villages and the health professional women. The health professionals seem to have a greater power over their own lives, as they have the autonomy and economic means to provide for themselves and thus they can be less concerned with the men's opinions.

Implications for practice

For health promoters, the kind of knowledge we have produced in this study can be essential when striving to promote the reproductive health of women in Uganda. In the following section we will discuss the implications our study can have for practice, both when planning and implementing interventions and in the processes of conducting policies and legislation.

Promoting Health, With the Culture in the Center

In our work we have investigated the perspectives of the women in rural Uganda, and this approach to the field can be beneficial when striving to promote these women's health. The Indian professor of communication Mohan Dutta (2008) has developed an approach to health communication called the culture-centered approach. In his work, he argues that it is of the utmost importance to place the culture, and the perspectives of the people whose health you wish to promote, at the center, when developing health promoting interventions. Our work is in accordance with this line of thought, as our findings can serve as a foundation to develop health interventions, which places the perspective of the women in rural Uganda, at the center. We will argue, that a reproductive health intervention in this area will face difficulties in succeeding, without taking into consideration, that the women find it essential to have many children in order to live a good live, as our findings have shown. Furthermore, we will argue that the power relations between the genders would need to be taken into consideration in the development of a reproductive health intervention, as our findings and

analysis clearly show that these relations have a large impact on the women's choices and possibilities. I addition a health promoter, who wish to empower women in rural Uganda, could draw important use of understanding that the women limit their number of children partly because of economical constraints. By turning a blind eye to these important mechanisms in the communities, an intervention could potentially fail completely, as the steps taken might not make sense to the target population.

Promoting Women's Reproductive Health - A Compromise Between a Bottom-up and a Top-down Approach

From a health promotion perspective, we argue that an intervention could be strengthened by applying a bottom-up approach, where the target group defines the goals from their perspectives and implement them supported by the health promoter. However, applying a bottom-up approach entails a number of difficulties and dilemmas for the health promoter.

Laverack (2004) describes how many health promoters have difficulties putting the ideas of empowerment into practice, as they find themselves torn between a top-down approach, where the issues are defined by an outside agent and the bottom-up approach where the issues are defined by the community. In many cases a health promoter is working for a government or NGO, which have a set of fixed goals they pursue, like expanding the use of family planning methods or decreasing the fertility rate. Dutta argues that the global health policies in present times are dominated by neoliberalism and focused on economic rationality, which entails that health interventions in the Global South need to be evidence based, effective and led by performance management in order to receive funding. This focus on performance and goals causes for a top-down approach to health intervention and a demand for a fixed set of indicators which can be evaluated, preferably with statistical outcomes (Dutta 2015). This kind of policy making in the field of global health promotion leaves the health promotor in a situation where the intervention, that she has to plan will in many cases already have a fixed agenda. Thus, if the health promoter in rural Uganda wish to empower the women in the sense that they feel an increased control over their own lives and their reproductive health, she could in many cases be faced with a dilemma.

As we have shown, the women would feel empowered if they were able to be economically capable of providing for a large number of children in terms of food and schooling. A bottom-up intervention would strive to make this possible for the women, as it would help them achieve what they perceive as a good life and thus a strengthened health in the holistic understanding. However, the health promotor might not wish for the women to have these large numbers of children, as the goal of the project could be to limit the fertility rate or because it is her own personal goal due to concerns of population-growth, poverty or other structural and political issues.

Likewise, it could cause for a dilemma for the health promotor if her goal is to promote the use of modern family planning methods, as it was clear that the women faced a number of health issues as a result of using the methods, they were advised to use. Our fieldwork showed how the women's preferred method of contraception in rural Uganda was the Depo, which caused for a number of problematic side-effect, and as a health promotor it would be natural to strive to make them use different methods with less side-effects.

In dilemmas like these, we will argue that it could be beneficial for both the women and the health promotor if a combination of the bottom-up and the top-down approach was to be obtained. By basing the health intervention on the perspectives of the women, but also engaging in a negotiation where she would bring her own values, she might be able to promote family planning methods with less side-effect, even if it was not the women's first choice from the beginning. Thus, we argue for a mix between the top-down and the bottom-up approach, where the health promotor centers the intervention around her knowledge of the women's preferences, but at the same time include her perspectives based on scholarly knowledge and experiences from similar interventions.

Empowerment of Women

If the goal of the health promotor is to empower the women, from a more feminist point of view, she might be interested in strengthening the women's power in the relation to the men. With this agenda in mind, in rural Uganda, we will argue that utilizing a bottom-up or culture-centered approach will be most useful. As we have shown in the analysis, the women in our field work are in many cases re-negotiation their power-relations to the men, and this development is far from easy, and it comes at a price. Thus, if a health promotor wishes to strengthen the women's position towards the men, she needs to fully understand how a woman who makes her own money and her

own decisions, is likely to face a reality where her man leaves his responsibilities towards her and her children and this can leave her in a vulnerable position. Failing to understand the importance of these mechanisms in the gender-relation in rural Uganda, can lead to the planning of interventions which aim to empower the women financially, but end up leaving them in even more vulnerable situations. Thus, we argue, in line with the GAD scholars, that interventions aiming for the empowerment of women in rural Uganda must carefully take the power-relations between the genders into consideration.

The Healthy Public Policies

Above we have argued how health promotors could benefit from the knowledge we have produced. In our analysis we have argued that the women's situations are in many ways determined by structural and socio-environmental factors, and this might in many cases not be targeted in a health intervention. In the following we will therefore argue how our findings could prove useful on a political level, where policies and legislations are developed.

Since the publication of the Ottawa Charter in 1986, a call for Healthy Public Policies (HPP) has been central in the field of health promotion, and their role have been reaffirmed and redeveloped by health promotors over the years. HPPs as opposed to Public Health Policies (PHP) are policies that are not designed for the health sector, but that can promote health by influencing the overall structural determinants of health and thus, create an environment where people and communities can take control over their own health and wellbeing (Dixey 2013).

Indeed, the women of rural Uganda would benefit from improvements in the PHPs, as they have a continuing need for improvements in access to contraception and good health services, to improve their relatively high rates of unmet need for family planning, early childhood- and maternal mortality (UBOS 2016). However, our findings show, that a number of other factors seemed to play an important role in the women's access to health and to achieve good lives. Therefore, we will in the following argue how different HPPs could lead to improvements in the health determining factors.

As described in the analysis, the women in many cases describe the men as irresponsible, because they do not live up to their roles as providers for the families. However, this "lack of responsibility"

towards the family might, in many cases will not arise, if the man would be able to get a job and provide for his children. Thus, policies which would limit the problem of unemployment could prove to be very beneficial to the women's health as they could provide stability in the families and economic security. Likewise, reforms of the school system, which would free the women from the pressure to furnish money for school fees could be beneficial to a woman's health, as it would empower her with a freer choice of how many children she wants. Certainly, our findings show that the women are generally very concerned about how to make the money for school fees, and that this has an impact on their reproductive choices. Generally, any political reforms which would limit the poverty in rural Uganda would strengthen the women's health, as it would enable them to make freer choices in their lives and to have less concerns about how to feed themselves and their children.

Other HPPs that could indeed benefit the women's health could be of a nature which promoted gender equality. The Ugandan legal system favors men in a number of ways (Tuyizere 2007; Tamale 2016). Some of the gendered structures we identified, which are supported by the law, is that women cannot inherit property and that the children belong to the men. These laws make it very difficult for a woman to divorce her husband, as it would entail that she lost her children and her home. A change in policies, in a gender equal direction, would empower the women to gain control of her life and her children and thus benefit her health. The Ugandan lawyer and women's rights activist Sylvia Tamale (2016) argue that many Ugandan laws and policies are linked to a deep and invasive structure of social control, sexual dominance and exploitation of women, and that today we witnessed a resurgence of masculine dominance in the policies and laws that are being passed. Thus, changing the public policies in favor of the women's empowerment might not be a battle easily won.

Perspectivation

In this perspectivation we wish to put our research into are global perspective,
and we wish to address a couple of issues surrounding our topic and our main findings, but which we have not directly addressed in our work. It is to be seen as a helicopter view upon some of the global structures which can affect the women in Uganda's experiences of poverty and access to family planning, which are core issues in our thesis. The issues we will address below is how the poverty the women experience can be connected to the immense population growth in Uganda and

how health promotion programs which aim to provide family planning methods can, in some cases experience political resistance and challenges in achieving funding due to the controversy surrounding the issue. At last we will address some of the issues that we believe need to be further researched.

Poverty and Population Growth

As we have shown throughout this study, the women's perspectives on the number of children they want, is to a large extent affected by the health determinant of poverty. By applying knowledge of demography and statistics, we can see that the levels of poverty in Africa are closely connected to the issue of population growth (UN 2017). Rapid population growth entails a number of adverse effects on societies, health of populations, and the world's ecosystems, but also issues like environmental degradation, immigration and political unrest, as well as the risk of poverty and hunger which seemed to play an essential role to the people we interviewed, (Bongaarts 2016; UN 2017; Kibirige 1997).

Approximately one billion inhabitants have been added to the world's population over the last twelve years and the growth is continuing. The anticipated growth in population is very unevenly distributed among the regions of the world and more than half it is expected to occur in Africa, where a staggering 1.3 billion people is expected to be added before 2050 (ibid). UN projects that half of the total population growth in the world, from now to 2050, will occur in only 9 countries and among these 9 Uganda is one(ibid).
Our study supports a future decline in the fertility rate in Uganda (UN 2017), as we have shown a trend that the younger generations chooses to have fewer children, which, along with the increasing access to family planning methods will lead to this decline. This as well supports the prediction of a future decline in the population growth which, because of the increasing population in the childbearing age as well as a decrease in mortality, will not occur before 2050 (UN 2017).

The issues connected to population growth are all at the very core of the 17 Sustainable Development Goals, launched by the UN in 2015, which constitutes the basis of most development strategies of both governments, the private sector, in most countries today (UN 2018). Thus, most countries would agree that the issue of population growth is to be addressed in development work.

Family Planning - A Controversial Issue

Our study has shown that knowledge about and access to contraceptives are of crucial importance to the women we interviewed. Thus, health promoters working in these areas will find it essential to be able to promote quality family planning methods, in order to empower the people to gain control over their lives and their health. However, achieving funding for programs involving family planning can prove difficult, as this issue have been surrounded with a great deal of controversy (Bongaarts 2016). The catholic church has consistently opposed to the use of contraceptives and actively battled the right to free abortion (ibid). In America the shifting republican leaders have introduced different laws which have been unsupportive of family planning programs and specifically the use of abortion (ibid). Indeed, in the area of our fieldwork deliberate abortion was illegal and surrounded with so much stigma, that we were advised not to bring up the issue in our interviews.

In January 2017, USA reinstated an even more restrictive version of the so called Global Gag Rule officially known as The Mexico City Abortion Policy, originally introduced in 1984. Under this rule, any organization engaged with abortion-related work is barred from receiving American funding, even if the organization does not perform abortions, but merely counsels about abortions or refer women to clinics that perform them (Bingenheimer and Skuster 2017). The Global Gag Rule was met by massive protests as experts and development workers all over the world fear it will reverse decades of progress in the reproductive health of women and children in developing countries and in turns cause fertility rates to rice (ibid). Large organizations like the International Planned Parenthood Federation and Marie Stopes have to some extent been relying on US funding, and will have to cut back greatly on their activities. Ironically, critics of the Global Gag Rule point out, that the rule will most likely have the opposite effect of the intended, as the numbers of abortions is expected to rice if family planning programs are closed down (ibid). As a response to the Global Gag Rule, the Dutch Ministry of Foreign Affairs initiated She Decides, as a financing mechanism to counter the impact of the rule and this initiative was backed by over 350 world leaders (Bingenheimer and Skuster 2017). These recent changes in the global political environment in the field of reproductive health, could have a large impact on the possibilities for health promoters to raise funding for reproductive health interventions in rural Uganda as well as in other settings.

Suggestions for Further Research

As our study clearly shows that men's perspectives on reproduction to a large extend affect the women's choices in regards to the number of children they will have, and thus the fertility rate in Uganda, we find it relevant to conduct further research into this issue. We therefore find it relevant to investigate the young men in Uganda's perspectives more in-dept and how they could be empowered to be better providers or to follow their wishes in regards to reproductive health, without suppressing the women.

Furthermore, our study revealed a large gap in the access to and knowledge about contraception for teenagers in rural Uganda, and a connection to the high incidence of teenage pregnancies. We would therefore suggest that further research is conducted into how this issue can be resolved.

References

Aakvaag, G., Jacobsen. M and Johansson, T. (2012). *Introduction to Sociology, Scandinavian sensibilities*. Pearson, Harlow

Alkire S. et. al. (2016). *Multidimensional Poverty in Africa*. OPHI. Oxford Poverty & Human Development Initiative. University of Oxford. pp 1-8.

Amialya E. et al. (2017). "Our turn to eat:" Shifting gender norms and food security in the Wakiso district of Uganda. *Journal of Hunger & Environmental Nutrition*. Taylor and Franci online. Published online: 18 Dec 2017, pp.1-28.

Beyeza-Kashesya, J. et al. (2010). "Not a Boy, Not a Child": A Qualitative Study on Young People's Views on Childbearing in Uganda. *African Journal of Reproductive Health*. 14(1), pp 71-81.

Biddlecom, A. E. et al. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health*. 11(3), pp 99-110.

Bingenheimer, J.B. and Skuster, P. (2017). The Foreseeable Harms of Trump's Global Gag Rule. *Studies in Family Planning*, 48(3), pp. 279-290.

Bongaarts, J. (2016). Slow down population growth. *Nature*. 530 (7591), pp. 409-412.

Bourdieu, P. (1986). The forms of Capital. *Handbook of Theory and Research for the Sociology of Education*, Westport, CT: Greenwood, pp. 241–58

Bourdieu, P. (1994). *Den praktiske sans.* Copenhagen. Hans Reitzels Forlag.

Bourdieu, P., Wacquant, L.(1992) *An Invitation to Reflexive Sociology.* Cambridge, Polity Press PP. 94-138, 140-173.

Brinkmann, S. Tanggaard, L. (2015) *Kvalitative Metoder.* Copenhagen. Hans Reitzels Forlag pp. 634

Byekwaso, N. (2010). Poverty in Uganda. *Review of African Political Economy,* 37(126), pp. 517-525.

Carmody, P. and Taylor, D. (2016). Globalization, Land Grabbing, and the Present-Day Colonial State in Uganda. *The journal of Environment and Development*, 25(1), pp. 100-126

Dixey, R. (2013). *Health Promotion – global principles and practice*. Oxfordshire. CABI.

Dutta, M. J. (2008). *Communicating health - A Culture-centered Approach*. Polity Press

Dutta, M. J. (2015). Neoliberal Health Organizing. Communication, meaning and politics. Left Coast Press.

Harboe, T. (2010). *Metode og Projektskrivning - En introduktion*. 1st Edition. Frederiksberg. Samfundslitteratur.

Kabagenyi, A. et al. (2014). Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda. *Reproductive Health.* (11)21, pp. 1-9.

Kabeer, N. (1992). *Triple Roles, Gender Roles, Social Relations: The Political Sub-text of Gender Training*. Discussion Paper No. 313, Institute of Development Studies, Brighton, pp. 1-45.

Kabeer, N. (1994). Gender-aware policy and planning: A social-relations perspective. In: Macdonald, M. (ed.) *Gender Planning in Development Agencies*. Oxfam, Oxford, pp. 80-97.

Katabarwa, N. M., Richards, F. O. and Ndyomugyenyi, R. (2000). In rural Ugandan communities the traditional kinship/clan system is vital to the success and sustainment of the African Programme for Onchocerciasis Control. Annals of Tropical Medicine & Parasitology, 94(5), pp. 485-495.

Kibirige, J. S. (1997). Population Growth, Poverty and Health. Social Science Medicine. 45 (2), pp. 247-259.

Koenig, M. A. et al. (2003). Domestic violence in rural Uganda: Evidence from a community-based study. *Bulletin of the World Health Organization*. 81 (1), pp. 53-60.

Kvale, S. and Brinkmann, S. (2015). *Interview - Det kvalitative forskningsinterview som håndværk*. 3rd Edition. Copenhagen. Hans Reitzels Forlag, pp. 158-250.

Larsen, K. (2010). Pierre Bourdieu. In: Andersen, P. T. and Timm, H. *Sundhedssociologi - en grundbog*. København. Hans Reitzels Forlag, pp. 50-77.

Laverack, G. (2004). *Health Promotion in Practice - Power and Empowerment*. London. SAGE Publications Ltd. pp. 1-138.

McNay, L. (1999). Gender, Habitus and the Field. *Theory Culture & Society*. 16(1), pp. 95-117.

Miller, C. and Razavi, S. (1995). *"From WID to GAD: Conceptual shifts in the Women and Development discourse"*. United Nations Research Institute Occasional Paper series. United Nations Research Institute for Social Development.

Morgan, R. et al. (2017). Gender dynamics affecting maternal health and health care access and use in Uganda. *Health Policy and Planning*. 32 (5), pp. 13–21.

Muhwezi, W. W. et al. (2015). Perceptions and experiences of adolescents, parents and school administrators regarding adolescent-parent communication on sexual and reproductive health issues in urban and rural Uganda. *Reproductive Health.* 12(110), pp. 1-16.

Nabuguzi, E. (1993) Response to economic Crises in Uganda; Rice Farmers in Busoga. *Review of African Political Economy*, 56, pp. 53-67

Ninsiima, A. B. et al. (2018). "Girls Have More Challenges; They Need to Be Locked Up": A Qualitative Study of Gender Norms and the Sexuality of Young Adolescents in Uganda. *International Journal of Environmental Research and Public Health*. 15(193), pp. 1-16.

Nuwagaba, A. (2012) Towards Addressing Skills Development and Employment Crisis in Uganda: The Role of Public Private Partnerships. *Eastern Africa Social Science Research Review*, 28(1), pp. 91-116.

Ogland, E. G. et al. (2014). Intimate Partner Violence Against Married Women in Uganda. *Journal of Family Violence*; 29 (8), pp. 869-879.

Prieur, A; Sestoft, C. (2006). *Pierre Bourdieu -En introduction.* Copenhagen, Hans Reitzels forlag

Reid, R. J. (2017). *A History of Modern Uganda*. Cambridge University Press. London.

Rudrum, S. et al. (2017). Antenatal Care and Couples' HIV Testing in Rural Northern Uganda: A Gender Relations Analysis. *American Journal of Men's Health.* 11(4), pp. 811–822.

Sen, G. and Grown, C. (1988). *Development, crises and alternative visions, Third World women's perspectives*. London: Earthscan

Sileo, K. M. (2017). "That would be good but most men are afraid of coming to the clinic": Men and women's perspectives on strategies to increase male involvement in women's reproductive health services in rural Uganda. *Journal of Health Psychology.* 22(12), pp. 1552 –1562.

Silverman, D. (2014). Interpreting Qualitative Data. 5th Edition. SAGE Publications. London.

Sonne-Ragans, V. (2012). *Anvendt Videnskabsteori - reflekteret teoribrug i videnskabelige opgaver*. Frederiksberg. Samfundslitteratur, pp. 112-119.

Tamale, S. (2016). Crossing the Bright Red Line. The Abuse of Religion to Violate Sexual and Reproductive Rights in Uganda. *Journal of Theology for South Africa.* 155. Special Issue, pp. 121-156.

Thisted, J. (2018). *Forskningsmetode i praksis - Projektorienteres videnskabsteori og forskningsmetodik*. København. Munksgaard, pp. 206-211.

Tuyizere, A. P. (2007). *Gender and Development: The Role of Religion and Culture*. Kampala: Fountain Publishers, pp. 447

UBOS. Uganda Bureau of Statistics. (2014). *Uganda Population and Housing Census – Main Report*. Kampala.

UBOS. Uganda Bureau of Statistics. (2016). *Uganda Demographic and Health Survey 2016 - Key Indicators*. Kampala.

UMoH. Uganda Ministry of Health. (2007-2015). *Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda*. Kampala.

UMoH. Uganda Ministry of Health. (2015). *HEALTH SECTOR DEVELOPMENT PLAN 2015/16 - 2019/20*. Kampala.

UMoH. Uganda Ministry of Health. (2017 (a)). *State of Uganda Population Report 2017*. Transforming Uganda's Economy: Opportunities to Harness the Demographic Dividend for Sustainable Development. Kampala.

UMoH. Uganda Ministry of Health. (2017 (b)). Uganda Population-Based HIV Impact Assessment (UPHIA). Conducted in collaboration with ICAP, Columbia University.

UN. United Nations. (2017). *World Population Prospects*. United Nations Department of Economic and Social Affairs. Volume I. 2017 Revision.

UNFPA. (2013). *Adolescent Pregnancy: A Review of the Evidence*. Prepared by: Edilberto Loaiza Mengjia Liang. New York. pp. 2-5.

UNPA. (2014). Harnessing Demographic Dividend to Achieve Uganda's Vision 2040 - Accelerating Socioeconomic Transformation In Uganda. Uganda National Planning Authority.

Wakabi W. (2006). Population growth continues to drive up poverty in Uganda. World Report. www.thelancet.com. Vol 367(9510), pp. 558.

Wolf, H. T. et al. (2017). The effectiveness of an adolescent reproductive health education intervention in Uganda. *International Journal of Adolescent Medical Health*. 29(2), pp. 1-7.

WRAP. (2014). Women's Reproductive rights Advocacy Project. Project Document. Reproductive Health Uganda (RHU) and Danish Family Planning Association (DFPA).

Young, K. (1993). *Planning Development with Women: Making a World of Difference*. London. Macmillan.

Young, K. (1997). Gender and Development. In: Visvanatha, M. et.al. *The women, gender and development reader*. 1. edition. London: Zed Books, pp. 51-54.

Webpages:

Oxford Dictionaries. (2018). Webpage attended 03.05.18
https://en.oxforddictionaries.com/

Promedicin. (2018). Webpage attended 15.04.18
http://pro.medicin.dk/Medicin/Praeparater/431

UN. United Nations. (2018). Webpage attended 26.02.18:
http://www.un.org/sustainabledevelopment/sustainable-development-goals/

UNFPA. (2018). Webpage attended 04.05.18
https://www.unfpa.org/sexual-reproductive-health

UNFPA. (2018(b)). Webpage attended 27.02.18
http://esaro.unfpa.org/news/president-museveni-clarifies-position-family-planning

UNESCO. (2018). Webpage attended 22.05.18
http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/poverty/

World Bank. (2018) Webpage attended 27.02.2018:
https://data.worldbank.org/indicator/SP.POP.TOTL?locations=UG

Planned Parenthood. (2018) Website attended 23.04.2018.
https://www.plannedparenthood.org.