The negotiation and management of sexual and reproductive health behaviour in marital relationships in rural south-western Uganda

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2019

Submitted for the qualification of Doctor of Philosophy in International Development

University of East Anglia

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Contents

List of tables, maps and photographs

Abstract

Despite changes in availability and uptake of modern contraception and several decades of HIV risk behaviour change intervention, rates of fertility and HIV remain high in south-western Uganda. This thesis set out to explore the reasons why and understand the specific challenges married individuals face negotiating and managing HIV risk and family planning. Data collection took place between 2015-2016 in six villages, located in a pre-existing general population cohort run by the MRC/UVRI Uganda Research Unit on AIDS in Kyamulibwa. The dataset includes 36 life-stories of men and women at different stages of the marital life-course, focus groups with married individuals, and interviews with religious leaders, health workers and a traditional healer/birth attendant. A social determinants of health approach was used as a base to investigate drivers of sexual attitudes and practices, fertility preferences, family planning use and navigation of HIV. A framework and network mapping technique guided interpretation and data analysis.

This thesis identifies social practices that are sustaining high fertility and contributing to a risk environment, which heightens HIV susceptibility for married individuals, particularly women in this setting. Unequal gender power dynamics are played out through practices of transactional sex, early and pressurised marriage for females, gender-based violence and the commonality of male engagement in extra-marital relations. Whilst types of marriage and marital circumstances vary substantially, widespread cultural beliefs underpin expectations of marital roles and obligations relating to unprotected sex. Over the life-course, females often try multiple family planning methods, frequently favouring approaches that do not require spousal involvement. Tensions are highlighted between the ways married individuals are told they should protect against HIV and manage fertility, and the cultural and religious discourses shaping marital gender roles, as well as the context and circumstances in which sex and sexual relations take place.

Glossary

Akasiimo – marriage gifts for the bride's family

Asajjalata – prove manhood

Baganda – the main ethnic group in the south of Uganda

Buganda – kingdom of the *Baganda*

Empaawo – bowl with lid

Gomesi – traditional dress worn by women

Hawker – street seller

Kabaka – the *Baganda* king

Kalungu – district of study site

kanzu – traditional shirt worn by men

Kyamulibwa – location of study site

Luganda – language spoken by the *Baganda*

Musawo – health worker

Muzungu – white person or foreigner

Mwenge – locally brewed banana beer

Okukyalira ensiko – visiting the bush (labia elongation)

Omutwalo – bride-price

Ssenga – paternal aunt

Acknowledgements

I would like to give thanks to my two supervisors, Dr Steve Russell and Professor Janet Seeley: Steve for his guidance, attentive and incisive comments and warm encouragement; and Janet, for facilitating my internship and then fieldwork with MRC in Uganda and for all the in-depth conversations and responsive emails. I also want to thank Dr Catherine Locke, who inspired and guided me through the first year of the PhD, and Dr Rob Newton for his friendship, mentoring and support during and after fieldwork.

I would like to acknowledge the help and support given to me in Uganda. To the MRC social science team and other staff members in *Kyamulibwa*, who made me feel part of the research site, particularly Eddy, Patrick, Alex, Ruth, Irene, Asiki, John and Clara who made me laugh, dance and play a lot of extremely competitive badminton. A very special thank you to Grace and Elizabeth, the assistant social scientists: two of the kindest, most intelligent, professional and hardworking colleagues I have ever had the pleasure to work with. Thank you also to Allen and Lazaro, who assisted with the facilitation, translation and transcription of the focus groups and Joseph presenting my study aims to village leaders to gain consent for undertaking the research. I also want to give a special mention to Jjajja Anastasia and Mama Cathy, two very strong women whom I admire greatly. They both welcomed me wholeheartedly into their families and talked to me at length about their lives, which helped me grasp the depth and nuance of some of my key research findings. Jjajja also taught me *Luganda* and translated during the key informant interviews. I will be forever grateful to both women for their love and kindness.

There are several friends who have been a great source of support and encouragement during the PhD process. Dorice, thank you for encouraging me to undertake the PhD and for believing in me every step of the way: you have been a solid mentor and a true rafiki. To my Dev buddies, Anni, Hao, Ines, Dafni, Pablo, Rik and Will, I feel so lucky to have shared this experience with you. Thank you for the hours of lunchroom debates, existential discussions and genuine friendship. An extra special thank you to Esme and Rosanne, for your boundless energy, consistent interest in my research and even during the most stressful times never failing to make me laugh. You are truly wonderful friends.

Last, but certainly not least, thank you to my family. To my parents and siblings for your love, support and emergency help with childcare. To my wonderful husband Ben, my rock and sidekick: thank you for always encouraging me to think big and follow my goals, even though it meant years living apart. And to Elenie, although you only came into existence part way through the PhD process and definitely made writing up more challenging, you also make me present, grateful and gave me the opportunity of motherhood, which provided a different lens to my research.

Chapter 1 – Introduction

When I began this thesis in October 2013, Yoweri Kaguta Museveni, President of the Republic of Uganda, had recently addressed the United Nations General Assembly on failing to meet some of the Millennium Development Goals (MDGs). Uganda had achieved or made significant progress on some of the targets, such as halving the number of people in poverty, increasing gender equality and empowering women, reducing child mortality and improving access to clean drinking water and sanitation; however, two goals Uganda was failing to meet related to maternal health, which had stagnated; and combating HIV/AIDS, which was deemed to be in reverse (MoH, 2013). More specifically, the number of new HIV infections was deemed to be rising, with increased prevalence amongst older groups of married or cohabiting couples; monitoring figures also highlighted high unmet needs for family planning, with 38% of married or cohabiting women reporting a desire to delay pregnancy, yet not using any family planning method (*ibid.*). Although progress has since been made on some of these areas, Uganda continues to have one of the highest birth rates in the world, and HIV and neonatal disorders remain two leading causes of death (CDC, 2018).

Eliminating HIV and lowering rates of fertility are key development issues. Global initiatives and public health discourses in these two areas have shaped Uganda's development strategy. Firstly, in the field of family planning, modern contraception has been deemed the silver bullet for reducing fertility rates and solving development problems. This ethos is reflected in global initiatives such as the FP2020, the Ouagadougou Partnership and the Sustainable Development Goals, which all have targets to increase access and numbers of women using modern contraception in the global south. A clear link between lowering the fertility rate and achieving economic development is evident in Uganda's strategic policy.

In the Uganda Family Planning Costed Implementation Plan 2015-2020, rates of fertility are highlighted as a key development issue: 'The high rate of population growth creates strains on the country's natural resources, which in turn drives up the poverty rate and threatens future development gains' (MoH, 2014, p5). The government's mission statement is 'Universal access to family planning to help Uganda attain the middle-income country status by 2040', which it intends to achieve through the operational goal to 'Reduce unmet need for family planning to 10 percent, and increase the modern contraceptive prevalence rate (mCPR) amongst married and women in union to 50 percent by 2020' (MoH, 2014, p1). The policy aims to increase demand, uptake and accessibility of modern family planning methods with the

bulk of the projected investment directed at hormonal contraception (i.e. injections, implants and IUDs) for married and unmarried women (*ibid.*, p.33). This means that hormonal contraception is framed as both safe and necessary to lower fertility rates and achieve development objectives. This biomedical intervention to manage fertility and control female bodies overlooks the structural factors shaping reproductive behaviours and the power dynamics of marital relationships that influence fertility choices, which are explored in this thesis.

The Uganda National HIV/AIDS Strategic Plan 2015/2016-2019/2020 similarly reflects global public health discourse, favouring biomedical intervention and focusing on individual behaviour. The tagline for the Plan is 'An AIDS free Uganda, My responsibility!' indicating the weight of the HIV epidemic being placed on the individual. The Plan is aligned with the UNAIDS 90, 90, 90 targets to achieve an AIDS-free Generation by 2020. This involves making 90% of all people living with HIV aware of their status; 90% of HIV positive individuals on antiretroviral treatment (ART); and 90% of those on ART with an undetectable viral load. The UNAIDS promotion of biomedical intervention is justified as 'HIV treatment has demonstrated by far the most substantial effect on HIV incidence' (UNAIDS, 2014a, p. 4).

Uganda's strategy plan involves four streams: prevention, care and treatment, social support and protection, and systems strengthening (Uganda AIDS Commision, 2015). The prevention arm of the strategy includes three objectives focusing on the promotion of safer sexual behaviours, scaling up biomedical interventions and mitigating the underlying socio-cultural, gender and other factors driving the HIV epidemic (*ibid.*, p.21). Prevention therefore overwhelming focuses on individual behaviour and 'at risk' populations. Although structural factors are acknowledged to drive the epidemic, within strategic actions there is no mention of addressing the unequal socio-economic power dynamics between men and women in the general population or in marital type relationships, which is argued in this thesis to be core in the negotiation of sex.

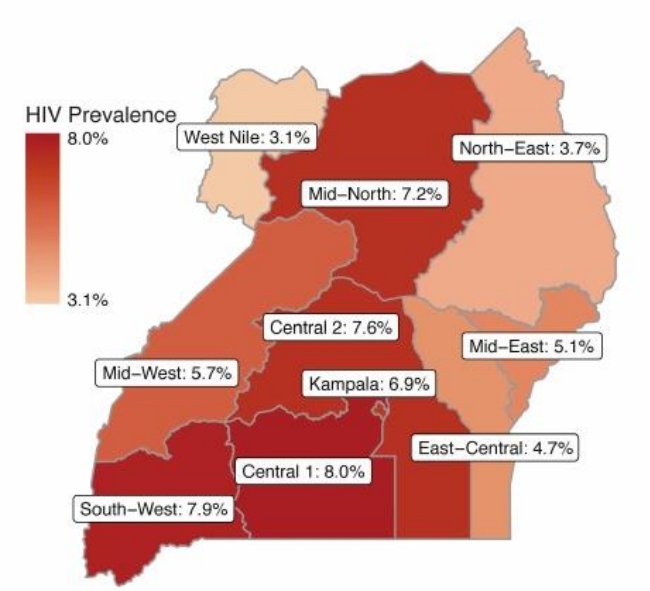
This thesis examines three key puzzles which relate to understanding marriage in this context and identifying the sexual and reproductive practices which contribute to high fertility and the spread of HIV. Married individuals or individuals who have ever been married are a key social target group, intersecting with policies on both HIV and family planning. Although promotion and uptake of modern contraception has increased and the country has undergone various social and economic transitions associated with fertility decline, fertility rates have remained generally high. This study has therefore tried to understand the different forms of marriage and how meanings of being married influence sexual practices, the ways in which

contraception is being used and the social determinants which are fuelling high fertility. In addition, the HIV epidemic has been going on in Uganda since the early 1980s. Although prevalence is inevitably increasing with the decrease of AIDS-related mortality due to availability of anti-retroviral treatment (ART), the incidence of new HIV infections remains high, particularly amongst females and individuals who have ever been married. This study therefore set out to examine how the onset and trajectory of the HIV epidemic and the public health responses to the epidemic have influenced sexual practices, especially amongst married individuals. The following sections present the case for specifically researching HIV risk, rates of fertility and family planning practices over the life-course in marital relationships. This research justification and context is followed by the study aims and research questions, an outline of the thesis and a brief background to the study location.

1.1 HIV/AIDS in Uganda

Since 2013 in Uganda, reinvigorated efforts to increase uptake of HIV prevention, care and treatment to supress HIV viral loads and reduce numbers of new infections have resulted in a drop of HIV prevalence from 7.3% to 6.2% in the general population (WHO, 2017). However, these figures mask geographic and social inequalities of the HIV epidemic, which pose specific risk for females and married individuals. It is estimated that 1.5 million people in Uganda are living with HIV: prevalence in the general population is approximately 6.2%, but there are stark differences between geographical areas and social groups (Uganda AIDS Commission, 2016, p.6). The spread of HIV in Uganda has been attributed to historical, social and economic processes that have facilitated the spread of disease, through sexual relations and migration (Seeley, 2014). HIV is most prevalent in the south-west and central regions of Uganda (Map 1.1), and the study site is located at the border of these two areas. There has always been significant migration from and within these regions, which has characterised the social lives of the *Baganda* people (Richards, 1966; Janet Seeley, 2014). This may be because the HIV-1 virus originated in the Congo and spread through Uganda and East Africa, predominantly through heterosexual sex along routes of economic trade and social migration (Pépin, 2013). Labour mobility, migration, the structure of gender relationships and power dynamics of sexual relations are therefore key dimensions of the HIV epidemic in Uganda discussed in this thesis.

Map 1.1 HIV prevalence in Uganda



Map source: UPHIA Uganda Factsheet (WHO, 2017)

Thus, HIV unevenly affects different social groups and sub-populations. Prevalence is highest amongst mobile populations and those linked to sex work i.e. fishing communities (15-40%), sex workers (37%), the partners of sex workers (18%), men with a history of having sex with men (13%) and men in the armed services (18.2%) (Uganda AIDS Commission, 2016, p.16). In the general population, females are also disproportionately affected by the epidemic as 8.8% of adult women are living with HIV compared to 4.3% of men; this figure rises to 13% among women aged 35 to 39 and HIV prevalence is calculated to be four times higher amongst young females than males (aged 15-24) (UAIS, 2016, p.2).

In Uganda (and importantly for this thesis), HIV prevalence is high amongst individuals who have ever been married. Studies indicate that within general HIV epidemics, a substantial number of new infections occur within cohabiting and marital-type relationships (Wabwire-Mangen *et al.*,2009; Kasamba *et al.*, 2011; Biraro *et al.*,2013). In Uganda HIV prevalence is highest amongst middle-aged individuals, i.e. women aged 35-39 and older men aged 45-49, at rates of 13% and 14% respectively (UAIS, 2016, p.2). There are conflicting messages about the role that marriage plays in terms of susceptibility to HIV. In the Uganda National HIV/AIDS Strategic Plan, HIV prevalence is stated as highest amongst individuals who have ever been married (i.e. widowed, divorced or separated); however, being married is still discursively framed as a protective factor and serodiscordancy is described as low in the

country (around 6%) (Uganda AIDS Commision, 2015, p.5). In this thesis the unequal power dynamics of marital relations, in addition to the HIV discourse promoting marriage and faithfulness to be protective factors, are argued to be key reasons that married individuals are susceptibility to HIV.

HIV is a disease driven by gender inequality and the structure of gender relations, which affect capabilities to negotiate sexual relationships. Key structural factors are associated with women's disproportionate risk of contracting HIV. These include gendered social norms that advantage male power in sexual relationships, age disparities between younger women and older male sexual partners, and structural factors that induce labour migration, family disruption, and cause entrenched social and economic inequalities (Harrison *et al.*, 2015). At the core of marital relations in Uganda are unequal power dynamics, which subordinate women and limit capabilities to negotiate sex. Underpinning this gender inequality is a 'patrilineal system in which the rights to land ownership, inheritance, and parentage extend only to male family members' (Obbo, 1980 cited in Koenig *et al.*, 2004). Whilst patriarchal beliefs are highlighted in this thesis to enhance male power and subordinate females, attention is also paid to the role of agency to examine the ways in which individuals, particularly females gain access to resources and use sexual and reproductive practices to negotiate marital relations.

Structural gender inequality and female vulnerability are most evident in the social norms of transactional sex and gender-based violence, which have both been linked to increased susceptibility to HIV (Parikh, 2004, 2007; Hunter, 2007; Swidler and Watkins, 2007b; Hirsch *et al.*, 2009; Stoebenau *et al.*, 2016). In Uganda, research suggests that one in four girls and women have been coerced into sex and one in three women have experienced violence from a current partner (Koenig *et al.*, 2003, 2004). Forced sex within marital-type relationships has also been documented as widespread and linked to other factors that affect marital relations and dynamics, such as the absence of sexual pleasure, pregnancy, poverty, infidelity and alcohol use (Cash, 2011). Research in Uganda has found that young women who have experienced intimate partner violence (IPV) are 50% more likely to acquire HIV than women who have not (Uganda AIDS Commision, 2020, p.5).

Although historical and structural factors have long been recognised to drive the course of HIV epidemics, HIV responses have been dominated by behaviour change and biomedical approaches, which focus on individuals, rather the social context of sex and sexual relations (Barnett and Whiteside, 2002; Auerbach, Parkhurst and Cáceres, 2011). In Uganda, prevention has revolved around the ABC message (abstinence, be faithful and use condoms), alongside the uptake of anti-retroviral therapy (ART) to suppress viral load, which remains central to

AIDS-policy and prevention strategy (Uganda AIDS Commission, 2016, p.8). HIV prevention messages were and continue to be reproduced and circulated through state led AIDS-policy and engagement of non-governmental organisations (NGOs), religious groups, community activists and the media (Barnett and Parkhurst, 2005). These prevention messages have moralised monogamy and stigmatised promiscuity; however, it is argued that, rather than having fewer extra-marital relationships, men have simply become better at concealing their extra-marital relations (Parikh, 2007). This questions the success of the ABC approach and it's implications for married individuals to protect against HIV, which is examined in Chapter 8.

1.2 Rates of fertility and family planning

Uganda has the third highest birth rate in the world, with women giving birth to an average of six children over a lifetime; this high birth rate means the population has almost doubled in twenty years to 40 million people (World Bank, 2015) The majority reside in rural areas, but 2 million people live in Kampala, the capital (Ugandan Bureau of Statistics (UBOS), 2013). Uganda also has a young population, as half the population is under the age of 18 (*ibid*). Fertility rates also vary by geographical area and social characteristics. Hormonal contraception is often used as a marker to determine success of family planning programmes, overlooking the complex forces driving demands for children (Price and Hawkins, 2007; Kavanaugh, 2008; Fabic *et al.*, 2014). The promotion and discursive framing of hormonal contraception as enhancing women's reproductive rights places focus and responsibility for managing fertility on women.

Social and cultural factors drive high fertility and shape family behaviours over the life-course (Price and Hawkins, 2007). In Uganda the number of children individuals say they want is on average, five for women and six for men, and this has not changed over the past ten years (UBOS, 2013). Although having a big family is a cultural norm, fertility rates are higher in rural areas and amongst women with low or no education. Rural women in Uganda give birth to nearly three more children during their reproductive years than urban women (3.8 and 6.8 respectively (UDHS, 2012, p.58)). Women with no education are also shown to have more children than women that completed primary education (6.9 compared to 4.8) (UBOS, 2013, p.140). Women also start giving birth young, with the average woman giving birth to more than three children by her late twenties and more than six children by her late thirties (UDHS, 2012, pp.61, 80). These features of fertility have influenced public health policy priorities to increase information and use of family planning amongst young people and increase access in rural communities (Uganda MoH, 2014, p.xiv)

As already mentioned, to address the issue of high fertility in Uganda, family planning policy is driving the uptake of modern contraception amongst women. A third of pregnancies are reportedly unplanned in Uganda and there is a supposed 38% unmet need for contraception, calculated by the number of women who are married or cohabiting reporting a desire to limit or space fertility and who are not using any contraception (Uganda MoH, 2014). The modern contraceptive prevalence rate (mCPR) is used to define the percentage of married women currently using a method of modern contraception, and levels of contraceptive use are the most widely employed and valued measurement of success of family planning programs (Fabic *et al.*, 2014). This Western approach to family planning, prioritising the uptake of biomedical technologies, particularly in marital-type relationships, can overlook the social determinants of and demand for children (Price and Hawkins, 2007). Applying the medicalized Westernised paradigm of reproductive health in the sub-Saharan context is therefore limited: the Western paradigm has been heavily dominated by rational choice approaches, framing 'fertility-related behaviour as a long-range planning process, modified by unanticipated life course contingencies' (Johnson-Hanks 2007, p.1011). This approach has been regarded as an unsuitable way to capture and comprehend the ways in which African women manage their fertility over the life-course (*ibid.*). From the Western perspective, high fertility is often associated with a woman's inability to manage or control reproduction, but in many African societies where children are valued and desired, 'high fertility is a social achievement rather than an accident of nature' (Bledsoe, 2002, p.5).

Furthermore the Western paradigm of reproductive health has asserted that delaying or avoiding pregnancy is a primary way through which women can upwardly increase social mobility and achieve stability (Kavanaugh, 2008, p. 83). However, in polygamous societies, a married woman's reproductive capabilities is tied to social status and negotiating power:

> Largely because of the polygynous – or potentially polygynous – character of married life, women need children to justify making demands on their husbands' wealth and estate. Infertility or subfertility, an anguishing problem in general for African women, is particularly severe in the context of polygyny. (Bledsoe, 1995, p.133)

Reducing fertility rates and promoting birth control have been deemed the answer to addressing development problems (i.e. poverty, over-use of resources, population pressure on land and infrastructure, mother and child mortality), with neo-liberal approaches placing responsibility on the individual to manage fertility and reproductive health (Bendix and Schultz, 2018,

pp.260-261). By placing responsibility for behaviour on the individual woman, the external factors that affect capabilities to control fertility are neglected (Kavanaugh, 2008).

The global initiatives and public health discourses surrounding the promotion of hormonal contraception frame biomedical technologies as safe and necessary. This perspective of reproductive management ignores how African women achieve fertility preferences. Analysis of fertility data from eighteen sub-Saharan African countries revealed birth spacing and fertility decline to be similar amongst groups of women who reported using contraception and those who did not, suggesting that demographic health surveys fail to capture the ways in which African women manage their fertility over the life-course (Johnson-Hanks, 2007). This was evident in Bledsoe's study on reproductive decision-making in West Africa, which found women using hormonal contraception to space births rather than limit them, to manage the process of ageing and enhance reproductive capabilities (Bledsoe, 2002).

Global initiatives driving promotion and uptake of modern contraception in the global south have paid critical attention to the barriers of uptake, informed understandings of risk and susceptibility to HIV. In sub-Saharan African, barriers to uptake and adherence to modern contraception have been frequently associated with cultural beliefs relating to menstruation, health and long-term fertility, and also male resistance to family planning (Glasier *et al.*, 2003; Wood and Jewkes, 2006; Laher *et al.*, 2010). The most common form of hormonal contraception in the sub-Saharan Africa is the injection (Depo-Provera), which is deemed highly effective (0.2% failure rate), easy to administer and can be used covertly by women (WHO, 2015). However there is a growing body of research suggesting a link between this form of contraception and HIV susceptibility, although it has been difficult to ascertain whether this link is causal or due to confounding social factors (Polis and Curtis, 2013; Colvin and Harrison, 2015; Lewis, 2015). Condoms remain the only widely accessible method of family planning which also provides a barrier to protect against HIV or STIs. Although there remains uncertainty regarding the interaction of hormonal contraception with anti-retroviral treatment or acquisition of HIV, the WHO (2015) maintains that offering women a range of modern contraception is necessary to uphold women's reproductive rights and the benefits of managing fertility are deemed to outweigh the associated risks (p.84). There are tensions, therefore between managing HIV risk and fertility, which raise pertinent questions around the use of biomedical technologies and informed choice, risk and susceptibility. To achieve targets in HIV prevention and family planning, it is therefore necessary to understand in more depth, and address, the needs and challenges married individuals face negotiating and managing sexual and reproductive health.

1.3 The sexual and reproductive health needs of married individuals

Recent WHO guidelines for 'differentiated care' mark a shift in service delivery, which aim to streamline HIV prevention to care services, increase adherence to antiretroviral treatment and improve acceptability and care outcomes (WHO, 2016). These guidelines use the notion of differentiation to identify HIV-related needs amongst different social groups to improve cascades of healthcare. I adopt this concept of differentiated care to address the sexual and reproductive health needs of married individuals. To differentiate HIV prevention and family planning programmes for married individuals, I argue it is necessary to understand the tensions and challenges married individuals face negotiating HIV risk and fertility. As already explained being in a marital relationship heightens female risk of HIV and pregnancy. Whilst it is known that structural inequalities and cultural norms affect power dynamics and capabilities to discuss and negotiate sexual and reproductive health-related issues in marriage; the ways in which married individuals, particularly women, negotiate sex are not well known. This study therefore seeks to illuminate the discourses and drivers of sexual and reproductive health practices for the purpose of differentiating HIV prevention and family planning services for this target group.

In Uganda, marriage is the leading social and demographic indicator exposing women to the likelihood of getting pregnant (UDHS, 2012, p. 4). Early marriage is also linked to increased sexual and reproductive health risks. Females who engage in early sexual debut or marry early have greater difficulty when negotiating sex even when there is risk of HIV, experience higher rates of unplanned pregnancy and pregnancy complications, and increased risks of domestic violence (Chandra-Mouli, Camacho and Michaud, 2013; Schlecht, Rowley and Babirye, 2013). In Uganda most females are married by the age of twenty, with the average age being 17.9 years; early marriage is highest amongst poor, less educated females living in rural areas (Uganda Bureau of Statistics and ICF International Inc, 2012, p.50). The age of marriage is often taken from when the couple start living together; however, studies in Uganda have found poor young females entering into informal marital-type relationships that do not necessarily involve the couple living together (Alsan and Cutler, 2013; Schlecht, Rowley and Babirye, 2013). Examining marriage as a process and identifying the reasons that individuals, particularly young females, enter or remain in marital relationships is argued in this thesis as crucial to understanding the sexual and reproductive needs and challenges married individuals face when negotiating HIV risk and fertility.

There are significant challenges for married individuals, particularly women, to manage the risk of HIV. Low levels of male testing and disclosure of HIV status within marriage have been identified as major challenges for Uganda's national response to HIV (UNAIDS, 2014b). Men are less likely to test for HIV or start anti-retroviral treatment (ART) and as a result have higher AIDS-related mortality (Mermin *et al.*, 2008; Kigozi *et al.*, 2010; Siu, Seeley and Wight, 2013). Mistrust, HIV stigma and fear relating to the instability of marital relationships are known barriers to married couples discussing HIV risk or testing (Nabaitu, Bachengana. and Seeley, 1994; Larsson, Thorson, Nsabagasani, Namusoko, Popenoe, Ekström, *et al.*, 2010). Research also indicates that women are most likely to contract HIV as a result of a husband's extra-marital activities and that male sexual secrecy, alongside structural determinates that intersect with gender equality, amplify HIV risk for women in marital-type relationships (Parikh, 2007; Hirsch *et al.*, 2009).

In Uganda the lived experience of marriage varies considerably, particularly in relation to gender, education, socio-economic status and geographical location. There are five legally recognised types of marriage: civil, Christian, Hindu, Muslim and customary. One in four women and about one in three men reported being in a customary marriage in the last census, making this the most common form of marriage (Uganda Bureau of Statistics and ICF International Inc, 2012, p.48). Although polygyny is a cultural practice, formal polygynous relationships have steadily declined in Uganda, from 32% of marital relationships in 2000 to 25% in 2011 (*ibid.*). Women in rural areas with no education and older men residing in rural areas are the two social groups most likely to be in a polygynous marriage (*ibid.*). The prevalence of polygamous relationships also varies by geographical area, with the highest proportion in the north-east and lowest in Kampala. Although formal polygyny is declining, extra-marital relations and relationship concurrency is common, with 17% of men and 2% of women reporting an extra-spousal partnership in the previous year (Kasamba *et al.*, 2011, p.3). The numbers of women in informal marital unions or cohabiting has also increased. The proportion of women who are legally married has decreased from 49% to 36% and cohabiting has reportedly increased from 14% to 27% during the same period (*ibid.*, p.47).

Social and cultural norms sustain gender inequality and reinforce female insecurity in marital relationships. In Uganda there is no connection between positive legal frameworks and lack of effective implementation, which means women's legal status is precarious, economic capacity is limited and rights are not guaranteed (UNDP, 2006). The drafting of the 1995 constitution legislated women's rights to property and children in case of divorce or death of a spouse, but the persistence of social and cultural norms and patriarchal attitudes serve to

exclude and discriminate against women and weaken their economic capacity through the burden of unpaid work (Kafumbe, 2010). As Seeley remarks 'If a husband dies or the marriage ends, a woman can only remain in her husband's home and on his land if his relatives agree'; this means 'women among the Baganda and other tribes with patrilineal systems experience insecurity in the marital home which is magnified by widowhood, conflict or HIV' (2014, p.46). The cultural custom of paying bride-price means a wife can be 'bought', like a commodity (Hague and Thiara, 2009). Cases of domestic violence and abuse have been widely linked to claims of a woman not fulfilling the role or value of being a wife, or attempting to leave a marital relationship and being unable to repay their bride-price (*ibid.*, p.18).

Although marriage and the concept of intimacy have been explored significantly in modern anthropology and notions of negotiating HIV risk have been central to the analysis of HIV epidemics, few studies have combined the investigation of both issues (Hirsch and Wardlow, 2006). The social landscape for marital relations has changed in Uganda due to socio-economic factors and the HIV epidemic, as evidenced through the demise of paying bride-price, increases in cohabitation, decreases in formal polygyny and rise in practices such as HIV testing before marriage and serosorting (i.e. selection a partner wholly or partly based on their HIV status) (Mukiza-Gapere and Ntozi, 1995; Mbonye *et al.*, 2013; Janet Seeley, 2014). The dominance of patriarchy means there is a 'culture of silence around women's sexuality' (Gupta, 2002, p. 183) and less is known about how women negotiate sex, particularly in marital-type relationships. To differentiate HIV prevention and family planning programmes for married individuals, it is therefore necessary to understand the tensions and challenges of negotiating marital relationships.

1.4 Research aims and questions

The overall aim of this study is to examine the social determinants of high fertility, family planning practices and HIV susceptibility in marital relationships in south-western Uganda. This aim has been broken down into the following three research questions.

1) In what ways do the different forms that marriages take, influence the sexual practice of people who consider themselves married and why? To answer this question, it is important to understand firstly what constitutes a marital relationship and the range of relationships considered as marital in this setting. This is important for acknowledging the diverse living arrangements and social circumstances of married individuals, which characterise

everyday interactions and relations. These factors can shape social perceptions of marital roles, power dynamics and the expectations and negotiations of sexual practices.

2) Why does the fertility of married women remain high, despite changes in the availability of different forms of contraception and other local changes that are often associated with fertility transition? Local transitions refer to socio-economic changes such as urbanisation and modernisation, which have changed the way in which people live. For instance, increasing female access to education, work or income and civil participation. This question seeks to understand the social determinants of high fertility. In this study a life-course approach is used to analyse motivations, priorities and constraints of family planning strategies and behaviours over the life-course and across generations.
3) How has the onset and trajectory of the HIV epidemic, as well as the public health responses to this trajectory, influenced sexual practices among people who consider themselves married? The last question seeks to explain and situate marital sexual behaviours within the historical context of the HIV epidemic. This thesis has aimed to consolidate the factors that facilitate the spread of HIV and make married individuals susceptible to contracting HIV in the study setting. This includes the micro and macro factors that can induce HIV vulnerability and risk.

1.5 Thesis outline

This introductory chapter provides background and the case for researching HIV, fertility and family planning in marital relationships in rural south-western Uganda. The research aims and sub-questions are briefly explained, and the study location and target population outlined. Chapter 2 describes the theoretical lens which guided the research methodology. A broad social determinants of health framework (Solar and Irwin, 2010) is used as a base to interrogate the interplay between structure and agency. I then introduce three concepts (gender, marriage and the risk environment), which have deepened exploration of the structure and organisation of gender relations, the sociality of sexual and reproductive health practices and the contextual factors that shape individual capabilities to negotiate marital relations and navigate risk over the life-course. Chapter 3 provides an overview and details of the research design, including epistemology, selection of qualitative methods, sampling techniques, processes of data analysis, ethical considerations and reflections on researcher positionality. Chapter 4 presents a typology of marital relationships found in this setting to illustrate the varied lived experiences and the shared notions of being married. Chapters 5 and 6 provide frameworks of gender, which influence perceptions of marital roles, duties, obligations and gender dynamics, affecting the

negotiation of sex in this setting. Chapter 7 examines the social determinants of high fertility and the family planning practices and approaches used by women over the life-course. Chapter 8 consolidates the factors that contribute to a risk environment and heighten susceptibility for females and married individuals. Chapter 9 summarises key findings and contributions relating to marriage in Uganda, construction of masculinities and sexual practices, family planning practices over the life-course and HIV risk environments for married individuals. The implications of these findings are then outlined as policy recommendations and suggested areas for further research.

1.6 Study location and population

This section briefly outlines the study site and some key characteristics of the local population. Uganda is often referred to as the 'Pearl of Africa', a phrase coined by Winston Churchill (1909). Uganda was valuable to the British Empire for crops such as cotton, rubber, cocoa, coffee, tea, vanilla, which grew easily in the fertile soil. 76.5% of the population live in rural areas, which means Uganda is often classified as a mainly agrarian society (Melo, Ng'ethe and Manor, 2012, p. 24). The influence of colonial discourses on gender and marriage is discussed in Chapters 5 and 6. This study took place within an existing longitudinal cohort located in *Kyamulibwa* in the district of *Kalungu* near the border of central and south-western regions of Uganda (map 1.2). The General Population Cohort (GPC) is the longest-running HIV monitoring cohort in Africa, established in 1989 by the UK Medical Research Council (MRC) and the Uganda Virus Research Institute (UVRI) to monitor the HIV epidemic. Today it tracks trends of other infectious and non-communicable diseases (Asiki *et al.,* 2013). The GPC covers a fixed area roughly 14km by 9km and containing 25 villages, approximately 22,000 people; half the population is under the age of 15 and the gender ratio is roughly equal. Most of the population is *Baganda* (75%), the largest ethnic group in Uganda. The most common religions in the area are: Roman Catholic (57.5%), Muslim (27.3%) and the Protestant Church of Uganda (COU) (11.4%). The Pentecostal Protestant religion (referred to in this thesis as Born Again) has become very popular in some parts of Uganda. In the GPC only 3.2% of the population follow this religion, but the Born Again Church is well known in the area.

Map 1.2 Study site

The main ethnic group in the area is *Baganda*, whose land is *Buganda*, language is *Luganda* and associated attributes are referred to as *Kiganda*. The *Baganda* are of Bantu ancestry, and the *Baganda* kingdom stretches across central and south-western regions of Uganda, which includes the capital city of Kampala and the second-biggest city, Entebbe, where the president's palace and main international airport are located. Amongst the *Baganda* there are 54 established clans and a further four contesting claims. Each clan is represented by a symbol or totem, which symbolises a branch of ancestral history, provides a shared sense of kinship and lineage (Roscoe, 1911). The totem serves a purpose for the identification of marital partners as all the *Baganda* clans but one (the Lungfish clan) are exogamous (*ibid.*, p.134). The *Baganda* have been described as following a 'loose patrilineal structure' as children are perceived to belong to the father's clan and households tend to be nuclear and segregated by considerable distances; this traditional pattern was prompted by the accessibility of fertile land and norms of residential mobility (Seeley, 2014, p.12). The social beliefs of patrilineal descent and polygyny shape perceptions of male superiority and ownership over wives and children. These beliefs also characterise the structure and organisation of marital relations and family life, and the power dynamics of gender relations, which are of central interest to this thesis.

Chapter 2 – Theoretical framework

The purpose of this chapter is set to set out the key theoretical concepts which have guided this study. To investigate the negotiation and management of sexual and reproductive health (SRH) behaviour in marital relationships in south-western Uganda, I argue for the need to focus on the social context and circumstances of sexual and reproductive health practices. Therefore, I start this chapter with a brief explanation of the recent movement in health research to shift attention away from individual-orientated health behaviour towards contextual framing of health practices (Kippax *et al.*, 2013; Cohn, 2014; Veenstra and Burnett, 2014; Blue *et al.*, 2016). From this debate, I build the case for starting this theoretical framework using a broad social determinants of health approach (Solar and Irwin 2010) and discussion on the interplay between structure and agency. I then introduce three concepts (gender, marriage and the risk environment) to explain how these constructs have deepened exploration of the structure and organisation of gender relations, changes in sexual and reproductive health practices over time and the contextual factors that shape individual capabilities to negotiate marital relations and navigate SRH risks over the life-course.

Over the past three decades, research on health behaviour has grown in popularity and joined mainstream debates on public health; however, programmes aimed at changing health behaviours have had limited success (Campbell, 1997; Cohn, 2014; Blue *et al.*, 2016). Health research findings persistently point to structural factors as the cause of health inequalities, but often fail to show how these structural influences translate into the daily lives of individuals and different groups in society (Blue *et al.*, 2016, p.36). Criticisms lie in the neo-liberal tendency to focus on individual risk behaviours and vulnerability, which assumes individuals to be responsible for and in control of changing behaviours, and risk to be attributable to specific structures or behaviours (Cohn, 2014; Frohlich and Abel, 2014). In the field of HIV, the individualistic framework has been specifically criticised for not recognising the communities in which people act and connect, and the context in which sex and sexual relationships take place (Barnett and Parkhurst, 2005b; Kippax *et al.*, 2013). Uganda has undergone major social and economic changes over the past three decades, yet fertility rates have remained consistently high. To broaden understanding of sexual and reproductive health practices over time, this research has tried to move beyond the individual-orientated analysis of behaviour to a more contextualised understanding of the social determinants which

contribute to gender inequality, high rates of fertility and risk of contracting HIV within marital relationships.

Exploring sexual and reproductive health practices in the context of individual lives and by comparing across generations has provided a base for identifying the social determinants contributing to high fertility and the spread of HIV. This lens is used to illuminate the factors specifically shaping the negotiation and management of SRH practices in marital relationships in south-western Uganda. The benefits of focusing on practices is that it provides a window into the 'patterned, routine and habitual ways in which people live their lives' (Blue *et al.*, 2016, p.38). Concentrating on what people do in terms of health practices rather than more broader categories of health behaviour can enable exploration of the contingent properties, sociality and dynamics of power that shape people's lives (Cohn, 2014). Social practices are recognised as complex and embedded within the context of individuals' daily lives and defined by relations of power (Veenstra and Burnett, 2014). This form of analysis is therefore suitable for critically exploring the influence and implications of socialised gender norms and inequality on expectations of SRH practices and capabilities to negotiate risk. The theoretical framework has therefore been devised to specifically investigate why fertility rates have changed relatively little in Uganda, despite the country undergoing major social and economic changes over the last three decades. Also, to explore how constructions of gender shape and/or impede SRH practices and individual capabilities to negotiate safer sex, particularly within marital type relationships.

In this chapter SRH practices are recognised to be located in space and time and are often 'not a direct result or outcome of mental processes but emerge out of the actions and interactions of individuals in a specific context' (Cohn, 2014, p.160). The most profound influences and constraints on social practices and actions are therefore understood to often be implicit. To expose these connections, health researchers are required to explore the interplay between 'context, circumstance and practice in order to decipher the informants' implicit assumptions, which may be hinted at or left unsaid' (Nettleton and Green, 2014, p.241). The design of this theoretical framework has therefore been driven by the intention to cut through these multiple layers and understand the context and circumstances of SRH practices in marital relationships in rural south-western Uganda.

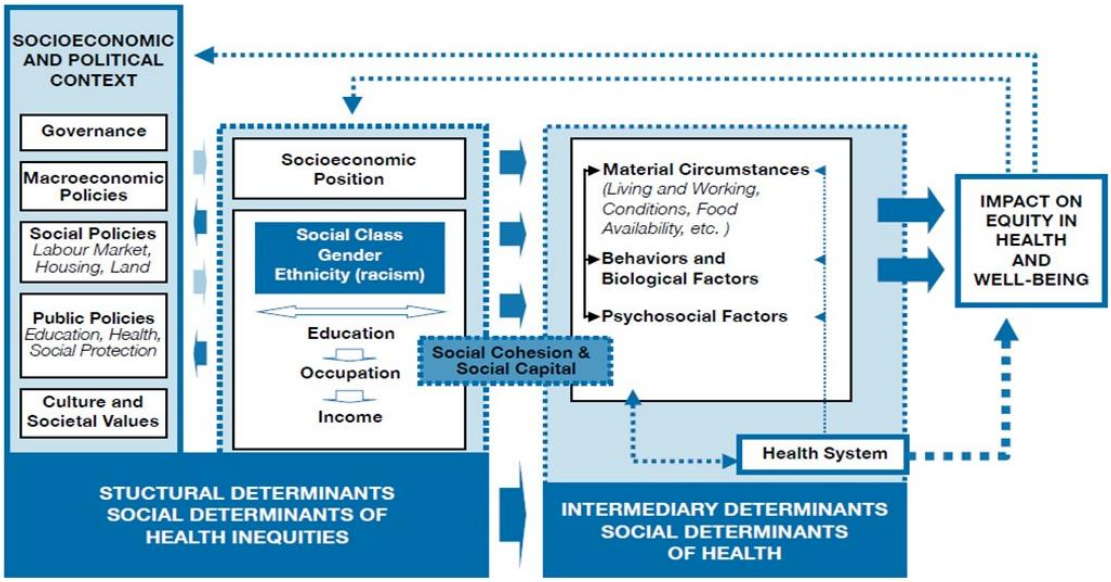
2.1 The social determinants of health

The starting point of this research was the Commission of Social Determinants of Health (CSDH) framework (Figure 2.1), which provides a broad overview of the multiple dimensions (structural and intermediary factors) that influence health behaviours and outcomes. There are many types of social-ecological models, which have sought to grasp and illustrate the structural forces that shape individual behaviours and health outcomes (e.g. Dahlgren and Whitehead, 1991; Barton and Grant, 2006; Glass and McAtee, 2006). The CSDH framework was specifically chosen for this study as it provides a platform to examine the factors which shape societal inequalities and gender power dynamics. It also provides a framework for examining population-based health practices, changes over the life-course and across generations.

In the CSDH framework the authors argue that health inequities occur as a result of the stratification of socio-economic positions, which affects access to resources, position within social hierarchies, social living conditions, health behaviours and outcomes (Solar and Irwin, 2010, p.5). The socio-economic context comprises social structures, defined as governance, macroeconomic policies, social policies, public policies, culture and societal values; these structures stratify populations by socio-economic status (Solar and Irwin, 2010, p.5). These broad structures determine an individual's socio-economic status and circumstances as indicated through intermediary factors. In the CSDH framework, the underlying social determinants of health inequities are deemed to operate through intermediary factors (*ibid.*, p.6), such as an individual's material circumstances, behaviours, and biological and psychosocial factors.

This framing of health inequities provided a useful starting point for examining gender inequality and the impact on capabilities to negotiate sex in the study setting. In this study gender equality has been examined in terms of division of labour and access to capital, which shape the material and social conditions in which individuals are negotiating sex and marital relations. To deepen understanding of how gender inequality affects the context and negotiation of sex and marital relationships, and also how SRH practices can change over time, I have explored the interplay between structure and agency. I have used this nexus to examine how the construction of gender relations interacts with socio-economic position within the household and community, which affects choices and capabilities to negotiate sexual relationships. Furthermore, I situate gender dynamics and social practices within individual lives and the context of socio-historical processes, I also compare behaviours across generations.

2.1: Diagram of The Commission of Social Determinants of Health (CSDH) Framework



Source of diagram (Solar and Irwin, 2010, p.6)

2.2 Structure-agency

There is widespread recognition today of the need to take into account the role of both social structures and individual agency in terms of shaping health behaviours and inequities (Glass and McAtee, 2006; Solar and Irwin, 2010; Frohlich and Abel, 2014). Social practices and agency are not only shaped by social structures, but also perpetuate social structures of inequality (Giddens, 1984). From research it is evident that the 'Social conditions that provide people with greater agency and control over their work and lives are associated with better health outcomes' (Solar and Irwin, 2010, p.12). This means that an individual's socio-economic status and position within the social hierarchy shapes the circumstances and context of health practices and outcomes (*ibid.*). Gender inequality in a society can therefore contribute to health inequities. This section explores the concepts of agency, capabilities and power as a means to understanding the social dimensions of gender inequality which shape the construction of sexual relationships and negotiation of SRH practices. Using Sen's theory of capabilities and life-course theory, I examine the structure-agency interaction and draw on HIV and family planning literature to show the relevance of using these theories to further understanding of gender inequality sexual and reproductive health practices.

Amartya Sen's (1985) capability theory provides a useful link between structure and agency, which has been used in the thesis to explore the constraints and opportunities surrounding the ways in which individuals navigate sexual and reproductive choices and risks. Sen regards individuals as active agents of change, operating at both individual and collective levels of society. An individual's capability to be and do what they value depends on the complex interplay between freedom and functionings. Sen conceptualises two types of freedom: opportunity, which is shaped by structural components; and the process through which individuals express agency and make choices. Functionings consist of states of 'beings or doings', such as being healthy, happy, active, working, resting. The structural setting can therefore constrain or facilitate an individual's choices and capabilities to achieve states of functioning.

Sen's theory is therefore useful for elucidating the unequal chances, opportunities or constraints that contribute to health inequalities in a setting and across populations (Frohlich and Abel, 2014). Existing HIV literature has highlighted the relationship between social setting, expected gendered sexual practices and capabilities to negotiate or manage risk. This analysis of sexual practices does not underplay the role of agency, but rather illuminates that the social setting can constrain or facilitate behaviours which can affect capabilities to manage SRH related risks. For example, Campbell's (1997) research on mining in South Africa showed that living in camp conditions facilitated the risky sexual practices. As a reaction to working in the life-threatening conditions of the mines and being in an all-male environment where masculinity is expressed through a culture of drinking and engaging in high risk sex for intimacy and sexual pleasure, the men engaged in sexual practices which increased susceptibility to HIV. In this study capability to negotiate sex has been predominately explored in relation to expectations of gender roles and practices within the social space of the home.

Whilst this theory of capability has been useful to analyse and interpret individual SRH practices and negotiation of sexual relationships, life-course theory has provided a wider lens to examine patterns and changes in behaviour over the life-course and across generations. In the CSDH, the life-course is outlined as a key pathway and process for health behaviours and outcomes. The life-course perspective 'recognizes the importance of time and timing in understanding causal links between exposures and outcomes within an individual life course, across generations, and in population-level diseases trends' (Solar and Irwin, 2010, p.18). For this study, I have found Glen H. Elder Jr.'s (1998a, 1998b) theorising of the life-course particularly useful for situating practices within individual lives and the broader context of the social and historical landscape. Elder outlines five key areas in which life-course theory has

contributed to understanding of behaviour, development and health outcomes. This includes the lifespan involving a collection of processes surrounding human development and ageing. The construct of agency with individuals living lives as a result of choices and actions, through which opportunities and constraints are shaped by history and social circumstances. The recognition that the life course is embedded and shaped by historical time and place. That development consequences, transitions, events and behaviours vary depending on the timing in an individual's life. Lastly that individual lives are interdependently linked and that socio-historical influences are expressed through networks of shared relationships. These key ingredients of life-course theory have been used in this thesis to deepen understanding of how sexual and reproductive practices are situated within the context of individual lives and dynamics of gender relations, which are shaped by social and historical processes.

The life-course is a key concept in reproductive health literature used to highlight the context of fertility attitudes and behaviours, family planning practices, the negotiation of sexual relations and how they change over time (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2007; van der Sijpt, 2014). Using key examples from the literature I show that individual practices and behaviours can be guided by institutional beliefs connected to gender, perceptions of fertility capabilities and intensions to manage risk and uncertainty by using sexual relations as a form of contingency.

Based on findings from Cameroon, Johnson-Hanks (2006) notes the need for a broader view of reproduction. Using a life-course approach, the author illustrates the importance of not only looking at live births but also the reproductive processes that surround them, including 'mishaps' (meaning lost pregnancies and children) and methods surrounding baby-making (*ibid.*, p.3). One of the key findings from Johnson-Hank's work is that Cameroonian women were found to not apply rational intention and actions to plan or try for pre-conceived future objectives surrounding having children, because life is perceived as unpredictable and uncertain. Instead, women viewed social and sexual relationships as a form of contingency or social capital to manage uncertainties and inevitable future risks (Johnson-Hanks, 2006). Fertility decisions and practices were therefore found to be guided in-situ by ideologies of motherhood (*ibid*). As Johnson-Hanks remarks, 'social institutions frame certain aspirations plausible, possible or unthinkable' (Johnson-Hanks, 2002, p.878). For women in Cameroon, the institutions of motherhood and marriage form dimensions of everyday life, as these gender frameworks are used to guide and interpret sexual identity, and negotiate gender relations, fertility-related capabilities and practices.

A second perspective on agency and negotiation of reproductive behaviours over the life-course relates to cultural framing of fertility capabilities and notions of ageing. In the Gambia, Bledsoe (2002) found women using hormonal contraception not because they did not want to get pregnant or have children, but rather to delay or space births. In this sense, women were interpreted as using contraception as a tool to preserve bodily resources and manage the biological stress of childbearing as they aged (Bledsoe, 2002). In this research, the reproductive life-course was therefore framed as a relative concept, tied to the cultural notion of the body as a resource that wears out with the passage of time (Bledsoe, Banja and Hill, 1998, p.47). Similarly to women in Cameroon, Gambian women were using ideologies of motherhood to interpret and manage capabilities, both to produce children and to care for those they already had.

These examples illustrate the usefulness of the life-course approach to explore the complex ways individuals navigate social structures and negotiate social practices. Reproductive desires, choices, perceptions of capabilities and practices are often contested, multiple and changing over the life-course in the context of inherently uncertain processes (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2002, 2005; van der Sijpt, 2014). Van der Sijpt (2014) suggests the usefulness of applying a 'framework of reproductive navigation that explicitly acknowledges the influence of sociality and corporeality on fertility aspirations and actions' (2014, p.278). This approach emphasises the embodiment of social practices and constant interplay between 'a person's actions and complex social forces' (van der Sijpt, 2014, p. 279). This interaction between structure and agency is further explored through the institution of gender, which is perceived to permeate and intersect every dimension of social life.

2.3 The institution of gender

The institutions of gender and marriage are inextricably linked. I firstly argue for the importance of recognising the role gender plays as a social determinant of health; I then use Martin's (2004) framework to define the characteristics of gender as an institution and explain how this has provided a lens for exploring gender power dynamics and the construction of marital and sexual relations in this setting.

In the CSDH framework, gender is recognised as a key social component which affects health behaviours and outcomes; 'Gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health' (Solar and Irwin, 2010, p.64). The authors go on to explain that gender differentials affect

vulnerability to health risks due to 'the interplay of biological sex with the social construction of gender, and the direct impacts of structural gender inequalities' (*ibid.*, 2010, p.69). To explore how gender mediates and effects the negotiation and management of sexual and reproductive health practices in the study setting, gender has been considered as an institution. Martin (2004) lists twelve criteria that define an institution and gender is used as the base example. Martin defines an institution as involving and characterising social groups, being based on a legitimate ideology, constructed over time and space, and associated with distinct social practices that constrain and facilitate the social behaviours of members (*ibid.*, p.1256). Within an institution there are social positions and relations that inform expectations, norms and procedures (*ibid.*, p.1257). Institutions are also constituted and reconstituted by embodied agents, internalised as identities and expressed through personalities (*ibid.*, p.1257). The involvement of social actors means that institutions are part of an ever-changing social process, which is inconsistent, contradictory and riven with conflict (*ibid.*, p.1257).

The role gender plays in facilitating and constraining sexual behaviours has been identified as a root cause of HIV transmission and susceptibility (Seeley *et al.*, 1994; Gupta, 2000; Dunkle *et al.*, 2004; Seeley, Grellier and Barnett, 2004; Wolff *et al.*, 2006; Auerbach, Parkhurst and Cáceres, 2011). The cultural constructions of gender prescribe male and female roles in society and Gupta (2000) argues that the sexual division of labour and social organisation of gender relations means that women generally have a low social and economic status, giving men power over women's sexuality. These social structures limit female capabilities to negotiate sexual interactions, including their ability to practice condom use, discuss fidelity with partners, or leave risky relationships (*ibid.*, p.183).

Women's roles and responsibilities within the domestic space have also been pivotal to debates on rights and entitlements in the home and bargaining capabilities to negotiate or exit marital relations (Whitehead; 1984, Roberts; 1991, Kabeer; 1994, Jackson; 2012) The socio-economic structure and organisation of gender relations has also been defined as central to understanding the patron-client dynamics of sexual relationships found across sub-Saharan Africa (Swidler and Watkins, 2007) and practices relating to transactional sex, which have arguably driven transmission of HIV (Stoebenau *et al.*, 2016; Wamoyi *et al.*, 2018). 'Transactional sex relationships are non-commercial, non-marital sexual relationships motivated by the implicit assumption that sex is exchanged for material goods or other benefits' (Wamoyi *et al.*, 2018). Whilst there is a broad spectrum of drivers for transactional sex, gender equality and the socio-economic processes that shape the power dynamics of gender relations underpin and drive transactional sex relations (Stoebenau *et al.*, 2016). Culturally prescribed

gender roles, relations and practices are also embedded in the institution of marriage, which is explored further in the next section.

2.4 Marriage

Marriage, similarly, to gender is viewed in this thesis as an institution, a dimension of social life that directly and indirectly shapes the practices and daily lives of married individuals. Foucault's (1978) definition of marriage highlights the institutional characteristics of this social phenomenon. Foucault viewed marriage as a system to govern and control sexuality and sexual relations, based on the ideology of developing kinship ties through the transference of names, wealth and possessions (*ibid.*, p.106). Foucault explained that the laws and beliefs surrounding matrimony made it the most intense focus of constraints, more than any other relation in society (*ibid.*, p.37). This section explores marriage as a framework of sexuality which guides gendered marital roles, the power dynamics of relations and expectations around sexual and reproductive practices.

Sexualities are not fixed, but are fluid, multifarious and enacted as 'configurations of practice that are accomplished in social action and, therefore, can differ according to the gender relations in a particular social setting' (Connell and Messerschmidt, 2005, p.836). Models or configurations of sexuality can be learnt and expressed through processes of cultural norms and selective practices and behaviours (Butler 2011). 'Different social contexts involve different rules and taboos associated with sex' (Helle-Valle, 2004, p.201), which means individuals may adopt or enact behaviours associated with multiple sexual identities depending on the social acceptability of practices in various contexts. Sexual identities are therefore viewed as socially constructed over the individual life-course and in relation to the social setting. It is beyond the scope of this study to grasp the full complexity of how individuals construct, contest and re-negotiate multiple sexual identities over the life-course (Giddens, 1992; Connell and Messerschmidt, 2005; Butler, 2011); however, the identity of being married has been used to explore expected sexual practices, reproductive duties and obligations associated with this sexual identity. Being married is also recognised as a concept that is not fixed, and the lived experience of being in a marital relationship can vary substantially.

Marriage is a gender stereotype, which Strathern argues is part of the social commentary or discourse of sexualities (2016, p.18). Stereotypes are 'not meant to be taken as realistic portrayals; they are explicitly reductionist in order to facilitate comparison' (Weber (1978) cited in Stoebenau *et al.*, 2016, p.187). Sexual stereotypes can therefore be used as a 'kind of filter through which the actions of men and women are seen' (Strathern, 2016, p.33).

They indicate cultural perceptions of biological differences and the assignment of personal and social qualities, characteristics and capacities (*ibid*). The stereotype of marriage acts as a framework of dominate beliefs characterising marital roles, expected behaviours and power dynamics. Gender frameworks indicate 'the boundaries of permissible behaviour and define the limits of deviance' (Stockdale cited in Campbell, 1997, p.274). Campbell describes these frameworks as 'recipes for living' as they define sets of behavioural possibilities and constraints, through which all behaviour and experiences are mediated (1997, p.274). These normative frameworks are used by individuals to interpret, construct and mediate identity and gender relations (Giddens, 1984; Connell, 1987; Goetz, 1995). An understanding of the cultural-specific interpretations of marriage can therefore illuminate the parameters, constraints and pressures of expected sexual and reproductive practices in a particular setting.

This framework of marital identity can aid investigating perceptions of sexual and reproductive duties, obligations and practices, and how they connect to broader ideologies of personhood and citizenship. Heterosexual marriage is often characterised by an expectation of 'commitment between spouses, often involving (or serving to facilitate) childbearing and rearing' (Stoebenau *et al.*, 2016, p.193). The sexual identity of marriage is therefore entangled with other cultural institutions such as personhood, motherhood, fatherhood and citizenship. Hubbard (2001) explains that the heteronormative model of marriage provides a basis for sexual citizenship, as the role of childbearing and the ideologies of motherhood and fatherhood are deemed the most appropriated modes for sexual relations, with procreation as the 'ultimate (and emotionally fulfilling) product of the sexual relation' (Hubbard, 2001, p.57). Marriage is therefore interpreted and experienced as a relational identity, which intersects with other roles, relations and identities over the life-course, such as age, sex, religion, ethnic group and place of residence. The concept of intersectionality offers a theoretical matrix with which to analyse the relationship between multiple social categories and from a feminist perspective can also aid interrogation of issues of power and social inequality in relation to social spaces (Valentine, 2007). The benefit of using intersectionality is that it 'provides rich, complex information on 'how people "do" or perform close relationships and roles within multiple systems, identity development, family processes, and generativity, and how they interact with symbolic representations and social structures (e.g., culture, institutions, laws) across the life course, generations and time' (Few-Demo, 2014, p.180). This theoretical approach therefore fits well with exploring the interplay between individual context, circumstance and practice.

Applying this framework of marriage to the Ugandan context can help illuminate the cultural expectations of gender roles and practices. As mentioned in the introduction, in the study area, the population are predominately *Baganda*, who are divided into clans in which and membership is acquired through patrilineal descent (Roscoe, 1911; Seeley, 2014). The traditions of the *Baganda* mean that clans are exogamous (excluding the Lungfish clan): men can legally marry more than one wife and live in nuclear-type family structures (Roscoe, 1911; Richards, 1966; Seeley, 2014). The persistence of polygyny indicates that this value system of marriage has been highly resistant to structural change and imported ideologies of monogamy (Seeley, 2012). Although religious and civil marriages have grown in popularity, customary marriage through the paying of bride-price, which enables men to legally marry more than one wife, remains the most popular form of marriage in the south-west (UDHS, 2013; Agol *et al.*, 2014). However as discussed in the introduction, the nature of marital relationships is changing in Uganda. Parikh (2004) concludes that sexual citizenship in Uganda has shifted away from kinship or clan perspectives of identity to being more heavily influenced by civic, educational, occupational and religious social structures (2004, p.103).

Demonstrating fertility and having children are also known to be salient in *Buganda* society, deemed necessary to marriage and respect as an adult (Roscoe, 1911; Richards, 1966; Seeley, 2014). Constructions of masculinity and the precedent of male superiority and authority are deeply rooted in the patriarchal and patrilineal belief systems of the *Baganda* (Roscoe, 1911; Wyrod, 2008). This creates an unequal power dynamic and limits females to demonstrate fertility capabilities in a marital relationship. This was observed by anthropologist Roscoe at the beginning of the twentieth century:

> Every married woman was anxious to become a mother and expected to show signs of maternity within a few weeks of her marriage. A woman who had no children was despised, and soon became the slave and drudge of the household. (Roscoe, 1911, p.46)

This importance of fertility and the consequence of fertility problems in marriage persists today, as Seeley remarks that ‘a woman who fails to have children or has repeated miscarriages may be sent away by her husband or find him taking a new wife in the hope of having children with her’ (2014, p.46). In the context of patriarchal beliefs and polygyny, there is unequal pressure on females to demonstrate fertility capabilities to sustain a marital-type relationship and avoid being socially subordinated or outcast. Fertility in this context is therefore integral to institutional frameworks of gender, marriage and clan citizenship.

From an intersectional perspective, the lived experienced of marriage is recognised to vary substantial depending on an individual's socio-economic position, daily conditions and relationship with their spouse. For this reason, in this thesis marriage has also been explored as a process, 'often occurring through markedly different sequences from couple to couple' (Bledsoe, 1995, p.137). In most parts of Africa, marriage often entails multiple rituals or life event transitions, which can occur in various orders (i.e. sex, living together, having a child, exchange of bride-price, etc.) (Johnson-Hanks, 2007). The dynamics and circumstances of marital relationships are therefore acknowledged to change over time, involving other kinship relations and intersecting or overlapping with other sexual relations (Seeley, 2012). A person's capability to negotiate a marital relationship is also shaped by gender power dynamics.

Power to negotiate or exit a marital relationship is unbalanced for men and women in this setting, due to the structure of gender relations and perceived rights and entitlements. Being married does not equate to guaranteed institutional rights or entitlement. As Whitehead contends, 'there is no concept of identical rights for all persons regardless of the social category of which they belong' (Whitehead, 1984, p.186). Patriarchal belief systems and intra-household relations are recognised to affect the perception of rights, negotiating power and the capability to exit a marital relationship (Jackson, 2012). In the context of Uganda, perceptions of rights in marriage are shaped by patrilineal beliefs and mediated through social relations. For example, 'If a husband dies or the marriage ends, a woman can only remain in her husband's home and on his land if his relatives agree, usually in the role of custodian of her children' (Seeley, 2014, p.46). The structural determinants of the institution of marriage therefore influence access to capital, choices and capabilities to negotiate or exit a marital relationship.

2.5 Risk environment

The concept of a risk environment is used in this thesis to draw attention to the social determinants and conditions that enable or encourage social practices that facilitate HIV transmission and increase susceptibility (Barnett and Blaikie, 1992; Barnett and Whiteside, 2002; Rhodes and Simic, 2005; Shannon *et al.*, 2008; Kuhanen, 2010). The concept is useful because 'it shifts the focus of intervention from individuals to the social situations, processes, and structures in which individuals participate' (Rhodes and Simic, 2005, p.222). This concept is therefore useful to think through social determinants shaping practices that lead to inequities. This section briefly outlines how the concept of risk has evolved with the global HIV epidemic, which laid the groundwork for the notion of a risk environment. The usefulness and application

of the concept is illustrated with key examples from Uganda, Eastern Europe and Canada. This provides a base from which to explore what factors might constitute a HIV risk environment for married individuals in rural south-western Uganda.

The conceptualisation of HIV risk has evolved alongside the trajectory of the global HIV epidemic. Firstly, risk was associated with certain groups deemed most likely to be infected; as more was learnt about the virus and the methods of transmission, risk shifted towards certain practices, such as anal sex or injecting drugs (Delor and Hubert, 2000). The theorising of risk then shifted towards the characteristics of relationships and interactions, and identifying situations of vulnerability (*ibid.*). HIV prevention has therefore tended to focus on risk and vulnerability, which conceptualises individuals as the problem and changing their behaviour as the solution. However, behaviour change has been largely found to be ineffective as it overlooks the structural influences and circumstances of social practices (Campbell, 1997; Auerbach, Parkhurst and Cáceres, 2011; Kippax *et al.*, 2013; Parkhurst, 2014). Glass and McAtee point out that patterns of risk more broadly depend on 'personal, community, and historical processes' (Glass and McAtee, 2006, p.1659).

Understanding what guides individual sexual and reproductive health practices and the navigation and management of risk is of central interest to this thesis. Risk-taking in health research has frequently been connotated as negative. However, Hayes suggests a 'wager' interpretation of risk-taking, which can result in both loses and gains, might be a more appropriate way of conceptualising risk-taking practices or behaviour (1992, p.404). As illustrated in the sexual and fertility examples in this chapter, individuals are often weighing up the risks and benefits of multiple outcomes attached to sexual and reproductive behaviours, such as notions of masculinity or motherhood, managing the body as a resource or maintaining sexual relationships as a form of contingency or capital. The concept of a risk environment has therefore been used in this thesis to illuminate the social structures and conditions that shape the social life, mediate social practices and capabilities to negotiate marital relations and risk.

Barnett and Blaikie (1992) first used the phrase 'ecology of risk' to argue that the HIV epidemic in Uganda was being driven by historical processes and broader social, political and economic factors, and that therefore bio-medical interventions alone would not address the transmission of HIV. Barnett and Whiteside (2002) later built on this theory with the concept of a risk environment, which was used to challenge the notion of 'risky behaviours'. The authors argued that behaviours are not intrinsically risky, but rather it is the social context and setting that determines the level of risk and susceptibility. The concept of the risk environment was further developed by Rhodes and colleagues (Rhodes, 2002; Rhodes and Simic, 2005;

Rhodes *et al.*, 2005). Rhodes *et al.* (2005) defined a risk environment as the 'factors exogenous to the individual that interact to increase vulnerability to HIV infection' (p.1026). Rhodes and Simic (2005) used a framework approach to illustrate the micro and macro dimensions of a risk environment, which cut across social, economic, political and physical structures of society, to illustrate the factors facilitating the rapid spread of HIV through injecting drug use in Eastern Europe. By illustrating the multiple structural dimensions surrounding the practice of drug use and hindering individual risk-reduction, the authors argued for a multi-disciplinary approach and large-scale intervention strategy. Rhodes (2002) highlights and defines the processes of vulnerability and susceptibility. In the context of HIV prevention, Rhodes explains that 'susceptibility is the chance of becoming infected, vulnerability is the degree to which the epidemic has an adverse effect on the capacity to respond' (*ibid.*, p.90). In this thesis the concept of susceptibility is consistently used following Rhodes, to reflect the chance of married individuals becoming infected with HIV.

Influenced by the work of Simic and colleagues, Shannon *et al.* (2008) adopted the risk environment framework to investigate drug use and survival sex work amongst women in Vancouver. The authors identified key factors that mediate women's agency and access to resources, and therefore capability to practice HIV prevention and harm reduction (*ibid.*, p.911). These factors (micro, meso and macro) illustrated everyday violence and unequal structural power relations to be pervasive in the lives of women who engage in survival sex work and hinder negotiation of risk reduction, resulting in heightened risk of HIV (*ibid*).

In the CSDH framework, Solar and Irwin acknowledge that those who are subordinated or disadvantaged in society tend to experience far more insecurity, uncertainty and stress during their life course, which contributes to social inequalities of health across populations. This is evident in the case studies of the injecting drug users in Eastern Europe and female sex workers in Canada. Solar and Irwin refer to the 'accumulation of risk' model to suggest that factors that raise disease risk or promote good health can accumulate gradually over the life course (2010, p.38). Across the life-course, the effects of risk can therefore cause a knock-on effect. For instance, in the Shannon *et al.* (2008) paper, the cumulative effect of risk was evident in the fact most of the female sex workers were from the disadvantaged First Nation social group and drug addiction was entangled with sex work and experience of violence or abuse.

In this thesis, the concept of a risk environment has therefore been applied to examine the social determinants and conditions that facilitate or enable the transmission of HIV and make married individuals susceptible to contracting the virus. Based on the existing literature, the institution of gender cuts across every layer of society, influencing the unequal structure

and organisation of gender relations. In this thesis, gender will be explored in terms of the division of labour, expected marital roles and power dynamics, to examine how these factors hinder capabilities to negotiate safer sex or facilitate engagement in sexual or reproductive practices in or outside of marriage, which increase susceptibility to HIV.

2.6 Summary

This chapter has illustrated the theoretical lens that has guided this study, with a focus on sexual and reproductive health practices rather than on individuals, seeking to understand the context in which practices are carried out. The theoretical framework is based on a broad social determinants of health framework, to firstly acknowledge the structural and intermediary factors surrounding health behaviours and then use this as a base from which to drill down into concepts that influence sexual and reproductive health practices. The framework provides a platform from which to explore the unequal structure and organisation of gender relations (i.e. division of labour and access to capital). I have used life-course theory and Sen's capability approach to dive down into the framework and interrogate the relationship between structure and agency, examining how socio-economic position and access to resources can constrain or facilitate choices and capabilities to negotiate gender and marital relations.

Using the life-course perspective and examples from reproductive health literature, the embodiment and sociality of fertility-related practices have been highlighted. The African case examples show that women's navigation of risk takes place within the context of the life-course, which is characterised by conflicting priorities, demands and uncertainties of everyday life. Fertility practices were also shown to be guided by interpretation of risk, capabilities, social capital and cultural capital (i.e. institutional frameworks relating to gender, such as motherhood or marriage).

The institution of gender has therefore been outlined as key in conditioning aspirations and shaping the unequal socio-economic power dynamics, social hierarchies, access to capital and capabilities to negotiate gendered and sexual relations. The institution of gender cuts across all dimensions and scales of society and is inextricably linked to the institution of marriage, which has been examined in this chapter as a system through which to govern or regulate sexuality and the structure of gender relations. Marriage has also been explored as a gender stereotype and framework of sexuality, guiding perceptions of gender roles, relations and practices. To acknowledge the relative experience of being married, marriage has also been viewed as a social process and relational identity that intersects with other social characteristics and shapes the perception of rights, entitlement and power to negotiate or exit a marital

relationship. The theory of intersectionality has been argued to assist in analysing the relationship between multiple social categories and aid examination of issues of power and social inequality in relation to social space.

Lastly, the concept of a risk environment has been used to draw attention to the structural processes and social, economic and political factors that facilitate the spread of HIV. This concept is useful to think through the social determinants that shape practices and lead to health inequities. The theory of the risk environment has provided a working definition of susceptibility as the chance of becoming infected, which is used in the thesis. Risk-taking has also been framed as something that can be negative, but that can also offer potential gains or benefits, each of which can have a cumulative effect on a person's health. The notion of a risk environment has provided a base from which to explore structural gender inequality and power imbalances between men and women, which facilitate practices or hinder negotiation, heightening susceptibility to HIV in marital-type relationship in rural south-western Uganda.

Chapter 3 – Methodology

This chapter includes an overview of the research design and a detailed account of the methodology. This includes an explanation of the epistemological and ontological grounding of the study, which draws upon critical realism, social constructionism and interpretivism. To conduct this study, I worked closely with local researchers based in the social science team at the MRC study site in *Kyamulibwa*. Working with a local research team enabled a process of co-production of knowledge, which (as I explain) was vital to data collection and interpretation. I also reflect on the strengths and limitations of being hosted by an institution and how this has shaped the study design and research findings. Details are then provided on the study site and HIV prevalence in the study area, which I used to explore the prevalence by social group and by village, selecting six villages for this study. Justification and application of research methods include life-story interviews, open interviews with key informants, focus groups and photography of respondents' homes. Random and purposive sampling techniques were used to identify and recruit respondents for this study. An iterative thematic approach was used in designing and adapting research tools, and to interpret and analysis the data. The final sections of this chapter highlight the strengths and limitations of the study design, ethical considerations and some reflections on researcher reflexivity.

3.1 Overview of research design

This mixed method study was conducted within a pre-existing longitudinal cohort, run by the MRC/UVRI Uganda Research Unit on AIDS in *Kyamulibwa* in rural south-western Ugandan. HIV surveillance data and information from MRC household surveys were used to select six villages of varying HIV prevalence and identify respondents who had ever been married for the life-story interviews and focus groups. Two local assistant social scientists (one male and one female) along with two other members of the MRC social science team based in the *Kyamulibwa* aided the implementation of this study. Data collection commenced in May 2015 shortly after a study brief was presented to local councillors and several pre-test and pilot interviews and focus groups were conducted. Over the course of nine months, two stages of life-story interviews were undertaken with 36 individuals in three age categories (20-40, 41-60 and over 61). Four focus groups (two male and two female) were also conducted with younger and older married men and women, and eight key informants were interviewed: four representatives from religious institutions, a traditional healer/birth attendant, a government midwife, a mobile health worker and an HIV counsellor. Interviews and focus groups were

guided by prompt sheets based on the theoretical framework. They were conducted in the local language of *Luganda*, audio recorded and later translated and transcribed. To better understand the variations of different marital settings, twelve of the life-story respondents were selected to discuss and photograph the structure of their homes. The interviews, focus group discussions and photographs were iteratively analysed and interpreted with the support of the research assistants. Thematic frameworks and network mapping techniques were used to organise the data, identify themes, cultural norms and deviant cases of attitudes, behaviours and practices.

3.2 Epistemology underpinning a mixed social science methodology

In the process of designing this study I questioned the ontological roots of my research, the epistemologies underpinning my methodology and the implications for the type and meaning of the data collected. This process provoked contemplation on the aims and parameters of this research, as well as my positionality as a researcher. I regard myself as a multi-disciplinary social scientist as my research interests cross the boundaries of development studies, social work, social geography and public health. A combination of epistemological standpoints therefore seemed appropriate. At the outset, critical realism seemed relevant to the broader scope and intention of this study, while during the research, the paradigms of social constructionism and interpretivism dominated the process of analysing and understanding the research findings. I also want to emphasise that the knowledge and understanding gained from conducting this study was made possible through working closely with a local research team, who helped me access, record and translate respondents' responses and life-stories. Working with a local research team therefore mediated the co-production of knowledge and aided my own cross-cultural critical analysis and interpretation of the research findings.

Critical realism

The main aim of this research has been to understand the complex factors that shape sexual and reproductive health behaviours in marital relationships in Uganda, with the intention that findings could aid HIV and family planning practice, policy and intervention. It is for this reason that this research was based upon a social determinants framework so as to examine the individual and structural factors that enable and constrain patterns of behaviour. This research intention and approach fits well within the epistemological paradigm of critical realism.

Critical realism is based on understanding the social context to critically explain shared or common patterns of behaviours and drivers of those behaviours. This epistemological approach is often used for the purpose of 'introducing changes that can transform the status

quo' (Bryman, 2012, p.29). This standpoint is useful for exploring the relationship between place and social behaviour and was therefore deemed particularly suitable for examining the concept of a risk environment. Social scientists working in the field of HIV have long argued for a shift in addressing structural and contextual factors facilitating the transmission of the virus, rather than focusing on the individual and biomedical interventions (e.g. Barnett and Blaikie, 1992; Barnett and Whiteside, 2002; Auerbach, Parkhurst and Cáceres, 2011).

In this thesis, critical realism has been used to examine the concept of a risk environment and highlight the social, economic and cultural factors that contribute to the unequal structure of gender relations and heightened susceptibility to HIV in marital-type relationships. This epistemological standpoint has therefore been used to stress the shared cultural dimensions of reality, which lead to widespread beliefs, attitudes, patterns of behaviour and the hierarchy and power dynamics of gender relations. However, the lived experiences of a culture are also recognised as relative, subjective and navigated via expressions of agency, which have been explored through the paradigms of interpretivism and social constructionism.

Interpretivism and social constructionism

This study sought to examine cultural norms of marital beliefs, roles and behaviours in a specific geographical area, but also collect life-stories and grasp how individuals navigate, negotiate and manage HIV risk and family planning over time. The life-story method provided a window onto how individuals subjectively perceive, interpret and construct identities and enact sexual and reproductive attitudes, behaviours and practices over the life-course. This standpoint embraces the interpretivist and social constructionist paradigms of epistemology. The life-story interview is a humanistic method within the paradigm of interpretivism, which fundamentally seeks to understand individual perspectives of reality and interpret the relative meaning of constructs that influence human behaviour and social action (Bryman, 2012, p.30). Interpretivism recognises the role of individual agency in the interpretation and selection of constructs that shape behaviour and interaction with social structures, as emphasised in Gidden's (1984) structuration theory.

A mixture of qualitative methods has therefore been used in this study to build a cultural realism representation of the setting, add richness to individual interpretations and understand the role of agency plays in individuals navigating these structures. The key informant interviews and focus groups were used to build a picture of the social, economic and political landscape in which marital relationships are being negotiated, while the life-story interviews

were used to gain deeper insights into individual agency and the strategies, approaches and practices used to negotiate gender relations. This study attempted to grasp the socially constructed notions of gender and sexuality and individual interpretations of these ideological frameworks on perceptions of identity and enactment of sexual and reproductive practices and behaviours. Lastly, the concept of risk has been explored from the cultural realism perspective of a risk environment and the standpoint of risk being social constructed, individually interpreted and negotiated. The risks relating to fertility and HIV are shown to be weighed and managed in relation to other priorities, fears and concerns. Capabilities to respond and negotiate these risks are argued to be enabled and constrained by the wider cultural and social setting. Building a representation of a social and cultural setting, whilst also grasping the nuances of individual interpretations, was made possible by working closely with a local research team.

Co-producing, assimilating knowledge and constraints of being hosted by an institution

This study benefited from the support of local MRC Social Science team in *Kyamulibwa,* which was facilitated by my supervisor Professor Janet Seeley, who is Head of the Social Science Programme. I worked with two social scientists, Grace (male) and Elizabeth (female); two research assistants, Allen and Lazaro (also one male and one female); and a former MRC employee called Anastasia taught me *Luganda* and translated for me during some of the key informant interviews.

Working with a local research team enabled access to communities, collection of detailed qualitative accounts and cultural interpretation of the data. Although not always mentioned, research assistants mediate between the respondents and the researcher and aid the co-production of knowledge in cross-cultural and cross-language environments (Caretta, 2014; Deane and Stevano, 2015). This was certainly the case in this study. Grace and Elizabeth played an integral role in the research process, as they tracked down respondents and used their professional and warm rapport in interviews and focus groups, which put respondents at ease. They acted as gatekeepers, enabling access and insights into intimate aspects of the respondents' lives. They also used their own life experiences and cultural knowledge to interpret and contextualise the respondents' attitudes, practices and life-stories. Allen and Lazaro attended the focus group discussions and afterwards translated and transcribed the audio recordings. Working with a local research team therefore enabled the implementation of this methodology and overcame barriers relating to language and my positionality as a foreign researcher (discussed more in section 3.9).

Being hosted by an institution also shaped the design, implementation and findings of this study. As listed above, being hosted by MRC offered significant benefits, it also came with the pressure and responsibility to respect and follow institutional procedures and processes. This shaped both my research journey and decisions made along the way. For instance, this study was required, as is the case with all MRC research projects, to acquire ethics approval from the Uganda Virus Research Institute Science Ethics Committee (UVRI-SEC). When my study proposal was submitted a statistician on the board suggested I needed a more formulaic approach for sampling. This meant I changed the sampling strategy, which is explained in section 3.5 to a more positivist approach. I also felt unable to adapt or change aspects of the study design after acquiring my research permit and passing through the ethics process as I would have had to apply for amendments. This meant that although I kept a detailed fieldwork diary, I had not included ethnography as a method, I therefore did not explore this method more and I have not directly quoted from ethnographic data I collected. Working with MRC also shaped this research in more nuanced ways. The MRC has been working in the study area for more than three decades. The organisation is a service provider and employees are perceived in the community as *musawo* (health workers) who are working with *muzungu* (foreigners). This historical framing of MRC will have inevitably influenced the local response to this study, in terms of individual perceptions of study aims, willingness to participate in the study and the framing of narratives. Being hosted by MRC therefore encompassed both significant benefits and constraints which have shaped this study.

3.3 Study site – HIV prevalence

In order to examine the concept of an HIV risk environment, investigation of HIV prevalence in the study area was used to initially explore the gendered nature of the localised epidemic and select villages. As mentioned in the introduction, this study took place in the General Population Cohort (GPC) located in *Kyamulibwa*, south-western Uganda and HIV surveillance data and information from household surveys was used to inform sampling. In the 2013 medical survey 5,857 people tested for HIV. Of this figure, 557 were HIV positive, indicating prevalence to be around 9.5% in the GPC population. This is slightly higher than the country-wide prevalence of 7.3% (Uganda AIDS Commision, 2015, p.vii). This section explains HIV prevalence in the GPC, broken down by sex and age, highlighting that women are disproportionally affected by HIV, but also that testing is lower among men. The testing

numbers and population size are relatively small, therefore the statistics that follow only provide an indicative snapshot of the epidemic at one point in time.

The GPC test results indicate that HIV prevalence is highest amongst women of childbearing age. Of those who tested HIV positive in the GPC, 35% (197) were male and 65% (360) were female. HIV prevalence is estimated to be around 8.7% amongst males compared to 10% amongst females. More stark differences are observed when these figures are broken down. Of the total number of people who tested HIV positive, 38% (213/557) are women between the ages of 26-45 years. Whilst the numbers and prevalence of HIV are higher amongst women, testing varies substantially across the different social groups and is lowest amongst young men. Over a third more women test for HIV than men in the GPC (3,586 compared to 2,271 respectively). Females are eligible to test from the age of 16 compared to 18 for males; and women are generally more likely to access health services then men. When testing is organised by age group, men aged 18-25 years are the group with the lowest uptake (55%); highest rates of testing in men are in those over the age of 66 (79%). Testing is generally higher amongst women (between 62-87%) and older women were the most likely to test.

There are multiple reasons for this gender disparity in testing (see Chapter 8). Factors influencing low male uptake of testing relate to the construction of masculinities in this setting, including male labour mobility, HIV stigma and fear of diagnosis, perceptions of health and risk-taking behaviour. It should also be noted that if an individual test for HIV as part of the GPC monitoring survey, they are eligible to access free medical treatment from the GPC clinic. It is for this reason that uptake of testing is particularly high amongst older people, as they can receive treatment and care for other health conditions. Although the testing figures are relatively small and only taken from one point in time, they indicate that HIV prevalence is highest amongst those in the mid to later stages of the reproductive life-course. Individuals were sampled at different stages of the life-course to investigate the factors that make married individuals susceptible to HIV and the challenges married individuals face when discussing HIV risk, testing and prevention (see Chapter 8). The next section explains how the HIV prevalence figures were used to inform the selection of study villages.

3.4 Village selection

Six villages were selected based on HIV prevalence within the GPC. As part of this sampling process, the villages were categorised based on HIV prevalence and plotted on a map. A mixture of purposive and random sampling techniques was used to select the six villages,

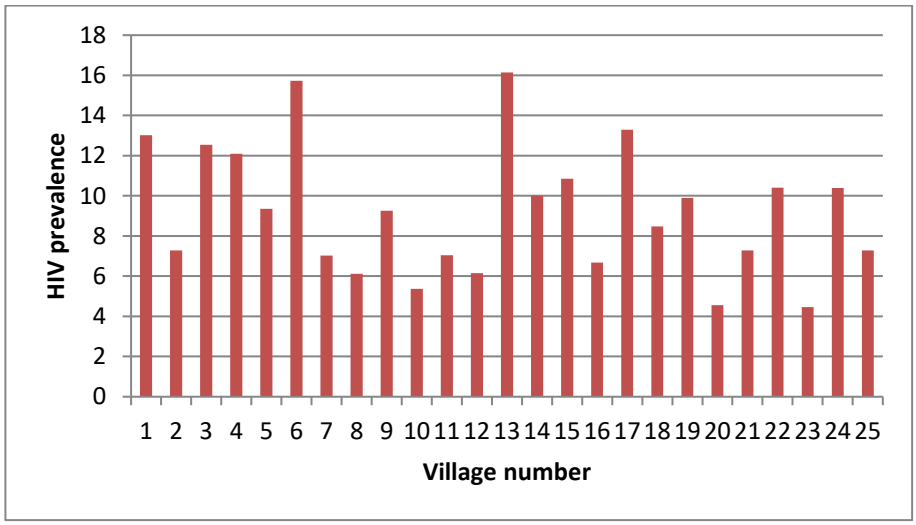
which allowed for the selection of two villages in each of the high, mid-range and low categories of HIV prevalence. This section provides details of this selection process.

There are 25 villages in the GPC area, which vary in terms of characteristics (i.e. dominant religion, HIV prevalence and level of urbanised development and services). Within each village there are also socio-economic differences between households. Whilst these household characteristics were not part of the village selection process, they were used to understand the residential circumstances and living conditions of the life-story respondents (see section 3.5.1).

Categorising villages by HIV prevalence

The 2013 GPC monitoring data provided a snapshot of HIV prevalence for each village, which was used to organise the villages into low, midrange and high categories. HIV prevalence was calculated based on the percentage of individuals from each village who received a positive HIV result at the mobile clinic. HIV prevalence was found to range between 4.5-16% across the 25 villages (Graph 3.1). It should be noted that population size in each village varies greatly and the overall HIV figures are relatively small. Village 2 has the smallest population, with 347 people, compared to village 17, near the main trading centre in the area, which has the highest population with approximately 1,690 people (Riha *et al.*, 2014, p.6).

Graph 3.1 HIV prevalence by village

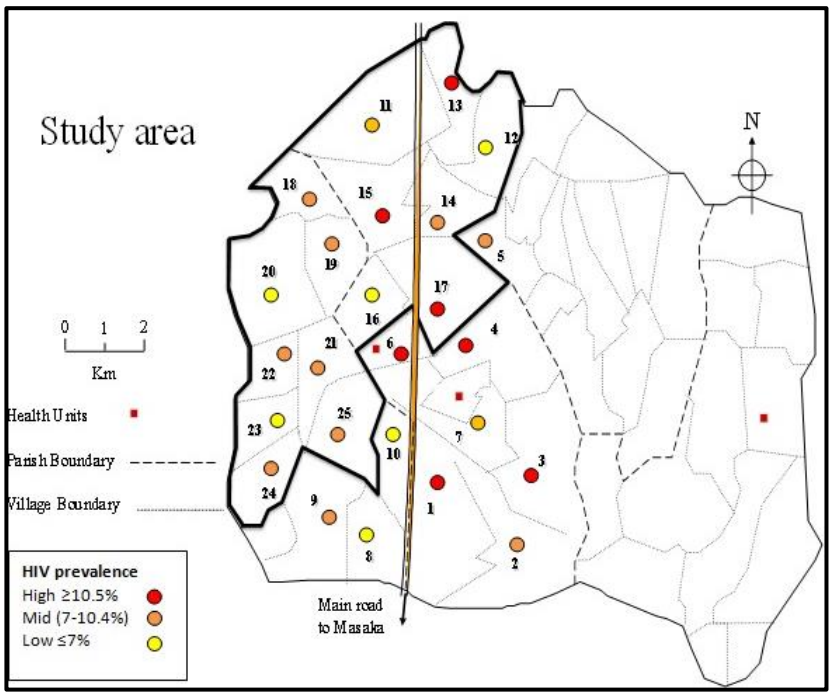


To explore spatial patterns of HIV, I organised the HIV prevalence figures into low, mid-range and high categories and plotted them onto a map of the GPC. To establish the categories I split the results into quartiles and used the first quartile to represent high HIV prevalence at ≥10.5%;

the fourth quartile was low prevalence at ≤7%; and the two middle quartiles were denoted mid-range. I colour-coded these three categories as red, orange and yellow to symbolise high, mid-range and low HIV prevalence respectively and plotted them onto a map (Map 3.2).

Map plotting showed that six of the seven villages in the high HIV prevalence category were situated along the only road, which intersects the area and is used for trade. The only village in the high category not on the roadside was village 3, which the research assistants informed me was known for having many informal bars. I used this information to select the six villages for this study

Map 3.2 HIV prevalence across the study site



Selection of villages

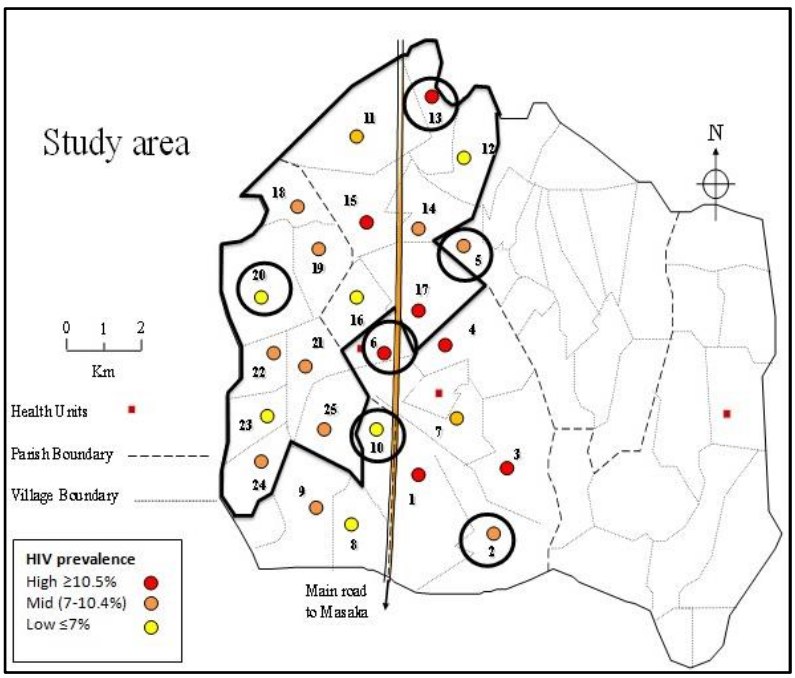
The selection of the villages involved both purposive and random sampling techniques. Villages 7 and 9 were excluded from the selection process as these contained the homes of the two local social scientists who were assisting on the study. As the villages are relatively small and the qualitative aspect of this study relied on the disclosure of personal information about sexual relationships, the research assistants both stated they would prefer not to carry out interviews in their home village.

The main trading centre, village 6, was purposively selected as one of the high HIV prevalence villages as it has characteristics distinct from the other villages in the GPC; it is the most urbanised area and is a central socio-economic hub, attracting residents from surrounding villages. Trading centres are places where people come to trade, access services (i.e. barbers,

clinics, mechanics) socialise and seek out entertainment (i.e. bars, discos, film screenings). Trading centres have been described as 'hot spots' for the transmission of HIV through rural areas in Uganda (Wawer *et al.*, 1991; Kuhanen, 2010). The remaining five villages were randomly selected using an online randomising calculator (www.randomizer.org). The villages from each category were put into numerical order and then the randomising calculator was used to generate a number from which to select a village. The selected villages were located across the GPC area; three were situated along the roadside and three at a distance from the main road.

The six selected villages are indicated in Map 3.3 symbolised by black circles. Four were predominately Catholic (villages 6, 13, 10, and 20), one predominately Muslim (village 2) and village 5 did not have a dominant religion, as 41% residents reported being Muslim and 41% Catholic. This study did not set out to specifically analyse the relationship between religion and the spread of HIV, but five of the six high HIV prevalence villages were predominately Catholic. Religious beliefs were found to influence and guide social perceptions of marriage, marital roles, reproduction and fertility, family planning practices and the negotiation of HIV risk (discussed in Chapters 4, 5, 6, 7 and 8).

Map 3.3 Selected villages and HIV prevalence



The selected villages varied by population size, access to health services, livelihoods, education, and house type. To identify key differences between the villages, a summary of village characteristics was compiled (Appendix D). The starkest differences between the

selected villages relevant to understanding the risk environment and life-stories of respondents relate to livelihood, education and house type. Village 6, the main trading centre for the GPC, was categorised as high HIV prevalence (16%). It is the most urbanised of the villages with the widest access to health services (i.e. pharmacies, governmental health clinic and private clinics). It has the lowest proportion of the population working in agriculture (7%) or living in mud and pole houses (1%); women also have on average the highest number of years of education (10 years) (Riha *et al.*, 2014). In contrast, Village 13 had the same HIV prevalence as village 6 but is one of the more rural and poor villages, with the highest percentage of the population working in agriculture (89%) and living in mud and pole houses (39%). The other villages were similar in terms of proportion working in agriculture ranging between 69-82% and women having an average of 6 or 7 years of education. I argue that these intermediary factors of socio-economic status, education, livelihood, house type and living circumstances affect the context and power dynamics of marital relations, and the negotiation of sex and family planning practices.

3.5 Sampling and data collection

This section outlines the qualitative methods used in this study and the sampling processes used to recruit respondents. Qualitative research 'consists of a set of interpretative, material practices that make the world visible' (Denzin and Lincoln, 2013, p.6). This study used life-story interviews, focus groups, key informant interviews and photography of the household spaces to build a picture of what it means to be married in this setting, the factors shaping gender power dynamics and capabilities to negotiate SRH behaviours.

Random and purposive sampling techniques were used to generate samples and recruit participants. Sampling for respondents was done in stages, firstly to recruit individuals for the pre-test and pilot stage and then for the focus groups, life-story interviews and key informant interviews. Using the residential lists from the GPC site, a stratified systematic random sampling method was used to ensure that the life-story respondent and focus group samples included married respondents at different stages of the life-course and living in each of the selected study villages. The original sample had to be extended and eligibility criteria adapted slightly due to unexpected difficulties in identifying and recruiting older married women. A purposive sampling strategy was also used to recruit key informants, to specifically identify leaders from the dominant religious institutions in the study area as well as two health workers, a traditional healer/birth attendant and an HIV counsellor. Using these two sampling techniques enabled a focused yet flexible approach to recruiting suitable respondents for this study.

3.5.1 Pre-test and pilot interviews and focus group

Two pre-test interviews were conducted to ensure the research assistants were confident explaining the study information sheet and consent form (Appendix C) and were collecting the necessary information for the participant sheet and prompt sheet (Appendix A). After the interviews, I met with the research assistants individually to discuss the flow of the interview discussion and the compatibility of the research tools. The pilot interviews were then used to check that the data being generated fitted the research aim and scope. The research assistants translated and transcribed the discussion; I would then organise and code the data and as a research team we would discuss and compare cultural interpretations of the findings. Based on these discussions I would make notes, edit and reorganise codes. This same process was used for trialling the focus group prompt sheet (Appendix B). Over time, this iterative analysis helped me identify topics for further exploration and build a broader picture of findings, while also serving to train the research assistants on the study aims, refine the research tools and clarify the research process.

3.5.2 Life-story respondent sampling and interviews

This study identified married individuals rather than couples for the interviews and focus group discussions. Although interviewing couples would have provided gendered perspectives on the same marital relationship, it was felt that individuals would be more likely to speak openly about their marital relationship if their spouse was not included in the study. This section firstly describes and justifies the research process used to undertake life-story interviews with the crucial support of two local social scientists. I then explain the sampling process and provide an overview of those who participated in the life-story interviews.

The life-story method was specifically chosen for this study as it provides a window into individual lives and a way to read and better understand broader social, cultural and economic history within a study site (Mason, 2002). As mentioned in the theoretical chapter, the individual life-course has been conceptualised in this study as being embedded and shaped by broader social and historical determinants. To understand seemingly personal problems can often reveal insights to the repercussions of broader social tensions (Elder, 1998a, p665). The life-story method was therefore identified as appropriate to investigate individual challenges and experiences negotiating SRH behaviours, whilst also offering insights which construct a representation of the social landscape that has contributed to high levels of fertility and the

spread of HIV in this population. In using this method, I recognise that the composure of a life-story involves a collection of social discourses and is based on a discursive construction rather than an empirical representation of reality (Mason, 2002, p35). I have used the term life-story, rather than life-history as I wanted individuals to share past experiences, present circumstances and future aspirations. I also wanted to indicate the interpretive and socially constructed nature of life-stories.

The life-story interviews were conducted by the two assistant social scientists (Grace and Elizabeth) in two stages. Grace interviewed the male respondents and Elizabeth interviewed the females. I decided the interviews would be conducted without me being present, so that the interviews could be conducted in the local language of *Luganda*. Without the need for translation, the conversation could flow more easily. The interviews were long, with the women's averaging 3-4 hours. If I had been present during the interview and needed translation, then the interview would have either taken twice as long or half as much data would have been collected. Grace and Elizabeth were also able to visit the respondents discreetly: when I moved around the villages, I received a lot of attention (see section 3.9). I did not want my presence to disturb or distract respondents from telling their stories. I therefore only visited twelve of the life-story respondents after they had completed the two stages of interview, to conduct the walk-through discussion and photograph the household. Lastly, I worked closely with Grace and Elizabeth to ensure that specific types of data were collected to answer the research questions, achieved through two stages of interviews and tailored data collection tools.

The first stage of the life-story interview involved asking the respondent for specific information to fill out a participant profile form, and an open discussion guided by an interview prompt sheet (Appendix A). The participant form was to ensure the same type of data was collected for each respondent. The form covered basic personal information (i.e. sex, age, village number, marriage type, level of education, livelihood, number of life-time sexual partners, number of children, current spouse characteristics, house type, size, material and living arrangements). The first interview prompt sheet was the same for male and female respondents. It asked the respondent to describe their life with four prompts: family structure and childhood; education; perceptions of marriage/sex education or advice; and livelihood and living situation. There were then three topics with prompts, which included topics included marital relationships (roles, practices and power dynamics), reproductive health and family planning (beliefs, preferences and practices), and HIV and negotiating risk (beliefs, practices and marital relations).

To recruit respondents for the pre-test, pilot and life-story interviews, a sample was generated from the GPC census data. Twelve individuals (six men and six women) were randomly selected from each of the six study villages, which provided a total sample size of 72 people (Table 3.4). Eligibility criteria included answering yes to the following question in the last GPC survey: 'Do you have a current main partner (i.e. spouse or most important regular)?' The respondents were randomly selected based on a stratification of age and sex. This was to ensure the study captured a representation of life-stories from both men and women at different stages of the life-course. The age categories were defined as 20-40, 41-60 and over 61.

Table 3.4 Respondent sample for pre-test, pilot and life-story interviews

Village	**Men**		**Women**		**Total**
	Number of respondents	Age group	Number of respondents	Age group	
Village 10 Low HIV ≤7%	2 2 2	20-40 41-60 Over 60	2 2 2	20-40 41-60 Over 60	4 4 4
Village 20 Low HIV ≤7%	2 2 2	20-40 41-60 Over 60	2 2 2	20-40 41-60 Over 60	4 4 4
Village 2 Mid HIV 7-10.4%	2 2 2	20-40 41-60 Over 60	2 2 2	20-40 41-60 Over 60	4 4 4
Village 5 Mid HIV 7-10.4%	2 2 2	20-40 41-60 Over 60	2 2 2	20-40 41-60 Over 60	4 4 4
Village 13 High HIV ≥10.5%	2 2 2	20-40 41-60 Over 60	2 2 2	20-40 41-60 Over 60	4 4 4
Village 6 High HIV ≥10.5%	2 2 2	20-40 41-60 Over 60	2 2 2	20-40 41-60 Over 60	4 4 4
Total respondents	36		36		72

For the pre-test and pilot interviews, four individuals (two men and two women) were randomly selected from this sample. The purpose of the pre-test and pilot interviews was to trial the prompt sheet and participant form (Appendix B), explained in section 3.5.2. The aim was to then use the same sample to recruit 36 respondents for the life-story interviews. The sample had included 72 individuals, assuming that some might be unable or unwilling to participate. This proved to be correct, as the research assistants found that: 26 people were not found or had moved out of their village; five people had died; one person was deemed mentally infirm; and four people refused to take part. Out of those that refused, one was a businessman who said he had no time and the other three were elderly women who had been single or widowed for a long time.

The sample was therefore increased, and eligibility criteria slightly adapted to address the key challenges of locating men who were often working away or had moved, and finding women over the age of 60 in a marital relationship, particularly in villages 2 and 6. The sample was therefore increased by 22 individuals and the eligibility criteria amended to include women who had ever been married but not necessarily still in a marital relationship. This provided the opportunity to find male respondents living and working in the area and meant that two older female respondents were recruited, one widow and one who had separated from her spouse and were therefore both single at the time of interviews. Thirty-six respondents were eventually recruited and participated in life-story interviews: eighteen men and eighteen women from six villages and across three age categories. When the research team tracked down the respondents, we found that some individuals were unsure of their exact age or it had been incorrectly recorded on the survey. As the age was only ever inaccurate by a couple of years, it did not warrant re-sampling, but this explains why Anatoli (aged 43) is listed in the 20-40 age group and Kenneth (aged 61) in the 40-60 age group.

Life-story respondents – social characteristics

This section provides a brief overview of the social characteristics of the life-story respondents. Social characteristics include ethnicity, religion, HIV status and living situation. In Chapter 4, a more detailed table is presented and discussed, including respondents' pseudonyms, the type of marital relationship they were in at the time of the study and their living situation.

Ethnicity and religion

Most of the life-story respondents were *Baganda* and either Christian or Muslim. These social and religious characteristics are explained in this thesis to shape perceptions of gender, sexuality and marriage (Chapters 5 and 6). Most of the life-story respondents (27 out of 36) characterised themselves as *Muganda*, the name given to those with *Baganda* lineage. The remaining respondents had either Burundi or Rwandese ancestry (Table 3.5).

Table 3.5 Life-story respondents by sex and ethnicity

Sex	**Ugandan (*Muganda*)**	**Born in Uganda with Burundi ancestry**	**Born in Uganda with Rwandese ancestry**	**Rwandese and born in Rwanda**	**Total**
Male	14	1	3	0	18
Female	13	2	0	3	18
Total	27	3	3	3	36

The majority of the life-story respondents were Catholic (23/36) (Table 3.6), followed by Muslim (8/36), Protestant (4/36) and one person defined themselves as Born Again (a domination of evangelicalism). Three female respondents admitted they had converted religion, two because of marriage and one due to sickness and wanting to be blessed by a priest.

Table 3.6 Life-story respondents by sex and religion

Sex	Catholic	Muslim	Protestant	Born Again	Total
Male	13	4	1	0	18
Female	10	4	3	1	18
Total	23	8	4	1	36

HIV status

At the time of the study, three of the life-story respondents stated that they knew they were HIV positive, while the rest reported as negative or unsure (Table 3.7). Of those who were HIV positive, two were female in the younger age category (Gladys, aged 28 and Dyana, aged 35), and one was a middle-aged male (Edward, aged 43). All three of these respondents defined themselves as Catholic. Two were in an informal marital relationship (Dyana and Edward) and Gladys was in a religious Catholic marriage with a mobile labourer. The life-stories of these respondents are discussed in relation to the HIV risk environment in Chapter 8.

Table 3.7 Life-story respondents by sex, age group and HIV status

	HIV positive	Negative	Unknown	Total
Male				
20-40	**1**	3	1	5
41-60	0	6	**1**	7
61+	0	6	0	6
Female				
20-40	**2**	3	0	5
41-60	0	5	**1**	6
61+	0	3	**4**	7
Total	**3**	**26**	**7**	**36**

Household type and living arrangements

All the life-story respondents were asked about their house type and living arrangements and twelve were selected to be photographed. The homes were purposely selected to give a cross-section of respondents based on sex, age, house type and geographical location of the home. To protect anonymity, I have not indicated which participants' homes were photographed. Photographing the homes provided the opportunity to walk through the household space with

the respondents and discuss everyday marital life in relation to the materiality of the home, for example the house structure, sleeping arrangements and privacy. Afterwards, the photographs were also analysed and discussed with the research assistants, who picked out additional information from the images, such as household objects or images and related them to cultural norms and symbols of identity. This information provided additional insights into the socio-economic status and living conditions of the respondents.

In GPC surveys, wall and roof type are used as indicators for socio-economic status and the number of rooms divided by household members are used for crowding indices. The respondents' homes varied substantially by size, material, household composition, access to utilities, furniture and other possessions. In the GPC survey there are three combinations of house material used to indicate household wealth: mud and pole, brick and mud, and concrete and brick. Of the twelve houses that were photographed, three were mud and pole, five were brick and two were concrete and brick, as shown in photographs (3.8). The photographs show the differences between house type and size, and also indicate the range in socio-economic status and living conditions between the respondents. These intermediary factors are argued to affect every day marital relations, impede sexual privacy, influence family planning practices and even drive engagement in extra-marital relations.

Photographs 3.8 Some of the life-story respondents' houses

As a gesture of appreciation and to compensate for their time, each life-story respondent was reimbursed 10,000ugs (approximately £2.20) per interview. Those who also gave permission for their homes to be photographed were also given a framed photograph of them taken

during the visit (these portraits have not been included in this thesis to preserve anonymity). The transcripts of the life-story interviews have also not been included, due to their great length. The ethical considerations of providing gratuities and photographing respondents' homes are discussed in section 3.8.

3.5.2 Focus group sampling and discussions

The aim was to conduct a total of five focus groups, including a pilot. For the pilot six local staff members (two men and four women) working for the MRC volunteered to participate. The aim of the pilot was to test the focus group prompt sheet (Appendix B) and to check the research assistants felt confident facilitating the discussion. Asking MRC staff to participate also offered an opportunity for them to learn more about the study and solicit their opinions on marital gender roles and difficulties married individuals face when discussing and managing sexual and reproductive health. The data generated from the pilot discussion have not been directly used in this thesis but were useful preparation for strengthening the prompt sheet.

The focus group method was used to culturally anchor the findings of this study. 'Focus groups provide researchers with direct access to the language and concepts participants use to structure their experiences and to think and talk about a designated topic' (Hughes and DuMont, 1993, p.776). The focus groups were therefore used in this study to explore how topics such as sex, marriage, family planning and gender roles are perceived and discussed in the study setting. This insight to cultural beliefs and social norms was used to develop an understanding of the social context. More specifically to define expectations, constraints and social pressures on gender relations and the negotiation of SRH practices.

Four focus groups (two male and two female) were conducted with married respondents from two age categories (20-40 and 41-60). These individuals were sampled from the villages near the GPC base due to access and transport costs. A random sample of 40 was generated from the GPC survey data based on the same eligibility criteria as the life-story respondents' sample (Table 3.9). The groups included individuals of the same sex and age category, as it was decided that respondents would likely feel more comfortable and speak more openly on intimate and sensitive topics in same-sex groups. I also wanted to compare the views of older and younger age groups. Once again, difficulties were experienced in tracking down respondents, as many were out working, often at some distance from the homestead, and some were reluctant to take time away from work to attend the discussion. In the end, 25 respondents participated, with either six or seven attending each focus group discussion.

Table 3.9 Respondents for focus groups

Focus group by sex	Age category	Village	Sample size	No. respondents who attended
Male	20-40	17	10	6
Female	20-40	16	10	6
Male	41-60	15	10	6
Female	41-60	14	10	7
		Total	**40**	**25**

As a gesture of appreciation and to compensate for time and travel expenses, each respondent was reimbursed 10,000ugs (approximately £2.20) and given a soda and biscuits during the focus group discussion. The ethical considerations of providing these gratuities are discussed in section 3.8.

3.5.3 Key informant sampling and interviews

The intention was to interview key informants from the study site, selected based on expertise on cultural and religious beliefs, sexual practices or family planning in marriage. I interviewed eight key informants (Table 3.10); four of the interviews were conducted in English and four in Luganda with support from a female translator.

The method of semi-structured interviews involves interactional dialogue and conversation with purpose, based around selected topics or themes to draw out specific knowledge (Mason, 2002, pp.62). The key informants in this study were selected based on the perceived knowledge that could be gained from interviewing them, which would aid building a more informed understanding of the social context. Informants were specifically identified as being key individuals who could provide information on the cultural and religious beliefs and social norms relating to marriage, family planning and HIV in the community.

Table 3.10 Key informants

Type of key informant	Number of respondents	Sex	Interview language
Muslim leader (Imam)	1	Male	English
Catholic Church Representative	1	Female	Luganda
Protestant Church Representative	1	Female	Luganda
Born Again Church Manager	1	Female	Luganda
HIV counsellor & health worker	1	Female	English
Government midwife	1	Female	English
Mobile health worker	1	Male	English
Traditional birth attendant (TBA)	1	Female	Luganda
Total	**8**		

The aim was to interview key representatives from the four dominant religious institutions in the study area. From the mosque, I interviewed a young Imam who had been in the position for less than two years, but he was confident and outspoken about Islamic beliefs surrounding sex, marriage and family planning. The representatives from the Catholic and Protestant churches were both female marriage counsellors, who prepare couples for marriage and advise those experiencing marital difficulties. Lastly, the Born Again church representative defined herself as the Church Manager, as she helped organise marital functions and the day-to-day running of the church. During these open interviews, the key informants were asked about the marital practices and belief systems of their religious institutions. For example, "what does the Church say about family planning?" or "What are the roles of a man and woman in marriage?" The key informants were also asked about the marital problems they have encountered and the advice they offer married couples. These interviews helped to build a picture of the discourse and beliefs being promoted and circulated in the community, but also the institutional approach to advising married couples around topics relating to sex, HIV risk and family planning.

The remaining four key informants were interviewed to learn more about the local sexual and reproductive health knowledge, belief systems, practices and uptake of services in the community. Four practitioners from different areas of the health sector were interviewed. This included an HIV counsellor and health worker who had worked on community-health projects for over 20 years and was currently working for MRC in *Kyamuliwa*; a government midwife from the main health clinic in the area; a mobile health worker who was tracked down after a respondent reported buying the hormonal injection from him in her village; and a traditional healer and birth attendant who was an elderly woman, well known in the community, offering home midwifery and herbal remedies. These four key informants provided insights on community health-seeking behaviours, beliefs and family planning strategies and barriers, discussed in Chapter 7.

3.6 Data analysis

This section explains the process of data organisation and analysis used in this study. Interviews and focus groups were conducted in *Luganda,* digitally recorded after gaining consent and then translated and transcribed with the support of the assistant social scientists. An electronic fieldwork diary was compiled to aid data analysis. Multimedia field notes were organised into a chronological diary and by theme to aid triangulation of results and reflexive thinking (Tam, 2017). Transcriptions were thematically coded and then organised using a

framework approach and thematic network mapping. These approaches provided multiple layers and lenses of data analysis, valuing the different types of knowledge, and also enabled reflection on the relational power structures that are inherent to conducting research (Caretta and Riaño, 2016, p.259). This section briefly outlines each stage of data analysis and how this used in this aided synthesising the data, building a big picture of the cultural context, whilst also retaining detail on individual life-stories, strategies and SRH practices.

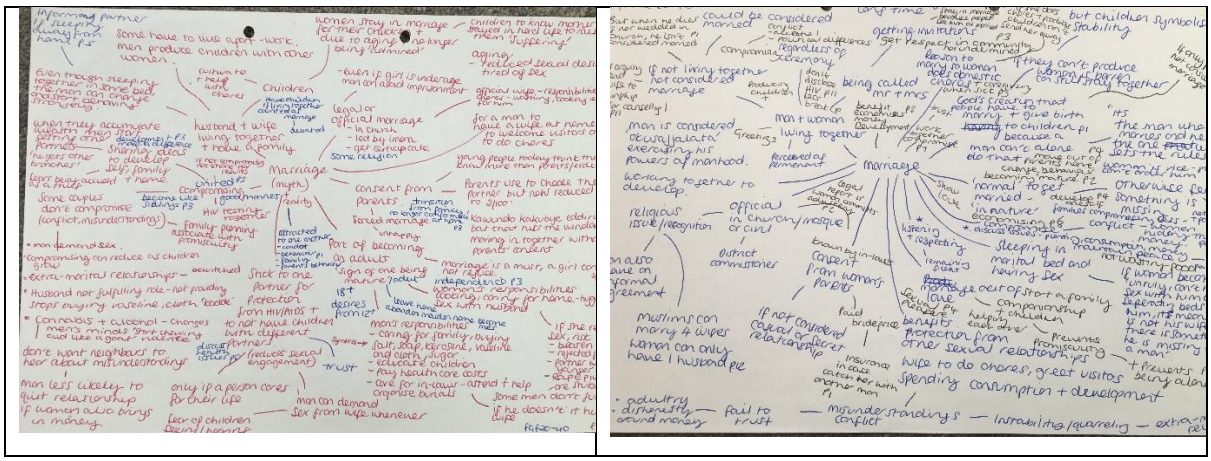
A thematic approach was used in the overall research design to structure interviews and focus group prompt sheets, to guide data analysis in terms of analysing transcripts and organising data in thematic frameworks and network maps. The themes listed on the interview and focus group prompt sheets (Appendices A and B) helped to focus and tailor data collection to the research questions and ensure that certain forms of data were systematically collected. After each life-story interview, key informant interview and focus group had been completed, they were translated and transcribed. Influenced by Ryan and Bernard's (2003) guidance, I analysed the transcripts and made detailed annotations to identify recurring topics, local expressions (i.e. phrases meaning an informal type of marriage, terms used for women who experiences miscarriages or local names for syphilis), metaphors and analogies used by respondents to express thoughts (i.e. "no money, no sex"), transitions (i.e. stages of life-course) and missing data, which can also include topics which participants omitted to talk about (Bryman, 2012, p.580). This iterative process aided the systematic organisation of data into thematic frameworks.

The thematic framework approach involves organising data into matrix table formats (Bryman, 2012, p.579). This framework technique was used to synthesise the respondents' life-story data in several ways. I created a matrix framework based on the life-story respondent profile data collected during the first stage of interviews. The framework involved the respondents' personal characteristics (i.e. sex, age, village, religion, ethnicity, marital type and whether living with the spouse) and information on SRH behaviours, for instance number of sexual partners, engagement in extra-marital relationships, cases of polygyny, number of children (alive and deceased) and HIV status. I created a separate framework to specifically detail female strategies and use of family planning practices. These frameworks aided comparison of respondent data and exploration patterns, for instance investigating connections between marital type and religion or education level and family planning tactics. I also summarised all the life-stories into a table and highlighted key interesting themes or topics discussed in each interview. A criticism of thematic data analysis is that it can result in a fragmentation of the data (Bryman, 2012, p.278). The summaries of the life-stories therefore

helped to aggregate, maintain an overview of individual cases and also identify themes and sub-themes for network mapping.

The third analytical process involved organising the data into thematic network maps. This technique aids the identification and mapping of salient themes to identify patterns, relational order and scale: 'Thematic networks are web-like illustrations that summarize the main themes constituting a piece of text' (Attride-Stirling, 2001, p.385). Making the thematic networks maps helps to organise, collate and interpret the data. I started by focusing on a theme, such as marital gender roles, fertility, love, HIV risk, faithfulness or the household space. I would then map out salient respondent remarks or experiences. This aided the identification of cultural norms, patterns of attitudes or practices and also deviant behaviours. Examples of these maps are shown in Image 3.10.

Photograph 3.11 Image of data network maps



Using these three stages of thematic analysis enabled an iterative research process. The first stage particularly aided the organisation and comparison of data to ensure continuity of types of data had been collected, and to identify missing data, which informed the development of research tools for the second round of interviews. Using the framework and network approaches also facilitated exploration of patterns of sexual behaviours and family planning practices in relation to intersecting social characteristics (i.e. type of marital relationship, gender, age and religion). These techniques also help me gain scalar perspectives on the data, building an image of the cultural context to identify and understand social determinants, shaping SRH behaviours and contributing to a risk environment. These methods of analysis also enabled exploration of individual agency in terms of interpretations of risk, family planning, enactment of sexual practices and negotiation of gender relations over the life-course.

3.7 Strengths and limitations of the data

The study was designed and conducted in accordance with Guba's criteria for a trustworthy qualitative study to ensure findings are credible, transferable, dependable and confirmable (Guba (1981) cited in Shenton, 2004). This included the adoption of established research methods; familiarity with the research context achieved through twelve months fieldwork and collaboration with the local MRC Social Science team; random sampling of respondents; triangulation of results from the different research methods following clear research ethics procedures; and using iterative questioning to guide data collection and analysis and interpretation of findings. Despite these strengths, there are also limitations relating to the study design, which include the approach used to analyse HIV prevalence and select the villages, the typicality of findings, the recruitment of married individuals rather than couples and key influences on the construction of respondent narratives.

Analysis of HIV prevalence to select villages

This qualitative study is based on a relatively small sample taken from a pre-existing general population cohort in south western Uganda. I used quantitative data to select and compare the HIV prevalence in the villages. On reflection, this might somewhat exaggerate differences between villages. The village boundaries are quite arbitrary, as a large proportion of the land included in the GPC catchment area was originally given by the *Kabaka* (King) to chiefs and other individuals of importance during the last century. Over time, land was sold off or rented for agricultural use and the population in this area expanded exponentially. Some villages have established community centres, while others are just a sprawling collection of settlements. The boundaries shown on the map are based on local government administration and do not necessarily capture the geographical dispersal of residents. On the ground, the villages merge into one another and there is a great deal of mobility between villages. The population of each village also varies greatly, which means that the numbers of people living with HIV in some villages is relatively small and may not be representative of the whole village, but rather attributable to a few individuals who may have transmitted HIV to others within their intimate social network.

Typicality of findings

The GPC also cannot be described as a typical Ugandan rural population for several reasons. The GPC is positioned within the *Baganda* Kingdom and therefore 78% of the population are

Buganda, the most dominant ethnic group in the country. This means the culture, livelihoods and social organisation might only be deemed typical of a rural *Buganda* population in south-western Uganda. The GPC population has had access to increased healthcare for over 25 years. This population may therefore no longer be representative of the general population and might have better health knowledge or outcomes than other rural populations in Uganda.

Recruiting married individuals, rather than married couples

For ethical and sampling reasons, I did not select or work with couples, but instead recruited married individuals for the focus groups and interviews. From an ethical perspective it was felt that respondents would speak more openly, could participate with or without a spouse's knowledge and feel a greater sense of confidentiality if recruited as individuals rather than part of a couple. From a sampling standpoint, we already experienced difficulties trying to locate and recruit married individuals and it would have been an added challenge to identify and recruit suitable couples, which was too big a risk given the study resources and timeframe. Interviewing a couple either together or individually would have offered gendered views on marital negotiations and power dynamics from within the same marital relationship, but this study could not offer these perspectives.

Some key influences on the narratives generated

Although respondents were selected at random, they were selected from communities who know the MRC and anyone who works for the organisation is referred to as *musawo*, meaning health worker. Respondents' stories are in themselves a representation or portrayal of reality, identity and behaviour. Respondents may have participated in the study and constructed their stories based on what they think is of interest to MRC health workers.

3.8 Ethical considerations

This study received ethics clearance from the University of East Anglia International Development Research Ethics Committee (August 2014), the Uganda Virus Research Institute (UVRI) Research Ethics Committee (ref no. GC/127/14/10/487) and from the Ugandan Government office, Uganda National Council for Science and Technology (UNCST) (ref no. SS 3669). Several measures were undertaken to ensure the study followed ethical procedures throughout, in terms of gaining informed consent, upholding respondent confidentiality, protecting data and paying gratuities to respondents. Although procedures were undertaken to uphold ethics requirements, during the research process additional considerations arose

surrounding the nature of research relationships, the use of photography and the responsibility of accurately interpreting, representing and sharing people's stories.

Acquiring informed consent, confidentiality and data protection

Informed written consent was sought from participants prior to conducting interviews and focus groups. The study information sheet and consent form (Appendix D) were used to ensure that participants understood the scope of the study; that any information provided would be anonymised; and that participants had the right to refuse or withdraw at any point; and that participating would not in any way affect receiving care or treatment at the GPC clinics.

To protect respondent anonymity and confidentiality, interview transcripts were numerically coded, and the respondents' names replaced with pseudonyms, which are used throughout this thesis. A key document containing the codes and the corresponding interviews was held on a separate device. All the devices used to store information were password protected. Photographs of respondents' homes have not been linked to individual life-stories or plotted on the maps, to protect participant identities and minimise risk of identification.

Respondent gratuities

As this study gained ethics approval from UNCST and UVRI REC, guidelines were followed for these two research bodies. This meant respondents were given gratuities of 10,000ugs (approximately £2.20) after participating in an interview or focus group. During the focus groups refreshments were also provided, including non-alcoholic sodas and biscuits. The respondents who consented for their homes to be photographed were also given a portrait framed photo as a token of gratitude. The portrait photographs have not been used in this thesis to protect their identities. These gratuities were given in line with UNCST guidelines, as a gesture of appreciation for people's time and to cover travel expenses. The amount was not deemed to motivate or persuade unwilling participation; several individuals refused to participate in the study, suggesting the gratuity did not encourage unwilling participation.

Building connections and sharing stories

Whilst undertaking the fieldwork, I made connections with colleagues and became friends with individuals who shared their stories and helped me gain deeper insights into the social context and the significance of my findings. This has provoked consideration of the relational ethics of conducting research, the interpersonal bonds created during the research process and the ethics of care involved in constructing narratives and characters for the purpose of supporting

research findings (Ellis, 2007). I used a fieldwork diary to track and reflect on these ethical considerations and this has also informed which stories and data extracts to use in this thesis.

During fieldwork I kept a detailed electronic diary, where I wrote accounts of relevant informal conversations, events that I attended and reflected on the progression of my research ideas (see Tam, 2017). I included annotated photographs of people and places to capture the vivid experiences of fieldwork. These interactions and friendships were integral to my fieldwork experience, the implementation of the study and interpretation of findings. However, for ethical reasons I have not directly quoted from my fieldnote diary extracts in this thesis. Although I was always open about the research I was conducting and my motivations to learn about gender norms, marital practices and sexual behaviours, I did not gain consent to use the data from these informal conversations. Furthermore, these conversations and stories were often told to me when people were regarding me as a friend, a colleague or a foreigner to which they were offering warm hospitality. Therefore, out of respect, gratitude, friendship and researcher inexperience, I have not directly quoted this ethnographic data and only included case studies and extracts from the qualitative data that were collected more formally.

Although I followed ethical procedures to gain informed consent and protect the respondents of this study, there remain ethical dilemmas in the way narratives are constructed and cultural norms are presented, which can affect the communities they represent. I have therefore tried to treat and represent the data with a duty of care and responsibility for the framing of these stories and how they are used to make empirical claims. The life-story respondents spoke openly about their family life, sexual practices and family planning experiences. Many shared painful and traumatic memories, including experiences of rape, violence, miscarriage, death of children and hardship from living in poverty. Having collected these stories, I feel a sense of duty as a researcher to treat this data with care and use it for the purpose which I relayed to the participants – namely to improve our understanding of HIV risk, family planning and the lives of married individuals in south-western Uganda.

3.9 Researcher reflexivity

As with any study, the research team influences the study design, the process of data collection, analysis and interpretation of findings. This section briefly reflects on my positionality as a researcher, the identity of my research assistants, our working relationship and how this influenced this study.

My research background and interests cross the boundaries of social work, anthropology, geography, development studies and public health, which shaped my research

aims and approach to investigating SRH behaviours in sub-Saharan Africa. As a feminist and health practitioner, I have been motivated to conduct research that examines power structures, social inequalities and injustice, for the purpose of inciting positive social change, particularly to improve women's health. This study has therefore been driven by those personal motivations and my multidisciplinary background. In terms of conducting this research, I recognise that my identity affected the way in which others perceived and interacted with me. I was inevitably viewed as a *muzungu* (white person or foreigner), and there were very few *muzungu* living or visiting the area. This made moving around discreetly virtually impossible as a large group of excited children usually sounded my arrival. There were both negative and positive connotations attached to being *muzungu.* I was frequently asked for money, or to buy drinks or sweets and told that I must be rich. However, I seem to also represent another world and that meant people were generally curious and interested to observe or interact with me. The general reaction to my presence whilst moving around the community, meant it was easier and more inconspicuous for the research assistants to track down respondents and undertake interviews in the village setting without me. This meant respondents could participate discreetly, interviews could be conducted in *Luganda* and my presence did not influence the way in which individuals told their life stories.

The reaction to my identity as a married woman living alone and not yet having given birth resonated with the writings of anthropologist Sharon E. Hutchinson, who was in a similar situation whilst conducting her fieldwork in Sudan. Like Hutchinson, I was not following local marital norms and could not be regarded as a 'full' woman as I had not given birth. I therefore found I was similarly perceived as an 'awkward cross between a woman and a girl' (1996, p.46). This positionality was just part of my fragmented intersected identity, alongside being a foreigner, a student, a researcher, a wife, a social worker, a friend and a colleague to name just a few. Being hosted by MRC also meant that I was perceived as being a health worker and employee, rather than an independent researcher. The way I was viewed undoubtedly affected the way people communicated with me and responded to my questions. This research can therefore not be regarded as unbiased, but rather shaped and influenced by own intersected positionality and role as a visiting researcher at MRC.

The friendships I made during fieldwork, most notably with colleagues on the research site and a few older women in the community, who referred to me as daughter or granddaughter and took me into their family, significantly shaped my experience of fieldwork and helped me understand the nuances of my data. Although I do not directly refer to these experiences in this

thesis, these relationships greatly helped me interpret and understand my data in relation to socio-historical processes, cultural beliefs and everyday life in the study area.

Although being an outsider has considerable challenges, such as not being accustomed to the language or social rules and not having a kinship support network, I also found this positionality aided mediation with my research assistants and afforded me the opportunity to question gender beliefs, norms and sources of power. The two local social scientists, Grace and Elizabeth were key to this study. I met regularly with Grace and Elizabeth both individually and together to discuss the data and debate the gendered perspectives on the topics. Due to my outsider positionality, it was acceptable for me to question these perspectives, mediate between them, and also challenge their insider views on the culture and gendered behaviours.

After completing fieldwork, whilst in the process of analysing the data and writing up, I became pregnant and gave birth to my first child. Although this delayed the completion of this thesis, this life-changing experience also provided new insights into pregnancy, childbirth and motherhood. These experiences helped me reflect on the impact these life-events have on notions of identity, re-evaluation of priorities and risks, and the negotiation of marital relations, which are all central themes of the thesis.

Chapter 4 – Marriage and types of marital relationship

The following three chapters explore the first research puzzle 'In what ways do the different forms that marriages take, influence the sexual practice of people who consider themselves married and why?'. This chapter outlines meanings of being married in this setting, showing that this can involve a range of marital type relationships. I demonstrate this by providing a very structured typology of marital relationships found in this setting and then explain these categories through case study vignettes which provide insights to the messy and unstructured lived experiences of marriage. I also identify some key trends from the life-story data in terms of the reasons men and women often enter and remain in marital relationships. These trends illustrate the ways in which marriage is shaped by and embedded within broader structures of gender relations, which reinforce gender inequality in terms of an imbalanced power in the negotiation of sex and marital relations. This provides an important backdrop to understanding the expectations of marital roles and SRH practices, which are closely examined in chapters 5 and 6. What is key to take from these three chapters is that in this setting marriage can take many different forms, however expectations and pressures to perform particular marital roles and social practices (including unprotected sex) is fairly consistent across all types of marital relationships. Structural gender inequality is also evidenced through explanation of the gendered drivers to enter and remain in marital relationships and the commonality of polygyny and male engagement in extra-marital relations.

The typology includes four types of marriage (informal, customary, religious and civil) broken down into nine sub-types, based on the couple's living arrangements and how the relationship has been socially recognised; these different arrangements influence perceptions of respectability and whether formal polygyny can also be simultaneously endorsed. This chapter shows that that being married in this context does not necessarily mean a couple have gone through a formal ceremony or are cohabiting. The institution of marriage is instead based on an expectation of marital roles. Marital relationships can be publicly presented as monogamous or polygynous, but privately conducted concurrently to other extra-marital relations. A life-course perspective of the case studies indicates that marital relationships often intersect or overlap with other sexual relationships, some of which result in polygynous arrangements.

The categories of marriage listed in this chapter are well documented; however, the life-course perspective is used to delve deeper into the reasons that individuals enter and sustain

these types of marital relationship. This reveals valuable insights into the structural factors shaping the construction and dynamics of marital relations, which is vital for understanding the challenges of managing sexual and reproductive health. The life-course perspective situates the types of marital relationship in relation to individual sexual history to highlight trends of gender inequality and structural violence towards women.

Regardless of the type of marriage, there are key components or shared attributes associated with being married. In eastern Uganda, Parikh found marriage to be discussed 'as a nuclear project that centered on raising children (including orphans and other dependants), "developing" the household, and acquiring goods and luxury items' (2007, p.1200). Similarly, in this research, perceived marital roles, children and the home were identified as the cornerstones of marriage. Institutional ideas about marriage and gender are explained as the basis for girls being pressured into marriage or with which individuals justify entering or remaining in a marital relationship. Marital ideals are also argued to be the source of marital dissatisfaction and related to drivers for extra-marital relations.

4.1. Typology of marital relationship

This section describes the typology of marital relationships found in this setting (Table 4.1). The typology includes four types of marital relationship identified by respondents (informal, customary, religious and civil). These four types of marriage, alongside living arrangements and whether the man has other wives, illustrate the number of relationships that can be considered a marriage in this setting. These four types of relationship are well recognised as part of the social landscape (Nabaitu, Bachengana. and Seeley, 1994; Parikh, 2007; Agol *et al.*, 2014) (Nabaitu, Bachengana. and Seeley, 1994); however, this study more deeply examined how these types of marriage arise and are negotiated over the life-course.

Although civil marriage (i.e. being married by a government official) was listed by respondents as a type of marital relationship, there were no respondents in this study in a civil marriage and therefore this type of marriage is not discussed in this chapter. Instead, the other three types of marriage, the cultural practices of polygyny and the concurrence of extra-marital relations are the focus here. The Uganda Demographic Health Survey (UDHS) indicates that formal polygyny has decreased from 32% of marital relationships in 2000 to 25% in 2011 (UDHS, 2012, p.49). Parikh contends there has been a social shift away from polygyny towards a rise in informal secondary households (2007, p.1205); however, Seeley (2012) argues that informal marital-type relationships are not new, as men have always had secret wives or girlfriends. Types of informal marriage are common and have arguably increased over time in

Uganda (Parikh, 2007; Seeley, 2012; Schlecht, Rowley and Babirye, 2013; Agol *et al.*, 2014). Informal marital relationships include individuals who regard themselves as married but have not gone through an official ceremony or paid bride-price. Informal marriage is not legally recognised by the state, but is sometimes recognised by the community.

The three most common types of marriage (informal, religious and customary) have been divided into eight sub-types. Table 4.1 indicates whether the community or the state recognises this sub-type of marriage, the living arrangement of the couple and whether the man can marry more than one wife according to the institution by which his first marriage is endorsed. Throughout the chapter I discuss how these aspects of the marriage affect social recognition, respectability and perceived rights. This analysis of the private/public dimensions of marital relations was inspired by James Ferguson's interpretation of sexual relationships on the Zambian Copperbelt. Ferguson observed how a marriage is publicly presented to 'induce varying degrees of social recognition and respectability' (Ferguson, 1999, p.186). This meant that the public enactment of marital relationship shapes perceptions of whether the marriage is legally recognised and social respected. I examine this public/private representation and enactment of a marital relationship in terms of living arrangements, the cultural and religious institutions used to endorse marriage, the practice of formal polygyny, and engagement in secret extra-marital relations.

In this setting, social recognition and respectability of marriage is based on whether there has been an introductory meeting between the groom and bride's family, payment of bride-price and if the marriage has been endorsed by a religious institution. Social recognition is discussed in terms of whether the community or state recognise the marriage and the associated rights over a spouse, children, inheritance, property or land, and burial practices. Religious marriage was regarded by respondents as the most revered type of marital relationship, often associated with commitment, loyalty and stability. This is because in the Christian institution a man can only officially marry one wife and in the Catholic dominion a man is not allowed to divorce. Although Christian marriages maybe be publicly presented as monogamous, marital instability and men (and sometimes women) engaging in extra-marital relationships was found across all types of marital relationship.

Table 4.1 Typology of marital relationships in the study setting

Type	Sub-type	Recognised by the		Couple living situation			Formal polygyny allowed
		State	Community	Together	Partially	Apart	
Informal	Secretive					✓	✓
	Public		✓	✓	✓		✓
Religious	Protestant	✓	✓	✓	✓	✓	
	Catholic	✓	✓	✓	✓	✓	
	Born Again	✓	✓	✓	✓	✓	
	Muslim	✓	✓	✓	✓	✓	✓
Customary	Formal	✓	✓	✓	✓	✓	✓
	Private	✓	✓	✓	✓	✓	✓
Civil	Civil	✓	✓	✓	✓	✓	✓

This young male respondent indicates the different types of relationship regarded as marriages in the community:

> There are three types of marriage, there is meeting a lady on the way and you admire each other and compromise to make a relationship, she comes to your place enjoys sex and goes back home like that. There is marrying the woman from her parents' home, you live together without separation. There is marrying the woman from the parents' home, but first going to the church to make vows and then start living with each other. (Richard, aged 22)

The institution of marriage is therefore malleable and can be interpreted and lived out in several different configurations. Although a couple may refer to a partner as their husband or wife, they may not live together or have gone through an official marital ceremony. The shared basis of these types of marital relationship is an expectation to perform certain gendered marital roles and sexual behaviours, which are discussed in more detail in Chapters 5 and 6.

4.1.1 Life-story respondents

Of the 36 life-story respondents, 34 defined themselves as married (one woman was a widow, and another had separated from her husband and never remarried). As mentioned in the methodology chapter the two women who were not married were included due to difficulties recruiting older married women in two of the villages. As shown in Table 4.2 eight respondents were in a customary marriage; sixteen deemed their marriage to be endorsed by a religious institution; and ten were in an informal marital arrangement. The table also indicates whether

the respondent was residing with their spouse. 23 respondents were living with a spouse; 11 were living either partially or consistently apart from their partner, and the two single women were living with other family members.

4.1.2 Patterns of marriage by sex and age

There are several noticeable features of the different types of marital relationship when organised by age and sex (Table 4.2). Firstly, the majority (6/10) of the respondents in an informal marital relationship were in the younger age category. Later in this chapter, life-stories are used to explain the circumstances surrounding informal marriages, which are often associated with the man being unable or unwilling to pay bride-price and/or the couple considering themselves married without family consent or knowledge. The challenges for men to pay bride-price are discussed in relation to socio-economic constraints and the construction of masculinities in Chapter 6.

Table 4.2 Life-story respondents by marital status, residency and age

Type of marital relationship			**Age and sex**						**Total**
			Age 20-40		**Age 41-60**		**Age over 61**		
			Male	Female	Male	Female	Male	Female	
Married	Customary		2	1	1	3	3		10
	Religious	Muslim	1	2	1				4
		Catholic		1	1	1	2	4	9
		Protestant			1				1
	Informal		3	2	2	2	1		10
Not married	Widowed/ Divorced							2	2
		Total	**6**	**6**	**6**	**6**	**6**	**6**	**36**

Secondly, older individuals were more likely to be in a religious marriage. Ten out of 14 respondents in a religious marital relationship were over the age of 41. A religious ceremony was often regarded as both expensive and highly respected in the community. A religious marriage is usually preceded by an introductory ceremony and exchange of bride-price. Males who had undertaken a religious marital ceremony when they were younger all had financial support from their family, whereas the females in this type of marriage had all been pressured into marriage by religious family members. Getting married in church or a mosque was often listed by respondents as a life goal. Older individuals expressed desires to be in a religious

marriage for reasons of social respectability, to demonstrate commitment, desire for a religious burial or reasons relating to inheritance rights.

Thirdly, the respondents who were or had been in a polygamous marriage were most likely to be in either a customary or informal marital relationship. Out of the 10 respondents in a customary marital relationship, most were either older males over the age of 61 or middle-aged women between 41-60 years old. Customary marriage is respected in the community and legally recognised by the state. It involves the paying of bride-price and an introductory meeting between the groom and the bride's family. As indicated by the sub-type, this payment of bride-price can occur during a private meeting or be part of a more public ceremony and celebration. The bride-price can vary substantially, as shown later through the life-stories, ranging from small gifts of beer, sugar or pieces of cloth to the payment of large sums of money and livestock. A man can marry an unlimited number of wives by this customary practice. Five out of the six men in a customary marriage had been married before, were in a polygamous relationship and/or had extra-marital partners.

4.1.3 Polygamous and extra-marital relationships

Polygamous and extra-marital relationships were a common feature of the respondents' life-stories and frequently linked with couples living consistently or partially apart. Eleven respondents (seven females and four males) stated they were in or had previously been in polygamous marital relationship and half of the respondents (nine males and nine females) stated that either they or their spouse had had an extra-marital relationship during the marital life-course. Only four female respondents admitted to having an extra-marital relationship. More women may have engaged in extra-marital sex, but might not have wanted to disclose this in the interviews due to the social stigma women face if perceived as unfaithful. Furthermore, respondent bias could mean individuals claimed their spouse to have cheated but not disclosed their own extra-relationships.

In this thesis, marital living arrangements and conditions have been explored in relation to practices of polygyny and extra-marital relations. Table 4.3 shows the life-story respondents by social characteristics and whether the individual was living with a spouse at the time of the study. There were eleven respondents who were partially or consistently not living with their primary spouse. This was often due to male labour mobility or the man being in a polygynous relationship and therefore living across households. Nine women were found to be living predominately alone, with children or grandchildren, effectively being head of their household,

because their spouse was either absent or partially living elsewhere. In Chapters 5 and 6, I explain that the social conditions of living apart from a spouse provide opportunities or can be a driver for extra-marital relations, or for the man to spend time with other wives. However, I also show that living together in cramped living conditions impedes sexual privacy and was therefore also identified as an excuse for men to engage in extra-marital relations.

Table 4.3 Life-story respondents by pseudonym, age, type of marriage and living situation

V	Pseudonym	Age	Type of marital relationship	Living with spouse	History of polygyny	History of extra-marital relation(s)		Female head of house
						Resp	Spouse	
10	Teddy	31	Informal - Public	Partially	✓		✓	✓
	Edward	43	Informal - Public	Yes	✓	✓		
	Julie	43	Customary - Private	No	✓	✓	✓	✓
	Joseph	60	Informal - Public	No		✓		
	Nakamaty	76	Religious - Catholic	Yes				
	Gerald	81	Customary - Formal	Yes	✓			
13	Gladys	28	Religious - Catholic	Partially			✓	✓
	Michael	32	Customary - Private	Yes		✓		
	Hamid	57	Religious - Muslim	Yes		✓		
	Ruth	46	Religious - Catholic	Yes		✓	✓	
	Wasswa	76	Religious - Catholic	Yes		✓		
	Paula	65	Religious - Catholic	Yes				
2	Shakirah	37	Religious - Muslim	Yes				
	Anatoli	43	Informal - Public	Yes		✓		
	Beatrice	44	Informal - Public	Yes			✓	
	Rakibuh	54	Customary - Private	Yes		✓		
	Fatuma	67	Widow	N/A			✓	✓
	Godfrey	85	Customary - Formal	Yes	✓			
20	Dyana	35	Informal - Public	No	✓		✓	
	Julius	24	Customary - Formal	Yes				
	Namakula	45	Customary - Private	Yes			✓	
	Mukisa	42	Religious - Protestant	Yes				
	Jessica	67	Religious - Catholic	Yes		✓	✓	
	Peter	61	Religious - Catholic	Yes		✓		
5	Aisha	29	Religious - Muslim	Partially	✓		✓	✓
	Richard	22	Informal - Secret	No		✓		
	Linda	43	Informal - Public	Yes			✓	
	Kenneth	61	Informal - Public	Yes				
	Kathy	66	Religious - Catholic	No		✓	✓	✓
	Mukasa	95	Customary - Public	Yes	✓			
6	Naomi	37	Customary - Private	No	✓			✓
	Moses	35	Religious - Muslim	Partially		✓		
	Ayra	41	Customary - Private	Partially	✓			✓
	Leo	52	Religious - Catholic	Yes				
	Kathleen	80	Single	N/A	✓			✓
	Henry	62	Informal - Public	Yes				

Polygyny and men having extra-marital relationships are common in Uganda (Parikh, 2007; Kasamba *et al.*, 2011; Siu, 2013; Agol *et al.*, 2014). The UDHS indicates that around 35% of marriages are polygynous; this figure is higher in rural areas and amongst older men and women with little or no education (2012, p.49). Whilst formal polygyny has generally decreased, particularly in rural areas, there has been an increase in other forms of multiple and/or serial informal marriages involving successive extra-girlfriends and 'outside' wives (Parikh, 2007; Seeley, 2012). The UDHS data suggest that most women (82%) start in a monogamous relationship and this figure decreases with age, indicating that women are more likely to end up in a polygynous relationship later in life (*ibid.*, p.49). A key finding of this thesis is that polygyny and extra-marital relationships not only operate as an intermediate social determinant of HIV risk for married couples, including women who think they are not at risk, but also generates tension and distrust that hinders conversations about HIV risk and the negotiation of safer sex in marriage (discussed in Chapter 8).

4.2 Informal marriage

Of the 34 married respondents, ten were in an informal marital relationship. This informal type of marriage is defined as the individual regarding themselves as married, but bride-price has not been paid nor has there been an official marital introduction meeting or ceremony. From the data, two sub-types of informal marital relationship have been identified: secretive and public. These types of marriage are discussed in relation to the couple's living arrangements, consent of family members and perceived social recognition and respectability.

Secretive informal marriage

The first type of informal marital relationship is conducted in secret. In the focus group discussions, respondents referred to such relationships as *kawundo kakubye eddirisa*, which translates to 'the bat that hits the window', meaning that couples meet at night without their parents' knowledge. The respondents remarked that this type of marriage has become increasingly common as younger individuals are selecting their own partners without seeking parental consent. One life-story respondent was in this type of relationship: Richard (aged 22) explained that he calls his partner his wife as he hopes to marry her one day, but they currently meet in secret because the girl is still living under "her parent's control". Richard said he needed to build a house before he could formally ask to marry her. It was commonly asserted that a man is expected to build a house so as to be perceived as mature, responsible and therefore suitable for marriage (this socio-economic pressure on men, linked to notions of

masculinity, is discussed in Chapter 6). A man taking a girl/woman without paying bride-price or gaining the consent of her family was deemed to be disrespectful to the girl's parents and undermining marital traditions. This type of marriage was often perceived to be driven by naivety or sexual desire, and the secrecy of the relationship means only the couple might perceive themselves as married, rather than being recognised as married by the community or the state.

Informal, public and cohabiting

The second type of informal marriage relates to the couple partially or consistently cohabiting. Seven respondents (four male and three female) were in this sub-type of relationship. This form of marriage is recognised in the community as the couple are living together at least some of the time and often have children. I found that the male respondents in this type of informal marriage had all chosen this arrangement, whereas the females entered the relationship in the belief that the spouse would make the marriage official (but he never had). Once in this type of relationship it is difficult for the female or her family to negotiate with the man to pay bride-price or legitimise the marriage with a religious ceremony, because the woman is perceived to be tarnished (i.e. no longer a virgin). If she has given birth then the family need the man to take responsibility for the child. If the couple are in an informal marriage, then a man can be perceived as already 'owning' the woman and therefore unwilling to pay bride-price.

The four male respondents in an informal marital type relationship had been married before and had children with those women; however, for various reasons those relationships had broken down and they were living with their current spouse. Two of these men (Edward and Henry) had been legally married (customary and religious marriages), while the other men had only ever been in informal marriages. Three of the four men (Anatoli (aged 43), Henry (aged 62) and Edward (aged 43)) were living with their spouse and had children, which they defined as key reasons for considering themselves married.

Of all the respondents, Henry had the biggest age gap with his spouse, who was a 19-year-old. When asked about his relationship Henry remarked, "We have never had an official introduction but at least the parents know that their daughter is at my place". Henry had produced 14 children with three women. He married his first two wives in a mosque; the first died in childbirth and the second divorced him as she was "tired of having sex and wanted to convert back to Christianity". The third wife he lived with for sixteen years but "she failed to produce any children" and Henry started a relationship with her niece, who was staying with them. After the relationship became evident, his wife left. This glimpse into Henry's marital

life-course shows how types of marital relationships can intersect, supervene or overlap with other sexual relations over time. Men's expectations to have sex and produce children are salient themes in this thesis, discussed further in Chapters 5, 6, 7 and 8.

The fourth male respondent informally cohabiting was Kenneth (aged 61); however, unlike the other men he did not have any children with his current spouse. Kenneth admitted to having over 100 sexual partners during his life-course and had seven known children. Kenneth stated he did not want any more children, he had therefore found his current spouse who was also divorced, and they had "accepted to live with each other and protect each other through old age". Although it was unknown whether Kenneth had tried to have more children, his apparent decision to stay with a spouse and not have children deviates from the norm. However, ideals relating to marriage and prescribed gender roles were being used as a strategy to prepare for older age.

Of the three female respondents who were informally cohabiting, the life-stories were similar in the sense that the women had all been convinced by family or friends to marry young, and the spouse had failed to formalise the marriage. All three women (Beatrice, Teddy and Linda) had children with their current spouse, which was listed as a key reason to remain in the relationship and it was inferred that this was why the spouse had not formalised the marriage. Despite the man often promising to formalise the marriage, once children are born, the man can avoid formalising the marriage due the associated costs. These women's stories illustrate how girls can face pressure to marry if they are not still in education, and that after giving birth it is difficult for the woman or her family to negotiate bride-price or an official marital ceremony, because there is pressure to remain with the father of the child to be perceived as respectable and live up to constructions of womanhood in this setting.

The women in this category were all forced into marriage as a livelihood strategy. Beatrice (aged 44) is Rwandese and was encouraged to marry when she was a teenager as her parents had died. Beatrice had been taken out of school at the age of 13 as her father said that "educating a girl child is a waste of resources as they can become pregnant while at school". Social norms and factors relating to poverty mean girls often drop out of school and are forced into marital-type relationships(McCleary-Sills *et al.*, 2015). A woman from Beatrice's village identified a partner for her, so she moved in with him and they went on to have nine children together. Beatrice converted from Catholicism to being Born Again to be the same as her partner, but he then converted back to Catholicism. Beatrice knows her husband has other sexual relationships but is unsure how many.

Teddy (aged 31) was also persuaded to get married as she was not in school. Paternal aunts told her to marry at the age of 18 to avoid pre-marital pregnancy. Teddy wanted a church marriage, but her mother convinced her to accept the relationship and cohabit with the man, saying they could formulise the marriage later. However, over time Teddy's husband kept "adding women to the relationship" and producing numerous children. At the time of the study Teddy's husband was moving between the houses of his three wives. Whilst he provided a little support, Teddy said it was not enough to cover the household's needs. The stigma of pre-marital pregnancy is a motivating factor to make young girls marry. Once in a marital-type relationship with children, women often feel trapped or forced to sustain the relationship. If in an informal marital relationship, a woman can be perceived to have no legal rights over children or inheritance in instances of divorce or death of a spouse.

Linda (aged 46) was also forced into marriage as a teenager (aged 15). Her parents were given a cow as she was a virgin, but the marriage later broke down as they lived apart and the man failed to provide support. Linda's friend then identified her second spouse and they started a relationship. Linda quickly fell pregnant, so decided to remain in the relationship. Unintended pregnancy was frequently listed as a catalyst for marriage and a reason for women to commit to a relationship. After Linda's first child was born, her partner went to Linda's father with some small gifts such as sugar, beer, and soap. This annoyed Linda's father, who said the visit was the man's way of avoiding officially asking to marry her and paying bride-price. Informal marriage was associated with failure to pay bride-price, which is deemed disrespectful to the bride's father and family. Bride-price symbolises the value placed on girls and the gender power dynamics surrounding the formation of marital relationships.

These three case studies situate marriage as a livelihood strategy. Young women are often pressured by family members to marry due to poverty, not being in education, the stigma of pre-marital pregnancy and the prospect of bride-price. Having children and living together were identified as features of a marital relationship and once this happens, women and their family can lose the power to negotiate for bride-price or an official ceremony. Furthermore, once these women had given birth and are living in the husband's home, they often feel trapped or forced to sustain the relationship for the benefit of the children.

Informal and living apart

There were two respondents (one male and one female) who were in an informal marital relationship and living apart from their spouse. These two cases share the feature of male labour mobility, which is a theme of this thesis due to the impact it has on marital relations and the

opportunity for extra-marital relations. The marital trajectories of Joseph and Dyana are briefly explained to illustrate how informal marital relationships can operate when a couple lives apart.

At the time of the study, Joseph (aged 60) was running a pork food joint and bar, living away from his wife. He had numerous other sexual partners. Joseph already had ten children with four women and a fifth partner whom he met in his bar was pregnant at the time of the interview. Joseph only regarded three of the women as his wives, but two of the marriages had broken down and with the remaining wife he said they were "still looking for money to legalise the marriage". This wife was living with two of his children in his home village, while Joseph was working in a trading centre where he could get more customers. Living apart had evidently put pressure on his marriage, as Joseph suspected his wife of having an affair and Joseph had also had numerous extra-marital relationships. Despite these problems, he remained adamant that he wanted to marry his wife in church one day. A church marriage was inferred to be a life goal, to demonstrate commitment to his wife and his religious beliefs, which were obviously part of the identity Joseph was trying to construct or publicly project.

The other respondent in an informal marriage living apart from the spouse was Dyana (aged 35), who was living with her aunt and two sons, whilst her spouse was working in Kampala as a fish trader. Dyana is HIV positive. Her story (discussed in more detail in Chapter 8) highlights a life and marital history shaped by factors that are also key risk factors of HIV: sexual violence, transactional sex, labour mobility, and social pressure to conform to gender ideals. Dyana first got pregnant at the age of 13 after a youth from her village gave her small amounts of money and forced her into sex. Dyana went on to have two other relationships. The first broke down as the man was very promiscuous. The second/current relationship began when the man started giving her fish. Although Dyana was not keen on the man, her aunt convinced her to remain in the relationship because she had got pregnant again and her aunt was concerned about her producing children from different men. Dyana's spouse had seven other children with another wife in the same village.

Joseph and Dyana's stories provide insight into the construction of informal marital relationships affected by male labour mobility. In these cases, living apart provides opportunities for the man to have multiple concurrent sexual relationships (discussed further in Chapter 8). Cultural norms of men as providers and women being socio-economically dependent sustains unequal power dynamics, which shapes perceptions of rights, entitlements and therefore capabilities. These culturally prescribed roles and unequal power dynamics underpin norms of transactional sex (discussed further in Chapter 5). Furthermore, females can

be pressured to remain in marital arrangements and lack power to challenge a spouse due to pregnancy, children and notions of gender norms (also discussed Chapter 5).

4.3 Customary marriage

Ten of the respondents (six male and four female) were in a customary marriage at the time of the study. A customary marriage was defined in terms of an introductory meeting having taken place between the groom and the bride's family, the paying of *omutwalo* (bride-price) and the giving of *akasiimo* (gifts for the family). It is evident from the life-stories that the value of the bride-price and type of gifts are linked to the groom's wealth, how the marital relationship is initiated, whether the woman is already pregnant or has children and the social condition of the bride's family. The life stories show customary introductions can range from a brief conversation and giving a few perishable goods to a formal ceremony involving large sums of money and livestock. Customary marriage is legally recognised by the state, respected in the community and there is no limit to the number of wives a man can customarily marry. This means that it is more affordable for men to follow customary marital traditions to acquire a wife, re-marry or have multiple marital partners. As a man can marry multiple customary wives, women do not have the same rights to inheritance as they might within a religious marriage, nor is either spouse entitled to a religious burial. This affects social recognition of the marriage and power to negotiate the relationship, particularly for women who know that their spouse could legally marry another woman.

Men in a customary marital relationship were often older, had been married before and had been in a polygynous marriage. Gerald (aged 81) and Godfrey (aged 85) had both married their first wives in a Catholic church, but the relationships had broken down and the wives had since died. Gerald said he intended to marry his current wife in church because, "After I die I want my wife to remain in charge of the house and the surrounding *kibanja* [land], I also don't want to be buried like an *mbidde* [banana]", meaning being discarded without prayer or ceremony. It was apparent from the narratives that customary marriage is respected as an official type of marital relationship. However, it does not have the same recognition as a religious marriage, which affects perceived inheritance entitlement and burial rights. The customary marriage is deemed more affordable, easier to arrange and sanctions men to marry more than one wife consecutively or over a life-time.

The three other male respondents entered a customary marriage when they were younger as an affordable and respectable strategy for acquiring a wife to avoid the risk of prison and HIV. Rakibuh (aged 54) and Michael (aged 32) both paid bride-price and got married to

avoid being sent to prison for having a sexual relationship with a school-aged girl. Both men had remained with the women. Rakibuh had eight children with his wife and Michael had two. In both cases the men implied that they had felt pressured to marry their spouse after she got pregnant. Customary marriage was recognised by respondents as a strategy to avoid accusations or prosecution for defilement. The unequal structure of gender relations and the context of poverty means that the families of pregnant schoolgirls will often accept bride-price as compensation and so the man takes responsibility for the girl and subsequent child, rather than pursue the costs of prosecution. Marriage also makes the sexual relationship, which is often started and based on transactional sexual exchange, more socially respected.

The third man in this type of marriage got married due to his desires to "own a wife and avoid contracting HIV". Julius (aged 24) was unlike many other male youths, as he admitted he was fearful of having multiple sexual relationships due to the risks of HIV. Julius had become a successful coffee farmer and built his own house, which attracted a lot of attention from girls in the village. Instead of capitalising on this attention, Julius asked a nephew to find him a wife. The nephew identified a 16-year-old girl from the neighbouring village; Julius was attracted to her, so proceeded to negotiate bride-price. The girl's father had died, so he negotiated with the mother, who requested a million shillings (approx. £250), which Julius agreed to pay in two instalments. Julius also gave four *gomesi* and three *kanzu*, which are traditional items of clothing (Photograph 4.4). This case shows how a girl can be easily bought through the customary marital exchange in order for a man to achieve a respectable notion of masculinity (discussed more in Chapter 6).

A combination of gifts and money can be given as bride-price, which can be an incentive for impoverished families to pressure girls to marry. Julius's case also provides an insight into the role of matchmakers, who are often instrumental in arranging marriages and can lead to marital relationships in which the couple know very little about each other.

Photograph 4.4 Kanzu shirt and gomesi dress

(Subjects in this photo were not part of this research)

Women in customary marriages were often in polygynous marital arrangements and their stories once again highlight gender relations and inequalities. Julie (aged 43) got married because she got pregnant, after being enticed into transactional sex at 15. I use the word 'enticed' as Julie admitted she consented to the sex as she wanted the money and small gifts the man offered her. The man was ten years older and Julie was living with her poor, blind grandmother at the time. Julie remained in the relationship with the man, who provided her and her grandmother with financial support. After giving birth to a second child, the man then contacted the grandmother and expressed a wish to take Julie to his home. As bride-price he gave the grandmother "a piece of cloth (for a *gomesi*), sugar and meat, plus a calabash of beer". Julie and her partner went on to have seven children and during this time her husband married two other women. At the time of the study, her spouse was living with the third wife. Julie said they had not had sex for three years, but still regarded herself as married as she lived on her husband's land.

Like so many marital type relationships in this setting, material transactions were central to the initiation or beginning of Julie's marriage, with the man offering gifts or financial resources in exchange for a relationship, and with that, sex. A woman's poverty or desire to leave a deprived or difficult home life can mean engaging in a sexual relationship that includes a form of economic support. At other times, females can be pressured or coerced into such exchanges and after getting pregnant feel there is no option but to remain with the man. Gender inequality characterises both these circumstances and continues into marriage. In Julie's case, her husband had married other women and even though Julie no longer had a sexual relationship with him, she remained living on his land. According to customary traditions a man can legally marry as many wives as he wishes, so the main source of power a woman has

stems from capabilities to maintain good relations with the spouse. Julie seemed content with her situation as her children were building her a new house and supporting her. Her husband no longer requested sex and his newest wife did all his washing and cooking. However, for other female respondents being in a polygynous marriage was found to limit their agency.

Naomi (age 37) and Ayra (age 41) were the two other female respondents in customary polygynous marriages, both deeply dissatisfied with their socio-economic situation. Both had attended senior school and were therefore the most educated female respondents. They were also both living in the trading centre (the most urban village) and were managing shops. Their homes were rented accommodation attached to the shop, built from concrete with painted walls, electricity and running water. Both women were effectively head of their household as their husbands moved between wives. Naomi and Ayra both described themselves as ambitious and business-minded, and they justified getting married to older men as they wanted to be respectable woman. However, over time their husbands 'added' other women to the marriages. Both women enjoyed the financial independence their husbands afforded them, but were also concerned about their husbands' sexual behaviour and exposure to HIV. Both women wanted more children but were avoiding sex and/or using family planning. These women had dropped out of education to get married, as they perceived marriage as a livelihood strategy and a way to develop themselves. However, as their husbands began relationships with other women, they became disempowered to negation the relationship as they had children to support. The structure of gender relations, in terms of cultural norms of polygyny and expected gender roles had therefore stifled their choices and capabilities.

The last female story of customary marriage emphasises how gender structure interacts with poverty to make marriage a livelihood strategy. Namakula (aged 45) had children with two men before getting married. Her previous relationships broke down due to problems with alcohol, violence and abuse and these structures of gender inequality and violence towards women are discussed more in Chapter 5. Namakula's neighbour acted as a matchmaker and she quickly moved in with the man; they started the relationship knowing little about each other. Namakula admitted that she accepted the relationship because the man did not have a wife and she had children to support. After a short time the man insisted on going for an introduction with Namakula's family as "he was worried that they would sue him if he had not done so". He took two calabashes of local brew, sugar, bars of soap, salt and some other small gifts to Namakula's family. At the time Namakula and her spouse were living with four children in a small dilapidated mud and brick house. Namakula got married as a livelihood strategy so to support her children. Pregnancy and children were frequently listed as reasons

female respondents had entered marital relationships, whereas her spouse was keen to legalise the marriage to avoid persecution and have legal rights and ownership over Namakula. These gendered perspectives highlight the unequal socio-economic structures surrounding marriage, which sustain female dependency and male ownership.

In summary, the customary introduction is a social practice that demonstrates respect to the bride's family, but also provides the opportunity to negotiate bride-price, which is socially recognised as a conjugal agreement and gives the groom ownership and responsibility for the wife. The amount paid in bride-price can vary substantially depending on the socio-economic position of both the bride's family and the groom. The income and gifts that can be received from bride-price are valued, which creates an incentive to force or encourage girls into marriage. There is no restriction on the number of wives a man can marry through this customary practice, which is one way a polygynous arrangement can be officiated. This type of marriage was also found to be common amongst older males who have been married before. A customary introduction is usually the first step to legalising a marriage and some couples then go on to have a religious ceremony.

4.4 Religious marriage

In this setting, a religious marriage means the relationship has been endorsed by either a Christian or Muslim institution. Fifteen participants said their marriage had been endorsed by a religious institution (four Islamic, nine Catholic, one Protestant). This type of marriage was regarded by respondents as highly respected in the community; however, as the life-stories illustrate, the lived experiences of a religious marriage can vary greatly. The endorsement of a religious institution and the respect of the community does not mean this type of marriage is necessarily stable or sexually exclusive. However, being in a religious marriage did seem to shape perceptions of commitment, entitlement and reasons to sustain the relationship.

In this section the role of religious and religious institutions endorsing and sustaining the organisation of gender relations and marital ideals is examined. Religious beliefs and traditions encourage females into marriage and promote male authority over women. Although Catholic and Protestant marriages are monogamous and Islamic beliefs endorse the marrying of four wives, men were found to have extra-marital relationships in all these types of marriage. The way the marriage is publicly presented or categorised can be very different to how it might be privately constructed or lived.

Catholic marriage

Catholic marriage was the most common form of religious marital relationship among my participants and more generally in the setting. There were nine respondents (three male and six female) who said their marriage had been endorsed by the Catholic Church. All the respondents and their partners defined themselves as Catholic. Most of the marriages had been arranged or facilitated by a family member and there were no cases of formal polygyny in this group, but most of the life-stories featured extra-marital relationships during the marital life-course. Respondents in this group tended to be older and referred to religious marriage with respect and pride, considering it an expression of commitment to their faith. The respondents' connection with these institutions was found to shape a sense of identity, respectability and eligibility for a Catholic burial ceremony.

The three Catholic men were all over the age of 50, living with their family and a relation had identified their marital partner. Firstly, Peter's (aged 61) father had arranged his marriage. The relationship had started as a customary marriage as he paid bride-price and after ten years the couple had a marital ceremony in a Catholic Church. Peter had had an extra-marital partner for two years, but the relationship broke down as the "woman was promiscuous". He said he apologised to his wife for the affair, she forgave him and they remain together. Secondly, Wasswa's (71) father also arranged his marriage and helped him to pay bride-price. At the time, Wasswa's wife had just finished primary six (aged around 18). Wasswa was a virgin and said this was one of the reasons he was keen to marry: his wife had already had sexual relations and therefore had to "teach him about sex". During their marriage, they had seven children; Wasswa admitted to having two extra sexual partners: one was a brief fling at a wedding and the other he met at a bar, and they produced two children together. Lastly, Leo (aged 52) had left his training as a monk to get married, as he had decided to dedicate himself to marriage and "serve God that way". Leo's sister arranged his marriage, as she knew the qualities he was looking for in a wife. When she identified a girl, he went there to "see if she was attractive". They then "went for HIV testing" and "preceded with paying bride-price and finally married in the church". HIV testing was found to be commonly promoted by religious institutions in the area. In Chapter 8 I discuss the role religious institutions have played promoting testing before marriage, serosorting (encouraging individuals to enter sexual relationships with someone of the same HIV status) and messages of being faithful to protect against HIV, which hinder the discussion of HIV risk in marriage.

In the three cases of male Catholic marriage, bride-price was exchanged before the religious ceremony and family members were involved in the partner selection and helping to

cover the costs of the marriage ceremony. More broadly, it was evident from the life-stories that individuals use religious discourse and institutional guidance to interpret and justify reasons to get married, define marital roles, define fertility preferences and family planning strategies (discussed further in chapters 5, 6, 7 and 8).

The six female respondents in a Catholic marriage were mostly in the older age category and family members had arranged the ceremony. Four of the women were over the age of 65 and half had been pressured to marry when they were very young. Jessica (aged 67), Nakamaty (aged 76) and Ruth (aged 46) were all pressured to marry older men by their parents when they were 14-16yrs. During the bride-price negotiations Jessica had sex with another youth who offered her gifts, and she was pregnant when she married her partner. The mother-in-law insisted the baby be removed from Jessica a week after the birth and given to a relative; the child later died, which she deeply regretted. Despite their marital problems, Jessica said in older age she now relates well with her husband and "prays they will remain healthy so that they celebrate 50 years". To sustain a marriage to the Golden Wedding Anniversary was framed as both a personal goal and reflection on how well the couple have fulfilled marital roles.

Nakamaty and Ruth had both been pressured into marriage and experienced a lot of difficulties with their husbands; however, they had remained in their marriages and were both caring for their sick husbands. Nakamaty (aged 76) said she accepted her arranged marriage to escape the "cruel" treatment of her mother, but found her husband did not take care of her. Nakamaty's father tried to intervene on several occasions. Once her father wrote a letter saying ''If you cannot care well for this wife who you married officially in church and are irresponsible, bring her back home for good!" Despite her husband being "stingy" and often neglecting her needs, in older age Nakamaty was caring for him "as if he is a child", expressing a sense of duty to fulfil her role as a wife and care for her husband.

Ruth (age 46) was also pressured into marriage by her parents when she was 16, to an older partner aged 28. As Ruth was a virgin this meant her parents were given a young female goat as part of the bride-price. Traditionally the goat is tethered outside the parents' home to signify to the community that the daughter's virginity has been protected until marriage. Ruth's partner was violent during the marriage until recently, when he became infirm and bedridden. Ruth said she has never felt sexual desire for her husband or other men; she once had a brief extra-marital relationship whilst pregnant with her husband's child, which only confirmed her lack of pleasure in sex. Despite being unhappy in the marriage Ruth felt unable to leave, particularly when her husband became sick. To uphold her sense of dignity and duty as a wife, she remained in the relationship to care for him, despite the way he had treated her.

In contrast Paula (aged 65) and Kathy (aged 66) were initially in a customary marriage and only in later life undertook a Catholic marital ceremony. Around 2010 Paula was very sick and when a priest found her bedridden at home, he proposed the sacrament of matrimony to rescue Paula from "dying in sin". The Christian congregation within the community supported the priest's proposal and so Paula and her partner were married by the priest in their home. This meant Paula and her husband would be entitled to a Catholic burial. Paula remarked that her husband was not interested in other women and perhaps wanted to marry to avoid HIV, which had become more prevalent in the village. Paula died after the first life-story interview, reportedly due to a stroke. Therefore, only part of her life-story was collected, she disclosed that she had been raped as a teenager; that her first customary marriage broke down due to conflict with her co-wife; and that she accepted her second spouse after she fell pregnant. Getting her marriage endorsed by the Catholic Church was an important life-goal for Paula as she was concerned about her health, wanted to be entitled to Catholic burial and craved the respect of the community.

Kathy and her husband had a Catholic marital ceremony to "cleanse" their marriage. Kathy's husband had married his first wife in church and after she died he could legally marry Kathy. She explained that they would have celebrated their Jubilee anniversary (50 years) that year (2015) if they had got married in church right away, but the years she spent in the relationship before did not count, according to the church. This meant that Kathy used religious beliefs as a lens to define and frame her marital life-course. Despite being together a long time, Kathy remarked "I have felt almost no joy in marriage". This was related to the partner moving away to farm, leaving her to raise their family in the village: "he abandoned me with all the work and the upbringing of the children. I have struggled with single parenting without him at hand". Kathy disclosed that the community do not respect her, as her husband is not around. "A household where a man happens to be, is a respected one". This shows that despite being married in church, living circumstances can affect social perceptions and experiences of marriage. Kathy also admitted to having an extra-marital partner for almost ten years to support her when her husband failed to send money home. The expectation of marital gender roles and the social determinants driving female and male engagement in extra-marital relations are discussed further in Chapters 5 and 6.

Gladys (aged 28) was the youngest female respondent in this type of marital relationship. Gladys had married her third sexual partner in church. The first sexual relationship resulted in Gladys becoming pregnant at the age of 18. The man was a much older banana trader who used to give her money. Due to the shame of the pre-marital pregnancy, after giving

birth, Gladys's family pressured her to get married. They choose a 50-year-old traditional healer, whom Gladys described as a "drunkard" and acted very violently towards her. After having several children, Gladys eventually divorced him. She was alone for some time before she met her current spouse, who said he wanted to marry her in church. Gladys referred to his "good character" as the reason he wanted a Catholic marriage, but it was inferred that her partner was not faithful. At the time of the study, Gladys had seven children and had been recently diagnosed with HIV. Gladys's life-story and the social determinants heightening susceptibility to HIV in this setting (i.e. early marriage, gender-based violence, labour mobility and extra-marital relations) are discussed in Chapter 8.

Protestant marriage

Although there were four respondents who defined themselves as Protestant, only one male had undergone a protestant marital ceremony. Mukasa (aged 42) married his wife in an Anglican church in 1996. He said his uncle had identified his spouse and they met once before deciding to marry. Before getting married, Mukisa reported that he had had several casual relationships and did not find it difficult to attract women because he had money (constructions of masculinity and sexual capabilities being related to wealth are examined in Chapter 6). During marriage Mukisa had several extra-marital relations, two of which he referred to as with his wives, although he never formally married them (but had children with them). Mukisa described himself as '*mulokole*' (saved), meaning that he had confessed his sins and asked for forgiveness. Mukisa described himself as a pious man, who had undergone a church wedding and had avoided HIV by being faithful to his wife; yet he was also unreserved about his extra-marital relations and children. The multiple interpretations of being 'faithful', the common practice of men having extra-marital relationship and HIV risk in marriage are discussed further in Chapter 6. Mukisa's case shows that although a relationship might be publicly presented or described as a monogamous marriage, the man might secretly have extra-marital partners.

Muslim marriage

Unlike Christian marriages, in this setting if a man would like to enter a Muslim marriage, he is expected to pay dowry to the bride. As the Imam explained during the interview, the bride sets the dowry but is expected to repay this gift if the marriage breaks down. Four of the respondents (two men and two women) were in a Muslim marriage during the study. According

to the Muslim faith, a man can marry up to four wives. However, as shown through these case studies, a man in this type of marriage may still engage in extra-marital relations and choose not to formally marry those women. When a man does legally marry other wives, this can still cause marital conflict, especially if the man is deemed not wealthy enough to support another family. The involvement of relations encouraging or pressurising individuals to marry is further highlighted in these stories, as are the prescribed marital gender roles, which causes an unequal power dynamic in marriage, making females socially and economically dependent on a spouse.

The two men each selected their own partners and married in a mosque. Hamid (aged 57) paid bride-price and married his first wife in a mosque in 1978. They went on to have ten children together. During this marriage, Hamid had a casual sexual relationship with a woman and they had two children. Hamid's wife found out about the relationship and "took revenge by having an affair", which caused the breakdown of the marriage. After several years of being single, Hamid's children convinced him to remarry, as they were worried about him living alone. Hamid's friend identified a woman and they married in a mosque and have since produced six children together. Revenge was raised as a driver of female extra-marital relations and cause of distrust in marital relationships, discussed further in Chapter 8. Hamid's story also shows that secret casual relationships are perceived differently to marital relationships and can be a cause of marital conflict/breakdown, especially if the man is deemed to be failing to fulfil his marital role (discussed further in Chapter 6). Hamid's case also highlights the involvement of kinship relations on the formation of marital relationships and the prescribed marital role of a wife being responsible for domestic work may be a reason men choose to get married.

Moses (aged 35) also married his wife in the mosque. Moses and his wife were living apart as he is a teacher and had been posted to a school approximately 3½ hours motorcycle ride from the family home. After his wife produced three consecutive boys, Moses told her he would look for a second partner as he wanted a girl child. Moses negotiated with a fellow teacher at his school and they had a sexual relationship, which resulted in the birth of a baby girl. Around the same time Moses' wife also became pregnant and gave birth to a girl. Moses finished the relationship with his colleague, but still gives some financial assistance for the child and said he would consider marrying a second wife in the future if he had a business opportunity that he wanted a wife to manage. In this case, the extra-marital relationship was driven by the desire for a girl child, inferring a widespread belief that the sex of a child is determined by the mother (discussed further in Chapter 5). Moses seemed willing to only marry an additional wife if it would be financially beneficial. Marriage and extra-marital relations can therefore be used by men to achieve fertility goals and/or developmental plans.

The two female respondents in a Muslim marriage were both living with their partners and, similarly to the women in Catholic marriages, had been pressured by family members to marry young. Shakirah (aged 37) was 15 when her paternal aunt identified a partner for her to marry. Shakirah had failed her last year of primary school exams and so was told by her family she had to get married. Shakirah was a virgin and so her parents were also given a goat amongst the bride-price gifts. The couple were married in a mosque and went on to have nine children together. Shakirah did not know if her husband has other partners or children. Similarly, Aisha (aged 29) married at eighteen and described it as a "blind marriage" as she had not met her spouse before the wedding day. Aisha was also pressured by family to marry because she had dropped out of education and had a one-year old child. She had become pregnant at the age of 16 by a youth from her village that used to give her money for sex. The child remained with Aisha and was brought up with the other four children. Aisha's husband had recently married a second wife, which had caused conflict. Aisha acknowledged polygyny to be part of the Islamic religion but said her husband could not support more wives. She said "we would have put up a better house and be living a better standard! We are however now stunted" Shakirah and Aisha further highlight the pressure placed on girls to enter early marriage, prompted by discontinuing education and pre-marital pregnancy as a result of transactional sex (themes discussed further in the next chapter). Both women also expressed a need to remain in their marital relationships for the sake of their children.

4.5 Summary

This chapter has provided a typology of marriage to demonstrate what constitutes a marital relationship in rural south western Uganda. The typology has been used to illustrate the various configurations and living circumstances of married individuals in this setting. Four main types of marital relationship were identified and then broken down into nine sub-types with the couple either living together, partially or consistently apart. The type of marriage depends on whether the man has paid bride-price, whether the couple have gone through a cultural or religious ceremony and whether the couple or community regard the relationship to be marital.

Whilst types of marital relationship vary, notions of gender roles and inequality of power were found to be largely consistent. This is evident in the reasons men and women marry or remain in marital relationships. As shown in this chapter, females often enter or remain in marital relationships due to reasons relating to pregnancy, children, financial dependency and social pressure from family members. Whereas males tend to possess greater power to choose marital partners, commonly marry more than once and/or have extra-marital partners. These

drivers to enter and remain in marital relationships indicates structural gender inequality. The construction and organisation of gender relations are central to understanding marital roles and power dynamics.

The institutions surrounding marriage sustain the patriarchal structure of gender relations and inequalities of power. Whether a marriage is legally recognised and/or endorsed by a religious institution shapes perception of rights and entitlement. In this setting, being married means a man is perceived to have ownership over his wife. The various cultural and religious institutions that endorse marriage indicate the number of wives a man should or can marry. The Catholic institution states a man should only marry one wife and not divorce; the Protestant agrees a man should only be married to one woman at a time but can divorce; and Islam states a man can marry four wives. The cultural custom of marriage in Uganda allows men to marry a limitless number of wives, while according to all these institutions a woman can only be married to one man at a time.

Whether the marriage is deemed legal and endorsed by a religious institution relates to entitlement/eligibility for a religious burial ceremony and shapes perceptions about legitimacy of children and rights to inheritance. However, as has been explained in this chapter, for females, entitlement to socio-economic support from a spouse and rights to inheritance largely depends on strength of relationship with a spouse and his kinship relations, rather than judicial rights.

The life-course perspective has been used to show that types of marriage are not fixed and that couples can transition from one type to another during the marital life-course. Furthermore, the institution of marriage is changing across generations. Cases of informal marriage seem to be increasing due to male unwillingness and/or inability to pay bride-price, cases of polygyny are also decreasing as men are increasingly choosing to instead only formally marry one woman and engage in extra-marital relations.

For each couple the process and transitions of marriage can vary substantially, and the relationship can evolve and change over time. These phases and transitions are shown later in this thesis to shape and influence perceptions of reproductive roles, negotiations of sex and female family planning practices. The process of marriage can involve various stages, such as pregnancy, childbirth, exchange of bride-price, living together or undergoing a cultural or religious ceremony. The stages can occur or be experienced in various sequences. Marital type relationships can also start as transactional sex or as a casual or extra-marital relationship. Over the life-course individuals can also go through several processes of marital relationship, as marriages can break down and individuals re-marry.

The institution of marriage extends beyond the couple and involves multiple individuals, which indicates that individual lives are interdependently linked through social relationships. Intra and extra-household relations influence marital relations at different stages of the marital life-course. As shown in this chapter marriages are frequently arranged by matchmakers, which mean the couple marry knowing little about each other, including their sexual history. Kinship relations also play an integral role in the negotiation of bride-price, counselling the couple and helping to raise children. Children are the expected product of a marital relationship and deemed an indicator of a successful marriage (discussed more in Chapters 5, 6 and 7). The life-course perspective also shows that marriages often intersect with other types of marital or extra-marital relationships. Co-wives and extra-marital partners are therefore also agents, shaping the dynamics of a marital relationship and are part of the risk environment heightening susceptibility to HIV (discussed in Chapter 8).

The lived experience of marriage therefore varies greatly, and the public representation of a marital relationship does not necessarily relate to how it might be privately enacted. Despite the differences between the living circumstances and the way a marriage might be endorsed, there are also shared patterns or features. Marital instability, male engagement in extra-marital relations and cases of polygyny occur across all types of marriage, regardless of how the marriage is publicly presented. The other shared feature relates to notions of culturally prescribed gender roles in marriage. Broadly, these marital roles, which are discussed in more detail over the next two chapters, centre around the husband as provider and the wife producing children and taking care of domestic work. The couple are expected to work together on a shared ideology of marriage, which is connected to developing the family and the home. These frameworks of gender shape the socio-economic power dynamics between men and women in marital relationships.

This chapter has therefore provided a starting point to understanding the social determinants shaping the institution of marriage and the unequal gender power dynamics of marital relationships. The cultural practice of bride-price indicates the transference of ownership of a female from her family to her husband. The incentive of bride-price and the livelihood strategy of becoming a wife are reasons girls are pressured into early marriage by family members (discussed further in Chapter 5). A girl's socio-economic situation, physical features, whether she is a virgin, already pregnant or has children, can all affect her value and the power the bride's family has to negotiate bride-price. Pre-marital pregnancy was commonly linked to engagement in transactional sex or the result of gender-based violence (explained in detail in next chapter), whereas the type of marriage was found to largely depend on the man's

socio-economic situation and actions, which link to his capabilities and motivations to attract a marital partner, pay bride-price and perhaps pay for a marital ceremony, and provide for a wife and family (discussed further in Chapter 6).

The next two chapters examine in more detail the cultural beliefs relating to marriage that shape perceptions of marital gender roles and social practices. The following chapters explore the expectations, obligations and conditions of sex and reproduction in marriage. Although love was rarely mentioned as a reason to marry, it was discussed as something that is expected to grow in marriage over time, expressed through the enactment of gender roles and social practices, which are explored further in Chapters 5 and 6.

Chapter 5 –Female roles, duties and practices relating to marriage

The aim of the next two chapters is to illustrate what it means to be married in this setting and how this influences social practices, particularly those relating to the negotiation of sex. To do this, the following chapters examine the ideologies and belief systems attached to marital gender identities and cultural norms to situate expectations of sex and reproduction within the context of marital roles, duties, and practices. Gender ideologies and cultural norms are frameworks, defining expected sets of gender behaviours and constraints, which inform 'recipes for living', through which practices, behaviours and experiences are mediated (Giddens, 1984; Campbell, 1997; Strathern, 2016). Building on the evidence presented in Chapter 4, marital ideologies and cultural norms are argued to shape gender power dynamics and act as social mechanisms to maintain the patriarchal order and control over female sexuality, by privileging male sexual entitlement and authority. Although women exercise agency by harnessing these ideologies to negotiate sexual relations, it is argued in this chapter that the conditions surrounding sex and responsibilities of reproduction disadvantage female negotiation and heighten unequal risk and vulnerability (Gupta, 2002).

A summary of Linda's life-story (aged 43) begins this chapter and is used to discuss key cultural norms and gender ideologies in the context of life-course transitions and the negotiation of sex and marital relations. It is recognised that individuals adopt, negotiate and adapt various gender ideologies to live their daily lives, interpret life-experiences and construct a sense of self depending on the audience (Giddens, 1984; Connell, 1987; Butler, 2011). Two key identities are deemed central to womanhood in Africa (wife and mother). Mungwini (2008) remarks that these identities are based on notions of 'belonging' and 'producing', illustrating the relational nature of these identities and that social recognition and value of being a woman is dependent on getting married and giving birth. The ideologies of wifehood and motherhood are therefore entwined with what it means to be socially recognised and valued as a woman (Whitehead, 1981). In this chapter, the cultural beliefs surrounding wifehood and motherhood are argued to be socialised from girlhood, and ideas are circulated and reproduced through religious institutions and intergenerational gender relations, which facilitate control over female sexuality and retain power structures of patriarchy.

In Uganda, being a 'good' woman is based on being married, hard-working and obedient; assisting the husband with development plans, fulfilling his sexual needs, producing children and maintaining cleanliness of the body and home (Bantebya Kyomuhendo and

Keniston McIntosh, 2006).. This discourse has been traced back to campaigns led by the colonial administration at the turn of the twentieth century to supposedly reduce the spread of venereal disease and increase fertility rates to improve agricultural productivity (Summers, 1991; Bantebya Kyomuhendo and Keniston McIntosh, 2006). These feminine ideals were built upon existing cultural beliefs and the power structures of gender relations to enhance male control over female sexuality and productivity (*ibid.*). Over the course of the century, Uganda has transitioned through major social, economic and demographic changes (see Chapter 8); however, ideas from this discourse are argued to continue to shape gender norms, not just for women but also for the gender role of men as providers and head of the household (Bantebya Kyomuhendo and Keniston McIntosh, 2006).

From childhood, girls are socialised to accept social practices of transactional sex and that sexual coercion and violence are an inherent part of the social landscape, in which male perpetrators are rarely held accountable (Nyanzi, Pool and Kinsman, 2001; Koenig *et al.*, 2004; Parikh, 2004; Maticka-Tyndale *et al.*, 2005). Girls are prepared for marriage by being socialised to take responsibility for domestic duties and conditioned into sexual practices such as labia elongation in preparation for sexually satisfying a future husband (Tamale, 2006). Girls are generally ill-equipped to negotiate sexual relations or practice safer sex (Gupta, 2002). Instead, girls are prepared for and pressured into marital relationships where they are expected to be subservient to their husband (McCleary-Sills *et al.*, 2015).

The discourses of wifehood and motherhood are therefore used as frameworks to illustrate the expected behaviours and constraints, which are used to compare, judge and blame women for not fulfilling marital roles and being the cause of men's extra-marital relations (Mungwini, 2008). The tension, power dynamics between roles, identities and gender relations are recognised to change over time, affecting marital relations and expectations, obligations and conditions of sex. It also shapes motivations and pressures to maintain and sustain a marital relationship.

5.1 Linda's story

Linda (aged 43) was in an informal marriage, cohabiting with her husband, their five children and grandchild. Linda was living in one of the more rural villages on the edge of the study site. Most of the village population are involved in agricultural work and HIV prevalence is around 9.3%. Linda's house had two bedrooms, one for the children and one for Linda and her husband; the rooms were separated by pieces of cloth (photograph 5.1) and there were no ceilings. Linda suggested that such living conditions impede on sexual privacy and might be a reason married men seek outside sexual partners: "You cannot act how you would have acted when you do not have children! I even think it is what leads the men to practice promiscuity!"

Linda suspected her husband to be having extra-marital relationships and speculated that this might be to try and produce a second girl child, as she had given birth to four boys and only one girl. Linda was concerned about contracting HIV and described her husband as "very promiscuous": he had previously infected Linda with syphilis and it was known that he had several extra-marital children with at least two other women. Although the couple did not test together or directly discuss HIV, her husband would leave his testing card on the coffee table to communicate that he was "HIV free". Despite being very dissatisfied, Linda had reasons to remain in the relationship. It was her second marriage: she had a total of nine children, three from her first marriage, one of whom died young; and six younger children from the current marriage whom she was desperately trying to educate. Paying school fees was therefore Linda's top priority.

> I stay for the sake of these children of mine who are young, because the older children never had an education as I became disturbed! When I think about being disturbed again, these too will not get a chance to study. I do not have hope to produce children anywhere else, I am ageing. I want to struggle for these young ones because they are the last children.

Linda's first marriage to a 24-year-old businessman from Kampala had been arranged by her paternal aunt (*ssenga*) when she was just 15. The man's parents lived in the same village as her aunt and Linda thought she was chosen as "a well-behaved girl". Linda's parents were given a cow as part of the bride-price and Linda began living with the man immediately after the ceremony. Within a year, at the age of 16, Linda gave birth to her first child.

Before getting married Linda had been in one sexual relationship with a classmate who gave her small gifts in exchange for "playing sex". Linda commented, "we were in love for just a short period, as children who try it through play". Linda's education was disrupted as she

was helping her aunt with domestic work and would also travel home and assist her mother each time she gave birth, which was every year or two whilst she was growing up. Before finishing primary school, Linda was taken out of school due to lack of money to pay fees, and so her aunt said it was time for her to get married. Linda said she felt bad about it, but had no say in the matter. Linda had lived with her paternal aunt from the age of one. Linda was the oldest child at her aunt's house and therefore grew up doing much of the housework, including cultivation, washing, cooking and cleaning. This irritated Linda, but after getting married she appreciated that her aunt had taught her to work hard without rest, because this helped her to sustain in marriage.

Linda learnt about sexual and reproductive health practices from her aunt and other girls in the village. Linda's aunt counselled her through the menses ritual and menstrual hygiene practices and prepared her for marriage with advice about the importance of sexually satisfying her husband. Girls in the village told Linda about labia elongation, which she started practising when she was seven or eight. Linda recalled the girls telling her,

> If you don't do it when you are older your mother-in-law will make you lie on the road junction and spill millet into your private parts so a cockerel will come and peck you.

Although Linda now laughed at this childish story, she more seriously explained:

> Men like it! I think when a man marries you and you do not possess it, he says you are not full! He can regard you as someone who never received counselling. I think if he has happened to have gone outside [the marriage] and meets a woman with such, he can regard you as someone who really lacks something, an abnormal woman.

As a married woman with children, Linda said she has no time to learn or engage in practices to increase male sexual satisfaction, and acknowledge that some women do use such tactics and this might be another reason men engage in extra-marital relations: Linda talked about other women who appear smart because they have extra partners. Linda emphasised that despite her husband failing to provide financial assistance for her to spend on her appearance, she had turned down sexual advances "to maintain my dignity as a married woman", although she also admitted to having had a short affair with a married man between her own marriages, who use to buy her gifts.

Linda's determination to sustain her current marriage was linked to educating her children and a sense of guilt for the failure of her first marriage. Linda's ex-husband had been working in Kampala and failed to send her money; her second child (1½ years old at the time)

became sick and died from suspected malnutrition. Linda was unable to contact the husband and was forced to bury the child alone. Linda said losing the child affected her very much, but when asked why the marriage broke down, she replied “I failed”, implying that it was down to her inability to sustain the relationship rather than her husband’s negligence. Linda’s current marriage was organised by her cousin who acted as matchmaker. Linda agreed to marry her spouse knowing little about him. They moved in together and had a child before the husband went for an introductory meeting with Linda’s family. He took small gifts (soap, beer etc.) but did not discuss paying official bride-price, which annoyed Linda’s father. He blamed Linda, saying she had been “paid off with simple gifts” and not “to expect the man to organise any other formal visit”, suggesting the husband would never formalise the marriage.

Problems in Linda’s current marriage started with her husband working away growing coffee. He gradually stopped sending money, but Linda waited, hoping he was saving or investing the money in developmental plans. Eventually the husband stopped providing completely. Linda overheard women gossiping about her appearance, which upset her very much. Linda discovered her husband had another wife, learning of the relationship after they separated; she then heard her husband was having an affair with her sister-in-law. “At first, he denied the relationship but then gave me a goat and asked for forgiveness”. However, her husband’s behaviour did not change. Over the course of the marriage Linda also experienced several miscarriages, during one of which she almost died. Her husband’s callous response to this trauma also damaged the sense of trust in the relationship considerably.

Photograph 5.1 Entrance to bedroom

(Note: To protect Linda’s identity this is not her bedroom, but an example of how rooms can be partitioned)

5.2. Girlhood

To draw out the beliefs and discourses touched on in Linda's story, this first section focuses on the meaning of being a woman, the associated duties, sexual practices and reproductive responsibilities, which are socialised and conditioned from girlhood. The prescribed gender roles burden girls from a young age with domestic chores and childcare responsibilities, are known dominant reasons that girls miss and discontinue education (McCleary-Sills *et al.*, 2015). In Uganda girls are taught to be submissive to male authority and encouraged through peer relations to engage in practices such as labia elongation to prepare for marriage (Tamale, 2006). Lack of work opportunities for girls, plus the incentive of bride-price and fear of pre-marital pregnancy, mean family members often encourage or force girls into early marriage (Schlecht, Rowley and Babirye, 2013). Exploration of sexuality and enticement of gifts or money are also drivers for engaging in sexual relations before marriage, which girls are ill-equipped to negotiate (Nyanzi, Pool and Kinsman, 2001; Wamoyi, Fenwick, *et al.*, 2011; Stoebenau *et al.*, 2016). A range of socio-economic factors including poverty, consumerism and structure of gender relations and cultural norms create a risk environment for girls being enticed into transactional sex and subjected to sexual coercion and violence (Koenig *et al.*, 2004; Stoebenau *et al.*, 2016).

5.2.1 Preparing girls for marriage

Girls are told to be well-behaved, hard-working and obedient, as these are the characteristics deemed suitable in a wife (Bantebya Kyomuhendo and Keniston McIntosh, 2006). Marriage is perceived as necessary and it is viewed as natural for a woman to want to start her own family and be socially recognised as an adult. The previous chapter highlighted marriage as a livelihood strategy, and a mechanism to control female sexuality and avoid the stigma of pre-marital pregnancy. This section examines the conditioning of girls for marriage, the characteristics of being a suitable wife and expected sexual practices within marriage.

It is necessary for girls to marry to be recognised as a woman in the community (Mungwini, 2008; Seeley, 2014). Life-story respondent Jessica (aged 67) remembers her grandfather saying *omukazi akula maka, genda ofumbirwe* ('a girl is only realised as an adult when she gets married'). This framing of marriage as being part of natural transition to becoming a woman is used to encourage girls to get married. One respondent reflected on the way her mother convinced her to marry:

> my mother comforted me and told me "you will get used to him and will become an adult woman! If you stay here they will snatch you away from me and take you to town

> because they admire you! Get married to this man: he will provide for you and your father has already accepted. (Kathy, aged 66)

The *ssenga* (paternal aunt) is a key figure in *Baganda* culture, responsible for teaching girls clan knowledge, sexual rituals and practices, counselling and shaping behaviour, and acting as a matchmaker for marriage (Tamale, 2006). Preparing a girl for marriage involves teaching work ethics and social etiquette to be obedient and demonstrate respect. Dyana (aged 35) said that her aunt taught her that "an obedient person kneels down properly and greets people", demonstrating both obedience and respect for authority; some respondents specifically mentioned that a woman should kneel to greet her husband. This social practice indicates that girls are conditioned from girlhood to respect patriarchal social order and authority.

Girls are also socialised into the practice of labia elongation to prepare for marriage and avoid the stigma of being perceived abnormal or sexually unappealing by the husband. Linda mentioned practising *okukyalira ensiko,* which literally translates to 'visiting the bush' and refers to labia elongation. As a girl she admitted to carrying out the practice due to the childish scare story told above, but also the fear that if she did not conform, she might be rejected by her future husband or mother-in-law. Paula (aged 65) explained she 'visited the bush' as her *ssenga* told her "it is vital for marriage so your husband doesn't look down on you and call you an *empaawo",* which is the term for a bowl that has no cover. She went on to say:

> That (elongated labia) is what makes the man regard his wife as a full woman. Failure to possess [it] makes the man regard his wife as a young child. A man does not enjoy sex with a woman who does not possess that.

Altering the appearance of the genitals is therefore practiced in girlhood in anticipation of male sexual satisfaction. Labia elongation is deemed a rite of passage and symbolises *Baganda* clan membership (Tamale, 2006). The *ssenga* often convinces girls that the practice enhances sexual pleasure for both men and women (Martínez Pérez and Namulondo, 2011), and thus perceptions of altering the female body and fears of social ostracism are socialised in girlhood.

Whilst the institution of the *ssenga* has been criticised for promoting male sexual entitlement and patriarchal control over female sexuality, Tamale (2006) argues the institution has also evolved with modernisation and has been harnessed by women to explore, discuss and share secrets to enhance female sexuality. More broadly, the role of the *ssenga* as a traditional mentor, as well as social pressure from peers, family relations and attitudes in the community, show that the reproduction of gender ideals and cultural norms that guide sexual behaviours are circulated and reproduced through complex intergenerational gender relations (*ibid*).

5.2.2 Domestic work and discontinuing education

Encouraging girls to get married is both a cause and a consequence of discontinuing education (McCleary-Sills *et al.*, 2015). Girls are conditioned into the female gender role, undertaking domestic duties and childcare practices, which are both attached to the home (Bantebya Kyomuhendo and Keniston McIntosh, 2006). The responsibility for this unpaid work burdens girls, interferes with educational attainment and is a driver for early marriage and transactional sex (Gupta, 2002; McCleary-Sills *et al.*, 2015). Poverty and responsibility for domestic work hindered Linda's education and meant she did not finish primary school. It is a cultural norm for family members (particularly aunts or grandparents) to request girl children to undertake duties in the home or for a house girl to be employed to assist the wife.

Prescribed social norms prevent girls from accessing education and are a driver of early marriage (McCleary-Sills *et al.*, 2015); boys' education may be prioritised over that of girls and Kathy (aged 66) remarked, "Our father never valued our education as girl children". Poverty and not being in school were common reasons for girls being encouraged to marry. Ten of the eighteen female life-story respondents stated that they had either been forced or encouraged into early marriage by family members, and all either failed to complete or only completed primary school. Many of female respondents spoke directly of the disadvantage of discontinuing education and stated that, if there had been a choice, they would have like to have continued. Living in impoverished homes was also identified as a driver to engage in transaction sex or a circumstance likely to make girls vulnerable to being coerced into sex.

5.2.3 'Playing sex', transactional sex and sexual coercion

Girls are deterred from engaging in sexual relations until marriage, often due to religious beliefs, fears of pre-marital pregnancy and to enhance marital opportunities and value of bride-price (Hague and Thiara, 2009). Although girls are prepared for marriage by *ssengas*, they are rarely taught about practising safer sex (Nyanzi *et al.*, 2008). Two-thirds of the female respondents had sex before getting married. Their stories show that when girls do start exploring sexual relations or experience sexual advances, they are often poorly informed of the risks, lack the skills to negotiate sex and are vulnerable to coercion and violence (Nyanzi, Pool and Kinsman, 2001; Gupta, 2002; Koenig *et al.*, 2004). The taboo of pre-marital sex and expectation of girls to be well-behaved, means sexual debut experiences often occur in secrecy and therefore girls lack guidance or social support (Nyanzi, Pool and Kinsman, 2001). Cultural expectations of male authority and sexual entitlement alongside the practice of transactional

sex also creates an unbalanced power dynamic that disadvantages girls (Maticka-Tyndale *et al.*, 2005; Wamoyi, Mbonye, *et al.*, 2011). This section examines the blurred boundaries between girls exploring sexuality and 'playing sex', engaging in transactional sex and being coerced or forced into sex (Stoebenau *et al.*, 2016).

The term 'transactional sex' has been used to broadly capture a range of interactions where sex might be exchanged for money or gifts in order to meet basic material needs, to improve social status or as part of a sexual relationship where material items are given as expressions of love (Stoebenau *et al.*, 2016). The context and drivers of transactional sex are therefore recognised to vary greatly, can change over the course of a relationship and are driven by entrenched socio-economic gender roles and dynamics (*ibid*). The boundaries between forms of transactional sex and other types of sexual interaction are blurred and complex. A selection of the respondents' stories is used to examine the boundaries between exploring sexuality and playing sex, being enticed or coerced into sex and being forced into sex without consent.

Exploring sexuality and 'playing sex'

Linda admitted to secretly 'playing sex' with a classmate, indicating consensual exploration of sexuality and sexual relations, and for her was wrapped up in feelings of adolescent love and excitement. This image of female sexuality is in tension with commonly held religious and cultural beliefs, which assert that respectable girls should abstain from sex until marriage (Gupta, 2002). Five other female respondents (Ayra, 41, Naomi, 35, Jessica, 67, Beatrice, 44, Teddy, 31) also engaged in sexual relations during adolescence, which they said was due to feelings of romantic love or lust. These women described their first sexual partner as a "fellow youth" who they met either at school or in the community. This type of sexual relationship was characterised by secret meetings, exchanging small gifts such as necklaces or handkerchiefs (implied to be symbolic, rather than a motivating factor) and mutually consensual sexual acts deemed to be driven by peer pressure and sexual curiosity, as explained by Teddy (aged 31):

> … as you know the influence from peers, even fellow girls at school would talk about boys falling in love with girls as being normal so I eventually made up my mind and said, why don't I try it?

None of these female respondents used contraception with their first sexual partner, indicating lack of awareness or skills to negotiate and protect against sexual and reproductive health risks. By chance, only one woman got pregnant. Jessica (aged 67) said her parents were furious when

they found out and wanted to "sue" the boy as they had already made marriage arrangements for her and been paid bride-price. The wedding went ahead whilst Jessica was pregnant, but the baby was taken away to live with relatives and later died. Jessica said she lived in regret at not being able to breastfeed the child and blamed herself for the child's death.

This framing of female sexuality implies young females defying traditional customs and gender constraints by selecting their own sexual partners and engaging in pre-marital sexual relations (Nyanzi, Pool and Kinsman, 2001; Parikh, 2004; McCleary-Sills *et al.*, 2015). In these cases, the transactional exchange of material gifts is seen as symbolic, indicative of consumer culture and notions of individualism (Hunter, 2002, 2010; Wamoyi *et al.*, 2011; Stoebenau *et al.*, 2016), while for other female respondents, sexual debut was driven by a desire for money and/or consumer items.

Transactional sex and sexual coercion

This second form of transactional sex emphasises girls using their sexuality or being coerced into sex in exchange for money or material items from an older male (Koenig *et al.*, 2004; Parikh, 2004). The reasons for engaging in transactional sex and the consequences are situated within the women's life-stories. This form of transactional sex particularly highlights the unequal power dynamics and driving socio-economic factors such as poverty, household insecurity and desire to improve social status (MacPherson *et al.*, 2012; Stoebenau *et al.*, 2016). The women who engaged in this type of transactional sex when they were young experienced higher rates of unintended pregnancy, which altered their life-trajectories, causing them to drop out of school or be pressured by family members to enter a marital-type relationship.

Four female respondents stated they were enticed into sex for the first time after being given gifts by an older man. From research in rural Tanzania, family and parenting structure and economic provision for children have been identified as key factors shaping adolescent girl sexual behaviour and drivers for transactional sex (Wamoyi *et al.*, 2015). This was the case with these four women, who during adolescence were all living in very impoverished conditions, meaning their families were struggling to cover school fees, food or basic everyday necessities. Three of the women were living with extended family members, which also explained their lack of personal provisions: Julie (aged 43) and Namakula (aged 45) were living with their grandmothers and Gladys (aged 28) was living with an aunt and uncle. Aisha (aged 29) was living at home with her parents, but she had nine siblings and money was so tight Aisha had been forced to drop out of primary school. In this study, the longing for material items was characterised as a driver to engage in transaction sex, as explained by Julie:

> You long for some Vaseline or even a pair of knickers, but there is no one to provide [it], your friend shows you what they got from their boyfriend, she tells you about this and you eventually become tempted to do it too.

These four female respondents were all approached by older men who offered them gifts of money and small consumer items in exchange for sex. Vaseline was mentioned by several respondents as a desirable item. Vaseline is used locally as beauty product, to soften the skin and hair. When Julie was fifteen and living with her blind grandmother, she met a 25-year-old businessman from her village. He gave her gifts for six months before she agreed to have sex with him. The first time they had sex, she conceived. In hindsight Julie, described the situation as a "trap", as she felt she was lured into sex by desire for consumer items that she was unable to afford whilst living with her poor grandmother. After falling pregnant, Julie dropped out of school and ended up marrying the man.

Gladys (aged 28) also got pregnant the first time she had sex after being given gifts by a "much older banana trader", who approached her whilst she was staying at an uncle's house. Gladys was eighteen and only found out she was pregnant when she returned home. Gladys never saw the man again, but her family then forced her to marry a 50-year-old farmer and witchdoctor, who ended up being an alcoholic and abused her for many years.

Namakula was also drawn into a sexual relationship at sixteen by a 20-year-old man who she said "trapped me by bringing me fish constantly". The man also gave her sister money to give to her and it was her sister who then told her she should have a relationship with him. Namukala explained, "After impregnating me he never came back and even when I had the baby and it became sick, I phoned him, he refused to come then the baby eventually died". Lastly, Aisha was also given gifts of money and items such as Vaseline, which she hid from her parents. Aisha was sixteen and the man was twenty, a cultivator who lived in the same village. Aisha remarked that she was enticed by "his words and money". The relationship lasted about four months and it was only afterward she realised she was pregnant. The man went on to marry another woman and Aisha's family arranged for her to get married.

In comparison to the first group, these women were enticed into transactional sex for money and consumer items and they all ended up pregnant. Structural factors such as poverty, gender norms and desire for consumer goods creates conditions which facilitate the practice of transactional sex with girls being enticed or coerced to use their sexuality to improve their social situation (Wamoyi *et al.,* 2011). An interest in modern lifestyles and desire for consumer items are known factors that drive girls to exploit their sexuality for pleasure and material gain

(Hunter, 2002; Wamoyi *et al.*, 2011; Stoebenau *et al.*, 2013). There is a blurred boundary between girls exercising sexual agency and being exploited by older men, who are also known as 'Sugar Daddies' in Uganda (Parikh, 2004). The Sugar Daddy power dynamic accentuates the vulnerability of adolescent girls (Gupta, 2002; Koenig *et al.*, 2004; Parikh, 2004), which is further expanded upon through an explanation of the social norms of gender-based violence .

5.2.4 Rape and culture of sexual violence

Sexual violence commonly occurs across Uganda both in and outside marital relationships (Koenig *et al.*, 2003, 2004; Osinde, Kaye and Kakaire, 2011; Kwagala *et al.*, 2013). A recent survey of adolescents in Kampala reported that 73.3% of respondents said that "it was common for strangers and relatives to force young females to have sexual intercourse with them without consent" (Renzaho *et al.*, 2017). Other studies have reported similar findings on high incidences of rape, sexual and domestic violence towards females across the country (Koenig *et al.*, 2003, 2004; Osinde *et al.*, 2011; Kwagala *et al.*, 2015). This culture of sexual violence was evident in the female life-stories, illustrated through incidences of rape, violence and social reactions to such acts: male perpetrators are rarely convicted; girls can be encouraged to marry a perpetrator after getting pregnant; and male perpetrators can still claim ownership and rights over children (Parikh, 2004).

In this study, three female life-story respondents disclosed that they were raped as teenagers whilst walking or working outside the home. At the time of the interviews, the three women were at different stages of the life-course, so their stories show that cultural attitudes towards sexual violence have remained relatively unchanged over time. In all three cases the perpetrators were known, yet not convicted of the crime and the women were the ones to suffer psycho-social consequences, which altered their life-course trajectories.

Dyana (aged 35) was raped aged thirteen whilst feeding the pigs at her aunt's home. Dyana knew the fifteen-year-old youth from school, who forced himself on her without a word. Prior to the attack the boy's sister had given Dyana gifts of "little money" and whilst walking to school, she had been told the money was from the boy and passed the message "love him and you will not encounter problems". Dyana said she was "confused" by his behaviour and her aunt later blamed her for not realising the boy's sexual intentions. Dyana became pregnant from the attack and the boy was never convicted; in fact, he asked to marry Dyana but her aunt refused saying "he had not yet developed himself", meaning he was deemed immature and not ready for marriage.

Paula (aged 65) was raped aged fourteen by a "Muslim youth" from a nearby village, whilst she was cutting grass near the home. She was so badly injured that she was hospitalised. Paula's parents died when she was 2 years old and she was brought up by a neighbour. After the attack, Paula said she was scared to move around the village alone and so would always walk with the woman she lived with. Paula said it took a long time to form a relationship after this.

Lastly, Kathleen (aged 80) was raped aged eighteen by a teacher from her school. The man pulled her into the bushes at the side of the road whilst she was walking home. Kathleen was shaken and injured, and pretended to her sister to be sick so she didn't have to go to school the next day. Her sister sensed there was something wrong and pushed Kathleen to disclose what had happened. Her sister's husband told the school; the man was not prosecuted but did lose his job and moved out of the area back to his wife and family. Kathleen got pregnant from the attack and the man appeared several years later to claim ownership over the child.

In all three cases, the rape occurred in broad daylight and not far from the girl's home. Despite being able to identify the perpetrators, no criminal charges were filed and two of the girls got pregnant from the attacks. These case studies extrapolate cultural attitudes towards sexual violence, which are set within a wider patriarchal system that prioritises male authority and dominance and subjugates female rights. Cultural norms that guide expected gender behaviours mean that from adolescence girls are conditioned to expect gifts in exchange for sex and to accept that male dominance and violence are part of the landscape in which gender relations are negotiated (Maticka-Tyndale *et al.*, 2005). Male dominance is evident in the attitudes towards male sexual entitlement and transactional sex, and girls can be blamed for not recognising or responding to male intentions (Parikh, 2004). Furthermore, men are deemed to have ownership over children, even if a pregnancy is the result of rape. Although the law changed fairly recently in Uganda to prevent the sexual exploitation of underaged girls, activists argue this has done very little to change cultural attitudes, which impede female capabilities to negotiate sexual relations and respond to sexual violence, both before and after marriage (*ibid.* p.82).

5.3 Wifehood

In *Buganda* culture, full realization of womanhood is achieved through becoming a wife, accompanied by the notion of being owned by a man (Nannyonga-Tamusuza, 2009 cited in Seeley, 2014, p.46). The wife identity is associated with respect, dignity and duty to serve the husband, which differentiates the wife from a man's other sexual partners (Bantebya

Kyomuhendo and Keniston McIntosh, 2006). In Mungawi's writings on womanhood in Zimbabwe, the status and identity of being married is used to differentiate women: "she is married and for that very reason she must not be equated to ordinary women" (*ibid.*, p.207). Whilst being married elevates social status, the role entails duties, responsibilities and is dependent on a relationship with the spouse (Mungwini, 2008).

As captured in the following quote, the role of being a wife has social value that comes with the burden of domestic work; and yet fulfilling the role and undertaking these practices is what differentiates a wife from 'other' women and protects that status:

> I am the only one who is officially married, the rest of my husband's partners are not. He introduced them to me, but I am the one who washes for him, cook[s] food and doing all the other chores because it is my responsibility. (FG females 41-60).

This section builds on the discourses and conditioning of daughters to situate the expectations, obligations and conditions surrounding sex and giving birth in marriage. In this setting there is pressure on women to fulfil marital duties to sustain the relationship (Agol *et al.*, 2014, p.90). Women were found to exercise agency and negotiate with a spouse through these gendered practices, as argued by Kawarazuka (2015) in her analysis of gender dynamics in Kenya.

The findings of this research also stress that patriarchal structures of gender inequality are sustained through defined marital duties and associated gender characteristics (Gupta, 2002; Mungwini, 2008; Strathern, 2016). If a woman does not live up to these gender ideals, it can be a source of marital instability (Agol *et al.*, 2014; Seeley, 2014). In such circumstances, women face the threat of being replaced by a younger woman or being blamed for men's extra-marital relationships. Female responsibility for unpaid domestic work creates an unbalanced economic power dynamic, but this does not mean females are powerless, as shown by women using sexual agency to negotiate marital and extra-marital relations.

5.3.1 The duties of being a 'good' wife

The defined duties of a wife burden women with unpaid domestic and childrearing work (Bantebya Kyomuhendo and Keniston McIntosh, 2006). Many women also engage in income-generating activities so to be less dependent on a spouse. Women therefore juggle triple roles, being responsible for reproductive work (childbearing and rearing), productive work (usually as secondary earners) and work at a local community level (Moser, 1989). Women are both constrained and burdened by this work on the one hand and use these gendered practices to maintain social relations (i.e. show love) and as a source of negotiating power on the other

(Kawarazuka, 2015). Failure to fulfil marital duties and associated practices is associated with marital problems. The framework of gender beliefs surrounding being a wife is are used to judge women and justify men seeking extra-marital relationships.

The unequal division of labour between men and women in marriage was highlighted in the focus group discussions. One respondent remarked that there had recently been a savings workshop in her village where the facilitator had asked the women to write down men's daily chores and women to write the men's. The answers emphasise the cultural imbalance of gender roles and duties:

> Women only wrote seven chores for men, which included playing board games with their colleagues. Whilst the men listed twenty-seven chores for women. My colleague also noted that during the session there were women breastfeeding their babies and reminded the men that they had forgotten to include that role. (Participant in FGD females 41-60)

The discourse of being a good wife is captured in this male respondent's remark:

> The role of a wife is to keep the home, to cook food, wash utensils and clothes for both the children and the husband, keep hygiene of the home and the surrounding place, care for the domestic animals at home and to care for the husband sexually. (Julius, aged 24)

Women also mentioned using domestic duties to negotiate with a spouse; for instance, Linda talked about cooking her spouse a meal, preparing tea and making sure he was relaxed before asking for money to pay school fees. Woman were therefore found to use domestic work as a source of negotiating power within marital relations (Kawarazuka, 2015).

Most of the female respondents were also found to gain independence and power through income-generating activities, such as growing or harvesting cash crops, rearing livestock, weaving mats or baskets, and one woman (Kathy, aged 66) was selling alcohol. Only one elderly female (Nakamaty, aged 76) was not undertaking one of these activities. The motivation to work, as illustrated in Linda's story, was covering household costs and school fees, clothes, cosmestics or costs of hair styling, and any other costs the spouse might be failing to cover. As mentioned in Linda's story, women are often judged by appearance and it is assumed that smart women are well looked after by sexual partners. By earning an indenepdent income, a woman can increase financial autonomy and independence, which in other studies this has been directly linked to increased female capabilties and power to negotiate sexual relations (Fiaveh *et al.*, 2014).

The increased financial autonomy and independence that women can achieve through working is a reason given by some men as to why married women should not work (although some men spoke positively about wives working as it allowed them to contribute towards a man's developmental plans). Resistance to women working was shared by the Imam, who stated "the Islamic religion doesn't support a woman to work, it is the man who works". In the focus groups, men complained that women who work do not share or disclose earnings ("their money is always hidden") and another respondent commented that a woman only spends her earnings on herself or her family (FG males 41-60). Men also expressed fear that women who earn an income become independent and are more likely to have extra-marital relations (FG males 41-60). Cultural beliefs about gender roles were therefore used to constrain female behaviour and produce reasons why women should not work. Male resistance to women working also indicates insecurities about their role to provide and female fidelity (Siu, 2013). Constraining women to domestic work can be interpreted as a mechanism to maintain male control and female dependency, to ensure loyalty and faithfulness (Gupta, 2002).

There is pressure on women to fulfil domestic duties in marriage, due to the threat of being replaced by another (Seeley, 2012; 2014). Women's concerns and insecurities about ageing and difficulties juggling multiple roles were evident in the focus group discussions. One female respondent remarked "If she [the wife] does not fulfil the roles, then the husband will just get a younger woman who will"; and another replied "When the man realises that his wife has grown old, he looks for another partner as she becomes less important to him" (FG females 40-60). From the male perspective, men complained that at the beginning of a relationship a woman will do anything to please the man but over time the woman reduces her care and attention, and this is a reason that men engage in extra-marital relations.

> When you have lived together for some time, there are certain things a woman stops doing for the partner which would increase love, such as serving the husband's food without kneeling, not ironing his clothes or warming water for him to bathe…In a causal relationship the woman will try as much as possible to prevent the man from going back to relate well with his wife at home. (Kenneth, aged 61)

Women also acknowledged that love, attention and sexual attraction towards a spouse can shift or decrease over time and this was associated with the challenges of juggling multiple roles (i.e. being a wife, mother and working), the increased demands of raising a family, tiredness, health problems and marital problems. Women were criticised and judged for not adequately undertaking domestic duties and therefore not being a 'good' wife. A woman failing to fulfil

domestic duties or show love towards a husband was associated with marital dissatisfaction and male extra-marital relations, as reflected in this remark from the Catholic Church representative: "Sometimes the man can fail to have good care at home, so he can go and find someone outside of the home to be in love with him". Fulfilling the wife's duties are therefore tied to expressions of love, which are explored more in the next section.

5.3.2 Showing love, cooperation and being submissive

The discourse of being a good wife was used by respondents to explain how a woman is expected to show love and submit to her spouse (Agol *et al.*, 2014). Respondents and religious leaders reiterated that a wife should be submissive to the husband, never deny the man sex, assist with his plans and show respect, through practices such as kneeling to greet him. The four religious representatives all remarked on the importance of individuals showing love to sustain a marital relationship: "The woman's priority is to love her husband, give him the first class of her love" (Catholic Church representative). The key informants reiterated that the wife should show love through being attentive to domestic duties, supporting the husband with development activities and by being submissive and showing respect.

> The lady is taught how to be under the authority of the husband, she has to obey him, take care of him, she has to cook for him, wash his clothes, iron them, be a housewife. She must show all her love to the husband, failure to do that and the man will be taken away from her by other the ladies. (Born Again representative)

This framework of characteristics was also used to criticise women, explain marital dissatisfaction and justify men engaging in extra-marital relations. Stigmatised behaviours include women not respecting male authority, drinking alcohol, refusing to cook or failing to adequately fulfil other duties in the home, doing paid work instead of caring for the home, being quarrelsome, refusing to produce children or having extra-marital relations. In one of the focus groups, a female respondent remarked, "When one quarrels, she disrespects herself" (FG females 40-60). Women being quarrelsome was frequently given as a cause of marital problems and driver for male extra-marital relations: "When women are quarrelsome men seek peace outside" (Rakibuh, aged 54). Gender frameworks therefore constrain female behaviour, enhance male authority and is used to blame women for men having extra-marital partners (Hirsch *et al.*, 2009).

To uphold dignity and sustain a marital relationship a wife is expected to also be faithful and loyal, expressed through being sexually exclusive, fulfilling domestic duties, not stealing

money or gossiping behind the spouse's back. This can make it difficult for women to directly challenge a spouse for not fulfilling his marital duties without then being labelled as quarrelsome. As shown in Linda's story, to maintain peace and marital stability, Linda avoided directly challenging her husband on his extra-marital affairs and they communicated about HIV risk indirectly through the testing cards. The expected characteristics of being a wife can also prevent women from asking others in the community about a spouse's sexual behaviour, as this can be interpreted as gossip.

5.3.3 Hygiene practices and sexually satisfying a spouse

This section outlines the expectations placed on a wife to sexually satisfy a spouse in marriage and how this connected to hygiene and cleanliness (Bantebya Kyomuhendo and Keniston McIntosh, 2006). Discussion of the expectations and symbolism of unprotected sex in marriage can be found in Chapter 7, while this section focuses on a wife's duty to sexually satisfy a spouse and how these discursive ideas are circulated through religious institutions and intergeneration gender relations. This places pressure on women to not deny a partner sex and are used to blame her if a man is not sexually satisfied and seeks outside marital relations. Reasons for women wanting to refuse sex are related to the context of marital relations, including the power dynamics, sexual desire and sexual privacy.

Sexual satisfaction is deemed key to sustaining a marital relationship in this setting (Tamale, 2006; Siu, 2013; Agol *et al.*, 2014). A third of the female life-story respondents (6/18) stated that they had sex for the first time when they got married. The women remarked that advice was given to them beforehand, often by a *ssenga* on the importance of maintaining bodily hygiene and a clean home. As Tamale remarks, "The basic *ssenga* message to married women is: 'be a nice, humble wife but turn into a *malaya* [prostitute] in your bedroom'!" (2006, p.95). Sexual satisfaction was deemed key to sustaining a marital relationship and was also listed as a primary cause of marital problems. It was stated by respondents that both the wife and husband have a responsibility to ensure their partner is sexually satisfied, which in the wife's case means fulfilling a husband's demands and not refusing sex. The four religious representatives all commented that this is part of the wife's role:

> The wife has to obey her husband and whenever he asks for sex, she has to agree. Even when she is peeling, she has to leave the food there and go and have sex. (Protestant Church Representative)

This rhetoric was also disseminated through intergenerational relations. For example, Paula (aged 65) admitted telling her daughter before getting married "when the husband asks for sex, do not deny him". Women also used this discourse to describe their own behaviour in marriage to satisfy a spouse: "I do whatever he tells me to do! When he says we go and have some rest [sex], I leave what I have been doing and I obey him!" (Shakirah, age 37). Thus these ideas of male sexual entitlement and satisfaction are reproduced and circulated through religious communities and intergenerational gender relations, which shape the way women think they should behave in marriage and creates an imbalance in the power to negotiate sex in marriage (Gupta, 2002; Harris, 2012; Strathern, 2016).

The rhetoric of male sexual satisfaction in marriage was also associated with the wife's duties to maintain hygiene of the body and in the home. Hygiene practices of the home and the body were emphasised by some of the religious representatives as being paramount to arousing a husband's sexual desire.

> The lady has to be very very clean so that she persuades the man to come to her. Failure to be clean might stop the man to love her and be persuaded to play sex with her. (Born Again Church leader)

Male and female respondents remarked on lack of cleanliness as a reason that a husband may not want to have sex with his wife and therefore engage in extra-marital relationships. A male respondent remarked, "the man loses desire for sex with his partner when there is no hygiene at home" (Michael, aged 30). A female focus group respondent also commented that "when he [the husband] finds the bedroom untidy, he loses appetite for sex with his wife, thus a married woman has got to be so careful with maintaining hygiene" (FG females 20-40). The duties of a wife in terms of maintaining cleanliness, submission and sexually satisfying a spouse were used to frame expectations of how a woman should act in marriage and to blame women for men engaging in extra-marital relations, making it harder for a woman to deny a spouse sex.

Women were found to exercise sexual agency and challenge ideals of being a good wife, by refusing a spouse sex and by having extra-marital relations. Reasons given included: partner's promiscuity, tiredness, lack of sexual privacy, menstruation, pregnancy, childbirth, menopause and other health-related reasons (FG females 20-40 and 40-60). Some of these factors were evident in Linda's story as her living environment made it difficult for her and her husband to claim time, space and privacy for sex or intimacy (i.e. small house, children in next rooms, no ceilings, and bedrooms divided by pieces of cloth). Linda said these living conditions hindered sexual intimacy and satisfaction, and therefore her husband and other men might

engage in extra-marital relations (Hirsch *et al.*, 2009). However, Linda's sexual desire had also been affected by her spouse's promiscuous behaviour, him spending money on extra-marital relations and producing additional children. The consequences of denying a spouse sex and incidences of obliged or forced sex in marriage are discussed in relation to HIV susceptibility in Chapter 8.

As indicated in table 5.2, out of the sixteen married women, eight stated their spouse has/had either other wives or extra-marital partners and four women admitted to having an extra-marital relationship (Julie, Jessica, Ruth and Kath). It is possible that other female respondents also had extra-marital relations but felt unable to disclose their experiences due to social stigma associated with women being unfaithful in marriage. Three of these women knew their spouse had other sexual relationships and one was unsure (Kathy) as she lived apart from her husband. The reasons the women gave for engaging in extra-marital relations related to marital dissatisfaction and desires for either romantic love, sexual pleasure or financial support. More information about these women's experiences are discussed in relation to family planning practices and HIV susceptibility in Chapters 7 and 8.

Table 5.2 Female life-story respondents reporting husband's extra-marital relationships

Husband has other wives	**Husband known to have/had extra-marital partners**	**Unknown if husband has/had extra-marital relationships**
Aisha (aged 29)	Gladys (aged 28)	Kathy (aged 66)
Teddy (aged 31)	Namakula (aged 45)	Shakirah (aged 37)
Julie (aged 43)	Jessica (aged 67)	Paula (aged 65)
Ayra (aged 41)	Beatrice (aged 44)	Nakamaty (aged 76)
Naomi (aged 35)	Linda (aged 43)	
Dyana (aged 35)	Ruth (aged 43)	

In summary, the discourse of the 'good' wife was used by respondents to define wife's duties, including sexually satisfying her husband, which privilege male authority and entitlement. The discourse is also used to judge, criticise and compare women both in and outside of marital relationships and justify men engaging in extra-marital relationships, women were often blamed for marital problems (Roscoe, 1911; Nabaitu, Bachengana. and Seeley, 1994; Agol *et al.*, 2014; Seely 2014). The ideal characteristics of the wife and the consequent perceived threat to marital stability can make it difficult for women to discuss, confront or challenge men about their behaviour, such as not materially providing or having extra-marital relations (discussed further in the next chapter on masculinities).

5.4 Motherhood

Being recognised as a woman and a good wife is entwined with the concept of 'producing' and being a mother. As part of analysing the construct of womanhood in Shona culture in Zimbabwe, Mungwini (2008) emphasises the centrality of 'producing' to female social status: 'a woman is seen as a woman only if she is a mother' (p.207). Mungwini draws parallels with cultural beliefs in Uganda, where childbearing, according to Ogden (1996) is a "central feature of a secure marriage". Mungwini goes on to argue that,

> Motherhood is important in the construction of the self as a 'woman' and there is accompanying prestige and social esteem and respect deriving from mothering especially if the children are born within a marriage (Mungwini, 2008, p.207).

The discourse of motherhood is a traditional way of defining a woman's status (*ibid.*). In this section, the gender framework of motherhood is used to highlight the pressure on women to demonstrate fertility capabilities, produce children and be a 'good'mother.

5.4.1 Demonstrating fertility capabilities

One of the perceived duties of a wife is to produce and care for children (Mungwini, 2008; Strathern, 2016). Children are deemed essential to mariage, necessary to cement a marital relationship and increase or develop love (Agol *et al.*, 2014). This also means a woman's social value in marriage is tied to her capabilities to produce children (Roscoe, 1911; Bledsoe, 2002; Janet Seeley, 2014). In discussing fertility and female sexuality in sub-Saharan Africa, Cornwall observes,

> Only by becoming a mother is a woman regarded as a 'wife' by a man's family; only through biological reproduction are ties created between a man and woman that provide a semblance of security, and the possibilities of maintenance. (Cornwall, 2001, p.141)

This construct was evident in cultural beliefs, reflected in the *Luganda* proverb *obufumbo ye mwana,* which literally means 'to recognise marriage, there must be a child'. The respondent (Kenneth, aged 61) who mentioned this proverb used it to explain that his marriage does not follow this social norm as he re-married later in life and does not have children with the spouse, but they have agreed to look after each other in old age. Culturally, children are framed as necessary to invoke and increase love in a marriage. Another older male respondent described having children in marriage as *omwana kimuli kyakumezza*, meaning 'a child is like a flower on the table'. He continued "giving birth to children is an advantage from God that becomes a must" (FG males 41-60). Another study conducted in the same area also found that 'sex for

procreation within a relationship was considered important by both men and women… as having children signified fertility, stability, commitment, security, respect, love, affection, intimacy and support' (Agol *et al.*, 2014, p.91).

The pressure to produce children in marriage is emphasised by the associated marital problems and social consequences of the man re-marrying (Roscoe, 1911; Nabaitu, Bachengana. and Seeley, 1994; Seeley, 2014). The religious representatives all reaffirmed the necessity of having children in marriage and indicated the social consequences of a woman not being able to conceive.

> We count marriage as being successful after seeing the children. Of course, here you can't stay with somebody one year, two year, three years without getting children. (Imam)

The expectation to produce children was frequently linked to the wife's reproductive capabilities, which determine her social value. Naomi (aged 37) remarked "if a woman is in a marriage and does not own children, she is not valued!" This expectation was acknowledged to trap or tie a woman into a relationship, as Linda acknowledged: "a man wants to own children with you so that you are tied up in that relationship". Failing to produce children is therefore associated with marital problems and the woman perhaps being replaced. A woman's position and social value as a wife are therefore closely tied to capabilities to reproduce.

Frameworks of being a wife and mother also affect marital decision-making (Strathern, 2016). As already discussed in this chapter, pre-marital pregnancy and the stigma associated with it are used to pressure girls into marriage (McCleary-Sills *et al.*, 2015). The stigma associated with women having children with mutliple partners was also identifed as contributing to social pressure on women to remain in marital relationships. Half of the female life-story respondents had children with more than one man, mostly due to pregnancies resulting from rape, transactional sex and marital relationships breaking down due to violence and abuse (see Chapter 7). This illustrates a disjuncture between the rhetoric of marital and gender ideals and the lived experiences of marriage and motherhood in this seting. Perceptions of fertility capabilities were also found to influence women's marital decisions, which echoes findings from other reproductive studies conducted in SSA (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2007). In Linda's case, she was not legally married to her spouse and therefore her sense and security of being married was based on the fact that they had children and were living together. Although deeply angry at her spouse's infideility and lack of financial assistance, Linda did not want to leave, as she had already produced children

from two partners and did not want to start another marital relationship so late in life. Linda's priority was to educate her younger children, as she had not been able to pay the school fees for the older ones. Her justification for remaining in the marriage was therefore linked to perceptions of her fertility capabilities and interpretations of being a good mother, which are discussed further in the next section.

5.4.2 Being a 'good' mother

The discourses surrounding motherhood and being a good mother influence social practices and behaviours (Strathern, 2016). Motherhood is recognised as both an experiential state and a marker for social status (Cornwall, 2001). Discourses relating to parenting highlight cultural beliefs relating to child resemblence and notions of ownership, which indicate drivers for male engagement in extra-marital relations and fears relating to female reproductive power and agency. Although women are shown to use the reproductive role and power to negotiate sexual relations, the discourse also constrains or traps women in marital relations. As Lewis argues, 'the mother image reinforces familiar gendered roles and ultimately reproduces patriarchal prescriptions' (cited in Mungwini, 2008, p.208). This is evident in notions of male ownership of children and the responsibility placed on women to care for and raise children.

In this setting, children are perceived to 'belong' to the father and extend male clan ancestry; however, childcare responsibilities rest with the mother (Roscoe, 1911; Seeley, 2014). As explained earlier, patrilineal beliefs mean that men can claim ownership over children, even in cases of rape. Although men are deemed to have ultimate rights over children, culturally the mother is a perceived a central figure influencing the outcome of a child's behaviour: 'The mother is responsible for the growth and behaviour of the child. When the child behaves badly, the mother is squarely blamed' (Kimal cited in Hamilton and Aummeeruddy-Thomas, 2013, p.415). The belief that a child's social and biological characteristics are determined by the mother was mentioned by respondents and used to justify men wanting to have children with more than one spouse (Agol *et al.*, 2014). In Linda's case she remarked that her husband might be engaging in extra-marital relationships in an attempt to conceive another daughter. Similarly, male participant Moses (aged 35) thought his wife had a "biological problem" as she kept producing boys and he therefore sought an extra partner to give him a daughter. Rakibuh (aged 54) also expressed this cultural belief, saying "if they [children] are from different mothers you get a variety". Research conducted in the same study area similarly found men associating the gender and behaviour of children to be a reflection on the mother and thus an excuse for extra-marital relations (Agol *et al.*, 2014). One male

respondent was quoted in that study saying "I never wanted to produce all my children from one woman. You can produce all your children from one woman and they all become fools, yet you can produce a child outside marriage who is a consolation" (*ibid*, p. 90).

A mother's influence on and relationship with a child was also framed as a source of female power and a cause of marital tension or distrust. One respondent quoted a *Baganda* proverb *Okukkaksa kitaawo nyoko amala kufa* meaning 'to confirm who your father is, your mother must first die' (Naomi, aged 37). The proverb infers suspicion of women, and a cultural norm of women using their reproductive role and power to select the preferred father of their child, only disclosing the truth at the point of death. Respondents talked of incidences of women giving birth, claiming the child belongs to her husband (it may or may not resemble him) and then later another man claiming the child. This happened to Godfrey (aged 85) and the child was aged seven when the real father came to claim ownership. He commented, "Usually women know the father of the child, but they keep it secret!" A child's resemblance to the father or paternal family was inferred to be reassuring, helping to prevent suspicion, marital tensions and increases the father's investment in the child (Apicella and Marlowe, 2004). In cases where there is suspicion, one respondent (Kenneth, aged 61) mentioned *okwalula abaana*, a cultural ceremony used to confirm whether a child belongs to the clan of the appointed father. The ceremony involves placing a piece of the child's umbilical cord in some specially prepared fluid. If the cord floats, it confirms ownership; if it sinks, the appointed man is not the father. This culturally derived 'paternity test' indicates a long history of suspicion about female fidelity and reproductive power, which is an underlying tension in gender relations.

The ideals and associated duties of being a mother were expressed in women's perceptions of fertility and childcare capabilities, the social pressure to remain in marital relationships and to maintain relations with a spouse. Gladys (aged 28) shared concerns about her children after being diagnosed with HIV: "I fear what will happen to my children if I die". Other women, including Linda, talked about remaining with their spouse for the sake of their children as they feared they would not receive an education or might be mistreated or abused if raised by a co-wife or other relatives. This was a reason female relatives were deemed to pressurise other female family members to remain in marriage. Kathy (aged 66) reflected that her grandmother told her, "Do not abandon my grandchildren! A child who is not brought up by their biological mother suffers". Another respondent (Nakamaty, aged 76) remarked that she remained in her marriage as that is what her mother had done. She remembered her mother telling her,

> I got married when I was aged fourteen. Your father used to shift from this land to another and we shifted to about four places, each time leaving the food I had grown on a certain piece of land flourishing! I never left him and went with other men. How can I ever hear you have done something I never did?

This mother discourse was therefore used to emphaise maternal duty and through intergenerational relations, assert pressure on women to prioritise the needs of children. Research indicates that men provide less support for children if no longer in a relationship with the mother of the children (Alvergne and Lummaa, 2010). Relationship stability can therefore be bound up in notions of being a good mother (Kavanaugh, 2008) and can make women feel trapped in a marital relationship.

In summary, discourses of motherhood are used to justify staying in a marital relationship and capabilities to negotiate with a spouse (Bledsoe, 2002; Johnson-Hanks, 2005). The discourse provides insight into the pressures on women to prove reproductive capabilities, particularly in the early stages of a marriage (Roscoe, 1911; Janet Seeley, 2014). Producing children was deemed to enhance the bond between husband and wife, but was is also a source of tension as women are often reliant on a spouse for support and men are reliant on women to produce children (Agol *et al.*, 2014). This gives women a source of power, which in turn makes men distrustful and fearful of women engaging in extra-marital relationships (Siu, 2013). Children are considered both the property of their father and express characteristics of their mother, these notions alongside beliefs of male sexual entitlement were also used to justify why men might choose to reproduce with multiple partners (Parikh, 2007; Siu, 2013; Agol *et al.*, 2014; Rutakumwa *et al.*, 2015).

5.5 Summary

This chapter has presented findings to further understanding of the expectations, obligations and conditions of sex and reproduction in marriage. By focusing on cultural beliefs and associated practices with female sexuality and discourses of marriage, this chapter has drawn attention to the social determinants shaping the power dynamics surrounding the negotiation of sex and reproduction in marriage. These findings are summarised in relation to the construction and circulation of gender and marital ideologies, which influence perceptions of marital roles and SRH practices (Strathern, 2016). These frameworks of gender and marital sexuality are normalised or socialised from girlhood to prepare girls for marriage. Females were found to use these prescribed roles and attributes to negotiate and maintain sexual

relations, but there remains an imbalance of power (Kawarazuka, 2015). The frameworks are argued to maintain the patriarchal structure of gender relations, which heighten female vulnerability and hinder female capabilities to negotiate sex both in and outside marriage (Gupta, 2000, 2002).

These frameworks evolve slowly in response to social changes; however, core beliefs have been linked to colonial campaigns at the start of the twentieth century, which aimed to increase fertility rates through the promotion of marital and nuclear family ideals, enhancing male authority over female sexuality (Summers, 1991; Bantebya Kyomuhendo and Keniston McIntosh, 2006; Parikh, 2007). These ideals built upon and tied into existing cultural and religious beliefs relating to male superiority, patrilineal ancestry and the importance of reproduction as a source of social respect and recognition as an adult (*ibid*). Religious institutions and intergenerational gender relations have been identified and highlighted in this chapter for reproducing and circulating these discursive ideals, which sustain the patriarchal structure of gender relations and female socio-economic dependency on men (Strathern, 2016).

Girls are socialised to take responsibility for domestic duties and childrearing practices, and told that to be socially recognised as a woman, they must marry and have children (Roscoe, 1911; Seeley, 2014). This division of labour and female responsibility for unpaid work reinforces female socio-economic dependency on men (Gupta, 2002; Strathern, 2016). Girls are also taught to be subservient and respect male authority. In preparation for marriage, girls are counselled by relatives (usually the *ssenga*) about the importance of sexually satisfying a spouse to prevent him engaging in other sexual relationships (Tamale, 2006). Labia elongation is practised in preparation for marriage, symbolises being a *Baganda* woman, and girls practice it to avoid being rejected (Martínez Pérez and Namulondo, 2011). The culturally-prescribed female role, alongside poverty and stigma relating to pre-marital pregnancy, mean girls are often forced to discontinue education and pressured into early marriage (McCleary-Sills *et al.*, 2015). The frameworks of gender that sustain unequal power dynamics also hinder female capabilities to negotiate sex both before and during marriage (Gupta, 2000, 2002).

The social determinants shaping unequal socio-economic gender roles and power dynamics mean girls are often ill-equipped to negotiate safer sex and are vulnerable to sexual coercion and violence (Nyanzi, Pool and Kinsman, 2001; Koenig *et al.*, 2004). The stigma associated with girls engaging in pre-marital sex and the shame of pre-marital pregnancy means girls are often prevented from accessing sex education and advice (Gupta, 2002; McCleary-Sills *et al.*, 2015). Girls are told not to engage in sexual relations, as the only respectable sexual relationship for a girl to be in is marriage. This means when girls do engage in sexual relations,

regardless of the drivers (i.e. exploring their sexuality, financial incentives, gifts, peer pressure, coercion, etc.) girls can lack the capabilities to negotiate safer sex and are therefore vulnerable to consequences such as pregnancy, HIV or STIs (Wamoyi, Fenwick, *et al.*, 2011; Stoebenau *et al.*, 2016). Female vulnerability stems from prescribed gender roles, the unequal power dynamics, the cultural practice of transactional sex and the widespread occurrence of gender-based violence (discussed more in Chapter 8). These social determinants that hinder female negotiation of sex also transfer into marriage.

The unequal power dynamics in marriage are shaped by marital gender roles, age, expected behaviour or duties and capabilities to leave the relationship (Gupta, 2002; Strathern, 2016). Male partners are commonly older and prescribed gender roles mean a wife is expected to be submissive, respect a husband's authority and assist with his development plan, be responsible for domestic duties and fulfil his sexual needs. Women were found to use these roles and practices as a source of power to negotiate with a spouse (Kawarazuka, 2015). The discourse of the good wife is also used to judge, compare and criticise female behaviour in marriage and pass blame for men engaging in extra-marital relations onto women. This can make it difficult for females to challenge a spouse or refuse unprotected sex, as it can result in marital tensions or instability and the spouse withdrawing economic support, engaging in extra-marital relations and/or marrying another woman (Parikh, 2007; Agol *et al.*, 2014).

A woman's social value as a wife is also attached to reproductive capabilities (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2005). Producing children is central to the ideology of marriage, deemed integral to developing and sustaining a marital relationship (Parikh, 2007; Agol *et al.*, 2014). Although ancestry is believed to be passed through patrilineal descent, a child's behaviour and characteristics are deemed a reflection of the mother. This was listed as a reason that men perceive it to be beneficial to have children with more than one woman (Agol *et al.*, 2014). The pressure on women to sexually satisfy a husband and produce children was found to change over the marital life-course depending on the woman's health and how well the couple relate. Having children increases a woman's domestic workload and men complained of women diverting love and attention toward children. Women were also criticised for exercising reproductive agency and power (e.g. secretly using family planning), which is a source of marital tension and may cause a man to seek to assert control over his wife (discussed more in Chapters 6 and 7). Women must also juggle the demands of being a wife with those of being a mother. Notions of being a good mother are connected to ideas of being a good wife and sustaining marital stability, as a woman is more likely to retain access to socio-economic support from a spouse if the couple relate well (Kavanaugh, 2008). Pregnancy and

children were therefore key reasons for women to try to sustain marital relations (Johnson-Hanks, 2005)|. In cases of marital breakdown, women are socially disadvantaged as they can face the loss of socio-economic support and risk being separated from children, as men are regarded to have ultimate ownership of their offspring (Seeley, 2014).

Chapter 6 – Manhood and the values of masculinity

This chapter examines the dominate discourses and value systems of masculinity that shape expectations, obligations and conditions of sex and reproduction in marital relationships. To analyse male sexual attitudes and practices, a life-course approach and a framework of masculinity values are used to shed light on the socially negotiated repertoires of masculinities that inform sexual and reproductive practices in this setting. The repertoires are used to demonstrate that practices 'are not a direct result or outcome of mental processes but emerge out of the actions and interactions of individuals in a specific context' (Cohn, 2014, p.160).

This chapter uses a life-course approach and framework of masculinities (Table 6.1) to interpret findings of masculine identities and practices. The framework and interpretation of values and practices has been heavily influenced by Siu's (2013a, 2013b) research on the construction of masculinities and the influence on health seeking behaviours in rural eastern Uganda. Siu adopted and applied Wilson's (1969) model of masculinity: one of respectability endorsed by wider society, based on values such as marriage, fidelity, authority, wisdom, providing and taking responsibility for family; the other on reputation endorsed almost entirely by men, which values sexual achievements, multiple sexual partners, fathering many children, a dedicated work ethic and socialising with peers. Wealth and financial independence are necessary to be a successful man in both value systems. There are obviously overlaps, tensions and blurred parameters in these value systems. The enactment of masculinities is also argued to be context-specific and the construction of identity is a dynamic and complex process, as notions of manliness can be gained, reconfigured or lost over the life-course.

Table 6.1 Framework of masculinity values

	Respectability	**Reputation**
Key values	- Married/head of a household - Control and authority - Fidelity - Responsible father/husband - Provider/protector - Leader of development plans - Wise, good at problem-solving - Respectful and self-respecting - Financially independent	- Sexual achievement - Multiple sexual partners - Fathering many children - Physical strength - Dedicated work ethic - Sociable with peers - Wealth and financial independence
Endorsed	Men and women (general public)	Mainly other men

Source: Framework based on the research of Siu (2013)

Throughout this chapter, the ways in which men adopt, portray or use these value systems of masculinity in the construction of attitudes, life-stories and identities are shown to be anything but straightforward. Tensions are indicated between the value systems and individuals are shown to simultaneously enact or use aspects of each depending on social circumstances or phase of life. I demonstrate this through the life-story of Michael (aged 32), who describes himself as a mature, hard-working and respectable family man, but also as a sociable youth who has had an extra-marital affair and was considering getting a second partner. Michael's story is used to illustrate the social pressures on men to conform and the struggles many men experience trying to achieve respectable notions of masculinity in this setting. Michael is atypical, in the sense that he expressed desire for a more egalitarian marital relationship based on respect and cooperation, rather than trying to assert authority and control over his wife through dominance or violence. At the time of the study, Michael was experiencing severe marital difficulties, which are explained in relation to expectations of marital duties and reproductive practices. As with the selection of any case study, it is used to illuminate features of social morphology and support broader theoretical conclusions; the atypical case specifically offers the opportunity to emphasise social norms through highlighting points of deviance, abnormality or contradiction (Mitchell, 1983). Michael's case is therefore used to deepen understanding of how social practices arise and the influences of social norms, pressures and stigma in the context of different social spaces, influence male negotiation of sexual relations. Michael's story is also used to discuss the social mechanisms used to sustain patriarchal organisation and structures of gender relations and the associated consequences for men who try to contest gender norms.

6.1 Michael's Story

The courtyard to his home was very overgrown. Michael remarked, "it's my wife's responsibility to clear weeds around the compound but she's on strike!" He continued, "she doesn't want to prune the banana plantation at home but prunes other people's plantations", meaning that she was choosing to do paid labour instead of working in the home garden. "I give her necessities to use at home such as sugar, salt and food, but she complains that if she wants expensive cloth or *gomesi* [traditional dress], can I give it to her?!" Michael later disclosed that his wife had not slept at home for a few nights and when she did return, she was "abusing" him. The roots of their quarrels are explained within the context of Michael's life-story and marital life-course and are connected to disagreements relating to marital roles, notions of developing the home and having children.

At the time, Michael (aged 32) was living with his wife (aged 26) and their four-year-old son in a mud and pole house with a grass thatched roof in village 13. They had an older daughter living with relatives paying her school fees. Village 13 is one of the poorer villages in the area: residents are predominately subsistence farmers and houses are commonly mud and pole. Photograph 6.2 shows a mud and pole house next to a house being constructed from baked bricks. Michael's wife was unhappy about living in the mud and pole house and refusing to have more children: "She doesn't hope to produce another child whilst we are still living in a grass thatched house, she said if I want more children I should first put up another house."

Photograph 6.2 Mud and pole house next to the construction of a new brick house

(Note: To protect Michael's identity this is not his house, but illustrates the two types of house)

Michael was given the plot of land by his grandfather to build a house and raise a family. Michael had grown up with his paternal grandparents as his parents moved to Kampala for work. He related well to his grandparents, helping with household chores while they paid his school fees. As they got older, Michael helped to care for them: he gave examples of cutting their toenails or giving them a lift to the medical centre on his bicycle. Michael's grandparents were his role models for a successful marriage. His grandmother advised him to:

> Handle a wife with care, always discuss together things to be done at home, dig together to have food at home, bring her food from the garden, bring her water if she is washing clothes and bring her firewood.

These marital values had influenced Michael's behaviour. He said that he loves his wife and therefore wants to demonstrate this by supporting her:

> If my wife is peeling food, I go to collect water. If she is cooking food, I go to the nearby trading centre to buy soap and salt to use at home. If she is washing clothes, I will give food to the baby, fetch water or go to the bush to look for firewood.

Although striving to cooperate with his wife, this approach seemed to be causing problems in his marriage. Michael explained "when my wife observes me doing household activities, she maybe regards me to be foolish […] even members of my village blame me saying that I am the one who made my wife become naughty". Michael complained that he fulfils his role as a good husband (unlike other men who have multiple partners and do not provide support), yet his wife does not listen to or respect him.

> Some men have several partners and don't provide them any support, whereas I am faithful, I provide my wife with necessities, when I get paid, I give her all the money to plan for it, because she makes the decisions of what is required at home, … but she doesn't listen to me.

Michael and his wife had been together for nine years. Their relationship started when Michael's wife, aged seventeen at the time, crossed the path outside his compound on the way home from visiting her grandmother. She was a student at his old secondary school, so Michael knew she was a "decent girl" and approached her with the intention of seducing her. Michael told her, "I'm looking for someone to marry, not to have a causal relationship". From that day they met secretly; after three months they started having sex and it didn't take long for her to conceive. She wanted to get an abortion, but Michael convinced her otherwise: "I told her that I was on her side, so she should not get worried, I would fight to ensure she would not get any problems". Once the girl's parents found out she was pregnant they went to the police and had Michael arrested. To get released from prison, he was charged 700,000ugs (approximately £144); his grandfather raised the money by selling a cow and a pig. The pregnant girl "refused to go back to her parents' place" and remained at Michael's home. Michael later went for an introduction with her parents, giving them gifts of sugar and *mwenge* (local brew) and paid bride-price to ensure the marriage was official.

When asked what they discussed before getting married, Michael replied, "we talked about developing each other". Michael seemed proud of what they had achieved: they owned "a mature pig, two goats and several chickens". Michael also had started making mud bricks to construct a new house and planned to generate money for iron sheets from the groundnuts they had planted. Michael explained, "if we are successful with the plan, does that not mean

we are developing each other?" This was said in a way to imply that their achievements were fitting Michael's expectations of development, but maybe not his wife's.

Before getting married, Michael had been in one other sexual relationship. He met the girl at a secondary school party. They danced, took photos together and then had sex on the way home. The relationship continued for a year, they met secretly and "exchanged gifts, such as a necklace or handkerchief". The relationship eventually ended as Michael dropped out of school and the girl's family moved her to Kampala. Michael left secondary school as his grandparents could no longer afford the fees, so he got a job teaching in a primary school for a year before deciding to go to Kampala to seek work. He worked as a hawker (street seller) for three years, which enabled him to save 150,000ugs (approximately £30) before returning to the village to ask his grandfather for land so he could build a house. Michael was looking for a wife to start a family when he approached the schoolgirl on the path.

Overall, Michael said the relationship with his wife was "still good because she doesn't roam around the village, she doesn't attend bars and she is not promiscuous"; however, he also admitted that they were arguing a lot. Michael wanted more children, but suspected his wife to be using the injection (hormonal contraception). When asked why he suspected this, he answered "she doesn't have menstrual periods and when I asked the nurses at the health centre, they told me that she could be using injections, it made me feel so bad". When Michael confronted his wife about using contraception, "she responded cruelly saying 'so what if I do use them?'" Michael admitted that his wife's possible secret use of family planning was a major marital issue, which might push him to get another partner. Michael said that, ideally, "it would be good for the woman to agree with husband and produce the number of children agreed upon"; however he complained "women go for family planning without informing their partners …they go secretly […] if she doesn't produce more children that may mean I get another partner".

Michael had already had one extra-marital relationship: he "just wanted to try having sex with another woman" and he "got attracted to the woman because of her beauty". They met in a nearby trading centre, where he likes to socialize and watch sport or films to relax. The relationship did not last long as Michael said he was worried his wife would find out and it would cause problems at home. Michael said he used a condom with the casual partner, but has never used a condom with his wife "as we trust each other […] I've never seen or heard that my wife has had a sexual affair, that gives me confidence that we trust each other". Michael's sexual desire for his wife had been affected by the suspicion that she is using contraception.

It sometimes affects my desire to have sex, because it seems like a waste of time. Contraceptives are only used by people who have the number of children they want to produce. My wife wants only two children, yet I want six.

6.2 Attracting and retaining sexual partners

This section explores the importance of sex in terms of proving manhood and constructions of masculinity. The respectable notion of masculinity revolves around having a wife and fathering children, whereas the reputational values are based on sexual achievement, having multiple sexual partners and fathering many children (Siu, Seeley and Wight, 2013, p.47). From the life-stories it is evident that male respondents met sexual partners in three main ways: in the village, whilst socialising or working, and/or through a matchmaker. Men were found to use various techniques and transactional negotiations to initiate these relationships. In this section I highlight the social practice of men giving gifts and money in exchange for sex or to initiate a relationship and the techniques males use to convince a female to have sex if they do not have money, such as begging, using charm or promises of marriage. Both approaches are based on a cultural expectation of men being providers. Although these practices are shaped and sustained by patriarchal structures of power (discussed in Chapter 5), the expectation on men to provide also hinders and puts pressure on poorer men.

Sexual desire in adolescence was described by male respondents as a normal and natural reason to seek a sexual partner or consider marriage. All the male respondents except Wasswa had sex before they got married. Wet dreams and sexual urges were listed as signs of growing up, prompting interest in sex and finding a sexual partner: “it starts with the body demanding [sex]; however, you fear to approach the girl” (Richard, aged 22). In this setting, boys learn that experiences of sex is one way to prove manliness to peers and other male family members (Kuhanen, 2010). Initiation of sexual relations in this setting are negotiated through gendered and transactional exchanges (Nyanzi, Pool and Kinsman, 2001; Nyanzi *et al.*, 2004; Bell, 2012; Schlecht, Rowley and Babirye, 2013). When Michael was asked what attracted him to his first sexual partner, who was a schoolgirl, he replied “that was the category I could afford”. Eleven of the male respondents met their first sexual partner in the village and described these girls as around the same age or younger. The respondents initiated these relationships, often by convincing, charming or begging the girl for sex. Gerald (aged 81) remembered “begging” a sixteen-year-old girl who was visiting his village: the “excitement of when she said yes, I had never felt in my life”.

Money was also mentioned as influential in terms of a man's capability to attract a partner. "I used to have money, so it was not hard to convince a girl to have sex with me" (Mukisa, aged 42). The local sayings of *kagwerawo* (meaning 'buy here and now') and *mpa nkuwe* ('give me, I give to you'), were used to explain the cultural expectation of males giving money or gifts in return for sex. Money was therefore listed as a key enabler of male access sex. One respondent remarked: "You go for a causal relationship knowing that you have money in your pocket, failure to give her money, means no sex" (Joseph, aged 60). The stress caused by having not having money was inferred to dampen sexual desire, whereas having money can increase sexual prowess: "stress can't allow you to have the desire for sex. When time comes and a man has money in his pocket you find he has high desire for sex" (Mukisa, aged 42).

Men were also found to use other techniques and forms of negotiation to initiate a sexual relationship or access sex, such as using matchmakers, convincing girls to get married, paying bribes and bride-price. Seven of the male respondents described using a friend or family member to find a suitable wife. Respondents also described the tactic of using charm or promises of marriage; Michael used this approach to "seduce" the passing schoolgirl, whom he later married. By applying the respectable values of masculinity, he convinced the girl he was looking for a wife rather than a casual partner. After she got pregnant, he convinced her not to abort by drawing again on these respectable values to reassure that he would provide and protect her. After her parents discovered she was pregnant, Michael then negotiated paying the police fine and bride-price so to avoid jail and legalise the marriage.

Four male life-story respondents (including Michael) admitted that they had been accused of having sex with an underaged girl. All the men stated they avoided gaol by either paying the police fine and/or the girl's parents. The men were of varying ages (Godfrey aged 85, Joseph aged 60, Anatoli, aged 43), suggesting this practice occurred across generations. These cases illustrate the cultural practice of men targeting young girls for sex (described already through the Sugar Daddy dynamic in Chapter 5; see also Parikh, 2004). Bribes and bride-price were framed by men as ways to mediate gender relations, taking responsibility and solving the problem, therefore mediating or upholding a respectable reputation. Social determinants relating to corrupt governance, poverty, gender inequality and cultural beliefs relating to male ownership and marriage, facilitate and sustain these social practices.

Pressure for males to get married was associated with cultural and religious beliefs about what it means to be perceived as respectable. The religious representatives all discouraged pre-marital sex and reaffirmed marriage as the only respectable sexual relationship. The imam affirmed, "if you want to have children and the sex, then you go and

get officially married". Some of the religious representatives acknowledged that some men have had sex before marriage, and for this reason the Born Again Representative stated advice is given on how to treat a wife, who is expected to be a virgin.

> If the man has played sex before then we explain to him you are going to face a girl who has never had sex before, so you have to be very careful when you are starting the action. (Born Again Church Representative)

One respondent (Mukasa, aged 95) sent one wife away as she was a virgin: "her private parts were so narrow that whenever we had sex the skin of my penis would peel off". Cultural beliefs asserting male sexual entitlement and the importance of sex in marriage (both discussed in Chapter 5) were evident in attitudes on retaining partners and sustaining marital relationships.

A man's capabilities to sexually perform and satisfy a partner were deemed important to retain a wife and prevent her from engaging in extra-marital relations or divorcing. One male respondent remarked that, "if the man is sexually satisfying his wife, she can't leave him even if they have got no money" (FG males 20-40). A man's sexually inabilities were used to discredit a man and explain marital problems. One female respondent remarked, "if you find the man is impotent, you cannot stay behind and cook for him!" (Paula, aged 65) and another male respondent commented "If he is sexually weak then she will just pack her belongings and leave the man" (FG males 41-60). Retaining a marital partner was also linked to man's capability to show love and fulfil his marital duty of providing and leading on development plans. Religious representatives asserted that a man should "provide for his family" and show love through "buying persuading gifts for the lady" (Protestant Church Representative). They said a man should try to fulfil this role regardless of his economic situation: "As a man you must provide food even if you have no money […] Any development idea at home must be implemented by the man" (imam). This sentiment was reflected in participant responses on how a man should show love in marriage: "It can be providing home requirements or whatever she needs, such as a piece of cloth or things that impress her" (Julius, aged 24). In the context of South Africa, Hunter (2010) used the concept of 'provider love' to illustrate the expectations and pressures on men to show love through providing and gift giving, which he argues has increased with the rise of individualism and consumerism.

Constructions of masculinity are entwined with widely-held beliefs of men being providers, which puts pressure on men to fulfil this role to sustain sexual relationships (Hunter, 2002, 2010; Swidler and Watkins, 2007; Siu 2013; Stoebenau *et al.*, 2016). In Michael's case, he portrayed himself as a respectable husband, despite his wife being unhappy with their

progress. Michael protests that he fulfils his role by providing necessities and emphasised what they had accomplished. Michael compared himself favourably to other men who have multiple partners and do not take responsibility or provide support.

Whilst men having multiple partners can enhance their sexual reputation, the practice was also criticised and linked to marital problems. Nine of the eighteen male life-story respondents admitted to having extra-marital relations and another four said they had been in a polygynous marriage at some point in their lives. The reasons for having multiple partners were linked to sexual desire/ pleasure, drinking alcohol and socialising, work and opportunities of development, and to achieve fertility preferences or goals (discussed in the next three sections). Criticism of men engaging in extra-marital relations was linked to poor self-control and failing to provide. The Catholic Church Representative related the practice to men being "greedy and not be satisfied with one wife", while female respondents also emphasised the consequences of men spending money on 'other' women and producing extra children, and therefore not fulling their role as providers (FGD females 20-40). Siu found poorer men to be more likely to be stigmatised for polygamy as they are 'considered to be […] taking on additional provider responsibilities' that they cannot fulfil (Siu, 2013a, p.105).

6.3 Work, mobility and spaces of sexual mixing

There has always been a great deal of mobility and migration in south-western Uganda, which has characterised the lives and structure of gender relations of the local population (Roscoe, 1911; Richards, 1966; Janet Seeley, 2014). In this section I identify patterns of migration and mobility identified in the life-stories and explain how movement is tied to notions of masculinity and influences sexual practices. Mobility is examined firstly in relation to work, framed as a rite of passage before getting married; and secondly in relation to social networking and spaces that facilitate meeting new sexual partners.

Patterns identified across the male life-stories illustrate the cultural norm of mobility and migration, particularly for young men for reasons of work. I refer to this theme as male labour mobility. Table 6.3 shows that almost all the male respondents (16/18) reported moving around the south-western region of Uganda; most (11/18) had travelled to other regions; and four had spent time in countries outside Uganda. Respondents frequently mentioned moving to more urbanised areas, such as Masaka, which is the nearest town and the capital city of Kampala. Three respondents also provided details of working at a fishing site, a sugar plantation and on a tree-planting project. The pattern of rural-urban migration has been broadly documented across Uganda (Roscoe, 1911; Richards, 1966; Kuhanen, 2010; Janet Seeley,

2014). Kuhanen (2010) suggests migration was accelerated by rapid population growth after decolonization, where the growth of urban areas became attractive, particularly for younger men seeking work.

Of the four men who had travelled outside of Uganda, two had migrated with family and two travelled for work. Mukasa (aged 95) was born in Rwanda and had migrated to Uganda during the 1941 famine. Over the years, he had moved back and forth between the countries until settling in older age. Gerald (aged 81) had been sent to Tanzania as a child to stay with family and attended school for a few years, whereas Kenneth (aged 61) and Rakibuh (aged 54) were both involved in trade (i.e. bananas, peanuts, animal skins and ivory) and travelled to countries bordering Uganda (i.e. Kenya, Tanzania, South Sudan, DR Congo and Rwanda). There has always been trade movement between bordering countries and Uganda, which has been hypothesised as a reason HIV spread so quickly across east Africa (Pépin, 2013) (discussed further in Chapter 8).

Table 6.3 Male life-story respondents' mobility and migration

Moved around within south-western Uganda	Moved to other regions of Uganda	Moved outside Uganda
16	11	4

The reasons for the male respondents to be mobile were mostly linked to work. As shown in Table 6.4, four male respondents shifted locations with family during childhood, whilst the vast majority (13/17) migrated or travelled for the purposes of training or work. Types of work included being involved in trading (i.e. transporting and/or trading items such as coffee, bananas, animal skins, ivory, clothes), manual labour (i.e. agricultural work, caring for livestock, building work) and undertaking education, training or professional work (i.e. training to be a mechanic or carpenter, working as a teacher or prison guard). Some respondents listed more than one reason to migrate at different points in their life.

Table 6.4 Male life-story respondents' reasons for mobility and migration

Shifted with family	**Trading**	**Manual labour**	**School education**	**Skill training or professional job**
4	6	4	1	4

Many of the male respondents indicated being forced to discontinue education, migrating in search of work and then settling in the village to build a house and get married. This pattern

was illustrated in Michael's story as he was forced to discontinue education due to his grandparents being unable to pay his school fees.

In this setting, male labour mobility is considered a rite of passage for younger men to prepare for marriage. Roscoe (1911) observed young men preferring to go and live with a chief some distance from their own or their wife's parents and that a man would usually only build a house after marriage: 'if he had built it earlier he would have been asked whether he meant to take other women, and to live an improper life' (1911, p.96). In the 1960s, anthropologist Audrey Richards wrote in detail about *Buganda* culture, remarking that 'Individual mobility was unusually great' (1966, p.19). To be respected, a man is expected to acquire land so as to build a house and start a family. Thus, ambitious men usually left their natal village in search of a patron (chief) to find work and acquire land; less ambitious men tended to remain local, cultivate and move between villages offering labouring services (Richards, *ibid.*).

Although most of the men had migrated and travelled at some point in their lives, they had all returned to the village setting to get married. At the time of the study, three of the male respondents were living apart from their spouse, and two of them (Moses and Joseph) stated this was due to work. Of the eighteen respondents, all were involved in subsistence farming except Mukasa (aged 95), who was supported by sons and grandchildren (Table 6.5). Four men, Richard (aged 22), Michael (aged 32), Mukisa (aged 42) and Anatoli (aged 43) were involved in casual manual labour, which included mobile agricultural work and brickmaking. Two were involved in skilled or professional work. Peter (aged 61) described himself as a carpenter and Moses (aged 35) was teaching in a local secondary school. Three men were involved in trading and selling: Julius (aged 24) was brewing alcohol, selling coffee and trading pigs; Joseph (aged 60) was running a pork joint and bar, and Edward (aged 43) had a small shop.

Table 6.5 Male life-story respondents' current work

Subsistence farming	Manual labour	Skilled/ professional	Trading/selling	Not working
17	4	2	3	1

Labour mobility across East Africa has been argued to sustain male engagement in multiple sexual relationships as the social practice of mobility makes it possible to maintain concurrent partnerships (Shelton, Cassell and Adetunji, 2005). Another argument is that 'Controls over sexuality weaken with distance' (Kuhanen, 2010, p.233) meaning that male practices change

when they move away from family and outside their community where sex and sexual practices are more closely controlled or regulated.

In the male life-stories, labour mobility evidently shaped sexual practices, facilitated engagement in multiple sexual relationships and/or was part of a process to find a marital partner. Gerald (aged 82) estimated that he had had sex with over two hundred women during his lifetime. He had earned a good income as a prison guard in Kampala, which enabled him to buy a motorbike, move back to the village and marry three women. Gerald stated, "the man has the advantage of being able to move around to meet extra partners". Mukasa reflected that traditionally men had wives in various locations to help work on land and generate wealth:

> In the past men used to marry or get an extra marital partner like having a business, every woman would like on his *kibanja* [land] with his children and all the families would accumulate wealth for him. A man was free to have as many partners depending on his financial situation. (Mukasa, aged 95)

Mobility was associated with generating wealth, therefore providing an opportunity to engage in multiple casual relationships. Kenneth (aged 61) admitted to having sex with over a hundred women during his lifetime and had worked as a truck boy transporting goods across East Africa, and then as labourer on a sugar plantation for five years. At the plantation, he said there were only male employees and after work they would drink alcohol and girls would come to sell sex. When asked whether the environment had influenced his sexual behaviour, he answered *"bwogenda ebulya mbwa nawe ogirya"* meaning 'when you go to a community where they eat dogs, you also eat dogs'.

This sentiment of wealth and access to sex being linked was reaffirmed by Rakibuh (aged 54), who also worked across East Africa trading peanuts and ivory.

> I used to get a lot of money, which I sometimes failed to control and ended up forming sexual relationships… I enjoyed myself. As a gentleman with money, when I admired a woman, I could not fail to get her.

However, Rakibuh also described this period as risky: "being young is good because you don't fear death". After narrowly escaping imprisonment on several occasions, Rakibuh said he was ready to return to the village and settle down with a wife. "I am now just a peasant farmer, but I enjoy my job as I don't worry about anything". During his marriage he admitted to having one extra-marital partner whom he met in a trading centre and had been in a relationship with for five years. In terms of meeting extra-marital partners, trading centres featured heavily in

the respondents' stories. Most of the respondents (10/18) mentioned meeting sexual partners at a trading centre and six mentioned the influence of alcohol on sexual behaviour. In rural areas of Uganda, trading centres are hubs of economic activity, where local populations congregate to trade, socialise and access services. Kuhanen argues that these hubs exhibit 'a different sexual culture from the surrounding countryside', which he conceptualises as 'sexualized spaces that enabled the formation and extension of sexual networks'(2010, pp.226 and 233). Kuhanen goes on to argue that these hot spots for sexual mixing have facilitated the spread of HIV across rural south-western Uganda (discussed further in Chapter 8).

Drinking alcohol, socialising and having casual sex or multiple sexual partners are features of reputational masculinity, endorsed and respected by men. Amongst the male life-story respondents, the trading centre featured as a place for these activities (as illustrated in Michael's story). Michael's extra-marital relationship occurred with a woman he met at the trading centre; although he did not mention whether he was drinking, many of the other male respondents mentioned alcohol as a facilitator for extra-marital relations. One respondent remarked "alcohol can increase sexual desire" (Leo aged 50). Joseph (aged 60) admitted to having several extra-marital relations with women, one of which was nineteen and pregnant at the time of the interview. Bars were mentioned by respondents as social spaces that married women should not enter. Michael remarked that his relationship with his wife was "still good because she doesn't roam around the village, doesn't attend bars and she is not promiscuous". The exclusion of married women from these spaces can be interpreted as a means of controlling female behaviour and protecting these male sexualised spaces to enable secret extra-marital marital relations.

6.4 Authority, control and violence

The social structure of gender relations and notions of masculinity mean that men in this setting are expected to possess power in marital relationships. Siu (2013a) points out that for a man getting married is accompanied with power in decision-making, being responsible for handling conflict and recognising the social value of the woman being dependent on the man (Siu, 2013a, p.104). This rhetoric of male ownership and power was expressed by male and female respondents: "it is the man who has power in the household" (FGD females 20-40). Religious institutions also promote a man's position of authority, whilst also asserting a man's responsibility to care for his wife and family: "The man is the head of the household and it is his responsibility to care for his wife and to show her all his love, failure to do that and the wife will be discouraged" (Born Again representative). A man's respectability and authority over a

wife and family were therefore suggested to be entangled with a man's capabilities to fulfil his duty to provide and show love.

This rhetoric of a married man having authority and power in marriage was contrasted with the fears, insecurities and struggles of men who fail to achieve this status. In Michael's case, he implied that he had lost authority and respect from his wife, demonstrated by his wife going on 'strike' from her domestic duties and instead doing paid labour, leaving the home for long periods without his consent, refusing to give him another child and secretly using contraception. Michael suggested that members of his community blamed him for his wife acting "naughty" and that she perhaps also regarded him as "foolish" for assisting his wife with her domestic duties and childcare. Masculine values were therefore not only used to define how a man should behave in marriage, but also state the parameters of behaviours. Male focus group respondents generally agreed that a man should only help his wife with domestic duties in certain circumstances: "it shouldn't be a daily routine because the woman might under look him" (meaning to think little of him) and another stated "it can give the woman more freedom, which means she gets another partner or won't complete her household tasks" (FGD males 20-40 & 41-60). One respondent used the term *yamuteeka mu ccupa* ('enclosed in a bottle') as an analogy for a man being under a woman's influence or control. In such cases, the woman may be believed to have put a curse on the man: "When people find you serving the roles of a woman, they think she has bewitched you" (Mukisa, aged 42). These attitudes indicate the pressure on men and women to conform to marital gender norms. The stigma associated with men undertaking 'female' marital practices can be interpreted as a social mechanism to deter, oppress and stigmatise behaviours that pose a threat to the social order of patriarchy and dominant ideals of masculinity.

A man failing to fulfil the role of provider was also associated with loss of power or control in marriage. In Michael's case, his wife was dissatisfied with their home and financial circumstances, which meant they had no money for consumer items such as *gomesi* (traditional dress). Socio-economic structures shaping work instability and the increasing costs of everyday life (i.e. school fees, medical bills, building materials, consumer goods) mean many men struggle to fulfil hegemonic notions of masculinity (Hunter, 2002; Connell and Messerschmidt, 2005). In resistance, Michael's wife was refusing to fulfil her marital duties, and her resistance indicates that women are not always subordinate in marital relationships and can use or subvert gender practices as tools for negotiation (Kawarazuka, 2015). Respondents' attitudes to married women working further highlight male insecurities and the social value placed on female dependency: "Men don't want their wives to work because it is hard to control them.

When they start working it leads them to become promiscuous, but since men have no evidence, they keep quiet about it" (Rakibuh, aged 54). Women working was therefore framed by some men as a potential threat to masculinity: "when the woman assumes the responsibilities of a man, he being the breadwinner ceases to exist, he loses respect and his wife can even be easily enticed with a bunch of a bananas" (FG males 41-60). A woman's faithfulness or loyalty to a husband was therefore suggested to be tied a man's capabilities to provide.

A wife refusing to undertake marital duties and spending time instead earning an income is deemed a threat or attempt to thwart masculinity. To boost masculinity and regain control, two approaches are examined: extra-marital relationships and violence. Engaging in extra-marital relationships was highlighted by male respondents as a practice to overcome, respond to or cope with marital conflict: "You may fail to give something to the wife at home and she loses her temper, in such scenarios you move outside marriage to have peace" (Rakibuh aged 54). Michael was openly considering this option, also driven by a desire to have more children (discussed below). However, Michael also acknowledged the potential risk of further conflict if his wife found out, which is why he had kept his previous relationship a secret. Infidelity is not part of the respected values of masculinity and if this becomes public it can have 'various social consequences, ranging from marital conflicts to public embarrassment, which is why men want sexual improprieties to remain secret' (Parikh, 2007, p.1202).

Another approach is exerting dominance through fear and violence. Michael made a point of inferring that this is what other men might expect or encourage him to do to take back control in his marriage. Violence was mentioned by respondents both in terms of violence directed towards a wife and more generally. In a female focus group, a respondent told a story of a man raping his wife in front of their children in response to her consistently denying him sex (FG females 41-60). In a male focus group, a respondent also told a story about "a man who cut his penis off after finding his partner having sex with another man because he was so angry (FG males 41-60). In both cases the man was shamed for losing control, as the violence was deemed excessive; however, more moderate forms of violence were felt to have a place in marriage. Male violence within marital relationships is entangled with 'tensions that derive from within masculinities themselves' (Hunter 2010, p.173), meaning that violence is both condoned by masculine notions of being physically strong and exerting power and can also be a reaction to not feeling in control or respected.

Research conducted in Uganda shows violence to commonly occur in marriage (Koenig *et al.,* 2003; Kwagala *et al.,* 2013; Wandera *et al.,* 2015). One study in south-western Uganda reported the most commonly-cited reason for male physical assault on a wife was her neglect

of household chores (Koenig *et al.*, 2003, p.53). Siu also found violence against women to be 'generally condoned and considered legitimate by both men and women if they [women/girls] proved inefficient in their core social roles such as cooking for the man and family' (2013a, p.109). Research has also shown an intersection between poverty, construction of masculinity, male vulnerability and violence against women (Jewkes, 2002). Men living in poverty may be unable to live up to ideas of successful manhood and can become "violent towards women they can no longer control or economically support" (*ibid.*, p.1424).

6.5 Virility and fathering children

Virility and having children are embedded in both the respectable and reputational value systems of masculinity. As Hunter points out, 'Fathering a child symbolizes sexual virility and improves a man's social status'; however, there is a difference between the 'biological consequence of penetrative sex' and 'fulfilling the social role of *fatherhood* [which] is much more challenging' (2010, p.170). As mentioned in Chapter 5, children are perceived to extend male clan lines and that men have ownership of children. Building on these findings, this section illustrates the social pressure on men to demonstrate fertility capabilities and produce children, but also male choices and reproductive practices are influenced by a range of social determinants. Male demand or desire for children also makes men reliant on women. Suspicions and fears relating to female reproductive agency are highlighted as a source of tension. Extra-marital relations are also identified as a pathway or practice for men to overcome, cope or respond to marital dissatisfaction or to achieve fertility goals.

Cultural and religious discourses were used by respondents to justify the importance of having children, implying that children are an indicator of virility and masculinity, and a form of social security. Having children was framed by respondents as natural and tied to religious beliefs: "Religion tells me to multiple on [the] earth" (Henry, aged 62). Children were also framed as necessary for men to leave a legacy: "one hopes to give birth to children so after he dies, he thinks how the children he has produced are going to live after his death" (FG males 20-40). They are also tied to notions of being a successful man: "A man can't prosper without having children" (FGD Males 20-40) and to therefore to be an indicator, through which men compare themselves with other men. As one male respondent remarked, "how can you say that you have children when you only have two children yet there are men with 20 or 25 children!" (Julius, aged 24) For these reasons it was suggested that "Most men don't mind having so many children" (Michael, aged 32). As already mentioned, cultural beliefs mean that each child is regarded as a blessing from God. Respondents suggested that "you can't predict which child

will be of help to you" (Mukasa, aged 95), meaning that each child may be a potential form of social security or support in older age.

Producing and fathering children is not a carefully thought-out process; rather, it can be interpreted as a social practice which occurs or emerges from a cluster of actions and interactions in a specific context (Cohn, 2014). When a man impregnates a woman, Hunter postulates that he has three options, each connected to, and with consequences for, notions of masculinity:

> The highest-status option is to marry their child's mother, but this is also the most costly. Another path, supporting a child but not marrying the mother, boosts a man's image as a good provider, even if it is a constant drain on resources … Abandoning a child allows a man to spend money to boost his masculinity in other ways, but it can lead to feelings of guilt. (Hunter, 2010, p.170).

Male actions after getting a female pregnant may therefore reflect values of masculinity, but his choices and capabilities are also influenced by other social determinants. These include the man's socio-economic status and stage in his life-course, the nature of the relationship with the mother and the circumstances in which sex/pregnancy arose, whether the man already has other sexual partners and children to support and social pressure for kinship or peer relations. Firstly, a man needs wealth and resources to successfully enact or achieve the respectable notion of being a father. At the time of the study, the *Kabaka* (king) was promoting the message that "couples should only have as many children as they can afford". Religious representatives in the area were found to also be promoting this message, alongside reaffirming the importance of producing children in marriage.

> If someone has been producing normally and they manage to provide food for these children, cloth them, shelter them, its OK. If you can provide small amount of education, like going to the first school, then it is OK, you can have as many as you can. (Imam)

This message suggests that male virility and fathering children are ultimately linked to wealth and capabilities to provide. The encouragement from religious institutions to reproduce was also identified as a social pressure on men and barrier to family planning: "it is not easy especially when one goes to churches/mosque because they do preach and urge couples to go and produce as many children as they can to extend the generations" (FG males 41-60). Barriers to managing fertility and using family planning are further discussed in Chapter 7. In Michael's

story, after getting the schoolgirl pregnant he invested all his resources in formalising the marriage and trying to be a good husband. They went on to have two children, but his wife was not satisfied with their socio-economic situation and refused to produce more. Michael's story indicates that although patriarchal beliefs assert that men should possess decision-making power in marriage, they are also reliant on women to enact values of masculinity.

Gender tensions and male insecurities connected to female reproductive power was most evident in fears surrounding women's faithfulness and secret use of family planning. As mentioned in Chapter 5, male suspicions surrounding female faithfulness and power over declaring the father of a child was identified as a cause of marital tension and male resistance to family planning. In cases where the man suspects a child to belong to another man, respondents stated the man can reject the child: "He tells the wife to take the child to his/her father" (Peter, aged 62) or "go ahead to pay school fees for the child because you want peace at home and also for your wife to serve you food" (Godfrey, aged 85). The benefits of rejection or abandonment can be retaining self-respect and resources, which the man can invest in another relationship or business opportunity. However, as Hunter points out, this can also lead to guilt and clashes with social values of taking responsibility. Alternatively, the man raises the child with the risk that another man might one day claim ownership: this practice maintains marital stability and can ensure the wife continues to fulfil her marital duties, which a man needs to uphold respectable notions of masculinity.

A woman's secret use of family planning was also identified as a cause of tension and suspicion in marital relations.

> It sometimes affects my desire to have sex, because it seems like a waste of time. Contraceptives are only used by people who have the number of children they want to produce. My wife wants only two children, yet I want six … It would be good for the woman to agree with husband and produce the number of children agreed upon. (Michael, aged 32).

The symbolic meaning of unprotected sex in marriage was expressed by respondents to be important for reasons of trust, sexual pleasure and reproduction (discussed further in Chapter 7). Female use of family planning also undermines a man's authority and control, which thwarts his masculinity.

Dissatisfaction in marriage and/or desires for more children were listed as key motivations for men to engage in extra-marital relations.

> A man wants to see his wife his wife breastfeeding a baby. He respects his wife when she gives birth ... Failure to give birth to a baby can lead to getting an extra relationship. (Mukasa, aged 95)

Engaging in extra-marital relations or marrying additional wives was asserted as one way in which men boost masculinity or *asajjalata* (proving manhood) (FG males 41-60). In 2012 the *Kabaka* announced the birth of his fifth child, a son born to a woman who is not his wife. Whilst this sparked controversary as the *Kabaka* and his wife were married in church in 1999, it also demonstrated the deep-rooted beliefs and widespread cultural practice of male engagement in extra-marital relations and polygyny (Kagumire, 2012). The *Kabaka* is a respected figurehead in Uganda, and this illustrates how a wealthy man is deemed able to simultaneously enact both the respectability and reputational value systems of masculinity.

For many men, engaging in extra-marital relations can be used to assert manliness, deal with marital conflict and achieve fertility goals. When a man does not have the economic resources needed to support extra wives and children, he may choose to keep the relationship a secret to avoid martial problems and public criticism. A man's reproductive choices and practices are therefore not simply based on a motivation of masculinity values, but pathways and practices shaped by other social determinants and gender power dynamics.

6.6 Summary

This chapter has used the dominant values of masculinity as a framework to explore the expectations, obligations and conditions of sexual and reproductive practices in marriage. Using the framework of values and analysis of life-stories and respondent data, attention has been drawn to the rise and enactment of male sexual and reproductive practices over the life-course and in different social contexts.

Attracting and retaining sexual partners is essential to proving masculinity in this setting. Men were found to use a mixture of gendered and transactional practices to attract and retain partners at different stages of the life-course. The prescribed cultural norm of men as providers and the socio-economic division of labour and gender roles means that men with money can easily attract sexual partners via gifts and money. Wealth and access to resources also enables men to pay bribes, police fines and bride-price if he is accused of defilement. Men were also found to use other gendered negotiations, such as charming, begging or coercing girls into sex and using matchmakers. Although cultural beliefs assert notions of male

superiority and sexual entitlement, accessing sex relies upon male practices of negotiation and retaining a sexual partner is linked to capabilities to provide.

Opportunities for male engagement in sexual relations has also been linked to mobility and sexualised spaces. The long history of male mobility and migration in this setting shows that young men are expected to leave home in search of work as a rite of passage before getting married. Earning money, being away from the regulated home and community environment, and being in the company of male peers, can encourage practices that enhance sexual achievement and reputation (i.e. paying for sex, multiple and concurrent sexual relations). Labour mobility also offers the opportunity to meet more sexual partners and retain concurrent sexual relationships with women in different locations. This can enable a man to discreetly have multiple sexual partners while retaining an image of respectability. Sexualised social spaces such as bars in trading centres have been argued to facilitate men meeting sexual partners. Socialising with peers and drinking alcohol enhances a man's reputation amongst peers. Drinking alcohol was also deemed to heighten sexual desire and encourage extra-marital relations. The fact that it is a taboo for married women to drink and socialise in bars is a social mechanism to control female sexuality, upholding reputational values of masculinity and protect male sexual privacy. This can enable men to simultaneously enact values relating to being a responsible husband, whilst also engaging in secret extra-marital relations.

Although men are conditioned to believe they possess control and authority in marriage, negotiating a marital relationship is not straightforward. Notions of male respectability are entwined with his capabilities to fulfil his marital role by providing for the family. In this resource-constrained environment, most men will struggle to live up to expectations of being a good husband and father. The social value of a wife being socially and economically dependent on a man is based on the expectation that women will be loyal and easier to control. In circumstances where a man feels a loss of power, authority or control, he might seek alternative ways to boost his masculinity, such as extra-marital relations or through violence. If done with discretion and control, men can engage in both the types of these practices whilst simultaneously upholding a respectable identity. In many cases, the wife might be blamed for driving the man to engage in these practices.

Lastly, notions of virility and having children are deeply ingrained in cultural constructions of masculinity. Cultural and religious discourses assert the importance of producing children to extend clan lines, to demonstrate masculinity and as a form of social security. Fathering children has been argued to occur as a result of sets of practices rather than being motivated by specific mental processes. Men's options and decisions after impregnating

a woman are not just driven by values of masculinity, but are rather shaped by multiple social determinants and mediated through the man's social economic status and the relationship with the mother. Male insecurities and fears surrounding female reproductive agency related to women's faithfulness in marriage and secret use of family planning. Marital dissatisfaction and desires to boost masculinity and achieve fertility preferences were listed as additional reasons for men to engage in extra-marital relations. In the circumstances of men having children with multiple partners, it has been argued that it is possible for a man to still publicly maintain a reputation as respectable if he takes responsibility for the partners and children (which requires a degree of wealth) or if he maintains secrecy.

In short, the construction of masculine identities and enactment of sexual and reproductive practices is complex, driven by multiple social and economic determinants, which constrain and facilitate behaviours in different social contexts over the life-story. Most broadly the values of masculinity in this setting sustain and encourage practices that maintain patriarchal structures of gender relations. The values also put socio-economic pressure on men, which disadvantages poor men and privileges wealthy men. The next two chapters examine how these practices affect the negotiation and management of fertility and HIV risk in marriage.

Chapter 7 – Fertility and family planning

This chapter is dedicated to answering the second research question; 'why does the fertility of married women remain high in this setting, despite changes in the availability of different forms of contraception and other local changes, which are often associated with fertility transition?'. The puzzle of high fertility in this setting is explained in this chapter in two ways. Firstly, by describing how sexual and reproductive health behaviours evolve and are situated within the individual life-course. Secondly by highlighting key trends or patterns across individual life-trajectories which indicate the influence of broader social determinants on the construction of gender relations and population level fertility related behaviours. These two approaches are captured and reflected in diagram 7.1. The diagram does not intend to oversimplify or generalise family planning behaviours or practices in this setting, but rather aid explanation of the social determinants and individual factors that have been found in this study to influence female family planning practices and capabilities to manage fertility and reproductive health. The design of the diagram was inspired by Glass and McAtee's (2006) health behaviour framework mentioned in Chapter 2. The female reproductive life-course runs along the bottom axis and practices/behaviours are shown to be nested within social structures and belief systems. This diagram is used to guide this chapter and evidence findings to explain the high fertility puzzle.

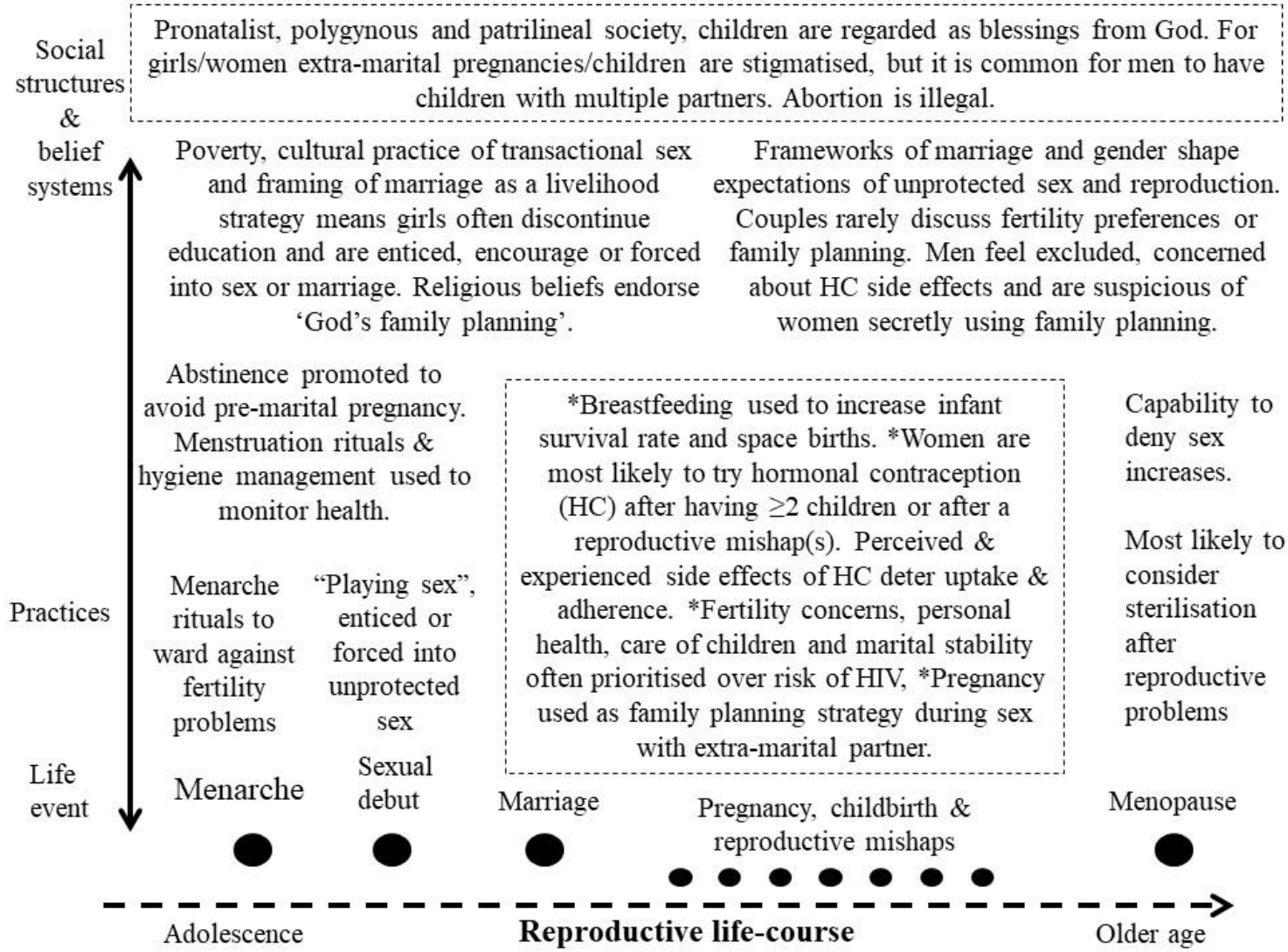
Situated along the reproductive life-course axis are the key events which characterise the lives of most females in this setting. These events include menarche (the onset of menstruation), sexual debut, marriage, pregnancy, childbirth, reproductive mishaps and menopause. I explain in this chapter that the interpretation and practices relating to these life events can be frequently drawn back to social beliefs relating to notions of gender and gender relations. These broader belief systems not only characterise the social landscape in which sexual relationships are negotiated, but they also inform notions of gender identity and agency, which have already been touched upon in chapters 4, 5 and 6.

High fertility has been found in this study to be driven by unintended pregnancies as well as cultural pressures and preferences to have many children. The nature of these drivers are explored in this chapter in terms of fertility preferences and female capabilities to negotiate sexual relations and manage reproductive health. As already illustrated in chapters 4 and 5, there are varying degrees in which females can be forced, pressured or obliged into sexual relations at different stages of the life-course, which can hinder capabilities to negotiate safer

sex. This chapter more closely explores female family planning agency, which includes female responses to social pressures, restrictions and barriers.

In this chapter, I provide details on the methods/practices used by females to try and manage fertility over time, often in response to changing life-events. Whilst there are variations in female sexual and reproductive experiences over the life-course, there was also found to be reoccurring patterns which highlight the consequences of structural gender inequality. I explain these patterns in relation to triggers which prompt changes in family planning behaviours over the life-course. I provide details on seven methods of family planning being used in this setting, which include relying on God, abstinence, the Safe Days Method, breastfeeding, condoms, hormonal contraception and sterilisation. I explain that uptake and change in behaviours is often triggered by life-events or circumstances. Whilst early sexual experiences are often 'unprotected' and females report relying on God, exploration of family planning methods is usually triggered by having two or more children and life events such as sickness, infant mortality, extreme financial hardship or marital conflict/breakdown. Options and uptake of methods are also explained to be characterised by cultural attitudes and religious beliefs, access and capabilities to discuss family planning with a spouse. To demonstrate these driving factors, comparisons are made between different stages of the life-course and also across generations. This shows that although the range of family planning practices have proliferated and the use of modern contraception has increased, fertility rates have remained high due to cultural beliefs surrounding having children and the imbalance of power in gender relations.

Diagram 7.1 Family planning trends over the female life-course



7.1 High fertility in this setting

Although this is a small sample, fertility rates are high across generations, average above the country average and most men and women have children with more than one partner. This section provides a brief overview of the life-story respondents and the number of children which they had produced at the time of the study.

Male life-story respondents

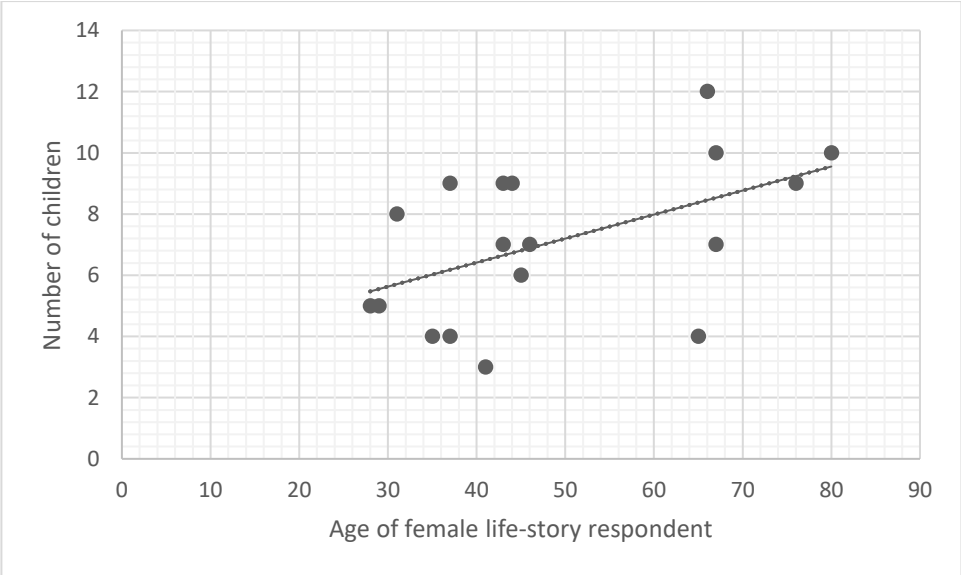
The male respondent data supports the cultural norm that men father many children from more than one sexual partner. Amongst the male respondents, there was one young man (Richard, aged 22) who had no children, but the remaining participants had fathered between two and 24 children, the average being ten. Of those who had children, 14/17 had fathered children with more than one woman, often from a polygamous arrangement, serial marriages or extra-marital relations. Of the three men who claimed to have children with only one marital partner, two were younger men (Michael, aged 32 and Julius, aged 24) who said they wanted more children and would consider getting another partner. Two of the male respondents (Kenneth, aged 61 and Gerald aged 81) also claimed to have had sex with over a hundred women during their life-time and not used condoms, so they could have unwittingly fathered many more children. Most of the male respondents started having children in their mid-twenties. The oldest respondent with the youngest child was Henry (aged 62), who at the time had a new-born child with his nineteen-year-old partner.

Graph 7.2 Male life-story respondents by age and number of children born alive

Female life-story respondents

Female life-story respondents had also given birth to high numbers of children and half had children with more than one sexual partner. The females had between three and twelve children, the average being seven. Unlike their male counterparts, most of the women gave birth to their first child while teenagers. This is in line with country-level statistics that estimates the median age for women to give birth is 18.9 years; the age is lowest amongst women in rural areas with no education (UDHS, 2012, p. 66). The oldest woman with the youngest child was Namakula (aged 45), who had a six-month-old baby. Half the women had children with one reproductive partner, while the remainder had children from two or more partners. Of the women who had children with more than one reproductive partner, six got pregnant as a result of being enticed or forced into sex as an adolescent. The other three women were encouraged into early marriage and the relationship broke down due to abuse or violence. This means that half the female cohort had children with more than one reproductive partner as a direct result of sexual cohesion, violence or abuse.

Graph 7.3 Female life-story respondents by age and number of children born alive



7.2 Infant deaths and reproductive mishaps

The respondent graphs on fertility only indicate the children born alive and it is important to note that loss of children and reproductive mishaps were a common feature in the women's life-stories. They were found to affect relations with a spouse, fertility preferences and family planning behaviours over the life-course. I borrow the term 'reproductive mishap' from

Bledsoe, Banja and Hill who use it to include stillbirths, miscarriages and the death of young children (1998, p.20). The authors use the concept to reflect two cultural concerns: 'the general failure to add a child to the compound and the possibility of adverse medical consequences for the mother' (*ibid.*). 'While fertility is important for both women and men, a woman who fails to have children or has repeated miscarriages may be sent away by her husband or find him taking a new wife in the hope of having children with her' (Seeley 2012 cited in Seeley 2015). Reproductive mishaps can therefore be detrimental to a woman's health and cause marital problems or breakdown. As explained in Chapter 5, women are deemed responsible for fertility and the health of children and can be blamed for fertility problems or reproductive mishaps. Two-thirds of the female life-story respondents (12/18) disclosed personal experiences of losing children and reproductive mishaps, and six male respondents similarly spoke about child deaths or a partner experiencing a mishap. More respondents may have experienced reproductive problems or loss but chose not to disclose during the interviews and women discussed this topic more openly than men.

In Uganda, one in every nineteen children dies before their first birthday, and one in every eleven children dies before their fifth birthday (UDHS, 2012, p97). Infant mortality is also higher in rural areas (*ibid*). Research carried out in Kyamulibwa found that a third of women had lost a pregnancy or experienced a stillbirth (Asiki *et al.*, 2015). The loss of a pregnancy or child at any stage of the life-course was framed as a waste of both a life and the resources invested in that life. As shown in the following sections, loss of children and reproductive mishaps were found to influence desires for more children; they were also used to justify wanting a big family and trigger changes in family planning behaviour.

7.3 Fertility preferences and discussing family planning with a spouse

An important aspect of family planning agency relates to fertility preferences (i.e. desire for children) and capabilities to discuss family planning with a spouse. Fertility preferences are explained in this section to be influenced by religious beliefs and cultural norms but are also influenced by the social environment and life-course events. In this setting the number of children produced in marriage is positively correlated with the length of a relationship (Agol *et al.*,2014). Fertility preferences prior to and during marriage are examined in terms of the number, sex and spacing of children and the number of reproductive partners. Cultural constructs of gender have been shown to shape gender preference of children, contraceptive use and pregnancy rates around the world (Arnold, 2007). As mentioned in previous chapters, the cultural practice of transactional sex, the commonality of male engagement in extra-marital

relations and polygyny, and religious beliefs induce unprotected sexual practices and pressure women to produce children in marital relationships. Building on these findings and to further explain high fertility, this section compares male and female views on fertility preferences to illustrate the shifting nature of social pressures and female priorities during the reproductive life-course as well as male concerns and feelings of exclusion from fertility planning related decisions. Together, these gendered perspectives aid explanation of the power dynamics and barriers to discussing family planning issues in marital relationships.

7.3.1 Female views on fertility preferences

Female fertility preferences allude to the social norms of high fertility, but also indicate generational perceptions on capabilities to manage fertility. Amongst the six older female respondents, one woman had four children, the remainder had between seven and twelve. Older females most commonly stated that they did not have pre-conceived fertility preferences, but rather just started giving birth and relied on God to manage fertility: "I never thought about it; I just looked forward to when God would make me stop!" (Jessica, aged 67). The cultural norm to have a big family was also evident in respondents' answers to questions on fertility preferences. Amongst the seven female respondents who had the fewest children (six or fewer), six said they wanted more children, but either because of issues relating to poverty, fertility problems or marital issues, they had not yet achieved their fertility preferences. In other words, the women with the fewer children were either waiting for the right time or had been unable to conceive.

Although male respondents complained that females today no longer want to give birth to high numbers of children, in the younger age category of the female cohort (20-40 years), half of the female respondents had given birth to seven or more children, which is above the national average. Gladys (aged 28), Teddy (aged 31) and Shakirah (aged 38) had given birth to seven, eight and nine children respectively. The other three younger women, Dyana (aged 35), Naomi (aged 35) and Aisha (aged 29) had between three and five children, and all stated they wanted more. Female desire for children and capabilities to achieve fertility preferences are explained further in relation to social determinants across the life-course. Women's fertility preferences were found to be influenced by cultural norms, notions of gender, social pressure from kinship relations, reproductive experiences and perceived capabilities as a mother. Female respondents used religious discourse to justify fertility desires: "I desire to have as many children as Allah affords to give me" (Shakirah, aged 37). Respondents also used gender stereotypes to explain preference for a particular sex of child ("why I love the girl child, she

remembers her mother more!! (Namakula, aged 45)) or justify the number of children desired: "I would have liked to have eight, an equal number of boys and girl." (Julie, aged 43). Fertility preferences were also explained in relation to personal upbringing: 'I wish my mother had produced siblings for me then I would have had relatives to share sorrows or joy." (Shakirah, aged 37). Female respondents also commented on pressures from children, a spouse or other kinship relations to produce more children.

Overall, fertility preferences were discussed as a process that occurs during the reproductive life-course, through which family planning approaches or practices might be adapted depending on the sex and number of children born or lost, perceptions of the woman's health and capabilities to produce and care for those children. This navigation of fertility and family planning resonates with Bledsoe's (2002) findings from West Africa, where women's desire for and management of childbearing was found to be guided by interpretations of motherhood and capabilities of being a good mother. Fertility preferences are therefore part of a dynamic process that women navigate in relation to childbearing, life events and ageing:

> I still have some time to produce more, I am still in productive age and I have four now, I would like six because that number is not very small in case God takes away any, yet it is not so big so I am able to care for them! (Naomi, aged 37)

The threat and common occurrence of reproductive mishaps and infant mortality was found to not only shape fertility preferences, but also the uptake and change of family planning practices over the life-course (discussed further in section 7.5).

7.3.2 Male views of family planning

Male insecurities, feelings of exclusion and concerns over female reproductive agency were evident in men's attitudes towards family planning and difficulties raised about discussing such issues with a spouse (Kabagenyi, 2014). As outlined in Chapter 6, fathering children is fundamental to proving masculinity and the number of children produced is often used as an indicator of virility and can increase social status (Hunter, 2010; Siu, 2013). However, this also makes men reliant on women to fulfil and enact these notions of masculinity. Younger male respondents complained "women today don't want to exceed having three children"; another participant replied, "They no longer want to give birth in poverty" (FGD males 20-40). These remarks encapsulate two blows to masculinity: female resistance to give birth and a man's inability to adequately provide. As illustrated in Michael's story (Chapter 6), men can feel thwarted by women who exercise reproductive agency by refusing to produce children or

secretly using family planning. It was suggested that this makes men feel their fertility preferences are not respected and that they have little involvement in or control over family planning decisions.

Male respondents were found to feel excluded from decision-making and perceive family planning to be a woman's domain. Reproductive health and family planning were culturally framed by respondents as a woman's domain: "I never discussed it with any of my wives, women usually talk about it with fellow women" (Godfrey, aged 85) and "Men don't attend family planning seminars as they don't see the benefit" (Kenneth, aged 61). Even the men who expressed interest in using family planning reported that they met with resistance, from partners who refused to listen to their views. Joseph (aged 60) remarked, "You can discuss family planning with women, but they don't accept it". Edward (aged 43) and Mukisa (aged 42) also claimed they had suggested using family planning, but their wives had refused. These findings support those reported in existing literature on Uganda, which highlight that ascribed gender roles, cultural norms of having a big family and health services being more tailored towards women's needs, are barriers for male engagement in family planning processes (Siu, 2013; Kabagenyi, 2014)

Men's concerns were mainly associated with desires to have children and suspicion or frustration with women for secretly using family planning (Kabagenyi, 2014). Men complained that a couple should decide on the number of children together, but "women join family planning without the husband's consent" (FG males 41-60). In addition to poverty as a reason woman do not want to give birth, other male respondents also remarked that women use family planning to avoid getting pregnant when having extra-marital affairs (FG males 20-40 and 40-60). Not allowing a wife to use contraception was interpreted as a way for some men to retain or exercise power in a marital relationship.

7.3.3 Discussing family planning in marriage

Married couples experience difficulties discussing fertility preferences or family planning due to cultural expectations of sexual and reproductive practices in marriage and concerns that different views may cause marital conflict or extra-marital relations (Kabagenyi, 2014). As discussed in Chapter 4, many marital relationships in this setting start as consequence of a transactional exchange and unintended pregnancy or arranged marriage with the couple knowing little about each other. Once married, there is an expectation to continue to produce children to grow love and sustain the marriage (Agol *et al.*, 2014). Despite the expectation to produce children, couples seldom discuss fertility preferences or family planning strategies.

Twelve out of eighteen female life-story respondents stated they had never talked to their current spouse about family planning. Women routinely expressed difficulties raising the topic with their spouse, suggesting this was due to fear it would cause problems in the relationship. The six women who had discussed family planning with a spouse said they were prompted to do so because of health concerns (i.e. HIV diagnosis, miscarriage, child sickness) or difficulties with caring for existing children. Whilst men fear women using family planning gives them an opportunity to engage in extra-marital relations without the fear of pregnancy, women worry that requesting to use family planning leads men to engage in extra-marital relations to fulfil their fertility preferences. This tension or perceived threat to marital stability hinders married couples from discussing family planning issues. It also means women are more likely to practice family planning approaches that do not involve directly engaging the spouse, as shown through Aisha's life-story.

7.4 Aisha's story

Aisha's story provides a insights into the broader social determinants shaping gender relations, the socialising of family planning beliefs and the triggers which can cause changes in reproductive practices over the life-course.

Aisha (aged 29) was the eighth of ten siblings and her mother's last delivery was twins. She grew up in her parents' home, completed primary school but was unable to continue education due to a lack of money. Aisha learnt about menstruation rituals and practices from her mother but only learnt about family planning from other women in the village after she got married. Aisha's first sexual relationship was at the age of sixteen with a 20-year-old from her village. Aisha described it as a childish affair and they never discussed or used condoms or any other form contraception. From this relationship, Aisha got pregnant and gave birth to her first child, which was a boy. When probed what really got her to accept the relationship, she said, "he used to give me money and gifts". When Aisha was eighteen and her first child was one, she was encouraged to get married; she called it a "blind marriage" as the couple did not meet before the wedding. They had a Muslim marriage ceremony blessed by the local Imam and giving of gifts at Aisha's parents' home. Soon after marriage, Aisha got pregnant and went on to produce four children, each spaced by an average of two years, which she attributed to God and breastfeeding.

Whilst Aisha was pregnant with her fourth child, she experienced a yellow discharge and went to the health centre, where she was diagnosed with syphilis. After much convincing,

her husband attended the clinic with her, and they were both given treatment. When the baby was born, she was sickly and eventually died at sixteen months old. It was then that Aisha decided to secretly sell some coffee to pay for the hormonal injection, which she bought from a mobile health worker. The injection made her bleed continuously and her partner accused her of using family planning, which she denied. He told her that contraception causes health problems and she would suffer the consequences. After some time had passed, Aisha came off the injection, her menstrual cycle returned to normal and she got pregnant again. When she was breastfeeding that child, she got pregnant again and gave birth. This meant that by the age of 28, Aisha was caring for five children under the age of twelve. Support from her partner decreased over time and months would go by without her receiving any money. Aisha began cultivating crops and looking after a few animals to generate an income. Her spouse had married a second wife in the same village and they had four children together; he also had several children with an extra-marital partner. Aisha was annoyed by his sexual behaviour and failure to provide, which prompted her to try another form of contraception.

This time Aisha pretended to go to the government clinic for a child immunisation and instead had an implant fitted. Aisha said she no longer felt any sexual desire for her spouse and she related this to his promiscuous behaviour and the side effects of the implant. However, regardless of her marital problems, Aisha said she would remain in the relationship for the sake of her children. Aisha said she had always wanted six children, which she would have had if one had not died. However, now she is content with five.

7.5 Family planning approaches over the life-course

Aisha's story illustrates how family planning beliefs, motivations and practices can shift over the life-course in response to life events. The life-story approach therefore offers an overview of the social context and triggers that prompt women to use, change or modify family planning practices over time. Tables 7.3 and 7.4 list the approaches that female life-story respondents had ever used and were using at the time of the study. On average women were found to try three or four approaches over the life-course. The three most common approaches included relying on God, breastfeeding and abstinence. All the women except Paula (aged 65) mentioned using at least one of these approaches; Paula died after the first interview and we therefore never had the opportunity to ask her about her family planning history. Table 7.4 provides a more detailed breakdown of the life-story respondents' social characteristics and family planning practices.

Table 7.4 Overview of family planning approaches used by female life-story respondents

	Ever used	Currently using
God	13	1
Abstinence	9	4
Breastfeeding	8	1
Condoms	6	
Injection (hormonal contraception)	6	3
Safe Days	4	
Implant (hormonal contraception)	4	3
Herbal remedies	3	
Pregnancy	3	
Pill (hormonal contraception)	2	
Sterilisation	2	2
Withdrawal	1	

Table 7.5 Female life-story respondents by social characteristics and family planning

Social characteristics								**Previously used**										**Currently using**
V	Name	Age	Edu	Religion	Discussed FP with spouse	No. of children born alive	No. of rep partners	God	Abs	SD	BF	WD	Con	HC	Herb	Steril	Preg	
10	Teddy	31	P5	Protestant	Yes	8	1	✓		✓				✓				Implant
10	Julie	43	P2	Catholic		7	1	✓			✓		✓		✓	✓		Sterilisation
10	Nakamaty	76	P6	Catholic		9	1	✓	✓	✓								Abstinence
13	Gladys	28	P2	Catholic	Yes	7	3		✓	✓	✓			✓				Injection
13	Ruth	46	P3	Catholic		5	1	✓					✓				✓	None
13	Paula	65	/	Catholic		4	3											None
2	Shakirah	37	P7	Muslim		9	1	✓										None
2	Beatrice	44	P3	Born again	Yes	9	1	✓					✓	✓				God & Implant
2	Fatuma	67	/	Muslim		7	2	✓	✓	✓	✓							Abstinence
20	Dyana	35	P7	Catholic	Yes	4	3		✓		✓		✓	✓				Injection
20	Namakula	45	P3	Catholic		6	3		✓		✓		✓		✓			Breast feeding
20	Jessica	67	P6	Catholic		10	2	✓			✓				✓	✓	✓	Sterilisation
5	Aisha	29	P7	Muslim		6	2	✓			✓			✓				Implant
5	Linda	43	P6	Protestant	Yes	9	2		✓			✓	✓	✓				Injection
5	Kathy	66	P3	Catholic		12	1	✓	✓		✓						✓	None
6	Naomi	35	S3	Catholic		4	1	✓	✓									Abstinence
6	Ayra	41	S2	Muslim	Yes	3	1	✓						✓				None
6	Kathleen	80	P7	Protestant		10	3	✓	✓									Abstinence
Total/Average					**6**	**7**	**2**	**13**	**9**	**4**	**8**	**1**	**6**	**7**	**3**	**2**	**3**	

Key	V – Village Name – Pseudonym Edu – Level of education Abs – Abstinence	SD – Safe Days BF – Breastfeeding WD – Withdrawal Con – Condoms	HC – Hormonal contraception (Pill, injection, implant) Herb – Herbal remedy Steril – Sterilisation Preg – Pregnancy

7.5.1 God's family planning

Religious beliefs have a dominant influence over social perceptions of reproductive management and family planning in this setting. Bledsoe uses the term 'God's family planning' (2002, p.98) to capture the widespread belief system that fertility and reproduction are spiritually governed. Religious institutions were found to harness these beliefs to emphasise marital obligations of sex and reproduction and condemn modern contraception as immoral. The notion of God's family planning provides a base for understanding the social pressure from religious institutions and the stigma associated with abortion and modern contraception. When respondents were asked how they had managed their fertility and family size, the most common reply and dominant power believed to affect fertility outcomes was identified as God. In the key informant interviews, the religious representatives all promoted reliance and trust in God over family planning.

> The church believes that God is almighty, if they can pray that a lady who does not have children gets pregnant and has a child or children, it applies the same way that God is able to stop the lady to produce any more. So, this means to only praise God. God can make anything possible. (Born Again church representative)

The premise of God overseeing fertility was used as a reason to refuse or not need contraception or other forms of family planning. Religious discourse was also used by the religious key informants and respondents to affirm marital obligations to reproduce and the condemnation of contraception. The four religious representatives openly rejected the use of modern contraception due to beliefs that one should reproduce and to not kill or prevent a life. For example, the Imam responded: "[family planning] it is not allowed because you are supposed to produce as many children as you can". Other religious representatives stated that modern contraception is sinful as it prevents the formation of life.

> We follow what the Ten Commandments are saying in the Bible, because one of the commandments says do not kill, you are not allowed to kill, so when someone uses a condom it stops a woman getting pregnant and that is like killing the making of a new baby. (Protestant Church Representative)

Religious representatives also stated it was important for married couples to only produce the number children they can afford. When asked how couples should manage family size, some religious representatives skirted around the question by saying "married couples have their ways", while others more directly suggested natural family planning methods. Some of the

religious representatives admitted that if a woman is experiencing serious health problems, they would encourage seeking medical assistance; if then the woman was then advised to use contraception or undergo reproductive surgery, they would not contradict medical advice. This suggests that religious representatives in this setting encourage and promote manageable reproduction, but rarely offer practical guidance on how couples should achieve this and will only make allowances for family planning in cases of severe ill-health.

The discourse of God's family planning was evident in respondents' attitudes and had a greater influence on older generations and the earlier stages of having children. Thirteen out of eighteen women mentioned calling or relying on God to oversee fertility. There were only four women (including Aisha) who claimed to believe in God's family planning but had also tried hormonal contraception (i.e. the pill, implant or injection). These women were all under the age of 41, so although God's family planning was mentioned by women across all age categories, younger women were more likely to try modern contraception after producing several children. All the older female life-story respondents (except Paula, who died after the first interview) had used God's family planning and a natural approach (i.e. abstinence, breastfeeding, safe days). Nakamaty (aged 76) said she prayed to God for help as she was using natural family planning (safe days) but kept producing children. After giving birth to nine children, Nakamaty experienced severe discomfort during sex, until she would almost pass out unconscious from the pain. For this reason, she began abstaining.

> I used to pray to God wishing to stop producing children because I would fall very sick during each pregnancy and suffer a lot because we were very poor. I would ask myself why am I producing all these children in such a poor state. My husband is a very stingy man. (Nakamaty, aged 76)

Options for family planning would have been much more limited for these older female respondents, which contributed to feelings of lack of control over managing fertility. In comparison, of the women in the younger age groups who stated they used God's family planning, six out of eight had tried a form of modern contraception (i.e. condoms and a method of hormonal contraception) and only Beatrice (aged 43, and also using an implant) was reportedly relying on God at the time of the study.

Findings suggests that the discourse of God's family planning has been very influential on the reproductive lives of older women and continues to shape family planning beliefs and practices of females in this setting. However, it seems women begin to realise after producing several children that relying on God is not very effective and therefore start trying other

approaches. Whilst the options for older women were limited, younger and middle-aged women were more likely to try a modern form of contraception.

7.5.2 Abstinence

Abstinence and natural family planning are commonly promoted by religious institutions to avoid pre-marital pregnancy and manage family size. Abstinence has also been a key message in HIV prevention behaviour change campaigns. Although half of the female respondents stated they had used abstinence at some point during their reproductive life-course, the interpretation of abstinence was found to vary and was mostly used either within a marital relationship, after having a negative sexual experience, or to avoid sexual advances/relations. The difficulties of administering this approach relate to the inequality of gender relations and cultural norms of male sexual entitlement, transactional sex and sexual violence.

Abstinence is the primary family planning method promoted to girls to avoid pre-marital sex; however, older women were more able to administer the approach due to better understanding of gender power dynamics and lower risk of sexual coercion and violence. Namakula and Dyana stated that they tried abstaining during adolescence, but both ended up pregnant after being given money and gifts by an older male who then either raped or coerced them into sex. Kathleen, who was also raped as a teenager, she abstained after the incident due to fear of getting into a sexual relationship. The two single women in the cohort also talked of abstaining. Kathleen (aged 80) abstained after getting divorced and Fatuma (aged 67) after her spouse had died, due to fears of pregnancy, HIV or getting trapped in a relationship with someone who would take her possessions (i.e. inheritance, house, land).

The remaining five women who talked of using abstinence as a strategy whilst being married. Two of the women (Linda, aged 43; and Kathy, aged 66) abstained so as to avoid sexual advances from other men whilst their husbands worked away for long periods. The other three women talked of temporarily abstaining from sexual intercourse with a marital partner. Naomi (aged 35) was angrily refusing her husband sex due to his promiscuous behaviour and fear of contracting HIV, whereas Gladys and Nakamaty stated they used abstinence for reproductive health reasons. Gladys abstained from postpartum sex to allow her body to recover from childbirth, whilst Nakamaty claimed to have abstained for ten years due to reproductive health problems experienced after giving birth nine times. Although abstinence is often perceived as an approach used by adolescence girls to avoid pre-marital pregnancy, women were found to use temporary or periodic abstinence to avoid risk or following a violent episode and whilst in a marital relationship or in older age. Younger women trying to practice

abstinence can face being coerced or forced into sex. It also seems that a woman's capability to refuse a partner sex and avoid unwanted sexual advances increases with age or if the woman experiences health problems in marriage.

7.5.3 The Safe Days Approach

Successful use of the Safe Days approach requires an informed understanding of the menstrual cycle and the fertile window, plus a woman needs to be able to track her own cycle and refuse sex on high-risk days. Although natural family planning is promoted by religious institutions, direct guidance is rarely given on how to apply this approach. The local health clinic was offering outreach advice about the Safe Days approach, but health workers noted that few women are able to implement it. General misunderstanding surrounding the menstrual cycle and the fertile window, in addition to the difficulties that women face in refusing a spouse sex means this method is very ineffective and might actually increase risk of unintended pregnancy.

The Safe Days Approach

The Safe Days or Standard Days Method is a natural family planning approach promoted by both religious institutions and reproductive health programmes. Georgetown University in the US developed CycleBeads (also called rhythm or moon beads), a tool for women to administer this method by counting the days of the menstrual cycle to identify days most likely to conceive (CycleBeads website cited 26/11/2016). CycleBeads have been promoted by UNFPA and rolled out in family planning promotion schemes across sub-Saharan Africa. In this study, when the government midwife was asked about CycleBeads, she remarked that they are a useful tool, but she did not have access to them, so women must buy them at one of the large pharmacies in the next town (40 minutes' drive away) and thus women do not use CycleBeads in the area. In the UDHS, out of the women using rhythm/moon beads method, only a third (33 percent) reported the correct timing of the fertile period (UDHS, 2012, p.88).

Misunderstanding of the menstrual cycle

The government midwife and the HIV counsellor/health worker said that women in the local villages struggle to track their cycles, due to misunderstanding of the menstrual cycle. Women's cycles are often irregular, particularly if a woman has recently given birth or been on hormonal contraception. Furthermore, the key informants posited that women in rural communities struggle to practise this form of natural family planning due to difficulties getting sexual partners to cooperate, as "husbands can't wait for the safe days" (government midwife).

Most of female respondents and the key informant traditional healer/birth attendant expressed confusion and had inaccurate information about the menstrual cycle, the fertile window and the safer days (period least likely to conceive). These findings are in line with country-level trends. According to the UDHS, only 14 percent of women could identify the correct timing of the fertile window (2012, p.88). Almost half (45%) stated they did not know when the fertile window occurs, whereas an equal proportion believed it occurs right after the period ends (UDHS, 2012, p.88). In this study respondents similarly expressed confusion and the misconception that the fertile window comes immediately after menstruation and safe days are in the middle or later in cycle (i.e. the times when a woman is most likely to get pregnant).

Empirical evidence indicates that most women have an average menstrual cycle of 28 days, which usually ranges between 23-35 days, if menstruation starts on day one then ovulation usually occurs around days 8-15 (Wilcox *et al.*,2000). The days when conception is most likely to occur are widely referred to as the fertile window. As shown in Graph 7.6, the length of the menstrual cycle determines the time of the fertile window. Wilcox *et al.* found the point of ovulation can be highly unpredictable, even for women with a regular menstrual cycle (*ibid.*, p.1259). Nevertheless, the likelihood of conceiving is lowest at the start and end of the menstrual cycle, and the fertile window occurs roughly in the middle.

Graph 7.6 Menstrual cycle length and projected fertile window

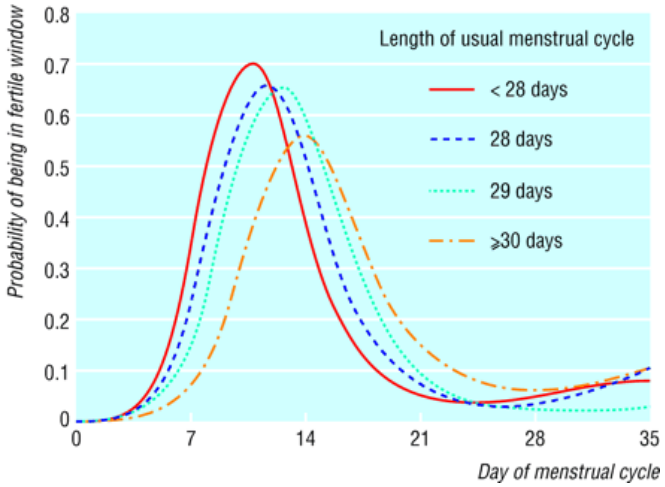


Figure citation: (Wilcox *et al.*, 2000, p.1261)

Some girls learn about the menstrual cycle, reproduction and family planning options in secondary school, but there is a lot of resistance from parents to sex education and many girls are forced to discontinue school before learning about it. The HIV counsellor and health worker

explained that it is difficult to organise sex education outreach in secondary schools as many parents refuse it because they think it encourages pre-marital sex. Furthermore, many girls do not reach secondary level. In this cohort, only two of the eighteen female life-story respondents attended secondary school, while the remainder either never attended school or dropped out before completing primary school. This meant that most female respondents stated that they learnt about menstruation and methods of family planning from peers or kinship relations, which gives rise to the circulation of misinformation.

Misunderstanding of the fertile window was found to be reproduced through informal discussions. One female respondent justified the notion that fertile window must occur after menstruation due to a comparison with other mammals, where menstruation is used as an indication of being ready to mate.

> I never knew that even humans go on heat, but from a neighbour I heard that a human being really goes on heat like an animal! It is within those days that the body is preparing to get a baby. (Teddy, aged 31)

The quote indicates how misinformation can be produced, reproduced and disseminated through informal social networks. Breeding cows and goats is a common practice in *Kyamulibwa*, where the doe or cow's menses blood is used as an indicator to determine if the animal is 'on heat' or ready to mate.

Whilst female respondents reported using this method, misinformation surrounding the menstrual cycle and fertile window suggest that this method is often not being practiced correctly, which can put women at increased risk of unintended pregnancies. This method is promoted by religious institutions, yet women are not equipped to apply this method. Even if a woman has an accurate understanding of the fertile window, the gender power dynamics in sexual relationships make it difficult for women to refuse sex on 'unsafe' days. For these reasons, other methods that do not involve a spouse's knowledge or consent are more commonly used.

7.5.4 Breastfeeding, pregnancy and herbal remedies

Breastfeeding, pregnancy and the use of herbal remedies are three family planning approaches found to be used by married women as they are deemed natural, therefore not in conflict with religious beliefs or perceived to have any long-term adverse effects on fertility. These methods also do not require a spouse to be involved and do not interfere with expectations of unprotected sex in marriage. These methods were used by married women to predominantly manage birth spacing and to avoid extra-marital pregnancy. Menstruation is used to implement and monitor the effectiveness of these approaches. The use of these family planning methods indicates that, for many married women, achieving fertility preferences in terms of birth spacing, desired number of reproductive partners and sustaining marital relationships are often prioritised above other risks relating to unprotected sex.

Breastfeeding

Eight women used breastfeeding to elongate birth spacing and to improve or sustain child health. The female respondents who used breastfeeding, including Aisha, attributed this method to achieving two years or more between births: "I used to breastfeed for a year and a half and I would not conceive before weaning the child!" (Jessica, aged 67). Breastfeeding is deemed a natural approach that does not require partner involvement; it also deters against infant sickness and mortality, which is a primary concern for women.

Short birth spacing is known to be dangerous for both mother and infants and breastfeeding offers a natural prevention against post-partum pregnancy. Research shows that 'infants conceived within 9 months of a sibling's birth are twice as likely to die as those conceived after an interval of at least 27 months' (PSI, 2015, p.1). WHO recommendations stated that 'children should be breastfed for at least one year and preferably for up to two years of age or more' (WHO, 1991); however more recent guidelines have focused on the importance of exclusively breastfeeding for at least the first six months (WHO online, 2018). Breastfeeding has been found to reduce mortality rates of children under the age of two by an average of 50% (Victora *et al.*, 2016, p.479) and can provide temporary protection from pregnancy, predicted to have up to 98% effectiveness if a new mother exclusively breastfeeds an infant who is six months or less and her monthly menstruation has not resumed (WHO online, 2018).

In Uganda, breastfeeding new borns is widely practiced, but duration of breastfeeding and length of post-partum amenorrhoea varies significantly amongst women of different social economic backgrounds. Poorer, less educated rural women have been found to breastfeed on

average four months longer than wealthier, more educated women (ranging between 21.4 and 17.2 months respectively) (UDHS, 2012, p.139). Rural women also report longer periods of postpartum amenorrhoea than urban women (ranging between 10 and 6.1 months, respectively) (UDHS, 2012, p.64). Although only 12% of Ugandan women apparently identified the Lactational Amenorrhea Method as a form of family planning (*ibid.* p.78), amongst women in this rural research cohort, breastfeeding was listed as one of the more commonly practiced method of family planning. To understand the context in which breastfeeding is used by women, I refer to the life-story of Namakula (aged 45). When Namakula was asked how she was able to space her children, she responded:

> Since I am still breastfeeding this baby, that is what's guarding me! Unless I have weaned it, I cannot become pregnant…. I take a long time to resume menstruation after having a baby, around two years. However, when I wean it, I will go to the health worker to seek advice on family planning. (Namakula, aged 45)

Namakula attributed breastfeeding to prolonged post-partum amenorrhea and birth spacing. However, from Namakula's life-story, it is evident that she only used this approach to space her last three children, which she gave birth to whilst being in a marital relationship. The first three children were born as a result of Namakula engaging in transactional sex and being pressured to marry an older man who abused her. Menstruation returning after weaning a baby was mentioned by respondents as an indicator of fertility and at risk of conceiving. In Luganda the term *okulabira omwana,* which literally translates as 'to see the child' is used to describe the first menstrual period after giving birth. Breastfeeding is therefore deemed to prevent pregnancy if menstruation has not resumed. The duration of post-partum amenorrhea was found to vary amongst the women, and some relied on breastfeeding more than others. Perhaps the number of women using breastfeeding as a family planning approach are particularly high in this setting due to health promotion from MRC. It was evident that women were using breastfeeding to also sustain child health and survival. Similarly, pregnancy was also associated with amenorrhea and therefore perceived to offer a form of protection during sex.

Pregnancy

Out of the four-female life-story respondents who disclosed that they had had an extra-marital relationship, three were Catholic women who mentioned using pregnancy as an approach to avoid conceiving from an extra-marital partner. Although the drivers for having an extra-marital relationship varied between the three women (as outlined in Chapter 4), they each

admitted to using pregnancy to avoid the risk of conceiving from an extra-marital partner. The three cases highlight female concern with extra-marital pregnancy, which is prioritised over HIV or an STI. Jessica (aged 67) had sex with the extra-marital partner when she was four or five months pregnant. When asked whether she used any form of protection she replied "*omwana atonderwa ku munne?*" meaning 'can a baby be created over another baby?' When Kathy (aged 66) and Ruth (aged 46) were similarly asked if they used protection during their affairs and they both stated that used being pregnant. Kathy had an extra-marital partner for ten years; she also gave birth to twelve children and stated she only ever used pregnancy, abstinence, breastfeeding and God. Pregnancy was therefore identified as natural approach used by women to avoid extra-marital pregnancy. In the context of these women's lives it is evident that there was a greater concern for the risk and consequences of extra-marital pregnancy than HIV or STIs. As already explained in Chapter 5, there is pressure on women to produce children from the same partner and stigma associated with women having extra-marital relations or producing illegitimate children. The risks of HIV transmission associated with women having extra-marital sex whilst pregnant are discussed in the next chapter. This approach demonstrates the difficulties women experience in negotiating family planning issues and therefore using the natural state of pregnancy, which does not interfere with expectations of male sexual entitlement or require partner compliancy.

Herbal remedies

Although many of the women mentioned using herbs as a family planning method, only three female respondents said they had tried and two of these women realised the herbs did not work. Julie (aged 43), Namakula (aged 45) and Jessica (aged 67) all mentioning trying herbs after they had already given birth to several children and wanted a break. These three women all defined themselves as practising Catholics. The women were recommended herbs by other women in the village or by a close family member. Herbs were sourced from a traditional healer and the women said they were instructed to tie them on a piece of cloth around the waist. Julie and Jessica stated that the practice did not work as they both got pregnant soon after, whereas Namakula believed the herbs helped to space three of her children. However, as explained earlier in this section Namakula also attributed this spacing to prolonged breastfeeding. According to the UDHS, only 0.5% of married women state using herbs (folk method) as a current form of family planning (UDHS, 2012, p.80). Although most women may not use herbs for very long as they realise that the practice is ineffective, it is evident that married women may be encouraged to try the practice by other female relations or peers. Herbs are easily

accessed in the community from a traditional healer and are perceived as a natural approach to manage fertility that is not in conflict with religious beliefs nor sex with a marital partner.

7.5.5 Condoms and withdrawal

Although six women reported using condoms at some point during the life-course, this section explains that this practice often took place at the beginning of a sexual relationship or was used only with a casual sexual partner; and only one woman mentioned the withdrawal technique. The association of condoms with high-risk sex and the expectations of unprotected sex in marriage means that condoms are often deemed unacceptable in a marital relationship even if there is a perceived risk of HIV. The stigma associated with women (particularly married women) buying or sourcing condoms means condom practice is rare: asking a marital partner to use a condom signifies distrust and prevents sexual intimacy, even if there is known risk of unintended pregnancy, STIs or HIV.

It is difficult for girls/women to buy or access condoms and men often reject using condoms due to expectations and symbolic meaning of unprotected sex in marriage. Only six women stated that they had ever used condoms. Five of these women were in the mid-range age category (40-60 years old) and one woman was in the younger age group. The women who had used condoms said it was either at the beginning of a marital relationship or with a casual sexual partner. Older women generally said condoms were not around or used by their age group: “we know the condom exists, but I cannot lie to you, we have never used it the whole of our lives!” (Kathy, aged 66), whereas all but one of younger women stated they had tried to use condoms, but their marital partners had outright refused.

In addition to religious reasons to not use condoms, respondents also talked about the difficulties for women to access condoms, either because they are shy, lack money or free condoms are often given to male youths. Using a condom is therefore often initiated and supplied by the man. Men were said to refuse using condoms in a marriage, due to sexual and reproductive expectations or a sense of entitlement to unprotected sex with a wife. Aisha remarked that her partner rejected condoms as “he does not like to lick a sweet from a polythene paper”. Rejection of condoms due to reasons of sexual pleasure, intimacy or desire to reproduce are in line with findings from across sub-Saharan Africa (see Maticka-Tyndale, 2012). As highlighted in Chapter 5, the expectations and obligations for women to have unprotected sex in marriage means condoms are perceived as incongruent with marital norms.

Trying to negotiate condom use in a marital relationship was associated with resistance, distrust and marital problems. Respondents noted that the perceived conflict was not worth the

risk. Life-story respondent Teddy (aged 31) was concerned about HIV due to her husband's "promiscuous sexual behaviour" but remarked "if you insist on telling him about using condoms, he can suspect you had a relationship with someone else, so it breaks into a quarrel". Requesting to use condoms in a marital relationship was therefore deemed as a sign of distrust and unfaithfulness, rather than a useful method of family planning or a tool to protect individual health. Trying to negotiate condom use in marriage was therefore associated with marital instability, which was framed as being potentially more detrimental than the risk of having unprotected sex with a spouse.

7.5.6 Hormonal contraception

Women were found to use hormonal contraception when they already had two or more children, to try and space births or take a break from childbearing due to a reproductive mishap or marital problems. Female respondents narrated strategies to access and use hormonal contraception, often without consulting their partner, and thus the injection was found to be the preferred method of hormonal contraception in this setting. The private healthcare market has evolved to meet this demand. Women's known secret use of contraception was found to be a source of suspicion and marital problems. Perceived and experienced side effects on menstruation were found to affect uptake. Over a third of the female respondents (7/18) had ever used hormonal contraception (i.e. the injection, pill or implant). These women were aged between 28-44 years old and all first started using hormonal contraception after having at least two children. Four of the women had tried two or more hormonal methods, showing that once they tried one type, they were more likely to try another.

A mixture of reasons prompt uptake of hormonal contraception, often with the goal to sustain health so as to be a good mother. Reasons prompting this practice were found to include miscarriage, child sickness or death; close consecutive births; marital problems; and diagnosis of HIV (Table 7.7). As shown in Aisha's story, she first secretly used the injection after her fourth child died and then had the implant fitted due to her husband having extra-marital relations and not providing financial support. One of the women was Catholic (Gladys) and she justified using hormonal contraception to sustain her health as she had been diagnosed with HIV: "I cannot keep producing because I see my health is limited. What if I die before these children grow up?" Gladys wanted more children to sustain the relationship with her spouse but feared she would suffer if she continued reproducing.

These findings support Bledsoe's family planning conclusions from West Africa, where women were found to most likely use hormonal contraception after a reproductive mishap or to space births to lengthen fecundity, strengthen reproductive capabilities and manage the process of ageing (2002, pp.325–328). This use of modern contraception centres on ideologies and expectations of being a mother and sustaining health to fulfil fertility capabilities and caregiving responsibilities. This is an alternative approach to Westernised framing of hormonal contraception being predominately used to suppress fertility and prevent having children.

Table 7.7 Female respondents using hormonal contraception

Respondent details			**Reason for using**			
Respondent pseudonym	Type of HC	Used secretly	Miscarriage, child death or sickness	To space births	Marital problems	Diagnosis of HIV
Aisha, aged 29 6 births 1 child death	Injection Implant	✓	✓		✓	
Linda, aged 43 9 births 2 miscarriages 1 child death	Pill Injection Implant	✓	✓	✓	✓	
Teddy, aged 31 8 births	Pill Injection Implant	✓		✓		
Beatrice, aged 44 9 births	Implant	✓		✓	✓	
Gladys, aged 28 7 births 1 miscarriage	Injection Implant	✓		✓	✓	✓
Arya, aged 41 3 births 1 child death	Injection		✓			
Dyana, aged 35 4 births 1 child death	Injection	✓		✓		✓

Although this is a small sample, the findings echo wider use of hormonal contraception in the area. The government midwife at the local health clinic affirmed the injection to be the most popular form of modern family planning, followed by the implant, IUD and the Pill. The UDHS also reports injectables to be the most commonly used method of contraception among married women in Uganda (14%) (UDHS, 2012, p.79). The mobile health worker explained that women do not like the Pill due to difficulties remembering to take it daily and hide it from a spouse, so the injection is preferred due to ease of having it secretly administered, and the protection lasts

three months with options to renew or stop if wanting to get pregnant. In Uganda, of those using the injection, a large proportion of women (39%) discontinue within one year due to a desire to become pregnant (UDHS, 2012, p.87). The injection is therefore the most popular type of hormonal contraception as it can be easily administered, offers full yet temporary protection and can be used without a spouse's involvement. Women were found to use various strategies to create opportunities to source and secretly use hormonal contraception. Five of the six women who had used hormonal contraception had done so secretly at some point in a marital relationship. Four said they later convinced a spouse to support use of contraception after having six or more children. In Uganda, women are known to secretly use birth control to manage fertility without their spouse's knowledge, particularly in relationships where there is domestic violence (Agol *et al.*,2014, Maxwell *et al.*, 2018).

In the life-stories, women outlined strategies to access contraception, such as Aisha secretly selling coffee to buy the injection from a mobile health worker. It is estimated that 60% of injectables are obtained from private facilities in Uganda (UDHS, 2012, p.84), indicating that the private healthcare market has evolved to meet women's demand for discreet and accessible family planning. Aisha also used the excuse of going to the clinic for a child's immunization, so she could get an implant fitted; other women described similar ways of generating money to cover costs and similar excuses given to marital partners to access, hide and use contraception. This expression of reproductive agency indicates women navigating structures and overcoming male resistance or marital problems.

Perceived and experienced side effects

Adherence and resistance to using hormonal contraception was often linked to perceived and experienced side effects. It is estimated that 43% of women in Uganda discontinue hormonal contraception within 12 months and fear of side effects is the main reason (UDHS, 2012, p.79). Aisha experienced menorrhagia (prolonged menstrual bleeding), which made her husband suspect that she was using contraception; he then scolded her for exposing herself to health problems. Men's resistance to hormonal contraception was often related to perceived side effects and associated medical costs and some men also expressed concerns about women using contraception to have extra-marital affairs (FG males 20-40 and 40-60). Men also complained about hormonal contraception weakening sexual pleasure and capabilities: "contraceptive pills have made this generation of men sexually weak" (Henry aged 62).

Women's concerns about hormonal contraception centred more around the effects on the menstrual cycle, reproductive health and long-term fertility. Female respondents expressed

concerns about hormonal contraception causing amenorrhea, which was perceived to be harmful as it meant dirty menstrual blood was not being purged from the body. Menorrhagia was also conveyed negatively, as it interfered with marital sex and made husbands suspicious of contraceptive use. A study in South Africa found that found 96% of injectable contraceptive users experience amenorrhea, which is often regarded as 'troublesome' and given as a reason for discontinuation (Laher *et al.*, 2010). Surveys have found that in many countries around the world women do not mind amenorrhea and prefer to not menstruate, whereas black African women were found to prefer a monthly period (Glasier *et al.*, 2003). Cultural beliefs on menstruation therefore shape interpretation of side effects and adherence to hormonal contraception, particularly if being used secretly.

In summary, the women using hormonal contraception were doing so after having several children, mainly for the purpose of spacing births or taking a break from giving birth due to health reasons or marital problems. Men expressed concerns about the side effects of hormonal contraception, associated medical costs, and women using it so as to have extra-marital relations, which this study found no evidence of. Women were found to use multiple strategies to create opportunities to secretly use contraception rather than risk discussing family planning with a spouse. However, it seems that women are more able to discuss and convince a spouse after having six or more children. Family planning decisions being based around beliefs to sustain a woman's health and reproductive capabilities are further explained in relation to motivations for undergoing sterilisation.

7.5.7 Sterilisation

Women who have given birth to many children (usually seven or more) and experienced reproductive health problems were found most likely to undergo sterilisation. Demand for this permanent method is argued to be driven not by a desire to limit children, but rather to protect a woman's health and sustain capabilities to care for existing children.

Infections and having many children were listed as key causes that weaken the womb and cause a decline in women's health, prompting consideration of sterilisation. In the life-story cohort, two women (Julie, aged 43; and Jessica, aged 67) and the wife of one male respondent (Leo, aged 52) had undergone sterilisation. The three respondents gave the primary driver for the sterilisation procedure to be reproductive problems caused by successive deliveries. Leo's wife had given birth to eleven children, and Jessica and Julie had given birth to ten and seven children respectively. According to the government health worker, around

thirty women per year undergo sterilisation in the small local health centre, usually women who have had ten or more children. Although the demand for sterilisation has grown in Uganda, it is often attributed to desires to limit children (Lutalo *et al.*, 2015); however, these case studies suggest sterilisation can be used as a strategy to protect and sustain a mother's health.

The three respondents suggested that sterilisation had been chosen because the woman's health was at risk due to problems caused by pregnancy and giving birth. In the narratives, the respondents referred to damage caused by childbearing, either in terms of the womb being weakened or infected, or the body being worn out due to the impact of reproductive issues, such as a life-threatening miscarriage or complications from labour. Leo (aged 52) encouraged his wife to go through the procedure and reassured her he would be faithful after the procedure.

> We had many children when my wife started facing complications giving birth, indicating that she was worn out. We discussed it and I reassured her that even when her tubes are blocked, I will remain faithful to her. Sometimes being faithful is hard to achieve, but God is with me to fulfil it.

Leo acknowledges that sterilisation would prompt some men to seek extra-marital relations and therefore reassures his wife. Julie and Jessica also underwent sterilisation because of health reasons. A doctor urged Julie to undergo sterilisation after having an emergency caesarean and telling her that her "uterus was infected". Julie's husband supported the sterilisation, saying that Julie's health and caring for their existing children was of most importance. Jessica was similarly prompted to undergo sterilisation after experiencing a miscarriage, which she said almost killed her. However, unlike Julie, Jessica underwent the operation without her husband's permission. Jessica said her brother took her to the hospital and signed paperwork, pretending to be her husband. Even though Jessica had been with her husband almost fifty years, she never told him. Healthcare procedures that state that a husband should give permission before a woman undergoes sterilisation show the institutionalisation of male control over the female body and that a woman's relationship with a spouse can affect access or uptake of sterilisation. However, Jessica's involvement of her brother demonstrates female agency and engagement of social capital to overcome this barrier.

According to the UDHS 7% of women have been sterilised in Uganda and demand for this family planning approach is often used to indicate women's desires to limit childbearing (2012, p.79). Although sterilisation has become more common in Uganda, it is not widely offered by rural health centres, where demand is argued to be high (Lutalo *et al.*, 2015).

However, in the UDHS and the study conducted by Lutalo and colleagues in Rakai, demand for sterilisation is presented in terms of women seeking to limit childbearing and the driver of reproductive health problems is completely overlooked, yet the findings from these three cases suggest that reproductive problems and a desire to improve or protect health are primary reasons women consider sterilisation.

7.6. Summary

In this setting, fertility rates are high, but this is not because women are not using family planning practices. Women use on average three or four approaches over the life-course to space births, avoid unintended pregnancy, take a break from childbearing, boost health and prioritise caring for existing children. High fertility rates can be attributed to cultural and religious beliefs that affirm the importance of reproduction and unprotected sex in marriage, the structure and power dynamics of marital and gender relations which impedes on female capabilities to negotiate sex, and also the ineffectiveness of family planning approaches and practices often used to manage fertility in this setting. Cultural attitudes and social norms surrounding family size are known to 'constrain the range of choices truly available to individual women' (Martin, 1995, pp.191-192). Cultural and religious beliefs shape marital gender roles, as do the socio-economic organisation of gender relations and family structure, influencing reproductive practices and family planning approaches (Price and Hawkins, 2007). This means that even though modern contraception has increased, and the country has undergone socio-historical transitions usually associated with reduction of fertility (i.e. processes of urbanisation and modernisation), cultural norms of gender roles and sexual practices (including unprotected sex) are key driving factors sustaining high fertility in marital relationships.

Gender belief systems surrounding fertility and family planning practices comprise social, spiritual and biological dimensions, which influence behaviours at different stages of the life-course and across generations. In this setting, family planning practices are hindered by religious beliefs, misinformation about the menstrual cycle, prevention of girls receiving sex education, high rates of child mortality, stigma surrounding fertility problems and reproductive mishaps and fears associated with modern contraception. Couples rarely discuss fertility preferences or family planning until there is a crisis or the couple have produced six or more children. Despite these constraints, family planning practices in this setting have proliferated and women's approaches to sourcing information and secretly trying and applying

various methods demonstrate an increase in female awareness and reproductive agency, which is also recognised to be a cause of male insecurity and marital tension.

Religious beliefs and reproductive messages promoted by religious leaders sustain high fertility rates and patriarchal control of female bodies. Religious discourse is used to assert the importance of reproduction in marriage and God's role overseeing fertility, which contributes to expectations of unprotected sex, rejection of modern contraception and abortion, and the ineffective application of natural family planning. Notions of God's family planning are ubiquitous and particularly influential on the attitudes and behaviours of older women and those in the earlier stages of marriage when the pressure to prove reproductive capabilities is at its highest. Religious discourses can discourage and disempower females from trying modern family planning practices, managing reproductive health and negotiating safer sex.

Girls are socialised to accept the importance of fertility and their sexual and reproductive roles in marriage. Lack of formal sex education, misinformation on the menstrual cycle, socio-economic gender inequality and the cultural practice of transactional sex, leaves females ill-equipped to monitor reproductive health or effectively negotiate safer sex. Whilst concerns about modern contraception are based on a mixture of myths and rational fears of the health implications, beliefs about the menstrual cycle and fertile window are generally mistaken, which means natural family planning practices are ineffective and can actually increase the chance of pregnancy.

Married couples rarely discuss fertility preferences or family planning due to the perceived threat to marital stability; this means women are more likely to try practice family planning without informing their spouse. Requesting to use family planning is associated with marital conflict and extra-marital relations, so desires to maintain marital stability mean women often make family planning decisions alone. Men may suspect women to secretly use family planning methods, which undermines their authority and control, both of which are pillars of masculinity. This makes men feel insecure and suspicious of women using reproductive agency or acting unfaithfully if they do not fear pregnancy. Although male resistance to family planning can be interpreted as an attempt to exert control over a wife, women's secrecy and avoidance makes men feel excluded and prevents their engagement in family planning.

Chapter 8 – HIV risk and navigation

This last data chapter sets out to answer the final piece of the research puzzle: 'How has the onset and trajectory of the HIV/AIDS epidemic, as well as the public health responses to this trajectory, influenced sexual practices among people who consider themselves married?' I argue that a risk environment has evolved in Uganda which makes married individuals, particularly women, susceptible to contracting the virus. Previous chapters have, of course, already been showing important levels and dimensions of the risk environment for married individuals. This chapter seeks to bring these factors together to explain the social determinants of the HIV risk environment and how these dimensions impede capabilities to negotiate and manage HIV in marital relationships. Findings contribute and build upon existing research on risk environments (Barnett, T. Blaikie, 1992; Barnett and Whiteside, 2002; Rhodes, 2002; Rhodes and Simic, 2005; Rhodes *et al.*, 2005; Shannon *et al.*, 2008) by examining the structural, intermediate and proximal factors, which shape conditions and influence sexual practices that facilitate HIV transmission and heighten susceptibility.

To address this last research question, this chapter is divided into three parts. The first builds a picture of the onset and trajectory of the HIV epidemic in Uganda. This historical snapshot is important for framing the HIV epidemic alongside other social, economic and political changes that were occurring in the country. As mentioned in the theoretical chapter, this study recognised that individual lives are embedded and shaped by historical place and time. The first section therefore provides a brief background to social life in the south-western Uganda and the national public health response to the HIV epidemic, both of which had significant consequences for how individuals interpret and manage the perceived risk of HIV.

The second section then looks more closely at aspects of social life and specific sexual practices, which are argued to have facilitated the spread of HIV and increase susceptibility in marriage, particularly for women. As indicated in life-course theory, individual lives are interdependently linked and socio-historical influences are expressed through networks and dynamics of social relationships (Elder, 1998a, 1998b). The second section is therefore used to demonstrate the socio-historical influences on the construction and dynamics of gender relations which facilitate the spread of HIV in this setting. I focus on four sets of social practices which contribute to a HIV risk environment, these include; transactional sex, early and pressurised marriage, gender-based violence and extra-marital relationships. I argue the

ubiquitous nature of these social practices illustrates the unbalanced power dynamics of gender relations and the disadvantaged position of females to negotiate risks relating to HIV.

The final section of this chapter specifically focuses on the ways married individuals navigate the risk environment and negotiate or manage HIV alongside other risks and priorities. Although HIV risk-taking and structural factors facilitating HIV transmission are well documented, there has been less research about how married individuals interpret, negotiate and manage HIV risk (Hirsch *et al.*, 2009). This final section therefore offers original insights to how married individuals interpret and negotiate HIV testing, diagnosis and prevention in the context of expected gender roles, practices and duties associated with being in a marital relationship. I outline the influence of the HIV prevention campaigns on the interpretation and negotiation of HIV. Campaigns have moralised marital type behaviours as protective and stigmatised against multiple or extra-marital sexual behaviours, I argue that this framing of HIV has contributed to a rise in sexual secrecy and contributed to a barrier, which prevents many married couples from openly discussing HIV. The HIV prevention messages are explained to be in tension with cultural and religious beliefs surrounding marital gender identities and the meaning of unprotected sex in marriage. It is shown that individuals are navigating multiple risks and that preferences to maintain marital relations and/or act out particular sexual and reproductive practices are often prioritised above the risk of HIV.

8.1 The social response to the HIV epidemic

Uganda is often regarded as an HIV success story, associated with the key ABC messages (abstinence, be faithful and use condoms), however in reality the prevention strategy has not been straight forward, there has been significant tensions with religious institutions and the HIV epidemic has occurred alongside major social, economic and political changes which have changed the landscape for sexual relationships (Parkhurst, 2002; Barnett and Parkhurst, 2005a; Kuhanen, 2015). As Barnett and Whiteside remark, ‘Epidemics do not just happen. They are not random events. They have histories. … Histories of infectious disease reflect the ways in which channels and paths of infection have been created part of the material and cultural lives of society’ (*ibid.,* pp.65-66). The public health response to HIV mediates both the social and imagined experiences of the epidemic (Streefland, 1998). It is argued that the HIV prevention messages which have been promoted during the epidemic are in tension with the context and circumstances in which sex and sexual relations are being negotiated in this setting. It is therefore of importance to this thesis to briefly explain how the HIV epidemic and prevention response in Uganda evolved alongside significant social, economic and political changes in the

country. The provides a socio-historical backcloth to living conditions and also the origins of the discursive ideas of the national HIV prevention campaign, which have shaped individual perceptions and experiences of the HIV epidemic.

In the initial stages of the epidemic, Uganda was in the process of rebuilding from civil war, there was extreme poverty and displacement; this was taking place alongside the emergence of new demands of modernity, a market economy and rise of consumerism, which the president perceived to be corroding traditional gender roles and structures (Kuhanen, 2015). Structural processes of population growth and migration to urban areas, created new sexual cultures that were free from traditional constraints on sexuality: as Kuhanen explains 'The urban sexual culture differed from that of the rural areas, as sex outside wedlock with irregular partners became common. Sex also became an important item of trade and a means of making a livelihood' (*ibid.*, p.229). These sexualised spaces and emergent cultures were perceived by the President of Uganda to be fuelling the HIV epidemic and therefore shaped the public health response (*ibid.*).

The public health campaign therefore focused on changing individual sexual behaviours and practices perceived to spread the virus (Parkhurst and Lush, 2004; Barnett and Parkhurst, 2005b; Kuhanen, 2010). As the HIV epidemic unfolded, "Museveni spoke about the need to return to traditional family values as a social prophylaxis against HIV, and about creating a fear of AIDS in Ugandans so that people would be too scared to be promiscuous" (Kuhanen, 2015, p. 4). Cultural and religious ideals of marriage and family life therefore became the backbone of HIV prevention, used to define prevention messages and stigmatise behaviours that were deemed a threat to society (Barnett and Parkhurst, 2005; Parikh, 2007; Kuhanen, 2010). This public health prevention approach is argued to have increased sexual secrecy of and hindered the negotiation of HIV risk in marriage (Agol *et al.*,2014; Kuhanen, 2010; Parikh, 2007)

The HIV prevention campaign in Uganda began with early slogans of "zero grazing" and "love carefully" to deter extra-marital relations and quietly promote condoms due to tensions with the Catholic Church and other religious institutions (Kuhanen, 2015). However, as prevalence of HIV increased, major donors such as USAID and the World Bank asserted pressure through the WHO to push the Ugandan authorities to more overtly promote condoms, education, HIV testing and counselling (*ibid.*, p.8). The HIV prevention response in Uganda therefore became more directly associated with key messages promoting abstinence, being faithful and using condoms (Barnett and Parkhurst, 2005).

This public health response to HIV has have been criticised for focusing on individual behaviours, rather than the structures. context and power dynamics in which sex and sexual relationships are negotiated (Barnett and Parkhurst, 2005). The moral framing of marital type behaviours and condemnation of promiscuity have also been blamed for fuelling HIV stigma and inadvertently increasing sexual secrecy, uncertainty and distrust, making it more difficult for married individuals to discuss and manage HIV risk (Barnett & Parkhurst, 2005; Kuhanen, 2010; Parikh, 2007; Seeley, 2014).

In Uganda's national HIV/AIDS strategic plan 2014/15-2019/2020, although the epidemic is acknowledged to be fuelled by social determinants cutting across multiple scales in society, there remains a focus on individual behaviour and responsibility. This in highlighted in the tagline for the policy which is 'An AIDS free Uganda, My responsibility!'. Approaches that focus on individual behaviours overlook the structural influences and circumstances of social practices which facilitate the spread of HIV (Campbell, 1997; Auerbach, Parkhurst and Cáceres, 2011; Kippax *et al.*, 2013; Parkhurst, 2014). The next section outlines four sets of social practices which contribute to the risk environment, which heighten HIV susceptibility for married individuals in this setting.

8.2 The HIV risk environment for married individuals

The construction of gender relations are argued to be a key social determinant shaping the HIV risk environment (Auerbach *et al.*, 2011; Dunkle *et al.*, 2004; Geeta Rao Gupta, 2000; J. A. Seeley *et al.*, 1994; Seeley, Grellier, & Barnett, 2004; Wolff *et al.*,2006). This section emphasises that culturally prescribed gender roles and division of labour reinforces notions of the male provider role and female economic dependency on men, fuel the spread of HIV (Gupta, 2002; Gupta, 2000; Stoebenau *et al.*,2016). Frameworks of gender are argued to facilitate notions of male sexual entitlement and dominance, which constrain female capabilities to negotiate sexual interactions and practice safer sex, and encourages male engagement in sexual risky practices (Campbell, 1997; Gupta, 2002; Gupta, 2000; Siu, Seeley, & Wight, 2013; Siu, 2013). Unequal power dynamics surrounding sex and sexual relationships create pathways for HIV transmission and hinder female negotiation of safer sex both within and outside of marriage. This structural gender inequality is highlighted through sets of social practices, which highlight notions of male sexual entitlement, dominance and violence. Four sets of social practices are outlined in this section, which includes transactional sex, early and pressurised marriage, gender-based violence and extra-marital relations.

Based on respondents' responses, eight stated that they had contracted an STI and/or HIV whilst being in a marital relationship. Two were male respondents who admitted to acquiring gonorrhoea from extra-marital partners and one of these men (Edward) also contracted HIV. The six female respondents who disclosed they had acquired either syphilis or HIV, inferred they were infected by a spouse. The patterns identified across the respondents' life-stories point to how sexual relationships are shaped by the socio-historical environment, influencing individual opportunities, choices and capabilities to negotiate sexual relations. The unbalanced power dynamics and expectation of gendered roles are emphasised to be a core social determinant fuelling the spread of HIV and STIs. The life stories of the three HIV positive life-story respondents (Gladys, Dyana and Edward) are used as case studies to illustrate the social determinants of key social practices within the context of individual life trajectories.

8.2.1 Transactional sex

It has been argued that a transactional element is a feature of most sexual relationships, whether marriages, long-term, extra-marital partnerships or short term relationships in many regions of sub-Saharan Africa (Caldwell, Caldwell and Quiggin, 1989; Hunter, 2002; Swidler and Watkins, 2007). Evidence suggestions that in this setting female engagement in transactional is driven by poverty and economic need, but also by aspirations relating to love, sexual exploration and desire for consumer items relating to modern lifestyles. Findings therefore build on existing literature on transactional sex, which point out the blurred boundaries between sexual exchanges and expressions of love, sex for material or monetary gain and to improve lifestyle, and engagement in sex due to poverty or coercion (Hunter, 2007, 2010; Wamoyi, Fenwick, *et al.*, 2011; Stoebenau *et al.*, 2013; Ranganathan, 2015).This section uses Gladys's (aged 28) story to situated transactional sex within the context of an individual's life-course, showing how this social practice can arise and the social consequences for marital decision making.

Gladys's story

Gladys was around 16 and living with her uncle's family when she secretly accepted money from an older banana trader in exchange for sex. Gladys had been sent to live with her uncle's family to assist the aunt with domestic work and help care for the two younger male cousins. Gladys had been living the family for several years. After completing year two of primary school her uncle stopped paying the school fees and Gladys was told "to remain at home to

cultivate and look after the children". Gladys deeply regretted not completing her education as she associated it with being unable to get employment later in life. She remarked: "I was made to fail". Gladys was given food by her uncle's family but nothing else, which was a driving factor to engage in transactional sex. Gladys explained "where I used to stay, they never gave me any material support! That man is the one who used to give me some little money privately so I could get what I wanted for myself!". After having sex with the banana trader, Gladys conceived, but only found out she was pregnant several months later when living back at home with her parents.

Gladys's early sexual relationship, which she used to obtain material rewards, changed the trajectory of Gladys's life-course. After she gave birth and had weaned her first child, her parents pressurised her to get married. They identified a 50-year-old, small-scale farmer and witchdoctor for her to marry. Gladys accepted the customary marriage so to be able to leave her parents' home and gain support. At the beginning of the marriage, Gladys said she was "attracted as I was somewhat relieved to no longer be staying at home. However later I experienced challenges and got fed up". The challenges included her husband being a heavy drinker and frequently acting violently or abusively towards her. Gladys also lost a baby, which she attributed to witchcraft. Gladys remained in the marriage for five years, during this time she gave birth to another three children. As her husband became increasingly more abusive, she started secretly using family planning (the hormonal injection). Then one day when she could take no more, she walked out only taking the child she was breastfeeding, as she knew she could not travel with the other two.

Gladys was living with her sister when she met her second spouse. Gladys described the man as having good character as he provided support and because he wanted to marry in church. The spouse was a casual labourer and would travel for days at a time leaving Gladys alone with the children. During their marriage Gladys gave birth to two children in close succession. When she was pregnant with the second, she was diagnosed with HIV during a standard antenatal screening. When Gladys told her spouse, he accepted for her to go on anti-retroviral treatment, but he refused to get tested or to use condoms. Gladys suspected her husband to have other sexual partners, but said "he doesn't make me suffer", meaning he returns home, provides support and does not quarrel. It is for those reasons she wanted to sustain the marriage. However, the precarity of Gladys's situation, in terms of her dependency and lack power surfaced during the interview, "you cannot predict what he is up to, will he abandon me and go away for good, such thoughts do come".

Gladys's story is not unique; as illustrated earlier in this thesis many females in this setting experience similar challenges due to the socialisation of gender roles and social structures of poverty. As already emphasised in Chapter 5, it is important to view transactional sex within the broader social and economic division of roles and power dynamics between males and females (Swidler & Watkins, 2007). Across sub-Saharan Africa, prescribed cultural gender roles mean that in sexual relationships men are regarded as the providers of material support, and women are expected to provide sex in return (Wamoyi *et al.*, 2018). These gender norms, alongside impoverished living conditions and desire for basic or luxury consumables, create conditions which facilitate girls exploiting their sexuality or being coerced into sex in exchange for material gain (Wamoyi *et al.*, 2011).

The drivers to engage in transactional sex can vary over the life-course and the consequences can alter life-course pathways, affect marital decision making and facilitate susceptibility to HIV. Although females may use sexuality or sexual agency to negotiate the exchange, the imbalanced gender power dynamic of most transactional sex relationships, puts females, particularly girls, at disproportionate risk of contracting HIV (Stoebenau *et al.*, 2016).

Although transactional sex is often distinguished from marital type relationships (Wamoyi *et al.*, 2018), it is important to note that relations based on transactional sex can transition into marriage (as shown through Julie's story in Chapter 5) and the consequences of transactional sex (i.e. unintended pregnancy) can result in increased social pressure to marry as illustrated in Gladys's story and discussed further in the next section. Transactional sex can also occur alongside marital relationships and facilitate the practice of extra-marital relations (expanded upon in section 8.4).

8.2.2 Early and pressurised marriage

Cultural and religious norms shaping ideas about gender, alongside socio-economic circumstances of poverty are recognised to drive early, forced and arranged marriages, which increase female susceptibility vulnerability to HIV (Chandra-Mouli, Camacho and Michaud, 2013; Schlecht, Rowley and Babirye, 2013). This section briefly covers the social pressures on girls to marry older men; the expectation placed on a wife to sexual satisfy a spouse which makes it difficult for females to negotiate safer sex; and lastly pregnancy and children are reasons females often remain in marital relations.

Some of the key reasons identified in this thesis for girls to be pressurised into marriage include poverty, the incentive of bride-price, not being in education, cultural and religious beliefs that assert the importance of marriage, and shame associated with pre-marital pregnancy

and females having children from multiple partners (McCleary-Sills *et al.*, 2015). Females were found to be pressured into marriage, usually to older men. The expectations for girls to marry older partners, be ignorant about sex, passive in sexual interactions and retain virginity until marriage, reflects a culture of silence surrounding female sexuality and pressure for females to adhere to ideals, which create barriers to practising safe sex (Gupta, 2002).

Once in a marital relationship, pressures to sexually satisfy a spouse and demonstrate reproductive capabilities make it difficult for females to deny sex or negotiate safer sex. Early marriage has been widely associated with increased coital frequency, decreased condom use, and female inability to abstain from sex (Clark, 2004). In this thesis, the barriers to females negotiating safer sex in marriage have been related to religious discourse stating the importance of unprotected sex in marriage and reproduction, which also creates a barrier for girls to access information, advice and family planning methods (covered in Chapters 5 and 7). It was also illustrated in Chapter 5 that girls in this setting are socialised by *ssengas* (paternal aunts) and other female relations into cultural norms of male sexual entitlement and the duty of a wife to sexually satisfy a husband (Tamale, 2006). When a girl gets married, there is pressure to demonstrate reproductive capabilities and produce healthy children to sustain the relationship, avoid marital problems or be blamed for the husband engaging in extra-marital relations or marrying another wife (discussed in Chapters 5 and 7) (Roscoe, 1911; Janet Seeley, 2014).

Evidence suggests that females who engage in early sexual debut or marriage experience higher rates of unplanned pregnancy and pregnancy complications, and also face increased risks of domestic violence (Chandra-Mouli, Camacho and Michaud, 2013; Schlecht, Rowley and Babirye, 2013). These social consequences of early marriage are evident in Gladys's life-story. After she was pressured into early marriage with a man thirty years older than her, she got pregnant quickly and went on to give birth to three children in five years, one of which died. Research suggests females are nearly three times more likely to become infected with HIV whilst pregnant, and four times as likely in the six months after giving birth, compared with the risk of HIV infection at other times (Thomson *et al.*, 2018).

Pregnancy and the birth of children were frequently listed as reasons females remain or feel pressured to sustain marital type relationships, even if dissatisfied or experiencing domestic violence. As emphasised in Chapter 5, women are more likely to receive support from a partner and be able to remain with children if they are in a relationship with the father of their offspring (Alvergne and Lummaa, 2010). Marital relationships can therefore be viewed as form of social capital, which enhance female capabilities to achieve ideals of being a good mother

(Kavanaugh, 2008). This is a reason females often remain in marital relationships, even if dissatisfied or experiencing violence, as discussed in the next section.

8.2.3 Gender-based violence

Gender-based violence commonly occurs in Uganda and can be understood as a by-product of unequal gender relations, and therefore is entangled with notions of masculinity (Koenig *et al.*, 2003, 2004; Hague and Thiara, 2009; Siu, 2013). Females who engage in early sexual debut or marry early experience higher rates of unplanned pregnancy and pregnancy complications, and also face increased risks of domestic violence (Chandra-Mouli, Camacho and Michaud, 2013; Schlecht, Rowley and Babirye, 2013). As shown in Gladys's story, after being pressured into marriage, her first spouse drank excessive amounts of alcohol and became violent, which was why she eventually left the relationship, leaving two children behind. The association between gender-based violence and susceptibility to HIV is examined further through Dyana's story and her experience of rape, which highlights cultural beliefs of male sexual entitlement and dominance. The examples of rape/forced sex, whether a result of sexual violence, coercion or marital obligation, decrease female capabilities to negotiate safer sex and heighten risk of acquiring HIV (Jewkes, Levin and Penn-Kekana, 2003; Koenig *et al.*, 2003; Cash, 2011).

Dyana's story

Dyana (aged 35) was born into a family of three children. From the age of three she lived with her maternal grandmother and from the age of eleven she lived with her *ssenga* (paternal aunt), who wanted to teach her about her clan history and beliefs. Dyana had been at primary school for just over a year when she was forced to drop out because of pregnancy, as a result of being raped at the age of thirteen by a boy from her village. For several months, the boy had given her small amounts of money and sent messages through his younger sister to tell Dyana that he liked her. One day when Dyana was feeding her aunt's pigs, the boy turned up, and, without saying a word, forced himself upon her. When Dyana told her aunt what happened, the aunt asked if she had accepted any money from the boy. When Dyana admitted she had, the aunt asked her what she expected would happen. The youth asked to marry Dyana, but her aunt refused as he was deemed too immature, did not have a job and was still living with his parents.

Dyana gave birth to a baby boy and received no support from the father. Dyana abstained from sex for three years until she met a man at the market, who expressed an interest in her. They started a relationship and within three months Dyana got pregnant. The man told Dyana he wanted to marry her, but she refused as she knew he had many other sexual partners

and she "could not cope with the man's promiscuous behaviour". Dyana gave birth to her second child, also a boy, and struggled to get support from the man as she was no longer in a relationship with him. A few years passed until Dyana entered a relationship with another man who started bringing her gifts of fish. The man was a fish trader and travelled between her village and Kampala. Although Dyana was not keen to remain in the relationship, she got pregnant and her aunt convinced her to stay with the man as she was worried about her reproducing with different men.

As Dyana had introduced the man to her aunt and given birth to his child, she regarded herself as married, even though they had not gone through an official ceremony nor lived together. When the spouse would visit, they would sleep together in an old chicken shed at the back of the property for sexual privacy and because of the taboo for a man to sleep under the same roof as his mother-in-law (or, in this case, Dyana's aunt). Dyana's spouse had another wife in the same village with whom he had seven children. During their relationship, the tensions with the co-wife gradually increased and when Dyana's fourth child was a stillbirth, she blamed the co-wife for bewitching her. Dyana was unsure if her spouse had other sexual partners; when asked about their relationship, she replied,

> OK, he is not all that supportive but like I told you last time I do not want to have relationships here and there [with different men], I decided to settle with this one. He also said he wishes to have at least one other child with me.

Dyana's aunt's reaction to her being raped implied that her aunt blamed Dyana for being naïve, accepting money and not being aware of the cultural practice that men give gifts in expectation of sex or a sexual relationship. As discussed in Chapter 5, rape and acts of gender-based violence often go unreported and perpetrators are not prosecuted in this setting. From adolescence. females are socialised into accepting male sexual entitlement and dominance as cultural norms (Maticka-Tyndale *et al.*, 2005).

Respondents also spoke about violence occurring within marital relationships. Ruth (aged 46) described how her husband use to be "very rough after taking alcohol and could at times send me out of the house … he would sometimes come back drunk, asking for sex saying he wanted another child!". Despite her husband behaving this way, Ruth remained in the marriage and, at the time of the study, was providing palliative care for her husband. As highlighted in Chapter 5, the expectation and perceived duty of a wife to be submissive to her spouse, fulfil his sexual needs and produce children can make it difficult for women to deny a spouse sex or exit a marital relationship. As discussed in Chapter 6, male violence in marriage

can be attached to notions of masculinity (i.e. authority, control and strength) and be used by men to reaffirm manliness or dominance in circumstances when masculinity is perceived to be challenged or thwarted (Jewkes, Levin and Penn-Kekana, 2003; Hunter, 2005, 2010).

In Uganda, violence in marriage is common: studies report that between 27-41% of women experience sexual and physical violence in marital relationships (Koenig *et al.*, 2003; Kwagala *et al.*, 2013; Wandera *et al.*, 2015). One study in Uganda reported the three top reasons given for domestic violence against women to be: neglect of household chores, disobeying a husband or elders, and refusing the husband sex (Koenig *et al.*, 2003, p.55). Although some women also commit violence towards a spouse, the majority are reportedly victims retaliating against domestic violence (*ibid.*). The same study also found that men who frequently or always consume alcohol before sex are five times more likely to be violent when compared with men who never drink (*ibid.*, p.28).

Whilst there are recognised links between alcohol use and sexual risks, there are clear gender differences surrounding the risk, as "men are more likely to drink and engage in higher risk behaviour, whereas women's risks are often associated with their male sex partners' drinking" (Kalichman *et al.*, 2007). Although men too experience problems with female partners drinking, as shown later in this chapter through the story of Edward, men drinking alcohol is much more socially acceptable and male violence relating to alcohol is much more common (*ibid.*). Both drinking and acting violently are entwined with notions of masculinity, alongside risk-taking and sexual achievement, which pose significant risks to men's health and acquisition of HIV (Mburu *et al.*, 2014; Siu, 2013).

Violence in marriage can hinder capabilities to negotiate and protect against the risk of HIV. There is significant evidence of a link between forced sex in marriage and risk of acquiring HIV, as it hinders capabilities to negotiate safer sex and makes females more physiologically susceptible (Campbell *et al.*, 2013). In Chapters 5 and 6 forced and obligated sex in marriage were discussed in relation to a wife's duty to sexually satisfy a spouse and constructions of masculinity, which reinforce beliefs that a man is entitled to sex from and should have authority over a spouse. Age disparity between marital partners, cultural practices of sexual coercion, marital rape and widow inheritance are recognised to limit women's ability to negotiate safer sex in Uganda (Uganda AIDS Commision, 2015, p.8). Cash (2011) found forced sex in marital relationships in Uganda to be widespread, often driven by male shame surrounding issues relating to pregnancy, absence of sexual pleasure, poverty, infidelity and alcohol. Notions of masculinity (i.e. physical strength, dominance and control over a spouse) and struggles to achieve or enact prescribed gender ideals can therefore drive violence in

marriage (Jewkes, 2002). The difficulty of negotiating safer sex and the risk of acquiring HIV from a spouse is further explained through the commonality of extra-marital relations.

8.2.4 Commonality of extra-marital relations

Extra-marital relationships (particularly men having multiple sexual relationships) not only provide HIV with a route of transmission into marriage (Helleringer, Kohler, & Kalilani-Phiri, 2009; Hirsch *et al.*, 2009; Swidler & Watkins, 2007), but are also a primary cause of distrust and marital instability (Parikh, 2007; Hirsch *et al.*, 2009). Social determinants of extra-marital relations in this setting are similar to those that contribute to transactional sex, notably unequal gender relations and women's economic dependency on men. I also argue that male labour mobility and sexualised spaces create opportunities for men to engage in extra-marital relations (Hirsch *et al.*, 2009; Kuhanen, 2010). Individual factors, including marital dissatisfaction, also drive extra-marital relations for both men and women. This section begins with a summary of Edward's story to provide context to the rise, formation and consequences of extra-marital relations over the marital life-course.

Edward's story

Edward was forced to drop out of primary school as his father could not afford the fees. Edward instead started working with his father trading coffee. Edward travelled with his father to trade with coffee farmers, and they would stay with his father's three wives at various locations along the trading route. Edward said that earning money from a young age meant it had always been easy for him to get sexual partners. Edward had eight sexual partners before he married his first wife, who was a schoolgirl who "had begged for sugar cane from [his] garden". They had a secret sexual relationship for a year, until one day she refused to go home, which meant her parents came looking for her. Edward sold a cow and paid the girl's parents in two instalments as a fine and payment of bride-price.

During 15 years of marriage, Edward admitted to having several extra-marital relationships, mostly with casual partners, including one from whom he contracted gonorrhoea and infected his wife. Although his wife was very upset and angry, she forgave him and they received treatment together. Edward also had two more long-term partners. He had a child with a woman who he "befriended" whilst trading coffee; however, their relationship broke down as she drank a lot of alcohol, so he took their 10-year-old son and gave him to his sister. Edward had also had a ten-year relationship with a woman in another place where he traded coffee and they had three children together.

The financial stress and pressure of supporting two households started to take a toll on Edward when the second wife had had a young baby and was consistently asking for money for milk. Edward remarked that "she was demanding support but not contributing to the household income" and so he decided to move her and the children nearer his marital home. Edward's wife was aware of the extra-marital relationship as the woman had brought the first child to the home to be named, but when Edward moved the woman and her children to the same village, it caused conflict and his first wife moved out. Around the same time, Edward was diagnosed with HIV. After he disclosed this to his first wife, she began "abusing" him, divorced him and later died. At the time of the study, Edward was cohabiting with his second wife and eight of his children.

Edward's story highlights key structural factors and cultural norms driving men to engage in multiple sexual relationships. As mentioned in Chapter 7, men's extramarital relationships can involve longer-term relationships, short-term or opportunistic encounters and relationships that occur whilst the man is away from home, often for work (Parikh, 2007). Opportunities for men to engage in extra-marital relations have also been explained as linked to practices of labour mobility and socialising in sexualised spaces (Kuhanen, 2010). Edward's story illustrates these themes, as he was socialised into norms of labour mobility and polygyny, by working with his father trading coffee and staying with father's wives whilst travelling. As discussed in Chapter 6, labour mobility and having multiple sexual partners or wives is attached to notions of masculinity, built upon attributes of providing, sexual achievement and virility (Siu, 2013). At the time of the study, 11 out of 36 respondents were living partially or consistently apart from their partners, and for five this was due to labour mobility. As shown in both Gladys's and Dyana's stories, both were in marital-type relationships with men who were mobile for work. Being mobile for work is therefore a social and cultural norm, which provides opportunities for men to meet other partners and sustain concurrent sexual relationships (Parikh, 2007; Hirsch *et al.*, 2009).

Edward mentioned that it was easy for him to acquire sexual partners as he had money and inferred that the commodity of sex was available to meet male sexual demands. He commented that "desire for sex can change depending on the money in your pocket" (Edward, aged 43). Of eighteen male respondents, four had been in a polygynous marriage and nine stated that they had had at least one extra-marital relationship. Whilst polygyny and extra-marital relations are different, they are both connected to masculine notions of sexual entitlement and achievement (Siu, 2013). As shown through Edward's story, extra-marital relations can also transition into marital-type relationships and arrangements of polygyny. The

colloquial term “side-dish” was used by respondents to describe a man’s extra-marital partner, inferring both the cultural norm of this practice and the patron/client dynamic.

At an individual level, male engagement in extra-marital relations was largely attributed to marital dissatisfaction, the search for pleasure or escapism, and notions of sexual entitlement or achievement, which have been identified in existing research (Siu, 2013; Rutakumwa *et al.*, 2015). Drugs, alcohol, sexual appetite and desire for children were listed as key drivers for male extra-marital relations, which are also linked to reputational constructions of masculinity (explained in Chapter 6). Extra-marital relations were also framed by respondents in relation to marital problems, as one respondent remarked: ‘‘In the home where there is no happiness there can’t be faithfulness’ (Hamid, aged 57). As outlined in Chapters 5 and 6, marital tensions and dissatisfaction were linked to failing to fulfil marital expectations or ideals and lack of time, space and privacy for sexual intimacy (Agol *et al.*, 2014). Woman were also blamed for men engaging in extra-marital relations and for not living up to expectations of being a good wife (i.e. not maintaining cleanliness in the home, denying sex or failing to sexually satisfy the spouse, and quarrelling).

Female engagement in extra-marital relationships provides an alternative perspective on the power dynamics of marital relations and deepens understanding of the wider unequal structure of gender relations. The colloquial term “painkiller” was occasionally used to describe a woman’s extra-marital partner, suggesting that women use extra-marital partners to ease pain or discomfort experienced in married life. This concept was evident in the drivers listed for females to engage in extra-marital relations, which were often equated to something missing from marriage such as sexual pleasure, expressions of love, excitement or financial support. These factors were evident in the stories of the women who admitted to having had an extra-marital relationship. For instance, Julie described feelings of romantic love and sexual attraction towards her two extra-marital partners, feelings that were absent from her marriage. This study also found that some women engage in affairs for economic support or revenge. Jessica admitted to having an extra-marital partner for over ten years to help pay her children’s school fees when her husband failed to send money home from working away. Revenge was also listed as a driving factor: “there are women who are hot-tempered and decide to [get] revenge on their partners after hearing rumours of them having extra marital relationships” (FGD females 20-40). Although female engagement in extra-marital relations is more of a taboo, it is evident from this small sample that a proportion of married women do engage in extra-marital relations, for reasons of pleasure, romantic love, financial support or to get revenge for spouse’s infidelity.

Whilst extra-marital relationships commonly occur in this setting, they are not openly discussed as the risks of disclosure are often deemed too high (Parikh, 2007; Hirsch *et al.*, 2009; Kuhanen, 2010; Siu, 2013). Hirsch *et al.*,(2009) use the term 'public secret' to reflect the commonality of men engaging in secret extra-marital relations; whilst women know men do this, it is not only publicly aired due to the associated shame or tarnishing of reputations. As discussed later in this chapter (section 8.4.3) sexual secrecy or discretion can be a mechanism to maintain marital relations and sustain a public representation of gender identity. Although some men recognise that sexual secrecy can increase risks of HIV infection as it can mean they do not get to learn about the sexual histories of potential partners, the benefits of sexual secrecy are deemed to outweigh the risks (Siu, 2013, p.119). Exposing an extra-marital relationship or openly acknowledging the relationship runs the risk of marital conflict and breakdown.

As illustrated through Edward's story, a man's extra-marital relations can be exposed due to the birth of children and transition into a polygynous arrangement, which can then put financial pressure on men. This was the reason Edward moved his extra-marital partner closer to his home and declared the woman his wife. Edward felt that the benefits of declaring the relationship (i.e. woman contributing to the man's household income and development plans) outweighed the risks of marital tension and conflict. The ways in which individuals interpret, prioritise and negotiate these multiple risks relating to being in a marital relationship are central to understanding susceptibility and negotiation of HIV risk.

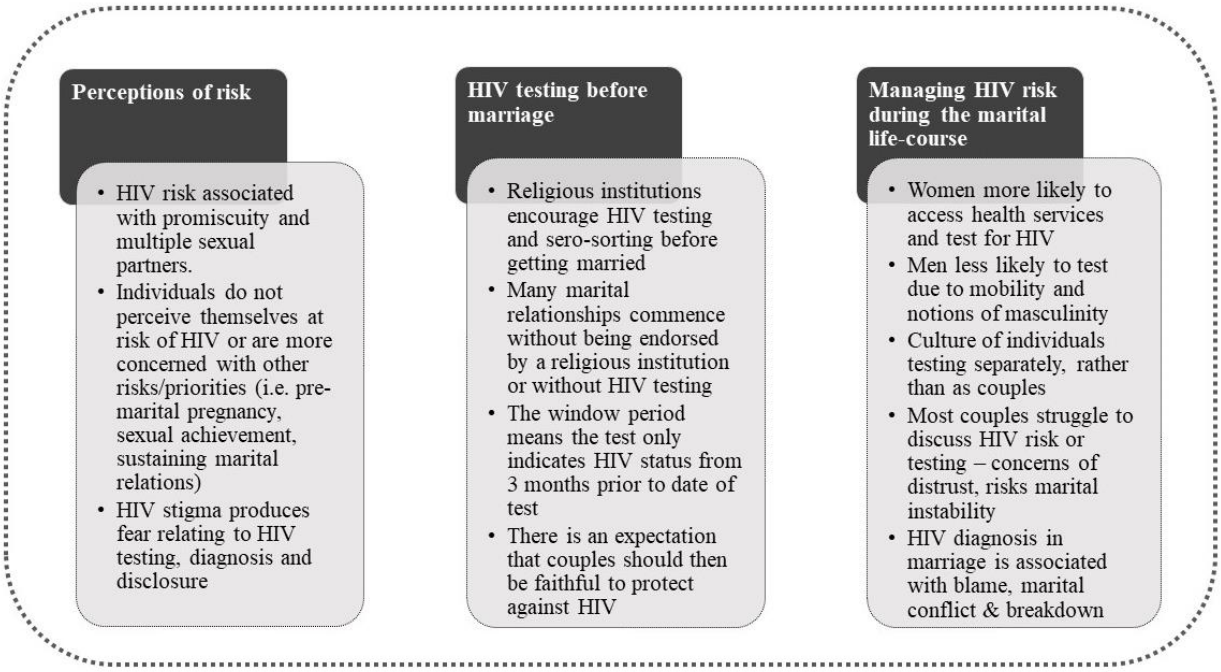
8.3 The challenges of negotiating and managing HIV risk in marriage

This section outlines how married individuals navigate the risk environment and negotiate or manage HIV risk. The public health messages on HIV prevention suggest individuals should test to discover their HIV status and use practices of abstinence, faithfulness or condoms to protect against HIV. These messages are explained to be in tension with cultural and religious beliefs about gender and marriage, and the contextual meaning of sex and sexual relations (Barnett and Parkhurst, 2005b). HIV is just one risk that individuals are negotiating or trying to manage. In this section, I highlight the associated risks of discussing HIV testing or risk in marriage, requesting to use condoms and denying sex. Overall, male and women in marital-type relationships are shown to face multiple challenges and barriers to managing the risk of HIV. A key finding is that in this setting married individuals were found to often prioritise sexual or fertility preferences and maintaining marital relations over HIV risk.

8.3.1 Testing, diagnosis and disclosure

Although HIV testing is highly promoted in the study setting and the MRC offer routine screenings in each village, there are barriers to uptake and openly discussing HIV testing in marital relationships. These barriers are described in relation to gender norms, marital power dynamics, stigma and perceptions of risk. My findings on the perceptions of HIV risk and testing over the marital life-course are summarised in diagram 8.3.1. The diagram indicates three dimensions, including perceptions of risk, testing before marriage and managing HIV risk during the marital life-course. The dimensions obviously overlap, and the diagram does not intend to oversimplify, but rather highlight key barriers affecting discussion of HIV risk and testing over the life-course.

Diagram 8.1 Dimensions of HIV testing over the marital life-course



The first dimension highlights the framing of HIV and social perceptions of risk in relation to the other risks and priorities that individuals are negotiating in this context. As a consequence of public health HIV prevention campaigns, socially HIV has been framed as a disease transmitted and contracted through risky or immoral sexual behaviours and marriage and faithfulness are ways to protect against the virus (Parikh, 2007). Respondents frequently mentioned avoiding HIV by getting married and being faithful; however, there were often contradictions and tensions in the way individuals described and justified their sexual practices and relations.

For male respondents, having multiple and/or consecutive partners before or during marriage was linked to notions of masculinity (i.e. sexual entitlement and achievement), rather than interpretations of promiscuity or risk. Internalising of masculine norms and expectations, means that men can feel entitled to unprotected sex and sex with multiple partners, which takes precedence over HIV risk (Rutakumwa *et al.*, 2015). Male respondents were found to navigate the social tensions of achieving sexual preferences and notions of masculinity with social stigma attached to promiscuity, through sexual secrecy or discreetness when engaging in multiple sexual relationships (Parikh, 2007). Sexual secrecy enables men to simultaneously avoid public shame, uphold respectable identity as a responsible husband, maintain marital relations with spouse and reach sexual achievement (Hirsch *et al.*, 2009).

From a female perspective, challenges negotiating safer sex and concerns relating to pregnancy, fertility preferences and managing marital relations were found to often take priority over HIV risk. Due to the stigma associated with girls engaging in pre-marital sex and getting pregnant outside marriage (discussed in Chapter 5), respondents noted that girls often "fear unwanted pregnancies and not HIV/AIDS" (FG females 41-60). As mentioned in Chapter 5, sexual debut for many of the females in this setting occurs as a result of engaging in transactional sex relations, a consequence of rape or early marriage. Condoms are rarely used, highlighting the difficulties girls experience negotiating safer sex (Gupta, 2002; Koenig *et al.*, 2004). In the context of marriage, this study has found females often prioritise fertility preferences and maintaining marital relations over risks of HIV (Agol *et al.*, 2014). Three out of four women who admitting to having an extra-marital relationship, stated that they had unprotected sex whilst already pregnant with their husband's child. This indicates greater concern for extra-marital pregnancy than risk of HIV. Furthermore, prioritising marital relations was explained in relation to the difficulties females experience discussing and managing HIV risk in marriage.

Fears caused by HIV stigma has been identified in this thesis as a barrier to test and discuss HIV in marital relationships. Respondents acknowledged that there are married individuals who maintain secrecy around their HIV status: "Today there are men or women who are infected with HIV/AIDS and don't want to disclose to their partners" (FGD males 20-40) and this was largely related to fear of marital conflict and blame. One respondent remarked that "when one of the partners is tested and found to be infected with HIV/AIDS, the one who is negative dumps the one who is infected" (FG females 41-60). Although some respondents acknowledged that misleading test results can occur due to the window period (FGD females

41-60), the fear associated with rejection and marital dissolution were raised as major barriers to openly discussing testing in marriage.

The individual and gendered nature of HIV testing means females are more likely to test than males. As mentioned in Chapter 3, testing is overall higher amongst females and lowest amongst young males in the study area. Females can test from the age of sixteen and for males eighteen. Testing relies on individual health-seeking behaviours and voluntary uptake engagement with services. Low male uptake of HIV testing and ART in Uganda is well recognised to be linked to HIV stigma and constructions of masculinity, which contribute to fears of testing, complacency surrounding health and illness, and health services being more tailored towards women and children (Larsson *et al.*, 2010; Siu, Seeley and Wright, 2013; DiCarlo *et al.*, 2014; Mburu *et al.*, 2014). In contrast, females access health services more frequently due to being responsible for child and family health, and are routinely screened for HIV during pregnancy if attending antenatal checks in a health facility (Siu, 2013).There is not a culture of couples testing together in Uganda, although it has become more popular to test before getting married (Larsson *et al.*, 2010).

In the study area, HIV testing before getting married was found to be heavily promoted by religious institutions. All four of the religious representations insisted that HIV testing should take place before a couple can undergo a religious marital ceremony. For instance, the imam remarked, "before you get married you must test your blood" and the Protestant Church Representative stated that she "could only refer couples to the reverend to get married if they have had an HIV test". The religious representatives were also found to be encouraging and facilitating serosorting. Some specifically remarked on the difficulties of assisting with this process; for example, one respondent commented "The hardness we face is finding another one who is also HIV positive and wants to get married" (Born Again Church representative). HIV testing was promoted before marriage as the expectation is that couples should then be faithful in marriage to protect against the virus. This promotion of testing before marriage does not encourage couples to discuss HIV risk or go for regular testing after getting married. Serosorting can also be interpreted as fuelling stigma associated with contracting HIV or serodiscordancy. Both HIV stigma and beliefs of being protected by marriage have been found to contribute to resistance and misunderstandings of the importance of couples testing for HIV (Larsson, Thorson, Nsabagasani, Namusoko, Popenoe and Ekström, 2010).

The stories of the three HIV positive respondents reflect these broader dimensions of HIV testing and the barriers to discussing in marriage. Gladys was diagnosed during an antenatal screening. After disclosing her status to her spouse, although he supported her to go

on ART, he refused to get tested. Dyana was diagnosed during an annual screening test offered by MRC in her village. Although Dyana had never directly discussed this with her spouse, she knew he was also HIV positive as they had seen each other whilst waiting to pick up their ART. Lastly, Edward had disclosed his HIV status to his first wife, who he said "started abusing me and then left", meaning that she divorced him. Edward's second wife, who had frequently tested negative, remained with Edward, but had refused to use condoms to manage the risk of HIV due to religious beliefs and wanting more children.

The challenges of discussing HIV testing and diagnosis with a spouse are therefore linked to fears of marital conflict and efforts to sustain marital stability. Broadly, stigma is well recognised as a barrier deterring individuals from getting tested, accessing care, receiving social support and disclosing HIV status to a spouse (Mahajan *et al.*, 2008; Roura *et al.*, 2009; Kuteesa *et al.*, 2012; Alemu *et al.*, 2013). The stigma and blame associated with HIV is often perceived to have worse consequences than the risk of contracting the virus or discussing HIV status with a spouse (Mahajan *et al.*, 2008). One study found that most women struggle to convince partners to undergo HIV testing and that many HIV-positive women fear to disclose their HIV status to a spouse for fear of abandonment, violence and accusations of bringing HIV into the family (Tumwine *et al.*, 2012). Another study similarly highlighted men's fears of HIV testing in terms of marital instability, as men described their marriages as 'fundamentally unstable and distrustful, making the idea of couple testing unappealing because of the conflicts it could lead to in marriages' (Larsson *et al.*, 2010, p.1).

These multiple barriers to HIV testing and disclosure emphasise that HIV is just one of many risks that individuals are weighing up. Females interact more frequently with health services and are more likely to get tested than males. Whilst religious institutions promote HIV testing before marriage, perceptions of protecting against HIV by being faithful hinder discussions about HIV risk and testing during marriage. Overall, the perceived risks of discussing HIV testing or diagnosis were often deemed to outweigh the perceived benefits of sustaining marital relations and stability. These themes of managing, interpreting and weighing up risks are discussed further in relation to the HIV discourse and the key prevention messages.

8.3.2 Abstinence, unprotected sex and condoms

According to the key HIV prevention messages, there are three main ways an individual can protect against HIV, through abstaining from sex, being faithful to a partner and using condoms. As already outlined in Chapters 5 and 7, unprotected sex is central to notions of being in a marital relationship, maintaining marital relations with a spouse and achieving fertility

goals. This expectation and obligation to engage in unprotected sex poses challenges for married individuals to abstain from sex or negotiate using condoms, even if there is a suspected risk of contracting HIV from a spouse (Parikh, 2007; Siu, 2013; Rutakumwa *et al.*, 2015). This section highlights two points: firstly, that unprotected sex is deemed so important in marriage that even after diagnosis of HIV, married individuals often continue with this practice. Secondly, abstaining from sex and using condoms are associated with marital tensions or conflict, meaning that maintaining marital stability or achieving fertility preferences through unprotected sex often take priority over risks of HIV.

Abstinence and condoms are deemed inappropriate within marriage due to the importance and symbolism of unprotected sex. As discussed in Chapters 5 and 7, expectations of unprotected sex in marriage are associated with sexual satisfaction, trust, intimacy and having children (Parikh, 2007; Maticka-Tyndale, 2012; Rutakumwa *et al.*, 2015). Although circumstances were identified in this study of women of abstaining or denying sex for reasons relating to menstruation, childbirth, health problems or older age, denial of sex and sexual dissatisfaction were generally associated with marital tensions, conflict and infidelity (Cash, 2011; Agol *et al.*, 2014).

An example of the risks associated with denying a husband sex was shared in one of the focus groups. A female respondent told a story about a woman from her village who asked her husband to stop demanding sex as they had grown old and their children had grown up. She asked him to instead have sex with his other wife, but one day he turned up early in the morning and raped her in the sitting room in front of their children, telling her that she had denied him sex for a long time and that now he had infected her with HIV (FG females 41-60). This example emphasises notions of male sexual entitlement and the use of sexual violence to assert dominance, control and therefore boost masculinity. Expectations of unprotected sex in marriage alongside the unequal power dynamics and cultural norms of gender-based violence can mean that abstinence is simply not an option for many women or will put them at far greater risk than unwanted sex with a spouse (Koenig *et al.*, 2003; Cash, 2011).

Condoms are specifically considered unacceptable within marriage as they are associated with distrust, decreased sexual pleasure and in tension with religious beliefs asserting the importance of reproduction. The framing of condoms in public health campaigns as a way to reducing risk of HIV means that they have become associated with high risk or casual sex (Maticka-Tyndale, 2012). As explained in Chapter 7, condoms are also incompatible with religious beliefs relating to procreation; they are perceived to prevent skin-to-skin intimacy and decrease sexual pleasure; and are associated with distrust (*ibid.*). This discursive

framing of condoms was used by female respondents to describe the barriers to negotiating condom use in marriage. One respondent remarked 'those who have sex here and there [with more than one partner] use condoms!' (Ruth, aged 46). Another respondent commented, "Condoms are used with a casual partner or whilst cheating, so how do I say to my husband let us use them?" (Shakirah, aged 37). For these reasons, requesting to use a condom in a marital relationship was associated with conflict, suspicion or dissatisfaction.

Notions of sexual entitlement and resistance to using condoms were acknowledged to disempower female negotiation of safer sex. Female respondents remarked that, "Men in the villages don't accept to use them [condoms]" (FG females 41-60) and "There are men who say they can't give money to a woman and use condoms whilst having sex with her" (FGD females 20-40). Notions of male sexual entitlement in marriage and transaction sexual relations mean that men ultimately have the power surrounding condom use (Maticka-Tyndale, 2012). In Uganda, condom use has been found to decline in relationships based on emotional attachment and intimacy (Parikh, 2007). More widely, the UDHS found that only 2.7% of married women use condoms compared to 19% of unmarried sexually active women (2012, p.80), indicating that condoms are far more likely to be used outside of marriage. However, of the four female respondents who admitted to engaging in causal extra-marital relationship, only one said she used condoms (Julie), suggesting that women also face challenges negotiating condom use with extra-marital partners.

In the cases of Edward, Gladys and Dyana, despite being diagnosed with HIV, their spouses still refused to use condoms. Gladys admitted to keeping her partner sexually satisfied by "not refusing him anytime he asks for it"; she also confessed that it hurt her that despite knowing her HIV status, he says he cannot use a condom as they "are already in a union and living together". Dyana mentioned using condoms at the start of her relationship, but her spouse stopped providing them as the relationship became more established. Edward claimed that after being diagnosed with HIV he wanted to use family planning, but his wife refused to use condoms or any other form of contraception. These cases indicate that even when an individual has disclosed being HIV positive to a spouse, marital beliefs surrounding the importance of unprotected sex and sexually satisfying a spouse to maintain marital relations are so strong that there is resistance to change sexual practices.

In response to being unable to use condoms, women use other practices to manage the risks of unprotected sex, which indicate prioritising of fertility preferences and maintaining marital stability over HIV risk. In this study, many women were found to use family planning techniques without their spouse's knowledge. Gladys and Dyana both admitted to wanting

more children and at the time of the study they were both using the hormonal injection due to concerns about health and desires to space births. As explained in Chapter 7, the injection does not protect against HIV and evidence suggests it might even increase susceptibility (Blish and Baeten, 2011; Polis and Curtis, 2013; Colvin and Harrison, 2015; Ralph, Mccoy, *et al.*, 2015). Women were also found to use being pregnant to manage the risk of unprotected sex with an extra-marital partner. Of the four women who admitted to having an extra-marital relationship, three purposely timed extra-marital sex whilst pregnant with their husband's child. The barriers that hinder female negotiation of condom use can therefore lead females to try other family planning practices to manage fertility preferences. These practices can heighten female susceptibility to contracting HIV, either from a spouse or an extra-marital partner.

8.3.3 Being faithful and sexual secrecy

As abstinence and using condoms are deemed inappropriate within marriage, being faithful was deemed by respondents as the principal way to protect against HIV in a marital relationship. However, from the dataset there were various interpretations of faithfulness, indicating that in this setting the concept of faithfulness does not necessarily relate to being monogamous or sexually exclusive. This section explains that being faithful is connected to cultural and religious beliefs and values relating to marriage, including fulfilling marital roles, loyalty and cooperation to develop the home and assets.

In this setting the meaning of faithfulness is broadly interpreted and does not necessarily relate to being sexually exclusive (Agol *et al.*, 2014). Respondents associated being faithful in marriage with a range of attributes: not being promiscuous or cheating; not stealing or lying; being responsible and loyal; being truthful; not gossiping about a partner; showing respect; and fulfilling marital roles. Interpretations of being faithful are also entwined with notions of masculinity (Siu, 2013). Perceived male rights to marry more than one wife mean that being faithful was interpreted by some men as treating each wife the same. Other male respondents talked of being faithful to a spouse, whilst also admitting to having extra-marital partners. It is suggested that men overcome these tensions through justifying being loyal to the wife, for instance through providing support, raising children together and developing the home.

Men were found to maintain notions of being faithful to a spouse by engaging in extra-marital relations secretly or discreetly. Parikh argues that men's sexual secrecy surrounding extra-marital relations has been heightened by the social stigma caused by HIV prevention campaigns and cultural and religious discourses promoting the moral virtues of monogamy (Parikh, 2007). Sexual secrecy therefore offers men the benefits of retaining public

representations of being a faithful and respectable husband, avoiding social stigma or public shame and achieving masculine notions of sexual achievement and reputation, which come with having multiple sexual partners (Parikh, 2007; Siu, 2013). Achieving this balance depends on economic capabilities to provide for a spouse(s) and children whilst maintaining discreet extra-marital relations (Hirsch *et al.*, 2009). Sexual secrecy is therefore deemed important to maintain marital relations and uphold respected notions of gender identity.

For women the benefits of compromising with a spouse were found to outweigh the risks associated with challenging a spouse or directly discussing HIV risk in marriage. As mentioned in Chapters 5, female respondents were found to value marital stability as it enables them to fulfil and uphold notions of being a good wife and mother. Female respondents talked of compromising to maintain marital relations, by not quarrelling or "turning a blind eye" when necessary. Female respondents like Gladys noted that they suspect their husbands to have other sexual partners, but would not act on it as they wanted to avoid marital conflict. One respondent spoke quite candidly about her husband's extra-marital partner: "I do not care if he is in love with her, providing he doesn't bring her to my home!" (Nakamaty, aged 76). Others spoke of the need to compromise with the spouse and his other wives/girlfriends to avoid risks such as being blamed for witchcraft or the husband decreasing support (Teddy, aged 31). These findings resonate with other research conducted in the study site, which found that women prioritise marital stability and security to uphold the welfare needs of their children, because the social-economic capital received from a marital relationship outweighs demands for sexual exclusivity in marriage (Agol *et al.*,2014). This can mean females overlook affairs even if there is a risk of HIV.

8.4 Summary

It has been argued in this chapter that the onset and trajectory of the HIV epidemic as well as the public health responses to this trajectory have shaped the social landscape and sexual practices of married individuals. This social setting has influenced the choices, actions and capabilities of married individuals to negotiate and manage HIV risk. This setting of an HIV risk environment has been linked to the unequal power dynamics of gender relations, which facilitates sets of social practices that heighten susceptibility to HIV, particularly for females. Frameworks of gender and sexuality have been argued in this thesis to guide the negotiation of sex and reproductive practices over time and in relation to social spaces (Campbell, 1997; Godfrey Etyang Siu, 2013; Strathern, 2016). The findings presented in this chapter emphasise the social practices that enable the transmission of HIV in marital

relationships have evolved and been shaped by history and social circumstances. Distinct gender roles and unequal power dynamics are played out through practices of transactional sex, female early and pressurised marriage, gender-based violence and male engagement in extra-marital relations, which provide pathways for HIV.

The HIV risk environment for marital relationships has been argued to cut across multiple layers of society, from macro factors and historical processes which shape interpersonal relations and characterise the lives of individuals living in this setting. The unequal structure of gender relations particularly effects female choices and capabilities to negotiate safer sex and marital relations. A key point to emphasise from this chapter is that HIV is just one risk or uncertainty that individuals are trying to manage. This means that for many females maintaining marital or sexual relationships and avoiding conflict, violence or unintended pregnancy are often prioritised over HIV risk. Unequal gender power dynamics mean that females face specific barriers to negotiating safer sex and are therefore disproportionally at risk of contracting HIV both before and during marriage. Social determinants shaping the construction of these social relations and sexual practices highlight male sexual entitlement and dominance, and female disempowerment to negotiate safer sex.

Although the HIV prevention response has been deemed highly successful in Uganda, it has been argued in this chapter that the key messages of abstinence, being faithful and using condoms are problematic for married individuals and might actually increase susceptibility to HIV. The messages are problematic as they clash with cultural and religious discourses surrounding marriage and the meaning and circumstances of unprotected sex in this setting. As discussed throughout this thesis unprotected sex is tied to expectations of marital roles and symbolises trust, intimacy, sexual pleasure and desires to have children. Abstaining, denying a spouse sex or requesting to use condoms are therefore associated with distrust, marital tensions, violence and separation.

Whilst there is pressure from religious institutions to test for HIV before getting married, many couples enter marital type relationships without testing and knowing little about a spouse's sexual history. Once married, couples (particularly women) face barriers to discussing HIV with a spouse. Fear of the consequences of HIV diagnosis on marital relations mean that individuals often avoid directly discussing HIV. The beliefs surrounding unprotected sex and marital roles are so strong that after HIV diagnosis there is often resistance to adapt sexual and reproductive practices. Rejection of condoms in marriage means married individuals living with HIV who are not adhering to ART are at risk of transmitting HIV to a partner or unborn child, and coinfection of another strain of HIV or an STI.

This means that for married couples there is pressure to be (or appear to be) faithful to protect against HIV. In this context, being faithful has been shown to have multiple interpretations, including compromising well with a partner and being loyal, which do not necessarily relate to sexual exclusivity. Fear, blame and stigma relating to promiscuity and HIV in marriage have contributed to sexual secrecy and created barriers to openly discussing HIV risk, testing and diagnosis in marital relationships. Whilst extra-marital relations commonly occur, they are not openly discussed, and this creates an air of distrust in marital relationships. Sexual secrecy enables individuals to publicly present themselves as being 'moral', whilst also maintaining both positive marital relationships and extra-marital relationships.

Chapter 9 – Conclusion

Although marriage and the concept of intimacy have been explored significantly in modern anthropology, and notions of negotiating HIV risk have been central to the analysis of HIV epidemics, few studies have combined the investigation of both issues (Hirsch and Wardlow, 2006). This study has examined in detail the beliefs and social practices of men and women in marital relationships over the life-course, this includes their negotiations around sex, children, family planning and HIV risk. In doing so, sexual and reproductive practices have been situated within the context, circumstances and power dynamics of gender relations and marital relationships. Insights gained illustrate how individual lives are interdependently linked through social relationships and the nature of these gendered relations are embedded and shaped by socio-historical processes. These broader social processes sustain unequal gender power dynamics and encourage particular sexual and reproductive practices, which contribute to high fertility and HIV susceptibility in marriage.

Grasping the complexities of sex and reproduction in this context has required careful unpacking of social norms and institutional frames of reference for gender, marriage and having children in *Baganda* culture. Nested within the MRC/UVRI General Population Cohort (GPC) in *Kyamulibwa*, south-western Uganda, this study has been able to utilise household survey and HIV surveillance data, build on existing research conducted in the area and work closely with the local social science team. This geographical region is at the epicentre of the HIV epidemic in Uganda and rates of fertility have remained consistently high. Considering the national objectives to curb both HIV and rates of fertility to achieve development goals, the findings from this research provide valuable insights into the practices, behaviours and social structures surrounding these health outcomes.

Health research that has focused on individual behaviours has often failed to account for structural influences and the social circumstances in which behaviours are played out (Barnett and Parkhurst, 2005; Glass and McAtee, 2006; Kippax *et al.*, 2013). Furthermore, whilst there are clear links between social environment, behaviour and diseases, much less is known about how practices and behaviours arise, are maintained and/or changed over the life-course (Glass and McAtee, 2006; Cohn, 2014; Frohlich and Abel, 2014). To address this issue, this study applied a broad social determinants of health framework (Solar and Irwin, 2010) as a base to begin examination of the structures that shape marital relations and gender power dynamics. Life-course theory (Elder, 1998a, 1998b) and Sen's (1985, 1987) capabilities

approach have been used to examine the relationship between structure and agency. This has involved investigating institutional frames of reference (i.e. gender and marriage), which guide individual negotiations and navigation of sex and reproductive practices over the life-course. Key social determinants have then been identified as contributing to a risk environment, making married individuals susceptible to contracting HIV.

A combination of qualitative methods (life-stories, key informant interviews, focus groups and photography of household spaces) has enabled a rich empirical study of married life in south-western Uganda. The findings provide contextualised case studies to illustrate how gender norms and sexual practices are played out in everyday life. Gender power dynamics and inequality have been highlighted in the social practices of transactional sex, female early and pressurised marriage, gender-based violence and the widespread occurrence of male extra-marital relations.

The strengths of this research lie within the rich qualitative accounts of married life in rural south-western Uganda. This study has been able to reveal the complex belief systems and social determinants which shape the dynamics of gender relations, the negotiation of sexual practices and the navigation of family planning decisions over the life-course. Collecting life-stories from married individuals at different stages of the life-course has also enabled a comparison of norms, beliefs and practices across generations. These cultural insights have been gained by collaborating with MRC social scientists, who aided access to the communities and the research process. In terms of limitations, this study was conducted within a pre-existing cohort involving a predominately *Baganda* population and therefore may not be representative of married life in other areas of Uganda. In this setting HIV is relatively high and this population has perhaps received greater access to HIV care and sensitization than other regions of Uganda. Furthermore, the MRC who have been working in this area for over three decades are well known in the community. Whilst this aided recruitment of participants, respondents may have also constructed responses based on what they think health workers would be most interested in. Furthermore, this study did not interview both partners within marital relationships or more broadly compare responses with individuals who are divorced or not married. Such findings would surely deepen understandings of marriage and sexual practices in this setting.

The following sections provide an overview of the key research findings in relation to the empirical and theoretical contributions made to literature on marriage in Uganda, the construction of masculinities and sexual practices, female family planning behaviours over the life-course and the social determinants of HIV risk environments for married individuals. The

implications of these findings are then outlined as policy recommendations and suggested areas for further research.

9.1 Being married in rural south-western Uganda

The findings of this research contribute empirical knowledge to an existing literature, and deepen understanding of the structure, organisation and gender power dynamics in marital relationships and causes of marital instability in Uganda (Nabaitu, Bachengana. and Seeley, 1994; Parikh, 2007; Seeley, 2012; Schlecht, Rowley and Babirye, 2013; Agol *et al.*, 2014). Although the four main types of marriage (customary, civil, religious and informal) are well documented, this study has more closely examined the social and spatial construction of the various types of marital relationships, the circumstances in which they arise, and the context in which sex and reproductive practices are negotiated. Although the lived experiences of marriage in this setting can vary substantially, this thesis has shown that there is a shared framework of marital ideals that underpin interpretations of marriage and expectation of sexual practices. Frameworks of gender guide perceptions of roles, obligations and duties, the reasons individuals enter and remain in marital-type relationships. Gender beliefs are therefore a source of marital tension and act as a barrier, hindering the discussion of SRH risks in marriage.

In this setting, marriage encompasses a range of marital relationships. In Chapter 4, the four known types of marriage were broken down into nine sub-types, with a couple living either together, partially or consistently apart. This typology of marriage emphasised the varied lived experience of being married, but also that it is common for individuals to regard themselves as married even if they have not gone through an official ceremony and live apart, either partially or consistently. Marriage type is associated with varying degrees of respectability, relating to whether the State legally recognises the marital relationship, which shapes perceptions of rights and entitlement to children, inheritance, property and burial practices. However, expectations of sexual practices were found to be consistent across all forms of marriage.

Life-course theory reiterates that individual lives are interdependently linked and shaped by socio-historical processes (Elder, 1998a, 1998b). Viewing marriage through this life-course lens has aided understanding marital relationships within the social context, part of social networks and community life. This approach has enabled the exploration of marriage as a process which commences, evolves, and crosses over with other sexual relations over time and is shaped by the social environment. Marital relationships frequently commence with the couple knowing little about each other, due to the mediation of a matchmaker or the relationship

beginning commenced through transactional sex. Girls are often pressured into early marriage, particularly if not in education. Marriage is perceived as a livelihood strategy and a respectable and necessary way for a girl to be recognised as a woman. Fears and stigma relating to pre-marital pregnancy and high rates of unintended pregnancy resulting from incidences of sexual violence or transactional sex are key reasons girls are pressured into marriage. Informal marriage was found to be more common in younger age groups, which was linked to the man being unable or unwilling to pay bride-price and/or the couple breaking traditions by being in a relationship without family consent or knowledge. These drivers of informal marriage have also been evidenced by Schlecht and colleauges in Western Uganda (Schlecht, Rowley and Babirye, 2013).

In Uganda, the institution of marriage socially reproduces patriarchal structures, which privileges male rights and reinforces female socio-economic dependency on a spouse (Parikh, 2007; Kafumbe, 2010). In this thesis, marriage has been examined as an institution that characterises and constrains sexuality and sexual relations, based on ideologies of kinship, transference of wealth, expected sexual behaviours and gender power dynamics (Foucault, 1978). Marriage is connected to socio-cultural ideologies of patrilineal descent and polygyny, meaning that children are perceived to belong to the father's clan; a man can customary marry as many wives as he wishes; and if a couple are legally married, the man is deemed to have ownership over the wife (Roscoe, 1911; Richards, 1966; Janet Seeley, 2014). Although women are supposed to have legal rights to property and children, lack of effective implementation means women's legal status is precarious, economic capacity limited and rights not guaranteed (UNDP, 2006). The findings from this study have found that persistence of socio-cultural norms and patriarchal attitudes subordinate women's position in marriage and weakens their economic capacity through the burden of unpaid work, which also increases socio-economic dependency on a spouse (Kafumbe, 2010). These patriarchal beliefs are particularly evident in cases of men claiming ownership of children born out of rape and paying bribes or bride-price to marry a girl to avoid prosecution for defilement. Female rights and entitlements are therefore not upheld by the judicial system, but largely dependent on negotiation tactics and the strength of social relations with a spouse and his kinship.

In this setting, marriage and sexual relationships are therefore a form of social capital (Johnson-Hanks, 2007; Swidler and Watkins, 2007; Thornton, 2009; Stoebenau *et al.*, 2016). In response to weak infrastructure and the uncertainties and challenges that characterise everyday life, marriage and sexual relationships offer a form of social capital or contingency (Johnson-Hanks, 2007). As Bledsoe argues, the 'success with which a woman can prevent or

contain future bodily harm depends on her investing broadly and deeply in social relations' (Bledsoe, 2002, p.25). In Uganda 'interdependence and contingency characterize most peoples' lives' (Whyte and Siu, 2015, p.31). Sexual interactions and marital relationships act as a form of social capital, as these can enable an individual to increase the size, diversity and strength of social ties of a social network (Swidler and Watkins, 2007; Thornton, 2009)

Socio-cultural beliefs of marriage are frameworks that shape expectations, duties and obligations of gender roles and affirm the symbolic importance of sex, having children and developing the home in marriage in this setting (Parikh, 2007). The institution of gender is therefore imbued in the construction and organisation of marital relations: it characterises social hierarchies, division of labour, expected roles, duties, obligations, access to resources and therefore gender power dynamics (Strathern, 2016). This study has shown that ideas about marital gender roles and relations, the importance of sexual satisfaction in marriage and having children are circulated through religious institutions and intergenerational gender relations (i.e. the *ssenga*). These frameworks of gender provide repertoires of behaviours and practices that influence the negotiation of sex and reproduction in and outside of marriage (Campbell, 1997; Siu, 2013; Strathern, 2016).

Women face more pressure to fulfil marital obligations than men and more severe sanctions/criticism if they do not live up to marital expectations (Agol *et al.*, 2014). Perceptions of what it means for a woman to be a good wife are tied to female capabilities to produce children, fulfil domestic chores and childcare, and maintain good relations with the spouse through sex and cooperation on development plans (Parikh, 2004; Bantebya Kyomuhendo and Keniston McIntosh, 2006; Mungwini, 2008). This study found this expectation of gender role and duties burdens and constrains women's behaviour in marriage, reinforcing dependency on a spouse and hindering women's capabilities to exit a marital relationship (Strathern, 2016). Gender ideals are also used to blame women for men engaging in extra-marital relations or marrying additional wives. However, women were also found to harness gendered practices of domestic work, sex and childbearing as sources of bargaining power to maintain relations and negotiate with a spouse (Kawarazuka, 2015).

Women often prioritise maintaining marital relations and stability, as this strengthens their social capital and capabilities to achieve gender ideals attached to being a good wife and mother. Women in this study regularly mentioned remaining in marital relationships for the sake of children. Research shows that men are more likely to provide support for a child if they are still in a relationship with the mother (Alvergne and Lummaa, 2010). Women also stated that they remain in marital relations to uphold dignity and respect associated with the identities

of being a wife and mother, which has found to be the case in many places across SSA (Mungwini, 2008). Constraints on behaviour imposed by gender frameworks stating how a woman should act in marriage, coupled with female desire to sustain marital stability, can mean it is difficult for females to challenge a spouse or refuse marital duties (i.e. unprotected sex). In doing so, females face the risk of conflict/violence, marital instability and the spouse engaging in extra-marital relations or marrying other women.

Marital instability, male engagement in extra-marital relations and cases of polygyny were found to occur across all types of marriage, regardless of how the marriage is publicly presented. This means that the public representation of a marital relationship does not necessarily relate to how it might be privately enacted (Giddens, 1992; Strathern, 2016). Despite imported ideologies of monogamy, the value system of polygyny has persisted in *Baganda* culture (Seeley, 2012). Male engagement in extra-marital relations is widespread in Uganda (Parikh, 2007; Kuhanen, 2010; Kasamba *et al.*, 2011; Agol *et al.*, 2014). Extra-marital relations and infidelity were identified as key causes of marital dissatisfaction and instability. These findings echo existing studies in Uganda, suggesting that marital tensions and conflict often stem from perceieved failures to fulfil expected marital roles and duties, sexual dissatisfaction, alcohol, fertility problems and infidelity (Nabaitu, Bachengana. and Seeley, 1994; Koenig *et al.*, 2003; Agol *et al.*, 2014; Seeley, 2014). Male sexual practices and engagement in extra-marital relations are outlined further in the next section.

9.2 Constructions of masculinity and sexual practices

A growing body of research has shown that notions of masculinity shape male engagement in sexual practices and types of sexual relationship (Hunter, 2002, 2007, 2010, 2015; Parikh, 2007; Hirsch *et al.*, 2009; Siu, 2013; Siu, Seeley and Wight, 2013; Rutakumwa *et al.*, 2015). This research contributes to this body of literature and furthers understanding of how masculinities shape male sexual practices within marital and extra-marital relations in four ways. Firstly, it is argued that notions of male sexual entitlement drives engagement in extra-marital relations and is used to justify sexual practices and fertility preferences. Secondly, men struggling to achieve dominant ideals of manliness can use extra-marital relations and violence to boost notions of masculinity. Thirdly, men ascertain privilege and are often able to use this privilege to avoid sanctions or punishment. This is evidenced through practices of domestic violence, rape, defilement and engagement in extra-marital relations and sexual concurrency. Lastly, male resistance to using condoms and other family planning methods is linked to

masculine notions of control and ownership, and insecurities relating to fulfilling the provider role and retaining female loyalty or fidelity.

This study found that internalising of masculine norms and expectations means that men feel a sense of entitlement to unprotected sex and sex with multiple partners (Rutakumwa *et al.*, 2015). This entitlement is evidenced through male resistance to using condoms in marital relationships or with sexual partners where money or gifts have been exchanged for sex. This practice not only exposes the man to HIV, but also acts as a barrier for females to negotiate condom use (Gupta, 2000; Parikh, 2007; Siu, 2013; Rutakumwa *et al.*, 2015). This notion of sexual entitlement was also evident in the reasons that men gave for marrying additional wives and engaging in extra-marital relations. In this setting, having multiple partners is a mark of reputational masculinity, demonstrating prowess, virility, male power, strength and dominance over women (Parikh, 2004; Siu, 2013; Rutakumwa *et al.*, 2015). More specifically, it was found that men engage in extra-marital relations to achieve particular fertility preferences, such as wanting to have children with different mothers (Agol *et al.*, 2014).

Male engagement in extra-marital relations has also been described in this thesis as a practice that men employ to boost masculinity if experiencing marital problems and struggling to achieve marital gender ideals (Hunter, 2010). In impoverished environments men can struggle to live up to respectable ideals of masculinity tied to being the breadwinner and head of a household (Parikh, 2007; Groes-green, 2010; Hunter, 2010; Siu, 2013). In circumstances where a man feels a loss of power, authority or control he might seek alternative ways to boost his masculinity; two ways highlighted in this thesis include extra-marital relations and gender-based violence (Jewkes, Levin and Penn-Kekana, 2003; Dunkle *et al.*, 2004; Groes-green, 2010). Both these practices are entangled with notions of masculinity and asserting dominance and power over women (Hunter, 2010). Poor men unable to live up to ideas of successful manhood can resort to practices relating to violence and sex to boost notions of masculinity (Jewkes, 2002). The social environment therefore constrains and facilitates male practices, which produces gender inequality, patriarchal control over women and structural violence.

Gender inequality of the social environment is further shaped by male capabilities to work through the system to avoid sanctions or severe punishment relating to sexual practices (Hirsch *et al.*, 2009). In this study, men have been able to avoid prosecution for domestic violence, rape or defilement (Koenig *et al.*, 2003, 2004; Parikh, 2004, 2007). In this study, male perpetrators were rarely convicted; instead men were found to use social and economic capital to pay bribes, police fines or bride-price to avoid public shame or jail. Male notions of ownership, privilege and authority were used to justify practices of domestic violence in

marriage and men paying to marry an adolescent girl or claim children, even in cases when this occurred as a consequence of sexual coercion or rape (Koenig *et al.*, 2003, 2004; Parikh, 2004; Siu, 2013).

The social environment also provides opportunities for men to engage in extra-marital relations, which offer benefits or gains for masculinity (Hirsch *et al.*, 2009). The prescribed cultural norm of men being providers and the socio-economic gendered division of labour, means that men with economic capital can easily attract new sexual partners through practices of transactional sex (Stoebenau *et al.*, 2016). Labour mobility and sexualised spaces provide opportunities for men to meet new sexual partners, engage in extra-marital relations and sustain concurrent sexual relationships (Parikh, 2007; Hirsch *et al.*, 2009; Kuhanen, 2010). The social environment therefore shapes the normalising of male engagement in extra-marital relations and risky sexual practices (Rutakumwa *et al.*, 2015). Male desires to be perceived as respectable and avoid public shame and/or marital problems produces a culture of secrecy surrounding male extra-marital relations (Parikh, 2007; Hirsch *et al.*, 2009; Kuhanen, 2010; Agol *et al.*, 2014).

Lastly, male resistance to using condoms and other forms of family planning have been linked in this thesis to male insecurities surrounding female reproductive agency and fidelity in marriage, largely related to dominant notions of masculinity, such as sexually satisfying a spouse and providing for her needs to prevent other men tempting her into a sexual relationship (Groes-green, 2010; Hunter, 2010). Fears relating to women using reproductive agency to select the father of a pregnancy also stem from male insecurities of raising a child that another man could later claim ownership over. Masculine ideals of ownership and providing therefore cut across other cherished means of expressing and asserting masculinity in marriage, such as having authority and control over a socially dependent wife (Siu, 2013). Male respondents expressed fears on the association between women secretly using hormonal contraception and engaging in extra-marital relations. These findings support existing literature in Uganda indicating that male resistance to family planning can be used to assert sexual entitlement and ownership over a marital partner and children; it can also indicate masculine insecurities and feelings of being excluded from family planning decision-making (Kaida *et al.*, 2005; Kabagenyi *et al.*, 2014). The next section explains that women often apply reproductive practices without spousal involvement, highlighting the difficulties individuals experience discussing fertility preferences and family planning in marriage.

9.3 Female family planning practices over the life-course

This study has provided rich qualitative findings which contribute to existing literature and furthers understanding of female reproductive behaviours in sub-Saharan Africa (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2002, 2006). These findings provide explanation to why fertility rates have remained consistently high in this area of Uganda despite the increased availability of contraception. These key findings also provide insights to how married women navigate family planning decisions, the types of family planning practices favoured in this setting and the triggers for changes in behaviour.

Fertility-related practices and behaviours have been shown to be complex, context-driven and part of a process in which females 'are continually trying to develop and negotiate strategies for dealing with competing interests and multiple perspectives in different social situations' (Price and Hawkins, 2007). Women were found to navigate family planning decisions over the life-course in relation to factors relating health, identity and maintaining social relations (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2002, 2006; van der Sijpt, 2014). Despite the structural constraints on female sexuality and behaviour, women were found to use various approaches and strategies to exert agency, secretly applying practices to achieve fertility preferences and manage family planning at different stages of the life-course.

This navigation of family planning is evident in the fact that females use an average of three or four approaches over the life-course. Navigation of decisions and trialling of practices are linked in this study to frameworks of gender and marriage, religious beliefs, social pressures from spouse or kinship, fertility preferences, efforts to space births and avoid unintended pregnancies, protect health and prioritise caring for existing children. Life-events such as an unintended pregnancy, reproductive mishaps, short birth spacing, health and marital problems were all found to trigger changes in family planning and priorities. The most common approaches used by female respondents in this study include relying on God, abstinence and breastfeeding. Methods that women could apply independently were the most popular, as women were found to frequently use strategies or practices without discussion with a spouse.

This study found that although females are often taught menstrual rituals, hygiene practices and the importance of having children in marriage, they often miss out or are prevented from learning about sex, fertility, the menstrual cycle and family planning options. Girls are taught to be obedient, domesticated, avoid sexual relations and abstain from pre-marital sex so to enter marriage as a virgin. This framework of gender identity acts as a social

mechanism to control female sexuality and also acts a barrier, restricting girls from developing skills and accessing information to negotiate sexual relations and protecting against HIV, STIs or unintended pregnancies (Gupta, 2002). Combined with unequal gender power dynamics, stigma associated with pre-marital sex and barriers to accessing condoms or other forms of modern contraception, this means girls are often ill-prepared for negotiating sexual advances or safer sex (Maticka-Tyndale, 1991; Gupta, 2002). Women are told by religious representatives about the importance of reproduction and to use natural family planning methods to manage fertility, but are often not given direct advice on how to do this. Misinformation surrounding the menstrual cycle and the fertility window means that women trying to apply the Safe Days Method might actually increase the risk of unintended pregnancy.

Similar to Bledsoe's (2002) findings from West Africa, women in this study were found to most likely use hormonal contraception after having two or more children or after a reproductive mishap. Hormonal contraception and sterilisation were also used to take breaks from childbirth, boost health and capabilities to fulfil duties attached to being a mother (Bledsoe, Banja and Hill, 1998). Concerns surrounding male demand for children and resistance to hormonal contraception mean most females who had used hormonal contraception often did so without a spouse's knowledge (Agol *et al.,* 2014). For these reasons the injection (Depo-Provera) is often preferred over the Pill or the implant. Although only a third of the women had tried hormonal contraception in this study, the findings indicate that when a woman tries one form of hormonal contraception, she is more likely to try a second. Barriers to uptake and adherence to modern contraception include religious beliefs, spousal resistance and perceived causes of conflict in marriage, feared and experienced side effects relating to menstruation, fertility and health. The link between menstrual beliefs and contraceptive use has been well documented across sub-Saharan Africa, showing that women's concerns relating to side effects, particularly amenorrhea and menorrhagia, are amongst the most common reasons for discontinuation (Glasier *et al.,* 2003; Wood and Jewkes, 2006, Laher *et al.,* 2010).

Demand for sterilisation has been argued in this thesis to be driven not by a desire to limit children, but rather to protect a woman's health and sustain her capabilities to care for existing children. Undergoing sterilisation seemed the most preferable option for women who have produced many children (i.e. seven or more) and are experiencing severe or ongoing reproductive health problems. Demand for sterilisation in Uganda is often discussed in relation to women's desires to limit having children, whereas drivers of reproductive health problems are rarely discussed (UDHS, 2012; Lutalo *et al.,* 2015). The findings from this study suggest that women's motivations to protect health, manage the process of aging and sustain

capabilities to look after children are more culturally-appropriate frames of reference to understand family planning motivations and decisions (Bledsoe, Banja and Hill, 1998; Bledsoe, 2002; Johnson-Hanks, 2005; van der Sijpt, 2014).

Methods of family planning have proliferated in this setting as shown by the increased use of modern contraception amongst women in the younger and mid-range age categories; however, barriers remain to openly discussing fertility preferences and family planning in marriage (Kaida *et al.*, 2005; Kabagenyi *et al.*, 2014). These findings are consistent with existing literature in Uganda, which highlights that ascribed gender roles, cultural norms of fertility and the structure of gender relations mean that men often feel excluded from family planning decisions and that discussing issues in marital relationships is generally poor (Kaida *et al.*, 2005; Kabagenyi *et al.*, 2014). Most often couples were found to only openly discuss family planning in times of crisis, where the mother or children's health are at risk or if struggling to cope after producing many children.

By placing responsibility for family planning on individual woman, the external factors that affect capabilities to control fertility are often overlooked (Kavanaugh, 2008). High fertility rates in this setting has been attributed to cultural and religious beliefs that affirm the importance of having children and unprotected sex in marriage, the structure and organisation of gender relations which hinders negotiation of safer sex, and the low effectiveness of family planning approaches and practices being used by females. Many women in this study had children with more than one partner. First-born children were frequently a result of rape, transactional sex and pressurised early marriages that had broken down due to violence and abuse. Cultural practices of transactional sex and widespread occurrence of gender-based violence both within and outside of marital relationships hinder female capabilities to negotiate sex and manage fertility (Koenig *et al.*, 2003, 2004).

The cultural meanings of unprotected sex in marriage to demonstrate love, intimacy, trust and prioritising sexual pleasure mean that condoms are perceived to be incongruous in marriage and to request their use can imply distrust and risk marital conflict (Maticka-Tyndale, 2012). The symbolic meaning of having children in marriage also puts pressure on females to prove their female capabilities and give birth to many children (Seeley, 2014). In polygynous societies, 'women need children to justify making demands on their husbands' wealth' (Bledsoe, 1995, p.133). In this setting 'children signify fertility, stability, commitment, security, respect, love, affection, intimacy and support in marriage' (Agol *et al.*, 2014). Children are therefore deemed necessary to sustaining and growing love in a marriage and are a vital form of social capital and contingency to prepare for uncertain future challenges

(Johnson-Hanks, 2006). Understanding the complex forces surrounding the demand for children is therefore paramount to understanding high fertility rates and women's family planning practices in this setting.

9.4 HIV risk environment for married individuals in this setting

This thesis has argued that particular sets of sexual practices, which highlight the unequal power dynamics of gender relations, heighten the susceptibility of contracting HIV and therefore contribute to a risk environment. These sexual practices have been situated within the broader context of individual lives, the interdependency of social relationships and gender relations, which are embedded and shaped by the socio-historical setting. The findings from this study therefore contribute new knowledge and build upon existing research on HIV risk environments (Barnett and Blaikie, 1992; Barnett and Whiteside, 2002; Rhodes, 2002; Rhodes and Simic, 2005; Shannon *et al.*, 2008; Rhodes, Bernays and Terzić, 2009; Kuhanen, 2010).

The findings are summarised in this section using a similar framework as Shannon *et al.*,(2008), illustrating the key social determinants that contribute towards an HIV risk environment for married individuals in this setting across the macro, meso and micro levels (9.1 framework). Similarly, to Shannon *et al.* (*ibid.*), these factors highlight the unequal power dynamics of gender relations and the everyday risks and uncertainties that heighten susceptibility to HIV, particularly for females. Secondly, tensions are identified between the public health response and specifically the HIV prevention messages, with cultural and religious beliefs surrounding marriage and gender practices, and the context or drivers of extra-marital relations and sexual secrecy. Building on the work of Kuhanen (2010) and Parikh (2007), findings from this study show how sexualised spaces and practices relating to transactional sex create opportunities and facilitate extra-marital relations. Lastly, by building on the marriage and sexual relationship literature in Uganda (Parikh, 2007; Siu, 2013; Siu, Seeley and Wight, 2013; Agol *et al.*, 2014; Rutakumwa *et al.*, 2015), the findings from this study have provided detailed accounts of the ways married individuals navigate the risk environment and negotiate HIV risk. A key finding is that achieving sexual or fertility preferences and maintaining marital relations can frequently be prioritised over managing HIV risk. This study therefore provides vital new insights to the social determinants that contribute towards a risk environment for married individuals and the ways married individuals navigate, negotiate and manage this risk.

Figure 9.1 Framework - the HIV risk environment for married individuals

Macro	▪ Patrilineal and patriarchal traditions ▪ Influence of colonialism – promotion of marital ideals and nuclear family ▪ Modernisation and urbanisation – increased migration, evolution of modern market economy, luxury goods and lifestyles ▪ Emergence of sexualised spaces in urbanised areas, shifts in sexual culture ▪ Public health response – HIV prevention campaigns, promote ABC messages (abstinence, be faithful, use condoms): monogamy framed as moral and protective and HIV risk associated with multiple sexual relations and promiscuous sexual behaviour ▪ HIV stigma increased sexual secrecy ▪ Individual responsibility to avoid and protect against HIV as indicated through test and treat – know status and manage HIV as a chronic disease
Meso	▪ Marital instability, polygyny and extra-marital relations are common ▪ Male extra-marital relations are connected to reputational notions of masculinity (i.e. sexual entitlement, pleasure, achievement and proving virility), migration, mobility and socialising in sexualised spaces ▪ Female extra-marital relations are driven by marital dissatisfaction, notions of sexual pleasure, romantic love and/or financial support ▪ Notions of gender facilitate practices of transactional sex and affect health seeking practices (i.e. HIV testing and condom use) ▪ Women more likely to access health services and test for HIV than men ▪ Men less likely to test due to migration and mobility, and constructions of masculinity (being strong, self-sufficient, brave or fearless)
Micro	▪ Abstinence and condoms are associated with marital dissatisfaction/conflict ▪ Being faithful is the main approach used by married individuals ▪ Multiple interpretations of faithfulness that may not include being sexually exclusive ▪ The values deemed most important in marriage are fulfilling marital roles, loyalty and cooperation to develop the home/assets ▪ Individuals navigate multiple risks and uncertainties in daily life relating to income, livelihoods, health. ▪ Benefits/gains of not directly discussing HIV risk is that it sustains marital relations as a form of social capital and can uphold respectable identity. ▪ Perceived risks of addressing HIV are marital tensions, conflict/violence and marital breakdown ▪ In cases of HIV diagnosis, practices of unprotected sex often persist ▪ Maintaining marital relations and stability is often prioritised over HIV risk

Macro determinants of the HIV epidemic

Uganda has undergone major social transformation during the last century, which has re-configured social perceptions and practices relating to marriage and sexual relationships. (Barnett and Whiteside, 2002; Parikh, 2007; Kuhanen, 2010; Seeley, 2014). As mentioned in Chapter 8, key historical and social processes have influenced shifts in practices and ideas about gender relations. The colonial administration, with the support of local leaders and missionaries, built upon tradition patriarchal beliefs to promote male control over sexuality to boost population growth and agricultural production (Summers, 1991; Kyomuhendo and McIntosh, 2006; Parikh, 2007). After decolonization, the country experienced rapid population growth, which increased migration to urban areas (Kuhanen, 2010). The processes of urbanisation occurred alongside the emergence of the modern economy and lifestyles, which provoked new cultural ideas about sex outside of marriage with irregular partners and sex as a commodity that can be bought and sold (*ibid.*).

Today in rural Uganda, most individuals engage in subsistence farming and low-income-generating activities (i.e. keeping a shop, manual labour, trading, making traditional items) (Parikh, 2007). As shown in this study, only one male respondent (Moses, aged 35, teacher) had a salaried wage. Marital aspirations have evolved to include demands for 'modern lifestyles' (i.e. formal education, access to healthcare, leisure activities) and desire for luxury goods (i.e. mobile phones, televisions, refrigerators) (*ibid.*). Low income, insecurity of livelihoods and increased costs of living have placed constrains on male capabilities to achieve respectable notions of masculinity (Siu, 2013). These processes have contributed to a decrease in formal polygyny and legal types of marital relationships and provoked a rise in informal types of marriage, casual sexual relations and extra-marital relations (Parikh, 2004; Schlecht, Rowley and Babirye, 2013; Agol *et al.*, 2014; Seeley, 2014). Poverty and desire for modern livelihoods are also recognised drivers for early marriage and adolescent girls being coerced or enticed into transactional sexual relations with older men (Nyanzi, Pool and Kinsman, 2001; Koenig *et al.*, 2004; Parikh, 2004). These broader socio-historical processes have therefore shaped individual lives, the interdependency of social relationships and sexual practices in this setting.

Public health approach - HIV prevention messages

Epidemics are both socially experienced and imagined (Streefland, 1998). This thesis has argued that the public health HIV prevention campaign provides a bridge between the social

and imagined experiences of the epidemic in Uganda. In Chapter 8 I explained how the HIV prevention campaign has provided a frame of reference or lens through which individuals interpret at-risk and protective behaviours. Campaigns have been based on 'visible medico-moral HIV prevention messages' (Parikh, 2007, p.1198), which moralised Christian-type ideals of behaviour (i.e. abstinence, be faithful and use condoms) as protective and safe, and stigmatised sexual behaviours deemed risky (i.e. promiscuity and multiple, extra-marital relations, sex work) (Barnett and Parkhurst, 2005b; Kuhanen, 2010). As the epidemic evolved and more was learnt about HIV, focus has shifted towards testing and anti-retroviral treatment to manage HIV as a chronic condition (Seeley, 2014). The individual focus and perceived responsibility for risk and prevention remain evident in Uganda's AIDS policy, which uses the tagline 'An AIDS free Uganda, My responsibility!'. The initial aim of the HIV prevention campaigns was to cause shock and change behaviour, but the impact has been that it has inadvertently led to a rise in sexual secrecy (Parikh, 2007; Kuhanen, 2010).

The landscape for marital relationships – extra-marital relations and sexual secrecy

In response to the stigma generated by HIV prevention campaigns and public reaction to the HIV epidemic, a culture of sexual secrecy emerged in Uganda (Parikh, 2007; Kuhanen, 2010). The findings from this study echo existing literature, stating that male extra-marital relations are common in this setting and occur across all types of marital relationship (Kasamba *et al.*, 2011). Male engagement in marital relations includes concurrent longer-term partnerships, casual or one-time opportunistic affairs and relations occurring whilst a man is away from home, often due to work (Parikh, 2007). In this thesis drivers for male extra-marital have been linked to reputational notions of masculinity (i.e. sexual entitlement, pleasure, achievement, children with multiple partners), labour mobility, sexualised spaces and marital problems or dissatisfaction.

Although female extra-marital relations in this setting are often acknowledged, they are rarely discussed in detail (Parikh, 2007; Agol *et al.*, 2014). In this study four women admitted to engaging in extra-marital relations for reasons relating to sexual pleasure or attraction, intimacy and financial support. These motivations speak to existing literature on the blurred drivers of transactional sex, which can intersect with love, intimacy, desires for modern lifestyle items and experiences, and the need for economic support (Wamoyi, Fenwick, *et al.*, 2011; MacPherson *et al.*, 2012; Stoebenau *et al.*, 2016). Sexual secrecy regarding extra-marital relationships not only operates as an intermediate social determinant of HIV risk for married

couples and route of HIV transmission into marriage, but also generates tension and distrust that hinders conversations about HIV risk and the negotiation of safer sex in marriage.

Negotiating and managing HIV risk within marital relations

Stigma and sexual secrecy generated by the HIV prevention campaigns has been argued in this thesis to hinder open discussion of HIV testing and risk in marriage. In Uganda, women are known to test for HIV more than men, due to reasons relating to constructions of gender (Dunkle *et al.*, 2004; Seeley, Grellier and Barnett, 2004; Siu, Seeley and Wight, 2013; DiCarlo *et al.*, 2014). Women more routinely access health services and test for HIV, which links to female notions of responsibility for managing child and family health, whereas males are less likely to test due to labour mobility or migration and constructions of masculinities (i.e. being strong, independent, fearless), which affect health-seeking behaviours (Siu, 2013). Mistrust, fear of HIV diagnosis and blame are reasons married couples routinely struggle to discuss HIV and there is resistance to couple testing (Larsson *et al.*, 2010).

This thesis has provided evidence of the tension or conflict between the public health messages to protect against HIV, the social and cultural beliefs shaping marital roles and practices and the context and circumstances in which sex and extra-marital sexual relations occur. Using frameworks of gender, the findings from this research have situated the symbolic meaning of unprotected sex in marriage within cultural and religious beliefs relating to marital duties to sexually satisfy a spouse and to have children as a way to demonstrate trust, intimacy, love and pleasure (Hirsch *et al.*, 2009; Agol *et al.*, 2014). Traditional beliefs that assert male sexual entitlement and ownership over a wife shape perceptions of sexual obligation, which can make it difficult for females to abstain or deny sex in marriage and can lead to cases of forced sex and sexual violence (Koenig *et al.*, 2003; Cash, 2011). This also means condoms are deemed inappropriate within marital relationships, as they have been framed in public health campaigns as symbols of promiscuity or high-risk sexual behaviours (Maticka-Tyndale, 2012). Furthermore, male refusal to use condoms has been linked to notions of male sexual entitlement to unprotected sex with a wife or woman to whom he has given money (Rutakumwa *et al.*, 2015).

This means the main way in which married individuals interpret being able to protect against HIV is through being faithful (Parikh, 2007). However, this study found that there are multiple interpretations of what being faithful means that do not necessarily equate to being sexually exclusive, as men can legally marry more than one wife and often have other sexual partners. Extra-marital relations are known to be common and sexual secrecy can mean it is

difficult for married individuals, particularly women, to discuss such issues with a spouse without causing marital tensions (Hirsch *et al.*, 2009). Findings echo those from existing studies on marriage in Uganda, which have found that married individuals value a partner fulfilling their marital role, being loyal and cooperating on shared goals (i.e. developing the home) (Parikh, 2007; Agol *et al.*, 2014). These marital values can be prioritised over risks of marital tension, conflict or HIV. It has been emphasised in this thesis that HIV is just one of many risks that individuals have to navigate in this setting and that sustaining marital type relationships is one way to manage or prepare for uncertainties or challenges.

It has therefore been argued in this thesis that married individuals apply a wager approach (Hayes, 1992), weighing up the potential risks and gains of directly addressing HIV risk in marriage. The potential risks of directly communicating concerns relating to HIV are shame, violence, ongoing tensions and marital breakdown, whereas the benefits of not directly discussing these issues include sustaining marital relations as a form of social capital and upholding respectable notions of gender identity. Even in cases where individuals have disclosed HIV status or the risk of contracting HIV is known, the pressure to enact marital gender behaviours means that individuals in marital relationships are still likely to engage in unprotected sex (Parikh, 2007; Rutakumwa *et al.*, 2015).

The HIV risk environment is therefore shaped by multiple social determinants across different scales of society. Within marital relationships, there remain barriers to open discussion of HIV risks and for females to negotiate or deny sex with a spouse. Due to the commonality of extra-marital relations, being faithful in marriage whilst engaging in unprotected sex can heighten susceptibility to HIV. Even when there is a perceived risk of HIV, married individuals can prioritise sustaining marital relations and enacting notions of gender identity over protecting themselves and each other against HIV.

9.5 Policy implications

It is evident from this research that tensions exist between public health messages, cultural and religious beliefs about gender and marriage and the circumstances in which individuals engage in sexual and reproductive practices. The findings summarised above indicate that policy and interventions need to take into account and address the social environment and belief systems surrounding social practices. To shift or change social practices needs engagement at all levels of society, which requires participatory processes to work with individuals and communities. Evidence indicates these are the ingredients to effective intervention and meaningful social change in a risk environment (Rhodes and Simic, 2005). Two suggestions to address the HIV

risk environment and high rates of fertility in this setting are programmes that focus on gender transformation and adolescence (WHO, 2007; Dworkin *et al.*, 2015; Jones and Presler-marshall, 2019). I briefly outline the potential benefits of these approaches and how these connect with the findings of this research below.

A key finding of this research is that the HIV risk environment for married individuals is based on the construction and organisation of gender relations, the expectations of gendered sexual and reproductive practices, and the unequal power dynamics of sex. More specifically, practices of transactional sex and expectations of gender roles, concerns about marital stability and commonality of extra-marital relations hinder married individuals in openly talking about and managing family planning and HIV risk. There is a need to reconfigure or transform expectations of marital and gendered roles so to achieve greater equity in sexual relationships and address risks relating to transactional sex (Stoebenau *et al.*, 2016). Gender transformation includes 'approaches that seek to transform gender roles and promote more gender-equitable relationships between men and women' (WHO, 2007, p.4). Public health programmes employing gender transformation techniques have had success at chipping away at entrenched social norms and the organisation of gender relations (Dworkin *et al.,* 2015). Research has shown that gender transformation has achieved successful outcomes relating to the transmission of HIV and STIs, contraceptive use, physical violence (both against women and between men), parenting and health-seeking behaviour (WHO, 2007).

Gender transformation should be implemented across multiple scales of society to meaningfully change expectations of gendered behaviours and practices (Dworkin *et al.*, 2015). Evidence indicates the importance of engaging men and women in the process of social transformation, as the process not only aids individuals to identify points of tension and re-configure notions of gender, but people are also more likely to change behaviours or practices, if they see their partner(s) and peers are also committed (Campbell, 1997; Mungwini, 2008). Interventions should also work towards structural and community-change, which can occur through interventions such as group education, community outreach, mobilisations, mass media campaigns and engaging religious institutions (Dworkin *et al.,* 2015).

The findings from this study suggest that to address the risk environment and lower rates of fertility, gender transformation programmes should include married individuals at all stages of the life-course, religious leaders, *ssengas,* health workers, teachers, traditional healers, community leaders, police and government officials who are all part of the system that produces gender inequity. Gender transformation could enable engaging married individuals and key community members to re-conceptualise gender and sexual frames of reference. This

would encourage more open discussions about fertility preferences, family planning, risks relating to HIV, reproductive problems and childbirth to help address issues of distrust, stigma and fear, which hinder dialogue and the negotiation of sex and reproduction in this setting.

The second policy recommendation is for interventions to target adolescents. Adolescence is known to be a critical phase of life: 'While these changes and developments can create major opportunities for girls and boys, they also expose them to new risks. The behaviours they adopt and the social context in which they live can set trajectories for their health and well-being as adults' (Chandra-mouli *et al.*, 2017, p.S5). This study found that female responsibility for domestic work and childcare, alongside circumstances of poverty, means that girls are often denied or withdrawn from education at primary level and are frequently pressured into early marriage (Schlecht, Rowley and Babirye, 2013; McCleary-Sills *et al.*, 2015). Girls are often ill-equipped to manage sexual advances or negotiate safer sex and are also vulnerable to sexual violence, coercion, and risks relating to transactional sex (Gupta, 2000, 2002; Wamoyi, Wight and Remes, 2015; Stoebenau *et al.*, 2016).

For males in this setting, adolescence was also associated with being forced to discontinue education and a time of sexual exploration. Strong peer influence, desire for sex and a wish to prove their masculinity prompt male youths to use transaction sex or other gendered negotiations to achieve goals of sexual achievement (Siu, 2013). Adolescence is also the period when male youths are most likely to first migrate in search of work. Access to economic capital, being away from the regulation of kinship relations and engaging in practices such as drinking alcohol and socialising with male peers for the first time are also social determinants that encourage male youths to engage in risky sexual practices (Kuhanen, 2010). Evidence from Uganda suggests that if a male youth is not initiated into condom use during adolescence, then he is unlikely to use condoms in adulthood (Rutakumwa *et al.*, 2015).

Adolescence provides a '"window of opportunity" to offset childhood disadvantage and support life-course and intergenerational gains' (Jones and Presler-Marshall, 2019). Interventions that support attainment in education, particularly for girls, and use gender transformation strategies could together lower fertility rates and reduce susceptibility to HIV (*ibid.*). It is clear that there is a multiplier effect associated with educating girls: 'increased education leads to improved health, participation in the formal labour market, higher earned income, having fewer children, and women being able to provide better healthcare and education to their children' (McCleary-Sills *et al.*, 2015, p.69). Findings from a longitudinal study of adolescents in six developing countries found that alongside gender transformation strategies, social protection interventions such as cash transfers can increase education uptake,

reduce girls exposure to risky practices and aid economic empowerment (Jones and Presler-Marshall, 2019). Programs that seek to change both gender beliefs and expectations, alongside enhancing economic opportunities, are regarded to be most promising at promoting positive sustainable social change (Dunbar *et al.*, 2014; Jewkes and Morrell, 2012). By enhancing education opportunities and social protection for adolescents could therefore address and improve health outcomes relating to HIV/AIDS and STIs, early pregnancy, childbearing and unsafe abortions (Chandra-Mouli *et al.*, 2017)

9.6 Future research agenda

Whilst promoting and defending women's rights to access a variety of family planning options, it also necessary to remain critical and advocate for improved methods and ensure that risks or side effects are effectively communicated. This means understanding and communicating the risks and efficacy of methods, which depends on the social context and circumstances in which they are being used (Price and Hawkins, 2007). From the findings of this study, there are two areas that warrant further investigation to examine the relationship between family planning and HIV risk in marital relationships in this setting. This includes further understanding of the relationship between the social environment, extra-marital practices and negotiations of risk. Secondly how the social environment interacts with women's access to and secret use of hormonal contraception. Research on these two areas could further understanding of the HIV risk environment and female family planning practices.

Although it is often acknowledged in studies that women also engage in extra-marital relations, details are rarely provided on how these relationships arise and how notions of risk relating to sex and fertility are negotiated (Parikh, 2007; Hirsch *et al.*, 2009; Agol *et al.*, 2014). In this study four female respondents disclosed that they had engaged in extra-marital relations. One of these women stated that she had used condoms, while the other three said that they had had unprotected sex while pregnant with their husband's child as a family planning approach. Pregnancy is known to increase biological susceptibility to HIV and STIs, and pose a risk of mother-to-child-transmission (MTCT) (Thomson *et al.*, 2018). This practice indicates women prioritising avoiding extra-marital pregnancy, lack of awareness of increased susceptibility to HIV and STIs and/or inability to negotiate safer sex. Depending on the point during pregnancy in which a woman has unprotected sex, if the woman contracts HIV, because of the 3-month incubation period, an HIV test might not detect the virus during an antenatal screening. If the virus is not detected and then intervention would not be prompted to prevent MTCT. This study only had a small respondent sample; therefore, further research could explore the context in

which women are engaging in extra-marital relations, perceptions of risk and whether pregnancy is used as strategy in this way more widely by women.

Further research could also investigate the context, social determinants and practices surrounding women's secret use of hormonal contraception. This study found that most women who have used hormonal contraception have done so at some point secretly. One woman disclosed buying the hormonal injection Depo-Provera (DMPA) from a mobile health worker, who was interviewed as part of this research. The mobile health worker was self-employed and was independently buying vials of DMPA and administering it to women in the villages who wanted discreet or secret family planning. In the Uganda Demographical Health Survey it is acknowledged that injectables are mostly obtained from private facilities (60%), which mainly refers to private hospitals and clinics (57%) (UDHS, 2012, p.84). Perhaps the remaining 3% includes informal modes of access, but this is unclear. The identification of an independent mobile health worker administrating injectables in the study area suggests that there could be a wider informal market for contraception that has evolved to meet women's demands for secret family planning.

Depo-Provera (the injection) is the most popular form of hormonal contraception in Uganda and is the method which the Ugandan government has committed the most investment to in the Family Planning Costed Implementation Plan 2015-2020 (MoH, 2014). To date there is evidence from observational studies indicating a link between Depo-Provera (DMPA) and increased HIV acquisition, although it is still unknown whether this link is causal or due to confounding social factors (Blish and Baeten, 2011; Polis and Curtis, 2013; Colvin and Harrison, 2015; Ralph, Mccoy *et al.*, 2015). One meta-analysis suggests that Depo-Provera could increase HIV acquisition by 40% (Ralph, McCoy, *et al.*, 2015). In this thesis two women who had been diagnosed with HIV were both using Depo-Provera and had done secretly for many years. However, both women were also in marital relationships with men who refused to wear condoms, were mobile for work and were known to have other partners. The social determinants surrounding women's secret use of the hormonal contraception could therefore also heighten risks of HIV susceptibility in marriage.

Given that Depo-Provera is the most popular form of hormonal contraception in sub-Saharan Africa, research findings indicating increased HIV susceptibility has raised debates surrounding women's rights to effective contraception and the implications for HIV prevention (Colvin and Harrison, 2015). More social science research is needed to understand the context of women's secret use of hormonal contraception and the interpretation or weighing up of risks that inform practices, both in this setting and other high HIV prevalent contexts.

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Appendix A: Participant profile and prompt sheets for life-story respondent interviews

Participant	
Name:	
Participant number:	
Age:	
Village no.	
Household number:	
Sex:	
Religion:	
Ethnicity:	
Livelihood activities:	
Education level completed:	
Relationship status described by participant: (i.e. married religious, civil, customary, cohabiting, non-cohabiting)	
Number of children (how many partners):	
Number of life partners:	
Partner	
Age:	
Education level completed:	
Livelihood activities:	
Religion:	
Ethnicity:	
Place of living:	
House	
Wall type:	
Roof material:	
House description (electricity, water, decoration)	
Total number of rooms:	
Number of rooms used for sleeping:	
Household composition:	

Interview prompt sheet – First round (male and female respondents)

Please tell us about your life

- Family structure and childhood
- Education
- Perceptions of marriage/sex education or advice
- Livelihood and living situation

Current sexual partner, past and concurrent relationships

- Description of relationship with spouse (i.e. ways the couple relate, marital roles)
- Sex – expectations, practices and experiences
- Changes in the relationship, over time, highs and lows, challenges
- Living arrangements and time/ space for sexual privacy
- Previous sexual experiences/partners
- Concurrent sexual relationships

Family planning

- Number of children, spacing, age range– age of participant
- Desired number of children (past and present)
- Knowledge of family planning and experiences
- Discussion of family planning with current or previous spouse – (decision-making, roles)
- Access to advice or services (informal, traditional or medical)

HIV & STI's

- HIV status (own and partner's) – perceptions of testing, discuss with partner
- Perception of HIV & STI risk, partner's fidelity - discussion with partner
- Methods of prevention/, perceptions on practicing safer sex and use of condoms
- Accessing advice or services (informal, traditional or medical)

Interview prompt sheet for life-story interviews – round two (female respondents)

Marital relationships – roles, practices and power dynamics

- Marital roles, duties and obligations
- Extra-marital relations
- Meanings of being faithful
- Perceived differences between negotiating sex in marriage and in a casual or extra-marital relationship
- Perceived role and involvement of spouse in family planning and childrearing

Reproductive health & family planning – beliefs, preferences and practices

- Knowledge of menstrual cycle and natural family planning (or Safe Days)
- Strategies used to manage fertility (avoid pregnancy or achieve fertility goals)
- Family planning – experience and use of methods – reasons for using or stopping, side effects and barriers to use
- Issues, fears or barriers relating to using family planning
- Pregnancy, childbirth and having children, impact on marital relationship
- Reproductive health problems and effects on marital relationship
- Onset and experience of menopause (for older females)

HIV and negotiating risk – beliefs, practices and marital relations

- Perceptions of HIV risk, testing and prevention
- Discussing HIV with a spouse
- Practices relating to negotiating/managing HIV risk
- Other risks/prioritises being managed in marital relationship

Prompt list for life-story interviews – round two (male respondents)

Marital relationships – roles, practices and power dynamics

- Marital roles, duties and obligations
- Extra-marital relations
- Meanings of being faithful
- Perceived differences between negotiating sex in marriage and in a casual or extra-marital relationship
- Perceived role and involvement of spouse in family planning and childrearing

Reproductive health & family planning – beliefs, preferences and practices

- Knowledge of family planning methods and experiences of using/partner using
- Strategies used to manage fertility or achieve fertility goals
- Issues or fears relating to partner using family planning methods
- Pregnancy, childbirth and having children, impact on marital relationship and experiences
- Reproductive problems (self and partner) and impact on relationship

HIV and negotiating risk – beliefs, practices and marital relations

- Perceptions of HIV risk, testing and prevention
- Discussing HIV with a spouse
- Practices relating to negotiating/ managing HIV risk
- Other risks/prioritises being managed in marital relationship

Appendix B: Focus group discussion prompt sheet

Marriage/marital-type relationships

- What is marriage?
- Why do people get married? (benefits, reasons, disadvantages)
- What are the expected roles for the husband and wife? What happens if these switch?
- What do people do to maintain their relationship/marriage? (i.e. to prevent breakdown, or to keep in balance.)

Having children

- Do men and women talk about having children?
- Family planning? Preferred methods, how might this change over the course of the relationship?
- Does having children have an impact on a relationship? If so, in what ways? (pregnancy, exhaustion/health, sexual desire, changing roles, splitting of attention, space)

Extra-marital relationships

- When and why do people have extra-marital relations?
- What are the triggers for men and women to have an extra-marital relationship?

Appendix C: Information sheets and consent forms

PARTICIPANT INFORMATION FORM – life-story interviews

Study title: The negotiation and management of sexual and reproductive health behaviour within marital relationships in rural south-western Uganda

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Lead Investigator*:*
Ailie Tam
PhD student at the School of International Development, University of East Anglia, UK
Email: a.tam@uea.ac.uk
Telephone: (local mobile number will be provided)

This consent form is to be read and explained to all participants and a copy given to the participant.

Why is this research important?
I greet you, sir/madam. My name is ..... I am a social science research assistant from the Medical Research Council/ Uganda Virus Research Institute in Kyamulibwa.

I am part of a team carrying out a small study with the aim of learning about the lives of married and cohabiting couples and the ways in which decisions are made in relation to having children, managing personal health and accessing the clinic for family planning advice or services. We very much want to learn about the health and family planning needs of individuals within long-term relationships so as to inform health interventions in future.

We are recruiting 15 men and 15 women that are in long-term relationships and live within the local area. We shall collect information from them regarding the ways they discuss health concerns with their partner and access local services for testing, treatment or care relating to family planning. As part of this study we will also be talking to local health workers, community leaders and religious leaders. In addition, we will be running some focus group sessions with men and women, which will involve discussions about topics such as marriage, having children and accessing local services.

It is for you to decide whether you want to participate or not to participate. If you decide not to participate, that will not affect you at all. But before you decide, I would like to first explain to you what exactly is involved in this study and what is expected of you if you agree to participate. If you agree to participate, I will request you to sign a document that will show that you have agreed before we start asking you questions. Do you have any question about that?

Why have you been selected to participate?
You have been selected as you already participated in an interview with a researcher and you said you would be interested in taking part in the next stage of the research. You were selected for the first stage of the study as you are over the age of 20 years and were listed as being in relationship in the last household survey.

For how long will a volunteer take part in this study?
If a volunteer agrees to participate, he/she will be requested to be interviewed twice, each time this will last around 60 minutes. Interviews with take place at an arrangement of a time, day and

place to suit the volunteer. The meeting would usually take place at the volunteer's home, but this could be changed if a different place was preferred. At the end of the first meeting the time, day and place for the second meeting would be arranged.

What procedures will be followed in this study?

We are going to include 18 men and 18 women who are in marital relationships. We shall ask each of these men and women individual questions over two meetings. We shall ask questions about relationship experience and decisions around having children or personal health. We shall ask questions regarding the ways in which health concerns may be discussed with a partner and around accessing local services for testing, treatment or care relating to family planning. The meetings usually take place in the volunteer's home during the daytime or early evening.

If the volunteer gives permission, we shall use a recorder so that we are able to pick up all that will be said without missing anything that will be said to us. If the volunteer doesn't want to be recorded, we shall not use the recorder; rather we shall just write down what is discussed in a notepad.

What risk might be there in participating in this study?

If there is any harm it will be very minimal when you participate in this study. We are not going to take any blood, we are not going to give out drugs or perform any form of treatment. We are only going to ask questions. You are free to refuse to answer some questions or you can stop answering questions at any time. Therefore, the problem that you may find is your time that you will spend with us as we ask you questions.

Confidentiality and voluntary participation

If you take part in this study, it does not mean that you cannot benefit from other studies or any other treatment that may be there in future. You can withdraw from this study anytime you want without any explanation. And that doesn't in any way affect the care you receive here at the clinic. The information you give us here will be confidential as the laws provide. All the information we shall collect concerning you and any results will only be seen by the investigators of the study only, together with the study team

What benefits are there in participating in this study?

There may not be any direct benefits in participating in this study, but your participation will provide useful information that will help in creating interventions in providing family planning and health services for couples here and elsewhere. You will receive 10,000/- shillings to thank you for the time you have given us.

What happens if you have questions?

If you have any questions, call 0417704000 and talk to Professor Janet Seeley or (add local contact name and number). You can also call 0414321962 and talk to the Chairman, Science and Ethics Committee at the Uganda Virus Research Institute about your rights as a person who is participating in this research. If you cannot access a telephone to call, you can ask xxxxxxxx (a person from your village) to telephone for you so you can ask your question.

STUDY PARTICIPATION CONSENT FORM - life-story interviews

Study title: The negotiation and management of sexual and reproductive health behaviour within marital relationships in rural south-western Uganda

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Lead Investigator*:*
Ailie Tam
PhD student at the School of International Development, University of East Anglia, UK
Email: a.tam@uea.ac.uk
Telephone: (local mobile number will be provided)

I have understood the information given, agreed to participate in this study and agreed to the following:

(REVIEW EACH ITEM AND TICK IF PARTICIPANT AGREES)	Tick
To be asked questions three times in this study	
What will be talked about while asking me questions will be recorded	
That nothing we will talk about while being asked these questions will be matched to my name or be used in any way that will affect how I receive treatment and care here at the clinic	
That I am free to refuse to participate in this study or to withdraw any time without any problem or affecting the care I get at the clinic	

I have read the paper that has information about the study and have also been given a similar copy to keep. I have been asked whether I have any questions and the questions have been answered to my satisfaction. I have agreed without any coercion to participate in this study.

PARTICIPANT:

_____ _____ _____

Name of volunteer *Signature of volunteer* *Date*

If thumb print, who witnessed: .....

Signature of witness ..... *Date* .....

I have given all the information above to the volunteer and have answered all questions asked about the study before asking him/her to sign on the paper

INTERVIEWER:

Name_____Signature_____Date _____

PARTICIPANT INFORMATION FORM –Focus Groups

Study title: The negotiation and management of sexual and reproductive health behaviour within marital relationships in rural south-western Uganda

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Lead Investigator*:*
Ailie Tam
PhD student at the School of International Development, University of East Anglia, UK
Email: a.tam@uea.ac.uk
Telephone: (local mobile number will be provided)

This consent form is to be read and explained to all participants and a copy given to the participant.

Why is this research important?
I greet you, sir/madam. My name is ..... I am a social science research assistant from the Medical Research Council/ Uganda Virus Research Institute in Kyamulibwa.

I am part of a team carrying out a small study with the aim of learning about the lives of married and cohabiting couples and the ways in which decisions are made in relation to having children, managing personal health and accessing the clinic for family planning advice or services. We very much want to learn about the health and family planning needs of individuals within long-term relationships so as to inform health interventions in future.

We are recruiting people to participate in a focus group session where we shall ask the group to discuss topics such as marriage, having children, talking about health and accessing local services for testing, treatment or care. In this session we are interested in people's opinions, it is not expected that personal information or stories would be disclosed. As part of this study we will also be talking to local health workers, community leaders and religious leaders. In addition we will be running some focus group sessions with men and women, which will involve discussions about topics such as marriage, having children and accessing local services.

It is for you to decide whether you want to participate or not to participate. If you decide not to participate, that will not affect you at all. But before you decide, I would like to first explain to you what exactly is involved in this study and what is expected of you if you agree to participate. If you agree to participate, I will request you to fill in a document that will show that you have agreed before we start asking you questions. Do you have any question about that?

Why you have been selected to participate?
You have been selected to participate because you are over the age of 20 years old and are in a marital relationship living within the study catchment area. In addition you have shown interest to your group or community leader that you may be willing to participate in this study.

For how long will a volunteer take part in this study?
If a volunteer agrees to participate, she/he will be requested to attend one of the focus groups which is being held in ..... building at ..... The session will last approximately 60 minutes.

What procedures will be followed in this study?

Between 5 and 8 people will be invited to attend the focus group. The room will be set up with chairs in a circle for people to sit. There will be a facilitator whose role is to lead and guide the focus group by asking questions such as 'do you think it is expected for married couples to have children?' and then will ask the group to discuss it. The facilitator will try and make sure everyone gets the opportunity to give their opinion. All group members have a right to an opinion. Information about personal experiences is not expected to be shared, however we will explain to all volunteers that issues discussed should remain confidential to the group. Once everyone has had the opportunity to speak, the facilitator will clarify the main points that have come out of the discussion before asking the next question. Other topics that may be discussed include: courting/dating, getting married, gender roles and accessing local health services for advice, testing or treatment relating to family planning.

If the volunteers give permission we shall use a recorder so that we are able to pick up all that will be said without missing anything important. If the volunteers do not want to be recorded, we shall not use the recorder; rather we shall write down all that will be said when questions are asked.

What risk might be there in participating in this study?

If there is any harm it will be very minimal when you participate in this study. We are not going to take any blood, we are not going to give out drugs or perform any form of treatment. We are only going to ask questions. You are free to refuse to answer some questions or you can stop answering questions at any time. Therefore the problem that you may find is your time that you will spend with us as we ask you questions.

Confidentiality and voluntary participation

If you take part in this study it does not mean that you cannot benefit from other studies or any other treatment that may be there in future. You can withdraw from this study anytime you want without any explanation. And that does not in any way affect the care you receive at the clinic. The information you give us here will be as confidential as the laws provide. All the information we shall collect concerning you and any results will only be seen by the investigators of the study only together with the study team

What benefits are there in participating in this study?

There may not be any direct benefits in participating in this study but your participation will provide useful information that will help in putting up interventions in providing family planning and health services for couples here and elsewhere. You will receive 10,000/- shillings to thank you for the time you have given us.

What happens if you have questions?

If you have any questions, call 0417704000 and talk to Professor Janet Seeley or (add local contact name and number). You can also call 0414321962 and talk to the Chairman, Science and Ethics Committee at the Uganda Virus Research Institute about your rights as a person who is participating in this research. If you cannot access a telephone to call, you can ask xxxxxxxx (a person from your village) to telephone for you so you can ask your question.

STUDY PARTICIPATION CONSENT FORM – focus groups

Study title: The negotiation and management of sexual and reproductive health behaviour within marital relationships in rural south-western Uganda

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Lead Investigator*:*
Ailie Tam
PhD student at the School of International Development, University of East Anglia, UK
Email: a.tam@uea.ac.uk
Telephone: (local mobile number will be provided)

I have understood the information given, agreed to participate in this study and agreed to the following:

(REVIEW EACH ITEM AND TICK IF PARTICIPANT AGREES)	Tick
To be asked questions in a focus group setting	
What will be talked about while asking me questions to be recorded	
That nothing we will talk about while being asked these questions will be matched to my name or be used in any way that will affect how I receive treatment and care here at the clinic	
That I am free to refuse to participate in this study or to withdraw any time without any problem or affecting the care I get at the clinic	

I have read the paper that has information about the study and have also been given a similar copy to keep. I have been asked whether I have any questions and the questions have been answered to my satisfaction. I have agreed without any coercion to participate in this study.

PARTICIPANT:

_____ _____ _____

Name of volunteer *Signature of volunteer* *Date*

If thumb print, who witnessed: .....

Signature of witness ..... *Date* .....

I have given all the information above to the volunteer and have answered all questions asked about the study before asking him/her to sign on the paper

INTERVIEWER:

Name_____Signature_____Date_____

PARTICIPANT INFORMATION FORM – key informant interviews

Study title: The negotiation and management of sexual and reproductive health behaviour within marital relationships in rural south-western Uganda

Lead Investigator*:*
Ailie Tam
PhD student at the School of International Development, University of East Anglia, UK
Email: a.tam@uea.ac.uk
Telephone: (local mobile number will be provided)

This consent form is to be read and explained to all participants and a copy given to the participant.

Why is this research important?
I greet you sir/madam. My name is ..... I am a social science research assistant from the Medical Research Council/ Uganda Virus Research Institute in Kyamulibwa.

I am part of a team carrying out a small study with the aim of learning about the lives of married and cohabiting couples and the ways in which decisions are made in relation to having children, managing personal health and accessing the clinic for family planning advice or services. We very much want to learn about the health and family planning needs of individuals within long-term relationships so as to inform health interventions in future.

We are talking to people in long-term relationships and live within the local area. We are collecting information regarding perceptions of relationships, having children and whether people discuss health concerns with their partner. We are also interested in whether people access local services for testing, treatment or care relating to family planning. As part of this study we are also talking to local health workers, community leaders and religious leaders. In addition we will be running some focus group sessions with men and women, which will involve discussions about topics such as marriage, having children and accessing local services.

It is for you to decide whether you want to participate or not to participate. If you decide not to participate, that will not affect you at all. But before you decide, I would like to first explain to you what exactly is involved in this study and what is expected of you if you agree to participate. If you agree to participate, I will request you to fill in a document that will show that you have agreed before we start asking you questions. Do you have any question about that?

Why have you been selected to participate?
You have been selected to participate because you have been identified as having specific professional or personal experience which is relevant to the aims of this study.

For how long will a volunteer take part in this study?
If a volunteer agrees to participate, they will be requested to be asked questions and this will last between 30-60 minutes. At the end of this time, you may be asked if you would be happy to be interviewed again. You would be able to decide at that point.

What procedures will be followed in this study?
We are conducting interviews and focus groups with individuals over the age of 20 years and are currently in a relationship. We are interested in the ways in which people make decisions in relationships in relation to having children and health. We will ask you some questions regarding issues that have been already raised in other interviews to gain your opinion. We do not expect you to share personal informal, but we do wish to know your thoughts on these matters.

If the volunteer gives us permission we shall use a recorder so that we are able to pick up all that will be said without missing anything that will be said to us. If the volunteer doesn't want to be recorded, we shall not use the recorder; rather we shall just write down what is discussed in a notepad.

What risk might be there in participating in this study?
If there is any risk it will be very minimal when you participate in this study. We are not going to take any blood, give out drugs or perform any form of treatment. We are only going to ask questions. You are free to refuse to answer some questions or you can stop answering questions at any time. Therefore the problem that you may find is your time that you will spend with us as we ask you questions.

Confidentiality and voluntary participation
If you take part in this study it does not mean that you cannot benefit from other studies or any other treatment that may be there in future. You can withdraw from this study anytime you want without any explanation. And that doesn't in anyway affect the care you receive here at the clinic. The information you give us here will be confidential as the laws provide. All the information we shall collect concerning you and any results will only be seen by the investigators of the study only together with the study team

What benefits are there in participating in this study?
There may not be any direct benefits in participating in this study but your participation will provide useful information that will help in putting up interventions in providing family planning and health services for couples here and elsewhere. You will receive 10,000/- shillings to thank you for the time you have given us.

What happens if you have questions?
If you have any questions, call 0417704000 and talk to Professor Janet Seeley or (add local contact name and number). You can also call 0414321962 and talk to the Chairman, Science and Ethics Committee at the Uganda Virus Research Institute about your rights as a person who is participating in this research. If you cannot access a telephone to call, you can ask xxxxxxxx (a person from your village) to telephone for you so you can ask your question.

STUDY PARTICIPATION CONSENT FORM – key informant interviews

Study title: The negotiation and management of sexual and reproductive health behaviour within marital relationships in rural south-western Uganda

Lead Investigator*:*
Ailie Tam
PhD student at the School of International Development, University of East Anglia, UK
Email: a.tam@uea.ac.uk
Telephone: (local mobile number will be provided)

I have understood the information given, agreed to participate in this study and agreed to the following:

(REVIEW EACH ITEM AND TICK IF PARTICIPANT AGREES)	Tick
To be asked questions in this study	
That nothing we will talk about while being asked these questions will be matched to my name or be used in any way that will affect how I receive treatment and care at the clinic	
What will be talked about while asking me questions to be recorded	
That I am free to refuse to participate in this study or to withdraw any time without any problem or affecting the care I get at the clinic	

I have read the information about the study and have also been given a similar copy to keep. I have been asked whether I have any questions and the questions have been answered to my satisfaction. I have agreed without any coercion to participate in this study.

PARTICIPANT:

_____ _____ _____
Name of volunteer *Signature of volunteer* *Date*

If thumb print, who witnessed: .....

Signature of witness ..... *Date* .....

I have given all the information above to the volunteer and have answered all questions asked about the study before asking him/her to sign on the paper

INTERVIEWER: Name_____ Signature_____ Date_____

Appendix D: Characteristics of selected villages

Village No.	HIV	Dominate religion	Urban ranking	Discernible characteristics
6	High 16%	Catholic	High	This is the main trading centre with the third-largest village population (1,089 people), highest education amongst women in the GPC (average ten years) and only 27% population are involved in agricultural work, as most work in services or trade. There is electricity in vicinity and a range of low-level health services including the only government health clinic in the area and dispensaries and private clinics. There are also lots of bars, shops and other services. Majority of houses are concrete or brick, only 1% are mud and pole.
10	Low 5.4 %	Catholic	High	This village is also along the roadside, it has a small population (564 people) and electricity in the local vicinity but very few houses have access. There is a primary and secondary school and women have completed on average seven years primary education. 69% population are involved in agricultural work and 14% live in mud and pole houses.
20	Low 4.5 %	Catholic	Mid	This has the second-largest village population (1,162 people) in the GPC area and is set at a distance from the main road. There is a primary school and women have an average of six years education. 81% of the population are involved in agricultural work and 33% live in mud and pole houses.
2	Mid-range 7.4 %	Muslim	Mid	This village has a small population (347 people) and is mainly Muslim. There is a primary school and women have an average of seven years education. 82% of the population are involved in agricultural work and 31% live in mud and pole houses.
13	High 16%	Catholic	Low	This village is also near the roadside but with a small spread out population (512 people). There is no primary school and women have an average of average 6 education. 86% of the population are involved in agricultural work and 39% live in mud and pole houses (highest in GPC).
5	Mid-range 9.3 %	Catholic & Muslim	Low	This village is set at a distance from the road and has a mid-range village population (965 people). There is a primary school and women have an average of 6 years education. 85% are involved in agricultural work and 16% live in mud and pole houses.