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BEYOND DYADS: THE PERCEPTION AND EMBODIMENT
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**BEYOND DYADS: THE PERCEPTION AND EMBODIMENT OF HIV/AIDS RISK
AMONG MUSLIMS WITHIN MARITAL UNIONS IN RURAL UGANDA**

VOLUME I

By

Teresa A. Swezey

A DISSERTATION

**Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of**

DOCTOR OF PHILOSOPHY

Department of Sociology

2004

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ABSTRACT

BEYOND DYADS: THE PERCEPTION AND EMBODIMENT OF HIV/AIDS RISK AMONG MUSLIMS WITHIN MARITAL UNIONS IN RURAL UGANDA

By

Teresa A. Swezey

The research for this dissertation was conducted over nearly two years in a rural area of eastern Uganda with Muslims of the Basoga ethnic group who had been reached by an intensive, faith-based HIV/AIDS education and prevention program (the Islamic Medical Association of Uganda's Family AIDS Education and Prevention through Imams Project). The primary research question addressed is how the social construction and practice of gender relations affects the perception and embodiment—or lived experience—of HIV/AIDS risk, particularly for women in marital unions. Individuals learn gender norms and are rewarded or sanctioned based upon the extent to which they practice (or "do") gender according to dominant norms. Qualitative and quantitative methods were used to examine (1) how doing gender among Basoga Muslims impacts access to and control over valued social and economic resources as well as control over sexuality and reproduction, (2) the way inequitable distribution of resources and control over sexuality and reproduction affects the perception and embodiment of risk, and (3) the different way matched wives and husbands in monogamous and polygynous unions assess their HIV/AIDS risk and their reasons for that risk. Perceptions of polygyny as a risk factor for HIV/AIDS were analyzed as a sub-set of the third research question.

Marital partners in polygynous unions are linked to each other through complex, multi-dimensional networks yet, the focus of research on HIV/AIDS risk within marital unions in Sub-Saharan Africa remains at the level of individuals or couples (dyads). This dissertation argues that we need to adopt a broader frame of analysis when conducting research on HIV/AIDS in areas of

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Sub-Saharan Africa with high levels of polygyny. To address this and produce data to answer the above questions, the risk cluster concept was developed as an analytical and methodological tool. This concept attempts to move beyond the level of individuals and dyads (or couples) to compare matched husbands and wives' responses to key issues related to HIV/AIDS risk and risk reduction. A risk cluster consists of all the marital partners within a union, whether living in separate or linked households. A linked household is one in which a husband has wives living in more than one compound (or house).

Consistent with other research, women were concerned about their husband's risk-related behavior as an influence on their HIV/AIDS risk. A new finding is that women in polygynous unions were also concerned about their co-wife/ves' behavior. This suggests the need to expand West and Zimmerman's (1991) concept of "doing gender" to include gender relations among women as well as between women and men. Another significant finding, not reported in other research, is that the majority of participants (nearly two-thirds) considered polygyny a risk factor for HIV/AIDS. Moreover, members of polygynous risk clusters were more likely than members of monogamous risk clusters to assess their risk as moderate/great. The conclusion presents the theoretical and substantive contributions of the dissertation, including implications for practice.

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Dedicated in memory of Dr. Ruth Simms Hamilton in profound gratitude for her
support, encouragement and mentoring on this journey

"Onward"



Also in memory of Galen Reay Strasburg who, through his spirited example,
taught us invaluable lessons about what matters in life, and to his parents,

Christine Reay and Gale Strasburg, in appreciation for all of
your support along the way

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CHAPTER 1

INTRODUCTION TO THE STUDY

Introduction

At the close of 2002, an estimated 42 million people, over 95 percent of whom were residents of developing nations were living with HIV/AIDS globally.¹ Heterosexual transmission accounts for the majority (80%) of HIV infections in the South. While the dynamics of the global HIV/AIDS pandemic are changing, Sub-Saharan Africa, with one-tenth of the world's population, accounts for 70 percent (29.4 million) of the estimated global total. Women comprise 50 percent of the adults (15-49 years of age) living with HIV/AIDS globally. The majority (58%) of women living with HIV/AIDS are located Sub-Saharan Africa, where heterosexual transmission is the main mode of transmission.² The rate of HIV infection in young women ages 15-24 is about twice that of men in the same age group (an estimated 6%-11% of women versus 3%-6% of men) (UNAIDS/WHO 2002: 18).

Within the context of the AIDS epidemic, there are a variety of ways that social forces may become translated into personal risk, particularly for women. Sociocultural norms shaping unequal gender relations may mean that women have less control over sexuality and reproductive decision-making than men. Norms that define women primarily in terms of their roles as wives and mothers may contribute to lower levels of education and earlier age of marriage for women than men, and potentially large age gaps between spouses. Men who are

several years older than their wife/ves or female sexual partner/s may have had several previous sexual partners, thus potentially increasing the risk of infection for their current female partner/s (Kelly et al. 2003; UNAIDS/WHO 2002).

Additionally, age and educational gaps between spouses may increase women's risk by decreasing the likelihood that condoms will be discussed or used within the context of a marriage (Blanc and Wolff forthcoming; Blanc et al. 1996).

Worsening economic conditions and increasing poverty in many African countries also has increased many women's economic dependence on men. Within this context, women may exchange sex for money or material goods to increase their financial and/or social security, thereby increasing their risk for HIV infection (UNAIDS/WHO 2002; Schoepf 1998; Simmons, Farmer, and Schoepf 1996; Standing 1992). Moreover, many Sub-Saharan African women's commitment to monogamy within a marital union or steady partnership is no guarantee against HIV infection. An estimated 60-80 percent of women infected with HIV in the region have had only one lifetime sexual partner (Adler et al. 1996, cited in Rivers and Aggleton 1999: 4; see also Whelan 1999: 15). Most women living with HIV/AIDS in Sub-Saharan Africa, as globally, were infected by their "primary partner" (O'Leary 2000).³ "Many married women may erroneously believe that they are in mutually monogamous relationships, or may not know that their partner is HIV-positive and putting them at risk" (Center for Health and Gender Equity 2004: 10). A ten-year longitudinal study in the Masaka district in Uganda found, for example, that "[i]n married couples where both partners are not infected, men bring HIV infection into the marriage at twice the rate of

women. . . . probably owing to extramarital sexual behaviour" (Whitworth 1999: 181).⁴ To address these issues, this dissertation explores the connection between culture, gender, and HIV/AIDS in the Busoga region of eastern Uganda.

Statement of the Problem

Notions of power, powerlessness, and empowerment are often applied uncritically across cultures by both researchers and practitioners. The lack of attention to clearly defining and understanding these concepts in various social contexts has implications for the success of health promotion efforts, particularly AIDS education and prevention programs. It is problematic to assume that HIV/AIDS risk reduction programs can 'empower' people to change their behavior without first defining power, powerlessness, and empowerment and addressing underlying structural issues such as gender and economic relations.

Power is often conceptualized in sociology in Weberian terms, that is, as the ability to impose one's will on others despite opposition (Weber 1947:152). Weber's formulation of power reduces power relations to domination and control and portrays power as something that is possessed by individuals; you either have power or you do not. Those who are assumed to be without power are viewed as 'victims' of the powerful (Gallin 2002:74; Villarreal 1992:255).

A Weberian notion of power also does not clearly illuminate the social structural bases of power relations and how "the *relations* of ruling" [emphasis added] shape how we experience the realities of our everyday world(s) (Smith 1987). Weber's formulation of power implies that it is the amount of power one possesses that matters (Villarreal 1992: 256). Consequently, it closes off the

possibilities for recognizing the multiple forms and fluid nature of power as well as the ways that the “powerless” resist (Foucault 1980) and manipulate the constraining and enabling social forces shaping their lives (Gallin 2002:74; Villarreal 1992:258). Finally, the Weberian notion of power does not address how power relations might be transformed nor does it shed light on the meanings of “empowerment.”

Empowerment directed toward promoting behavior change is a goal of both international and Ugandan AIDS prevention programs. These programs often target their messages to women. Implicit in this approach is the assumption that improving knowledge is equivalent with empowering women to negotiate a reduction in their HIV/AIDS risk (Campbell 1995; Ulin 1992). Yet the varied meanings and experiences of power, powerlessness, and empowerment within particular contexts as shaped by gender and economic relations are rarely examined (Campbell 1995; Heise and Elias 1995; Schneider 1992; Schoepf et al. 1991b). Any program that seeks to increase people’s ability to control their risk of AIDS must address the way that personal biography and social structure (Mills 1959), particularly gender and economic relations, interact to create differing degrees of opportunities and/or constraints within particular social contexts.

In addition to the need to redefine and recontextualize the meanings of power, powerlessness, and empowerment within the field of HIV/AIDS research and practice, there is a need to expand the analytical lens. To date, the majority of research on HIV/AIDS in Sub-Saharan Africa has been analyzed at the individual level, using either women alone, men alone or wives and husbands,

i.e., "couples") as units of analysis. This research has greatly contributed to our understanding of the ways that gender inequality contributes to different levels of risk and ability to act on risk reduction messages for women and men. Gender power differentials disadvantage the majority of women in ways that make it difficult for them to reduce or control their risk for HIV/AIDS. With valued socioeconomic resources generally controlled by men, women's socioeconomic vulnerability negatively affects their ability to negotiate a reduction in their HIV/AIDS risk. The primary HIV/AIDS prevention messages of fidelity, condom use, and partner reduction are of limited relevance to women, largely because the balance of power in sexual relationships rests with men (Center for Health and Gender Equity 2004; Rao Gupta 2000; Schoepf 1998, 1992; Reid 1997; Farmer, Connors, and Simmons 1996; Rao Gupta, Weiss, and Whelan 1996; Baylies and Burja 1995; Basset and Mhloyi 1991; Carovano 1991). Even when women put HIV/AIDS prevention messages into practice, they still perceive themselves to be at risk because of concerns over their husbands' or steady male partners' behavior (Kengeya-Kayondo et al. 1999; Baingana et al. 1995; Caraël 1994; McGrath et al. 1993).

While existing studies move beyond the failure of many risk reduction models to factor in gender-power as a reality check on whether women are able to reduce their HIV/AIDS risk, they ignore an important issue: Sub-Saharan Africa has the highest incidence of polygyny in the world. Recent research (Blanc and Gage 2000; Dodoo 1998b, 1996, 1994; Ezeh 1997; Blanc et al. 1996) highlights the need to include analyses of gender power differentials within

polygynous unions as they influence reproductive preferences and decision-making. What is missing from the literature on HIV/AIDS is an analysis of whether wives, in addition to being concerned about their husbands' behavior as a factor in their HIV/AIDS risk, are also concerned about the possible effects of their co-wife/ves behavior.

Multiple partner relationships—whether formally or informally polygynous—expand the sexual network for all involved. When it comes to HIV transmission, it is not so much the type of union that matters as the openness of the network. A “monogamous” husband with several outside partners or perhaps “outside wives” is actually at greater risk (as is his wife) than those in a polygynous union in which all partners stay within the union (Berkley 1994).

Women's attitudes toward polygyny in Sub-Saharan Africa vary. While some women identify cooperation as a benefit of polygyny, many other women identify conflict among co-wives as a major disadvantage. Co-wives may compete for their shared husband's resources, and such competition can affect their fertility decisions. Women stand a better chance of claiming a larger share of their husband's resources if they produce children. To the extent that women are able to control their own reproductive decisions, co-wives in polygynous unions may compete with each other to bear the most children (Meekers and Nadra 1995; Bledsoe 1993; Wittrup 1990; Ware 1979). In fact, co-wives in a family may not limit their fertility unless they have some sort of guarantee that their fellow co-wives will do the same (Ware 1979). Given the influence of co-

wives on each other's reproductive behavior the question arises whether co-wives consider each other in assessing the extent of their HIV/AIDS risk.

This dissertation puts gender back into gender relations by exploring relations among women as well as between women and men. HIV/AIDS research in Sub-Saharan Africa too often focuses on "couples" as though they exist in isolation from the larger units in which they are embedded. In the instance of polygynous unions—again, whether formal or informal—each dyadic "couple" is linked to the others within a complex web of social, economic, and sexual networks. Generally, studies focus on comparisons in risk assessment, behavior, and risk reduction among wives and husbands (or male and female partners) and rarely address the question of co-wives.

Over 20 years ago, Ware (1979: 190) questioned the wisdom of using "couples" as the unit of analysis in areas with high rates of polygyny: "No one seems to have given thought to the problematical meaning of the couple as the basic unit for family planning communication or economic decision-making in the context of the polygynous family." Failing to address gender relations among women—particularly co-wives in linked or separate households—as an influence on risk and risk reduction is a critical gap in the HIV/AIDS research in Sub-Saharan Africa. This failure also raises serious questions about how the absence of such analyses affects HIV/AIDS education and prevention efforts.

Drawing upon two complementary theoretical foundations, this dissertation argues for the need to move beyond the level of dyads, or couples in areas with a high level of polygyny, to explore how gender inequality impacts perceptions of

HIV/AIDS risk and ability to reduce that risk. The first theoretical foundation used is Farmer's notion of the embodiment of risk (1996: 24; see also Farmer, Simmons, and Schoepf 1996) , which examines the ways that social forces such as poverty, gender inequality, and other forms of discrimination become embodied as personal risk. This dissertation focuses on what the embodiment of risk means for women. More specifically, it asks, how do the gender power relations in which women's lives are embedded related to their HIV/AIDS risk?

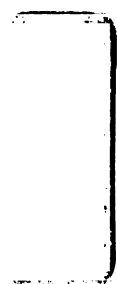
The form that these gender power relations take and the types of inequalities that they produce are related, in large part, to the way that gender relations are socially constructed and practiced within societies. Thus, West and Zimmerman's (1991: 24 and 32-33) concept of "doing gender" serves as the second theoretical foundation. Doing gender involves the enactment and re-enactment (i.e., practice) of socially constructed norms about differences between women and men, which legitimate and sustain the inequitable distribution of power and resources (such as education, employment, income, land ownership) at both the interpersonal and societal levels. These social norms about gender relations are learned, and individuals are rewarded or sanctioned based upon the extent to which they practice (i.e., do gender) according to the dominant norms. The way that gender is socially constructed and practiced within societies also impacts the extent of women's control over their sexuality and HIV/AIDS risk.

In arguing for the need to move beyond dyads, this dissertation introduces the concept of "risk cluster" as an analytical framework. A risk cluster consists of

all the marital partners in separate or linked households (a linked household is one in which a polygynous husband has wives in more than one location). The concept of risk cluster attempts to move beyond an individual level of analysis of comparisons of women and men (or wives and husbands) to an analysis of husbands' and wives' responses within the same or linked households. The notion of risk cluster is based on themes that emerged around inter- and intra-household dynamics with regard to HIV/AIDS risk and risk reduction during my pre-dissertation (1994-95) and dissertation (1997) research in Uganda. These themes focused on the social, economic, and sexual links between marital partners in separate or linked households and the way that these connections shaped perceptions of HIV/AIDS risk and risk reduction.

Participants in the research expressed an awareness of self-assessed risk beyond the level of the dyad. A consistent theme was that the behavior of all partners within the marital union impacted one's HIV/AIDS risk and ability to reduce that risk. Wives were concerned about their co-wife/ves' as well as their husband's behavior and husbands were concerned about their wife or wives' behavior. In risk cluster terms, everyone within a risk cluster is affected by everyone else's risk-related behavior and even though a wife, for example, may consider her risk as low because of her own behavior, she may nonetheless assess her risk as moderate to high because she has no control over her husband's and/or co-wife/ves' behavior.

The central research question asked in this dissertation is how the social construction and practice of gender relations among the Basoga Muslims who



participated in the study shape the embodiment—or lived experience—of HIV/AIDS risk particularly that of women within marital unions.⁵ Beyond that, how do differences in control over valued social and economic resources, sexuality, and reproduction impact differences in wives' and husbands' perception of HIV/AIDS risk and ability to reduce that risk? Specifically: are there differences in how matched wives and husbands in monogamous and polygynous risk clusters assess their HIV/AIDS risk and their reasons for that risk?

Background and Setting of the Study

Uganda's success in reducing its HIV prevalence rates from as high as 30 percent in the early 1990s to as low as the single digits from the mid to late 1990s onward is unequalled in other countries.⁶ For example, the HIV prevalence rate in women attending antenatal clinics in the capital city of Kampala fell from 30 percent in the early 1990s to eight percent in 2002. Similar substantial declines in HIV prevalence have been documented in other urban areas as well as in rural areas (UNAIDS/WHO 2003). Recent research (Whitworth et al. 2002: 1049) from the Masaka District of Uganda shows that HIV incidence (the estimated number of new HIV infections) has also decreased, particularly among "young women aged 13-24 years and young men aged 20-29 years."

Uganda's implementation of the "ABC" (abstain, be faithful, use condoms) approach to HIV/AIDS prevention is generally acknowledged as *one* of the key elements in what some refer to as the "Ugandan miracle." The relative weight of each part of the "ABC" approach in contributing to Uganda's success is,

however, a subject of debate.⁷ What is agreed upon is that the “Ugandan miracle” is related to a combination of a reduction in multiple partnerships, promoting faithfulness, abstinence, and correct and consistent condom use. In addition, Uganda encouraged youth to delay sexual debut and addressed the economic vulnerability of women by promoting their empowerment through financial independence (USAID 2002: 8).

The reasons for Uganda’s success are not limited to the “ABC” approach, however, and a number of additional factors played a crucial role in the country’s declining HIV prevalence and incidence rates. These include a strong political commitment to HIV/AIDS prevention and education at the national level characterized by a multi-sectoral approach; the development of a national AIDS policy early in the epidemic along with a national AIDS Control Program; strong donor support; and involving people living with HIV/AIDS in prevention and education efforts to address the issues of stigma and discrimination. Moreover, Uganda’s approach to HIV/AIDS education and prevention emphasizes community-based approaches and the involvement of religious leaders and faith-based organizations as well as civil society organizations. After initial resistance at the national level, the country also actively promotes condom use through social marketing and free condom distribution. Efforts to prevent and control other sexually transmitted infections, which are known to increase the risk of HIV infection, were also increased. Finally, Uganda’s national-level approach emphasizes voluntary counseling and testing (VCT), treatment, and care. The country is internationally recognized for its leadership in this area. The first

confidential VCT center (the AIDS Information Centre) in Africa was established in Uganda in 1990 and The AIDS Support Organization (TASO) is also an international leader in providing counseling and support services (Hogle et al. 2002; USAID 2002).

The above discussion provides a background to the national context. Below, I identify my social location to show how it shaped the research experience and I provide a brief summary of the context, setting, and methods I used in my dissertation research. I am a white, middle-class, American woman, who was raised as a Catholic (although I no longer practice that faith). I was unmarried, childless, and in my 40s at the time I conducted this research with Ugandan Muslims of the Basoga ethnic group—the vast majority of whom were married and had children. I entered the field for my dissertation research with a masters degree and having completed six years of course work toward my Ph.D., including training in three East African languages: Lusoga, Luganda, and Kiswahili.

My social location shaped the research experience in a number of ways. During my pre-dissertation research, I was a participant/observer at a number of training sessions for family based HIV/AIDS educators. Because of my status as a Westerner, many of the rural people who were being trained as HIV/AIDS educators tended to view me as an “expert” on all matters related to HIV/AIDS. This created some awkward moments for me, as I felt that my colleagues from IMAU who were the trainers were better educated about the realities of HIV/AIDS prevention and able to convey that information in a way that was sensitive to the

local context than I was. While I answered the questions to the best of my ability, I also stressed my Ugandan colleagues' expertise and encouraged people to take advantage of their "local" HIV/AIDS experts. My location as a Westerner affiliated with a project that had formerly been funded by USAID also affected my relationship with research participants and other community members. Some people felt that, as a white Westerner, I must be well resourced and connected to donor funds. While I was certainly much better situated financially than members of the communities who participated in the research, we often joked about how I was still only a student (albeit an old student).

Community members viewed my status as a student, who had never been married or had children as an anomaly. On the one hand, I was a highly educated woman in my 40s. On the other hand, because the social definition of "woman" is linked to having "produced" a child, or children, I was socially defined as a "girl." People were very curious about why I had never married or had children (although I often joked that I was 'married' to my books) and a frequent response to my unmarried, childless state was "sorry for you." My social status as a "girl" also made for some interesting discussions during and after the focus groups that were held, in part, to discuss and define key sociological concepts, such as head of household. The question debated was whether I could be head of my own household, even though I was a "girl."

Additionally, while I had learned three local languages, I was nonetheless very aware that I was a child both culturally and in terms of my ability to express complex concepts and questions linguistically. This often frustrated me and I

was grateful for my research assistant's patience and impressive skill in working with me as a translator as we teased apart the various meanings of power and empowerment as they relate to women's status and HIV/AIDS risk reduction. Community members also were very patient in answering all of my outside researcher questions about taken-for-granted aspects of every day life (such as how households and heads of households are defined, and economic and reproductive decision making processes) as well as sensitive questions related to HIV/AIDS risk and risk reduction. In some ways, because of my outsider status, it was easier for me to ask these types of questions than for my Musoga research assistant to ask them.

I conducted the fieldwork for this study in two stages over a period of 18 months in the Busoga region of eastern Uganda. The first stage (pre-dissertation) took place over seven months in 1994-95 and the second stage (dissertation) was conducted during 11 months in 1997. I carried out the research in collaboration with the Family AIDS Education and Prevention Through Imams (FAEPTI) Project of the Islamic Medical Association of Uganda (IMAU). IMAU is an indigenous non-governmental organization, which has a number of health-related programs. The FAEPTI Project trains imams (religious leaders) and community members how to be family-based AIDS educators (Family AIDS Workers). The target population of the FAEPTI Project was Muslim and the vast majority of people who participated in this research are Muslims of the Basoga ethnic group.

During both periods of research, I studied the impact of gender and economic power relations on HIV/AIDS risk and risk reduction among Muslims reached by the FAEPTI Project. The first stage of research was region-wide (i.e., throughout the three districts of Busoga), while the second stage was focused in a rural parish (a political administrative unit) within one of the districts. I used a combination of qualitative and quantitative data collection methods including focus groups, key informant and in-depth interviews, participant-observation, a parish-wide census of all Muslim households, and a household-based survey organized by risk cluster.

Organization of the Study

In this chapter, I introduced the study and my research questions. I present the conceptual/theoretical framework, review of relevant literature on gender power relations and HIV/AIDS, research questions, and risk cluster concept as an analytical tool in Chapter 2. I then move to a description of the setting of the study and research methods used in Chapter 3. Given the centrality of marital relations and other unions to the embodiment of HIV/AIDS risk for women in Sub-Saharan Africa in Chapter 4, I provide an overview of the major themes in the literature on marital relations in the region, including a discussion of the characteristics of polygynous societies. The fluidity of marital unions emerges as a major theme in this literature, i.e., the challenges to defining marital relations and other unions and the fact that monogamy and polygyny as

types of marital unions appear to be situated along a shifting continuum, rather than being fixed opposites or endpoints.

My purpose in this review is to provide a context for understanding marital relations and other unions in Uganda in general and among the Basoga Muslims who participated in the study in particular. I also include a discussion of Islam, marriage, and the status of women among the Baganda and Basoga of Uganda in Chapter 4. My focus is the similarities and differences between the way gender is done in Islam and how it is done among Baganda and Basoga Muslims. These two systems of doing gender often result in a gap between Islamic ideals and practice (i.e., Islam as filtered through culture and acted upon by Muslims at the local level).

In Chapters 5 through 8, I present the major findings of the dissertation. The framework of analysis in each of the chapters highlights how the way gender is done among the Basoga Muslims who participated in the study shapes the embodiment of risk—particularly for women in marital unions. I examine marital relations and risk in Chapter 5. Here I show that while power and empowerment are frequently identified as central to women's ability to reduce their HIV/AIDS risk, these concepts are rarely defined or contextualized. Thus, I include a discussion of the different types of power (which are highly gendered) among Basoga Muslims and focus on power, resources and risk in Chapter 6. In Chapter 7, I extend this focus to include power, sexuality and risk.

While the lens in each of these chapters is widened to include gender power relations at the household and risk cluster levels, in Chapter 8, I present

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the risk cluster level analysis of self-assessed risk, including comparisons of risk assessment between monogamous and polygynous risk clusters. There I also provide a discussion of respondents' views on polygyny as a risk factor for HIV/AIDS. My emphasis throughout Chapters 5 through 8 is on the challenges confronting women within marital unions as they attempt to reduce their HIV/AIDS risk in the face of seemingly unyielding social structural obstacles. Within this context, some women manage to exercise their agency to reduce their risk through both direct and indirect means. In Chapter 9, I summarize my major findings, discuss the contributions as well as the limitations of my research, and make suggestions for future research.

NOTES

¹ The phrase, "living with HIV/AIDS" refers to all individuals who are HIV positive, regardless of whether they have developed symptoms associated with AIDS (UNAIDS 2002).

² It should be noted that more men are living with HIV AIDS in all regions of the world, aside from Sub-Saharan Africa (UNAIDS/WHO 2000: 4).

³ For further examples of the risks posed to women by their steady male partners in Sub-Saharan Africa, see Carpenter et al. (1999) and Allen et al. (1992, 1991).

⁴ The largely rural Masaka and Rakai districts in southwestern Uganda have been especially impacted by the HIV/AIDS epidemic.

⁵ A linguistic note about the use of terms used throughout this dissertation: the first language spoken by the majority of people in the study is Lusoga, a Bantu language. In very simplified terms, Bantu languages are noun-class driven, meaning that words belong in certain noun classes and the noun classes are distinguished by prefixes, infixes, and suffixes. This means that the prefixes "lu," "bu-" and "mu-" or "ba" refer to language, place, and person or people, respectively. Thus, using "-soga" as a root, the language is Lusoga, the place (or region) is Busoga, and a person hailing from Busoga is a Musoga (plural, Basoga).

⁶ Prevalence refers to the percentage of adults who are estimated to be living with HIV/AIDS at one point in time. Incidence refers to the number of new HIV infections over a specified time period (usually one year). For a discussion of other Sub-Saharan African countries' success in reducing their prevalence rates see UNAIDS/WHO (2003).

⁷ See Hogle et al. (2002) and Greene (2003) who argue the importance of the "A" and "B" component over the "C" component of the "ABC" approach in contributing to Uganda's substantial reduction in HIV/AIDS. For a critique of the "ABC" approach see the *AIDS and Anthropology Bulletin* (Volume 15, Number 2, 2003), and the recently published (March 2004) monograph by the Center for Health and Gender Equity. See Parkhurst (2002) for a challenge to some of the claims made about the Ugandan success story.

CHAPTER 2

THE PERCEPTION AND EMBODIMENT OF HIV/AIDS RISK

Introduction

Much of the focus in HIV/AIDS research on risk and risk reduction centers on two key questions. First, how do people perceive their risk? Second, what determines whether and how people act on their risk perception? The way these questions are framed helps to determine their policy-level outcome, i.e., the scope and focus of HIV/AIDS education and prevention programs. "Research paradigms tend to define what questions will be asked and help to determine which problems will be legitimated as issues....If the dominant paradigms reflect limited perspectives, then the policy conclusions they suggest or legitimate may be ineffectual or even counterproductive" (Schoepf 1991: 749; see also Packard and Epstein 1991).

The dominant paradigm used to frame AIDS risk and risk reduction has been based in the field of public health. The hallmark of the public health approach is population-based studies of the modes of HIV transmission and factors influencing the patterns and distribution of the HIV/AIDS epidemic. Epidemiological research continues to be an important tool in delineating and tracking changing patterns of seroprevalence rates, AIDS cases, and biological and behavioral factors contributing to the spread of the epidemic.¹ It also plays a central role in efforts to reduce transmission (Whelan 1999). As discussed below, however, there are major limitations to the emphasis on risk groups—or more

recently, risk behaviors—in public health HIV/AIDS research and interventions (Gilbert and Walker 2002; Parker 2001; Schoepf 2001; Treichler 1999; Farmer, Connors, and Simmons 1996; Rhatigan et al. 1996; Epstein 1995; Hart and Boulton 1995; Rhodes 1995; Reid 1992; Wermuth, Ham, and Robbins 1992).

The major public-health HIV/AIDS risk reduction models are based on psychological and/or social-psychological principles emphasizing the determinants of individual-level risk perception and behavior change.² While posing differing mechanisms and processes leading to risk reduction these models assume that changes in attitudes and cognition result in increased preventative behaviors and “that individuals behave rationally and that certain theoretically relevant elements affect their behavior. They assume that individuals are free to choose a rational course of action and that they have the necessary resources...” to implement change (Fisher and Fisher 2000: 47; see also Rhodes 1995; Ingham, Woodcock, and Stenner 1992). Mainstream models generally do not consider gender power differentials that shape differing degrees of knowledge about HIV/AIDS, as well as social definitions of masculinity and femininity that impact attitudes and behavior, along with control over sexuality and risk (Rao Gupta 2000; Whelan 1999; Reid 1997, 1992; Rao Gupta, Weiss, and Whelan 1996).

Such models have been critiqued for their failure to recognize that individuals' attitudes, behaviors, knowledge, risk, risk perception, and ability to act on that perception are embedded within a wider matrix of social forces (Parker 2001; Schoepf 2001; Schoepf 1998; Reid 1997, 1992; Connors 1996;

Farmer, Connors, and Simmons 1996; Rao Gupta, Weiss, and Whelan 1996; Ankrah et al. 1994; Ankrah 1991; Worth 1989). While research based on individual-level studies has "...monitored the changes in risk behavior as the epidemic has progressed," they have been limited in their ability to contribute to a sociological understanding of risk and risk reduction (Hart and Bolton 1995: 56).

In restricting themselves to psychological or at best social psychological parameters of human action they have failed to take account of the social dimensions beyond membership in a "peer group." In this schema, socio-economic location, age, and ethnicity are simple descriptive variables included with others in statistical analyses rather than what they really are—shorthand terms for complex and multi-dimensional social processes and experiences (*ibid.*: 57).

Risk Groups versus Risk Behaviors: A Shift beyond the Individual Level?

Over the first two decades of the AIDS pandemic, the epidemiological gaze and discourse on who is most infected and affected has shifted from an emphasis on risk groups to risk behaviors. Many researchers argue, however, that this linguistic shift is more subtle than substantial, i.e., it still results in an overemphasis on individual behavior and behavior change. From this perspective, risk behaviors, while perhaps an improvement over the highly stigmatizing risk group concept, do not expand the scope of analysis and intervention to the broader range of social forces shaping such behavior (Rao Gupta, Weiss, and Whelan 1996; Rhatigan et al. 1996; Simmons, Farmer, and Schoepf 1996).

During the early years of the AIDS pandemic, the concept of risk groups was used to identify those at highest risk of both infection and infecting others.

The focus was on individual risk and risk reduction. The risk group framework created boundaries separating those in high-risk groups (e.g., gay men, "prostitutes," long-distance truck drivers in Sub-Saharan Africa, or injecting drug users) from the "general population." Members of high-risk groups were targeted for research and intervention with an array of consequences including stigmatization and a denial of the possibility of risk in the "general population" (Epstein 1995; Treichler 1999, 1989)

In the case of the U.S. until the early to mid 1990s, women and the heterosexual transmission of AIDS were excluded from the social and scientific construction of the epidemic. AIDS was constructed primarily as a gay male disease, with serious consequences for women.³ While this is no longer the case, the initial exclusion of women from "risk groups" contributed to a lack of research and knowledge about the clinical manifestations of HIV/AIDS in women, and meant that women were denied access to treatment and care for HIV/AIDS (Simmons, Farmer, and Schoepf 1996).⁴ It also contributed to the denial of heterosexual transmission in the U.S. and to creating a false sense of security among women that they were safe from HIV infection (Rao Gupta, Weiss, and Whelan 1996; Treichler 1989). Even when the language changed from "risk group" to "risk behavior," the fact remained that women in the U.S. (and elsewhere) who "had no known behavioral risk factors were contracting HIV..." highlighting the inadequacy of the individualistic emphasis in the conceptualization of "risk behavior" (Rao Gupta, Weiss, and Whelan 1996: 149).

Whereas women were missing from the initial construction of risk groups in the U.S., they were central to the construction of risk groups in Sub-Saharan Africa and other parts of the world where heterosexual transmission was recognized as part of the dynamics of the HIV/AIDS epidemic.⁵ In this case, however, women were dichotomized into two groups: “mothers” and “whores”, or “good women” and “bad women.” In other words, the primary focus of research and intervention was in terms of women as reproducers and transmitters of the HIV virus to children, and on “prostitutes” as “reservoirs of infection” (Carovano 1991). Aside from their status as reproducers or “as dangerous vectors,” women were not conceptualized as worthy of HIV/AIDS free health in their own right. The term “prostitute” was rarely problematized; “prostitutes” may also be wives and mothers (Booth 1998; Carovano 1991). Nor was there much recognition of the fact that in times of economic crisis more women were turning to sexual exchange as a way to support themselves and their children (Schoepf et al. 1991a, 1991b).

A few years into the epidemic in Sub-Saharan Africa, an additional “core group” was added—i.e., long distance truck drivers. AIDS in Africa was thus constructed as a disease of promiscuity spread by the “core groups” of prostitutes and long-distance truck drivers (Simmons, Farmer and Schoepf 1996; Packard and Epstein 1991).⁶ The consequences of this construction were increased scapegoating and stigmatization of “prostitutes” as responsible for the spread of AIDS. “Prostitutes” were viewed as infectors rather than infected and limited attention was paid to their risk of infection. Additionally, because of the

stigma attached to prostitutes, men reclassified their casual partners as "friends" (Simmons, Farmer and Schoepf 1996: 69-70).

The stigmatization of prostitutes and of AIDS as a disease of promiscuity reinforced barriers for women seeking treatment for AIDS or other sexually transmitted diseases (STDs). Condoms were associated with prostitutes, and women who had multiple partners "were reported to refuse condoms in order to protect their virtue, even when condom use was a possible option" (Simmons, Farmer, and Schoepf 1996: 70). Additionally, women were viewed as solely responsible for the vertical (mother-to-child) transmission of HIV. During the initial years of the epidemic, the focus on women as reproducers—or women of reproductive age—deflected attention from the need to develop education and prevention programs for adolescents (Carovano 1991).⁷ Finally, the utility of risk groups as a conceptual, epidemiological, and ultimately intervention framework was further belied by the high levels of HIV seroprevalence in women attending antenatal clinics and at blood banks—both sources of data reflect the HIV infection rate in the "general population" (McGrath et al. 1993).

The transition from "risk group" to "risk behavior" has had the unfortunate effect of reinforcing the individualistic bias in public health and behavioral science analyses of HIV/AIDS (Rhatigan et al. 1996: 241).

There is thus an enormous body of literature examining "high risk behaviors" and AIDS. AIDS interventions, accordingly, have been designed to educate or persuade individuals to choose to avoid the demonstrably risky behaviors. Such an approach...permits individual risk behaviors to be divorced from the larger social world in which such behaviors are embedded. It also tends to exaggerate the agency of the poor and poor women in particular. In epidemiology and in public health, these individualizing trends have

a common tendency to *desocialize the social* (*ibid.*: 241, emphasis in the original).

The explicit awareness of the ways that broader social, economic, political and cultural contexts shape risk is more pronounced in much recent research. For example, the most recently published global AIDS epidemic update by the United Nations AIDS Programme (2002) highlights all of these factors. Their summary of the resolutions passed by the UN General Assembly Special Session on HIV/AIDS also shows the need to address the underlying structural factors such as poverty, discrimination, underdevelopment, and women's lack of empowerment that drive the AIDS pandemic. The language of "risk groups" or "vulnerable groups" as opposed to the "wider population" persists, however, reinforcing the idea that the categories are mutually exclusive.

The next section reviews a framework that extends the analysis of HIV/AIDS beyond the individual level.

The Embodiment of Risk and Gender Power Relations

Farmer and his colleagues' notion of the "embodiment of risk" provides an alternative framework to the dominant discourse on HIV/AIDS risk and risk reduction (Farmer 1996b; Farmer, Connors, and Simmons 1996). The emphasis throughout is on the ways that gender inequality contributes to the embodiment of HIV/AIDS risk for women in developing nations, with a specific focus on Sub-Saharan Africa. While gender inequality is not the only axis of stratification affecting women's risk, "[g]ender relations enter and are constituent elements in

every aspect of human experience..." (Flax 1990: 40). Gender is thus inseparable "from other social relations of inequality" (Baylies and Burja 1995: 195). As noted by Rao Gupta (2000: 2), the imbalance of power between women and men translates into an imbalance of power in heterosexual relations. In many geo-social contexts, men's pleasure takes precedence over women's and "men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behavior, male or female, thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power."

In moving beyond individualistic models of AIDS risk and risk reduction many authors argue for the need to examine the economic, political, and sociocultural forces that shape differing degrees of risk and ability to reduce that risk (Gilbert and Walker 2002; Parker 2001; Schoepf 2001; de Bruyn et al. 1998; Bond, Kreniske, Susser, and Vincent 1997; Reid 1997; Farmer, Connors, and Simmons 1996; Hart and Boulton 1995; Rhodes 1995; Wermuth, Ham, and Robbins 1992). The concept of the "embodiment of risk" helps to reframe individualistic, decontextualized approaches to the HIV/AIDS epidemic. This concept, which is based in a political economy of risk approach, is framed by the following query: "By what mechanisms, precisely, do social forces (such as poverty, sexism, and other forms of discrimination) become embodied as personal risk? What role does inequality, per se play in HIV transmission?" (Farmer 1996b: 24).

Throughout this dissertation the focus is on what the embodiment of risk means for women, i.e., that risk is a part of the lived experience of women because of the gender power relations in which their everyday lives are embedded. These gender power relations, which more often than not translate into greater control over valued social and economic resources, sexuality, and reproduction for men than for women, structure women's risk and their ability to reduce that risk by acting on HIV/AIDS prevention messages.

The notion of the embodiment of risk is embedded in the concept of structural violence. In formulating his concept of structural violence, Galtung (1969: 168) begins by defining violence "as the cause of the differences between the potential and the actual, between what could have been and what is." Structural violence equates with social injustice and exists whenever people are disadvantaged in ways that are "avoidable." For example, structural violence is present whenever "[r]esources are unevenly distributed as when income distributions are heavily skewed, literacy/education unevenly distributed, medical services existent in some districts and for some groups only, and so on. Above all, the power to decide over the distribution of resources is unevenly distributed" (*ibid.*: 171).

Farmer defines structural violence as the ways in which social forces such as poverty, gender inequality, and racism structure risk in such a way that it becomes embodied as personal experience. In this view, for those "...occupying the bottom rung of the social ladder in inegalitarian societies," individual agency—which is assumed unfettered in the dominant paradigm of HIV/AIDS

discourse—is constrained by social structure (Farmer 1996a: 1-2).⁸ “Choices” i.e., of whether and how to act on risk perception, are shaped by multiple and intersecting axes of social structure including gender, race or ethnicity, class, and sexuality. Commenting upon theories based on rational choice models Strassmann (1993: 63) contends that,

“A theory that focuses on the choices people make assumes that individual outcomes are a consequence of those choices. Although choices are directly influenced by background circumstances and constraints, the emphasis on choice over constraints leads to a tendency to direct attention toward choice instead of toward the constraints that direct and underlie choice” (cited in Christensen 1998: 12).

In other words, both the perception and the embodiment of risk do not occur in a social vacuum. Structural violence means that one’s position within these intersecting hierarchies of social structure either amplifies or shields one from risk (Parker 2001; Schoepf 2001; Farmer 1996a, 1996b: 23; Farmer, Connors, and Simmons 1996).

Structural violence combines with women’s greater physiological vulnerability than that of men and helps to explain the dynamics and distribution of the heterosexual transmission of HIV on a global scale (Whelan 1999; de Bruyn et al. 1998; Farmer 1996a, 1996b; Farmer, Connors, and Simmons, 1996; Simmons, Farmer, and Schoepf 1996; Doyal 1994).⁹ In the next section, the physiological factors that put women at greater risk of HIV infection than men are briefly reviewed.

Physiological Vulnerability¹⁰

Women are at greater physiological risk to HIV infection during unprotected sex for four primary reasons. First, "the male deposits several millilitres of potentially infectious semen over the surface of his partner's vagina, where it is likely to remain for some time" (Doyal 1994: 13). In other words, HIV transmission is more efficient from man-to-woman than the reverse.¹¹ Second, women's reproductive anatomy and physiology increases their risk of infection. The vagina and cervix provide a broad surface area for infection and ensure longer exposure to HIV as well as other STDs. Additionally, the mucosal lining of the vagina is more permeable than the surface of the penis; microscopic tears in the reproductive tract lining occurring during vaginal sex can act as portals for the virus. Moreover, cervical cells and the lining of the genital tract are "immature" and especially fragile in young women, further increasing their risk of infection (Campbell 1999: 19-20).¹² Third, along with HIV, other STDs are more efficiently transmitted from men-to-women than the reverse.¹³ Women are more likely to have asymptomatic, undiagnosed STDs, which facilitate HIV infection, thus increasing their risk (Campbell 1999; de Bruyn et al. 1998; Simmons, Farmer, and Schoepf 1996; Doyal 1994).¹⁴ Finally, women in Sub-Saharan Africa (as well as other developing countries) "are more likely to receive transfusions of blood or blood products as a result of anemia and blood loss during labor, miscarriage and induced abortion, and are therefore more likely to acquire HIV through transfusions of infected blood" (Elias 1991 cited in Rao Gupta, Weiss and Whelan 1996: 149).

Women's physiological vulnerability to HIV infection is only one aspect of their increased risk. Differences in gender power relations help to structure differences in knowledge, attitudes and behaviors that affect individuals' risk (Rao Gupta 2000; PANOS/Zed 1999; Rivers and Aggleton 1999; Whelan 1999; Rao Gupta, Weiss, and Whelan 1996; Mbizvo and Bassett 1996). They also create differing degrees of access to and control of valued social and economic resources and participation in the paid economy. All of these factors combine to give men greater control over sexuality and, by extension, limit women's ability to reduce their risk of HIV/AIDS. Because of this imbalance in gender power relations, the major AIDS prevention messages have little relevance to women's everyday experiences (Rao Gupta 2000; Whelan 1999; Schoepf 1998; Reid 1997, 1992; Farmer, Connors, and Simmons 1996; Campbell 1995; Bassett and Mhloyi 1991; Carovano 1991; Schoepf et al. 1991a, 1991b; Bledsoe 1990). In the following sections, each of these issues is addressed to show how gender power relations influence HIV/AIDS risk and risk reduction.

Differences in Levels of Knowledge, Attitudes, and Behaviors

The concept of "doing gender" (West and Zimmerman 1991) provides an additional and complimentary framework to the embodiment of risk for understanding how gender power relations influence HIV/AIDS risk and risk reduction.

Doing gender involves a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine 'natures.... Rather than as a property of individuals...gender [is] an emergent

feature of social situations: as both an outcome of and a rationale for various social arrangements and as a means of legitimating one of the most fundamental divisions of society (*ibid.*: 14).

In other words, “doing gender” involves the social construction of differences “between girls and boys and women and men, differences that are not natural, essential or biological. Once the differences have been constructed, they are used to reinforce the ‘essentialness’ of gender.” The consequences of doing gender shape “the allocation of power and resources not only in the domestic, economic, and political domains but also in the broad arena of interpersonal relations” (*ibid.*: 24 and 32).

“Doing gender” serves to produce and reproduce the social system and allocation of power and resources:

... If we do gender appropriately, we simultaneously sustain, reproduce, and render legitimate the institutional arrangements that are based on sex category. If we fail to do gender appropriately, we as individuals—not the institutional arrangements—may be called into account (for our character, motives, and predispositions)....

... The sex category/gender relationship links the institutional and interactional levels, a coupling that legitimates social arrangements based on sex category and reproduces their asymmetry in face-to-face interaction. Doing gender furnishes the interactional scaffolding of social structure, along with the built-in mechanism of social control. In appreciating the institutional forces that maintain distinctions between women and men, we must not lose sight of the interactional validation of those distinctions that confers upon them their sense of ‘naturalness’ and ‘rightness’ (*ibid.*: 33).¹⁵

Norms of femininity and masculinity shape socially expected and accepted levels of knowledge, attitudes, and behaviors regarding sexuality, reproduction, AIDS, and other STDs. These norms often dictate what amounts to a double standard for women and men. In many societies, ideals of femininity stress that

women should not be knowledgeable about their bodies, sexuality, reproduction, and STDs. For women to possess and call upon such knowledge is considered a sign of diminished virtue. Women are expected to be virgins at marriage and to remain faithful throughout their marriages. In contrast, men are expected to be more knowledgeable about these matters, are not expected to be sexually inexperienced or mutually monogamous, and are expected to take control of sexual decision-making (Rao Gupta 2000; Whelan 1999; Rivers and Aggleton 1999; de Bruyn et al. 1998; Rao Gupta, Weiss, and Whelan 1996).

Because of a lack of information about the signs and symptoms of AIDS or other STDs, women are less likely than men to seek treatment. The stigma attached to seeking treatment for STDs also plays a significant role in whether women are treated for them (Rao Gupta 2000; Whelan 1999; de Bruyn et al. 1998; Rao Gupta, Weiss, and Whelan 1996). Lack of knowledge about how to treat STDs can contribute to an incomplete course of self-medication with antibiotics. This, in turn, often leads to further problems, since many people stop using antibiotics once symptoms disappear (Caraël 1994).

STDs that remain undiagnosed and untreated over a long period can contribute to infertility in women.¹⁶ In many parts of Africa, women's social status is linked to their ability to produce children. "Childless women may seek out various sexual partners in an effort to become pregnant" (de Bruyn 1992: 251). Women who are assumed sterile are at risk for their husbands' bringing another wife into the family. In a study of polygynists and their wives in five Sub-Saharan African countries (Uganda, Kenya, Ghana, Senegal, and Zambia) Timæus and

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Reynar (1998: 156) found that husbands married to childless women were about twice as likely to be polygynists as those married to women who had produced children. Similarly, women who are childless may either be forced out of or leave their present marriages. They often remarry quickly into polygynous unions as junior wives (Timæus and Reynar 1998). Finally, if a childless woman is unable to remarry, she may have to resort to exchanging sex for money in order to survive, thereby increasing her risk of exposure to HIV (de Bruyn 1992: 251).

The construction of "good women" as ignorant about matters related to sexuality and expectations that they will yield to male authority in sexual interactions contributes to their risk. The "culture of silence" (Rao Gupta 2000) whereby women are not expected to be knowledgeable about their bodies or sexuality and the stigma attached to seeking out such knowledge creates barriers to women getting the type of information that they need in order to reduce their risk. This is especially true for young women, who are expected to be virgins at marriage in many societies. Many young women are afraid that by asking for information about sex, they will be accused of being sexually active. Similarly, many adults resist making such information available to young women because of fears that it will encourage them to be sexually active (Rao Gupta 2000; Weiss, Whelan, and Rao Gupta 2000; Whelan 1999; de Bruyn et al. 1998; Rao Gupta Weiss, and Whelan 1996).

The emphasis on virginity, barriers faced by young women in accessing information, and their disadvantaged position within hierarchical social structures are of special concern for several reasons. First, in many Sub-Saharan African

countries the HIV prevalence rate among the 15-24 year old cohort is as much as three times higher in women than in men of the same age (MAP 2000). While intensive and multisectoral HIV/AIDS education and prevention campaigns have contributed to a dramatic decline in the overall adult (15-49) HIV prevalence rate in Uganda, women in the 15-19 year old age group continue to be four to six times more infected and affected than men of the same age (Uganda AIDS Commission 2001.)

One of the reasons for this is that older men are having sex with younger women. In areas with high rates of HIV, older men seek out younger women as sexual partners thinking that they will be HIV negative because they are virgins. Young women may find it difficult to resist pressures to have sex in exchange for money or gifts because of their socioeconomically disadvantaged position (Stewart 2000; Weiss, Whelan, and Rao Gupta 2000; Whelan 1999; de Bruyn et al. 1998; Rao Gupta, Weiss, and Whelan 1996). Other studies have shown that some men seek out virgins thinking that sex with a virgin will cure them of HIV or STDs (Whelan 1999). Second, the pressure to remain virgins combined with a lack of knowledge about safer sexual practices means that adolescent women may engage in sexual practices that increase their risk such as anal sex (Vasconcelos et al. 1995; Bezmalinovic et al. 1994, cited in Weiss, Whelan, and Rao Gupta 2000: 4).¹⁷

Finally, in many parts of Sub-Saharan Africa women marry at early ages and often marry men who are several years older than themselves (Adepoju and Mbugua 1995; Berkley 1994; Bledsoe and Pison 1994; Bledsoe 1990;

Lesthaeghe, Kaufman, and Meekers 1989). Such a practice has the potential to increase young women's risk if they marry older men who have had unprotected sex with several partners (MAP 2000). Large age gaps between spouses may also reinforce men's greater control over issues related to sexuality and reproduction, and by extension, may make it even more difficult for younger wives to negotiate a reduction in their HIV risk (Luke and Kurz 2002; Becker and Costenbader 2001; Caraël 1988, in Carballo and Kenya 1994: 501;).

In addition to the physiological vulnerability of young women discussed above,

The risk of exposure to an HIV infected partner at a young age depends on the age of sexual debut, the number of partners, and the likelihood that those partners are infected. Reported age at first sex [in Africa] is similar for men and women, and even at young ages men generally report higher numbers of partners than do women. Since HIV prevalence increases with age, the tendency of young women to have older partners both within and outside marriage may increase their exposure to HIV-infected partners...[in one study], the older a woman's most recent sexual partner, the more likely she was to be infected with HIV (MAP 2000: 4).

Gendered differences in expectations about appropriate knowledge, attitudes, and behavior also create obstacles for women suggesting condom use as a risk reduction measure. "Good women" are not expected to know about or suggest condom use, for to do so is to open one up to accusations of mistrust and infidelity (Carovano 1991). The dilemmas that women face in implementing condom use as an AIDS prevention measure are discussed detail below.

The social construction of masculinity and femininity that gives men more power and control contributes to the likelihood that women may be forced to have

sex against their will. Violence against women is associated with sexual coercion, unprotected sex, and obvious risks to women's health and well-being, including an increased risk of HIV infection (Rao Gupta 2000; Whelan 1999).

Analyses of the determinants of gender-specific violence have concluded that the situational factors that provoke violence against women are vast. They include: male dominance and histories of family violence; male control of family wealth; divorce restrictions on women; verbal marital conflict; heavy alcohol consumption; economic stress and unemployment; isolation of women and the family from community support; delinquent peer associations; notions of masculinity linked to toughness and honour; rigid gender roles; a sense of male entitlement and ownership of women; approval of physical chastisement of women; and a cultural ethos that violence is a valid means of solving interpersonal disputes (Schuler et al. 1996; Heise, forthcoming, cited in Whelan 1999: 11).

A study in Dar es Salaam, Tanzania suggests that violence may be a predictor of HIV infection for some women. Women attending a voluntary testing and counseling center who were "HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship as those who were [HIV] negative" (Rao Gupta 2000). The threat or fear of physical violence also acts as an obstacle toward women broaching the subject of HIV risk reduction with their male partners (*ibid.*; Whelan 1999).

Until fairly recently, most of the data collected on AIDS in Africa came from women attending antenatal clinics and studies of female sex workers. The focus on women—in their roles as reproducers and targeted "vectors" of the AIDS epidemic—follows the general pattern of focusing on women in reproductive health and sexuality. One of the major negative consequences of this approach is that it reinforces stereotypes at the community level that STDs

are women's diseases. Additionally, it reinforces the idea that fertility control and infertility are women's problems (Mbizvo and Bassett 1996). The emphasis on women in AIDS prevention ignores men's role in sexual decision-making, buttresses the belief that it is only women who are responsible for safer sex, and lifts the burden for AIDS prevention from men's shoulders. Moreover, it relies on women to change men's behavior (Campbell 1995: 198). Given the gender-power differentials that give men more control over sexuality, reproduction, and risk, an increasing number of studies have begun to focus on the need to include men in both research and interventions (Rao Gupta 2000; Panos/Zed 1999; Rivers and Aggleton 1999; Reid 1997, 1992; Mbizvo and Bassett 1996).

Control of Valued Social and Economic Resources, Sexuality, and Risk

"Interpersonal sexual scripts are played out in the context of hierarchical social structures in which some people have the power to determine the sexual and reproductive lives of others" (Dixon-Mueller 1993: 279). Men's greater control over sexuality and reproduction (and by implication, HIV/AIDS risk) is linked to gender inequality that gives men greater access to and control over valued social and economic resources than women in many societies (Rao Gupta 2000; Whelan 1999; de Bruyn et al. 1998; Schoepf 1998; Farmer Connors, and Simmons 1996; Baylies and Burja 1995; Mason 1994; Ankrah et al. 1994; Dixon-Mueller 1993; Kirumira et al. 1993; de Bruyn 1992; Standing 1992; Ulin 1992; Ankrah 1991; Kisekka 1990). In developing countries, women comprise the majority of the poor. They have low levels of education and high

levels of illiteracy, are more likely to be denied property and inheritance rights, and have less access to training and credit (UNIFEM 2000; Riley 1997).

Additionally, compared to men, women in developing countries have lower rates of participation in the paid work force, are paid less when they work outside the home, often work in unregulated employment in poor working conditions, and experience high levels of job insecurity. Gender inequality also means that women may not fully control the income that they earn from their work in the formal or informal economy (UNIFEM 2000; Riley 1997).¹⁸ These conditions translate into women's social and economic vulnerability and dependence on men, which severely limits the extent of their control over sexuality, reproduction, and risk for HIV/AIDS and other STDs (Rao Gupta 2000; Whelan 1999; de Bruyn et al. 1998; Schoepf 1998; Reid 1997, 1992; Farmer, Connors, and Simmons 1996; Mason 1994; Ankrah et al. 1994; Dixon-Mueller 1993; Kirumira et al. 1993; de Bruyn 1992; Mann and Tarantola 1992; Standing 1992; Ulin 1992; Ankrah 1991; Kisseka 1990).

"Individual" decisions about AIDS risk reduction are shaped by the broader social, economic, political, and cultural contexts in which such decisions are embedded. The primary AIDS risk reduction messages of (1) abstinence; (2) mutual monogamy; (3) consistent and correct condom use; (4) partner reduction; and (5) treatment for STDs are of little relevance to the everyday experiences of women who have limited control over their sexuality, reproduction, and risk (Rao Gupta, Weiss, and Whelan 1996; see also Reid 1997, 1992; Campbell 1995; Bledsoe 1990). Sexual double standards that provide fewer sanctions for male

infidelity and multiple partnerships and limit women's control over their sexuality make it difficult for women to suggest, much less insist upon, their husband's or steady male partner's mutual monogamy and/or partner reduction (de Bruyn et al. 1998; Rao Gupta, Weiss, and Whelan 1996; Mason 1994; Ankrah et al. 1994; Kirumira et al. 1993).

Where many women gain access to valued resources through men and where women are defined primarily in terms of their reproductive capacity (as in Sub-Saharan Africa), their social and economic security is tied to producing children. Condoms are a male-controlled method of AIDS/STD prevention that also prevents contraception. This may create a potential dilemma for women who want to reduce their AIDS risk and also bear children. Due, in part, to their association with AIDS/STD prevention, condoms are generally viewed as used with outside partners rather than within a marriage or stable relationship. For women (or men) to suggest their use is to raise the possibility of accusations of mistrust and infidelity. Women assess a wide range of risks related to acting on AIDS prevention messages, including the possibility of violence, as well as being socially and economically dispossessed if they attempt to negotiate a reduction in their HIV risk. Many women decide that the potential risks to their health do not outweigh the other negative consequences (Rao Gupta 2000; Weiss, Whelan, and Rao Gupta 2000; Whelan 1999; Reid 1997, 1992; Cohen and Trussell 1996; Farmer 1996a, 1996b; Farmer, Connors, and Simmons 1996; Simmons, Farmer, and Schoepf 1996; Wallman 1996; Lamptey and Coates 1994; Obbo 1993; de Bruyn 1992; Larson 1992, 1990; Standing 1992; Ankrah 1991; Bassett and

Mhloyi 1991; Carovano 1991; Schoepf et al. 1991a, 1991b). "For many women, faced with divorce or dire poverty on one hand and the risk of HIV infection on the other, the choice becomes one of 'social death' or 'biological death'" (Bassett and Mhloyi 1991: 146).

Even when women take steps to reduce their own risk by, for example, staying faithful, they are still at risk of HIV infection. The majority of HIV positive women in Africa (an estimated 60-70% in 1990) have had only one lifetime sexual partner (Reid 1997). Most HIV positive women in Sub-Saharan Africa—as throughout the world—were infected by their husbands or steady male partners (O'Leary 2000). Thus, a woman's decision to be monogamous (or faithful to her partner) does not necessarily shield her from the risk of HIV infection. While polygyny in itself is not a risk if everyone stays within the polygynous union, if one or more spouses have unprotected sex with outside partners, it may increase the risk for everyone. Marriage thus needs to be recognized as a significant risk factor for women in many societies (de Bruyn et al. 1998: 14).

Married women attribute at least part of their risk perception to their marital status and their lack of control over their husband's behavior (Bernardi 2002; Baingana et al. 1995; Caldwell et al. 1994; McGrath et al. 1993). A World Health Organization/Global Programme on AIDS study showed that marital status is related to perceived risk for women, but not for men (Cohen and Trussell 1996: 139). For example, McGrath et al. evaluated the applicability of the AIDS Risk Reduction Model (ARRM) in Kampala, Uganda with HIV positive

and negative Baganda women (McGrath et al. 1993).¹⁹ The ARRM consists of three stages leading to behavior change: "(1) the presence of variables supporting change, (2) a decision to change and (3) taking action" (*ibid.*: 435).

Variables supporting change include "perception of the morbid event as problematic; perception of associated behaviors as problematic; knowledge of behaviors involved in disease transmission; perceived susceptibility; perceived norms; and adverse emotional status associated with problem behavior." The second stage of the ARRM, "decision to change behavior," involves an assessment of the perceived costs and benefits of low as opposed to high risk behaviors; an assessment of perceived norms; and skills and self-efficacy. The third and final stage, "taking action," involves "help-seeking behavior; skills in healthful sexual behavior; sexual communication skills; and perceived norms" (*ibid.*: 435).

Sociocultural norms dictate that women are to remain faithful, and women's infidelity is a frequent cause of husbands leaving their wives, although the reverse is less common. Women who are unfaithful risk divorce, domestic violence, and economic disenfranchisement. Despite these sanctions, however, the AIDS risk reduction message of mutual monogamy runs up against both the sexual double standard and the economic realities of women's lives (*ibid.*).

McGrath et al. highlight the intricate connection between the perception and embodiment of risk. Models that overemphasize individual behavior fail to account for multiple sociocultural and structural forces—such as gender relations and economic inequality—shaping "individual" decisions about HIV risk and risk

reduction. The authors contend that focusing on empowering women with knowledge to reduce their risk is inadequate. Their research demonstrates that women perceive themselves to be at risk even after taking steps that are within their control to reduce risk. McGrath et al. call for expanding the focus of AIDS research and interventions to include men and developing programs “to promote better sexual communication, faithful sexual unions, and increased sexual decision making powers for women” (*ibid.*: 436).

The findings and recommendations of McGrath et al. about the impact of women's lack of control over their own as well as their male partner's sexuality are a definite improvement over individualistic and decontextualized AIDS risk reduction research. Nearly 40 percent (38%-39%) of the women in their study were in polygynous unions (higher than the national rate for urban Ugandan women of 31%) (*ibid.*: 433). Uganda's national rate of women in polygynous unions places it within what Ekeh (1997: 4-5) defines as a “high polygyny regime” (20% or more of all currently married women in polygynous unions).²⁰ The high percentage of women in polygynous unions highlights an interesting absence in McGrath and her colleagues' research: that is, are women, in addition to being concerned about the influence of their male partner's behavior on their HIV risk also concerned about the behavior of their co-wife/ves. The possible influence of co-wives on the perception and embodiment of HIV risk is a sizable knowledge gap in HIV/AIDS research in Sub-Saharan Africa, which has the highest polygyny rates in the world.

Multiple Partnerships and HIV/AIDS Risk

The relationship between multiple partners, unprotected sex, and HIV risk is well established (O'Leary 2000; Whelan 1999). Much of the focus on multiple partnerships—as extrapolated into sexual networks—has focused on the risks involved when the network involves “prostitutes.” “Prostitutes” are framed as part of what are called “core groups” of transmitters, in epidemiological parlance.²¹ The point often raised is that it is not so much the absolute number of partners in the network as the characteristics of the partners involved that defines the risk (Berkley 1994: 481; see also UNAIDS 1998; Caldwell et al. 1994).

[I]t is the selection of partners, not the absolute number, that affects the risk for acquiring the virus. Each new sexual contact carries with it a risk that depends on the aggregate of the sexual experience of all previous partners. An increase in the number of sexual partners overall, then, will increase the risk of acquiring HIV as one increases the risk of encountering an infected partner. For an individual, however, the slope of the increasing risk will change based on the society and the type of sexual partner chosen. Therefore, the number of sexual partners is only a crude approximation of the true risk of an individual's sexual behavior. The sexual network defines the risk (Berkley 1994: 481).

The relationship between polygyny as a form of multiple partnership and sexual networking and HIV risk is, however, highly complex. If all partners stay within a polygynous union, everyone remains at low risk. For example, a polygynous man who is married to three wives, all of who stay within the union is at less risk than a monogamous man who makes regular visits to a “prostitute.” Here again, the focus is on “prostitutes” as “high frequency transmitters” because of their contact with a large number of sexual partners and the risk that they will infect the “general population.” Berkley makes this observation within the context

of suggesting that the most cost-effective AIDS prevention interventions are better targeted at "prostitutes" as a core group than the "general population" (*ibid.*: 481).

The cordoning off of "risk groups" from the "general population" in the social and epidemiological imagination comes with a number of negative consequences. As increasing numbers of women are trading sex for money or material goods in order to survive during economic crises, the "boundary" encircling the "general population" becomes increasingly blurred (Schoepf 2001; Farmer 1996a, 1996b; Simmons, Farmer, and Schoepf 1996; Standing 1992; Schoepf 1991; Schoepf et al. 1991a, 1991b). "Prostitutes" are set in opposition to "wives and mothers," a dichotomization based on the assumption of mutual exclusivity, which "...invisibilizes most women at risk. Most women, including those who sell sex, may become pregnant someday but a significant number will not. Some women may at times exchange sex for financial security, material goods, or specific services—including support for their children. Many women who sell sex do not identify themselves as prostitutes" (Booth 1998: 130).

Additionally, casting prostitutes as core transmitters makes no mention of the possibility of them being infected by their clients. This elision of men as infectors as well as infected, obscures their role and responsibility for the heterosexual transmission of HIV (*ibid.*: 130). In this regard, Caraël (1994: 261) acknowledges that,

[t]he definitions of prostitution that we commonly employ obscure numerous problems in the African context. Under this rubric are grouped specific practices, which do not necessarily bear the same meaning from one culture to another. And the concepts of

sexuality, sexual relations, and sexual partners are themselves relatively culturally specific, as are the exchange networks, the relationships between clients and prostitutes, and the place that they occupy in the sum total of sexual exchange.

Despite the problems with the definition of prostitute and lack of conceptual clarity in much of the research on the subject, Caraël argues that studies show that, “in Africa, relationships with prostitutes play a central role in the spread of STDs in urban areas: 30-50 per cent of prostitutes are infected with a sexually transmitted disease at any given time, with clients infecting other prostitutes and other sexual partners” (*ibid.*: 261; see also Carballo and Kenya 1994: 506-507).

In general, the sexual double standard that socially sanctions and validates men having multiple partners—whether through formal or informal polygyny—while expecting women to remain faithful, contributes to STD transmission. This is especially true in urban areas, but it is not the “urban situations” that increase the transmission of STDs.

Rather, inequalities in male and female sexual behavior—particularly the double standard in urban areas where men may accumulate sexual partners as a sign of status or most notably as a transgression of traditional control of their sexuality in rural areas, while women are expected to be faithful to one partner—appear to comprise a social structure that is particularly susceptible to the AIDS epidemic (Caraël 1994: 270).

Based on a study of HIV positive and negative couples in Kigali, Rwanda in 1986, Caraël (*ibid.*: 269) suggests that, “[p]olygyny apparently intensified two [HIV] risk factors: the man’s accumulation of several sexual partners and the woman’s likelihood of having been in other unions.” Women in the HIV positive

couples reported "more episodes of STDs" than those in HIV negative couples (47.6% as opposed to 11.3%). As with other studies cited above, however, "the risk factors for HIV infection in the unions were principally those related to male sexual behaviour." The greater likelihood of women in polygynous unions having been in other unions is related to the pattern of women in polygynous societies remarrying after divorce or widowhood, which increases their number of lifetime sexual partners. Men's accumulation of several sexual partners may be linked to the gap between men's age at first sex and age at first marriage in polygynous societies. Gender norms and ideals of masculinity sanction men's sexual activity before marriage. Thus, the delay between first sex and first marriage means that men may have multiple partners before marriage (Caraël et al. 1988, cited in Carballo and Kenya 1994: 501). Men's delay in marrying is linked to the fact that it is generally older and wealthier men who can afford to marry. This increases the likelihood that younger men will have several sexual partners before they marry and they will bring that sexual history with them to their marriages (Berkley 1994).

Based on extensive research with the Yoruba of southwestern Nigeria and comparisons with other ethnographic data, the Orubuloye and the Caldwells (1994a, 1994b, 1994c, 1991) and their colleagues (Caldwell et al. 1994; Caldwell, Caldwell, and Quiggin 1994; Caldwell, Caldwell, and Orubuloye 1992) have explored the relationship between forms of marriage, women's control over their sexuality, and risk for STDs, including AIDS. Their work on what they term an "African sexual system embracing sexuality, marriage, and much else"

(Caldwell, Caldwell, and Quiggin 1994: 131) is frequently cited in discussions of sexual networking and HIV/AIDS in Sub-Saharan Africa. Their formulation of the African sexual system has, however, also been severely criticized for its overreaching generalizations and serious methodological and data quality flaws (see Mfunne 1999; Heald 1995; Ahlberg 1994; LeBlanc, Meintel and Piche 1991; Turshen 1991). Among the points that have been most harshly critiqued are Orubuloye and the Caldwells' contention that, polygyny, along with the lineage structure contributes to a "weak emotional and economic conjugal bond." Additionally, they argue that the African sexual system is predicated upon both a lack of control of female sexuality and a limited moral value placed on sexual activity itself (Heald 1995).

While Orubuloye and the Caldwells (and their colleagues) do tend to over generalize based upon the limitations of both their own data and the other ethnographic data that they draw upon, parts of their arguments are useful.²² Particularly germane to this study is their formulation of polygyny as a form of multiple partnership and sexual network. What follows is a brief summary of some of their relevant findings that are specific to their work with the Yoruba (rather than generalized to all of Africa) regarding the relationship between marriage form and STDs as well as AIDS risk and risk reduction.

Caldwell et al. (1994: 245) note that,

[p]olygyny presents no greater danger of STDs or AIDS to polygynists, and in fact, probably gives some protection. However, at the level of the whole society, it undoubtedly is a major factor in placing that society at greater risk of coitally-related diseases because of the necessity for males to marry later and because of the message that they sexually need many women.



Additionally, in many Sub-Saharan African societies women are permitted—and in fact sanctioned—to abstain from sex during pregnancy and for an often-extended period after delivery. Prolonged periods of post-partum abstinence common among the Yoruba mean that at any given time, 67 percent of men in monogamous unions and 58 percent of all currently married men have “no sexually available wife.” Further, men’s delay in marrying means that 42 percent of men aged 17 and above are single at any point in time (Caldwell, Caldwell, and Orubuloye 1992: 390-391). The long period of post-partum abstinence contributes to husbands having extramarital affairs. While husbands in monogamous and polygynous unions both reported outside partners, those in monogamous unions reported more liaisons than polygynously married men (Orubuloye, Caldwell, and Caldwell 1994a: 81).

Orubuloye and the Caldwells also document other instances in which a Yoruba woman is permitted to refuse sex with her partner. In cases where the male partner is known to be infected with HIV or another STD, women are entitled to refuse sex until they have undergone treatment (*ibid.*: 81). The ability of Yoruba women to refuse sex under these circumstances, however, is conditioned by several factors

They can exercise this right because of the leverage they possess from the instability of Yoruba marriages, from the fact that nearly all earn incomes, and because they and their children will be received back into their family of origin. They can also exercise it because they have a traditional duty to refuse sex at times of impurity or disability such as during menses or in the post-partum condition and it is easily accepted by partners and by the community that STDs can be classified in this way (*ibid.*: 81-82).

As noted by Orubuloye and the Caldwells (*ibid.*: 86), the conditions under which Yoruba women can refuse sex or demand safe sex or abstinence when they know that their male partner is infected with HIV or other STDs may apply to much of the rest of "coastal West Africa." These conditions do not prevail, however, in east and southern Africa. In these regions, women do not generally have the same extent of economic independence and autonomy as Yoruba women (who are well known as independent traders). Additionally, differences in women's ability to leave their marriages when they feel they are at risk from their partner are linked to differences in the lineage systems in eastern and southern Africa as compared to those in West Africa. In West African lineage systems, women do not break with their families of origin when they marry.

It is this which gives them the unchallengeable right to return "home" from an unsatisfactory marriage and secure access to land, which allows them to become independent market women and also keep much of the product from their farming and sell it, to keep and control their own savings, to suffer no loss of face when they leave a marriage for their parents' or brothers' houses, and to weaken any claim by their ex-husbands or their husbands' relatives on the custody of their children. This is a vast array of resources which make their situation very different from women elsewhere in Africa (*ibid.*: 86).

West African women may not be able to take advantage of these resources, however, since most women in the study were unaware that their husbands or steady male partners had STDs or were infected with HIV (*ibid.*: 87). Whether women are in monogamous or polygynous unions, if wives repeatedly refuse to have sex with their husbands at other than the culturally proscribed times, it may lead to the dissolution of their marriages or to their husbands

seeking sex elsewhere. If it is a polygynous union, husbands may turn to other wives. If it is a monogamous union, the husband may bring in additional wives. In either type of union, the husband may turn to extramarital partners for sex (*ibid.*: 80).

Approximately 50 percent of the Yoruba men in this study and two-thirds of all women supported the idea that sexual relations should be confined to marriage. Both groups were asked about reasons why they take outside partners. For rural women, the most frequently mentioned reason was for financial assistance. Some rural women also mentioned getting outside partners to meet their sexual needs during long periods of separation from their husbands or if they were younger wives in polygynous unions. Fifty percent of urban women respondents mentioned sexual enjoyment as a reason for having outside partners, and some women also mentioned material assistance as well as revenge on a wayward husband. The majority of women identified fear about the dissolution of their marriages as a brake on having extramarital affairs, while 25% of both rural and urban women identified fear of STDs as a reason for remaining faithful. Men cited culturally prescribed abstinence during and after their wives' pregnancies as a reason for having outside partners, along with "the need to have fun and assuage their sexual urges at other times. Some add the need for sex when their wives are away (Orubuloye, Caldwell, and Caldwell 1994b: 22).

As Caraël (1994: 255) notes: "Different kinds of unions, with their associated obligations and expectations for partners and their families affect the range of sexual behaviors that occur before and outside the union: elements that

are important for understanding sexual behaviour overall and the prevalence of STDs [including AIDS].... The complexities of conjugal partnerships are crucial to our present understanding of STD transmission." Moreover, unions are likely to take a variety of forms that are not necessarily captured in the narrow dichotomy of married/unmarried. Especially in urban settings, "a man who has a customary marriage in a rural setting, cohabits in the city with a regular partner, and sometimes stays with more casual partners will be classified simply as 'married'".

Additionally, inter- and intra-household relations between co-wives may affect their reproductive decisions and, by extension, their HIV/AIDS risk. Because women in polygynous unions gain access to their shared husband's resources through bearing children, they may compete with each other in childbearing. Thus in polygynous unions, wives' reproductive decisions are not necessarily limited to the dyad of wife/husband, but may also be influenced by their co-wife/ves' behavior (Meekers and Nadra 1995; Bledsoe 1993; Wittrup 1990; Garenne and van de Walle 1989; Ware 1979). Within this context, wives may bear children, even though they are concerned about their husband's behavior (Ankrah et al. 1994: 537). Wives in polygynous unions who feel neglected by their husbands "may seek compensation elsewhere" (Schoepf et al. 1991b: 216).

HIV/AIDS research in Sub-Saharan Africa shows that wives' assessment of their HIV/AIDS risk is influenced by concerns over their husband's behavior (Bernardi 2002; Cohen and Trussell 1996; Baingana et al. 1995; Caldwell et al. 1994; McGrath et al. 1993). It is reasonable to ask if wives in polygynous

unions—whether formal or informal—also consider the role of their co-wives' behavior in their assessment of HIV/AIDS. To explore this, it is necessary to evaluate data from each husband and his wife or wives (whether in separate or linked households) at a level beyond individuals or couples. In the next section, a conceptual framework is posed for moving beyond the level of individuals, or "couples" in areas with a high incidence of polygyny to explore how gender inequality affects views on polygyny and self-assessed HIV/AIDS risk at the "risk cluster level." (i.e., matched husbands and wives within the same or linked households).

The Risk Cluster Concept as an Analytical Tool

Many scholars argue that it is the household—and not the "family"—that is the appropriate unit of analysis for research in Sub-Saharan Africa. Households are the basic unit of production and consumption in rural Sub-Saharan Africa (Adegboyega, Ntozi, and Ssekamatte-Ssebuliba 1997; Ocholla-Ayayo 1997; Jiggins 1989). Household dynamics, including the division of labor, as well as the access to, distribution, and control of resources are all profoundly impacted by gender relations (Elson 1992; Wolf 1990; Dwyer and Bruce 1988). Because of gender power dynamics within households and the societies in which they are embedded, individuals within households are not all on equal footing (Cloud 1994; Peterson 1994; Wolf 1990; Dwyer and Bruce 1988). Households are characterized by relations of both conflict and cooperation between interdependent members with differing interests, degrees of power, and access

to and control of social and material resources (Elson 1992; Kabeer 1991).

Given the centrality of households—whether linked or separate—there is a need to widen the framework used in conducting research with married people in Sub-Saharan Africa to explore relationships that may affect HIV/AIDS risk and risk reduction at the household level.

The notion of risk cluster emerged out of the analysis of data produced by both the pre-dissertation and dissertation research.²³ In analyzing data from individuals in marital unions, “risk cluster” refers to inter- and intra-household dynamics related to HIV/AIDS risk and risk reduction in a population with a high rate of polygyny. The concept attempts to move beyond an individual level of analysis or comparisons of women and men, to an analysis comparing matched husbands and wives’ responses, whether within households in a single physical space or living in physically separate, yet linked households. A linked household is one in which a polygynous husband has wives in more than one location. At times, a husband may have all of his wives one compound (or house). Other times, they may be located in separate compounds. If wives are in separate compounds or households, the husband typically moves between his households, with most husbands trying to maintain the ideal of an equal number of nights with each wife (although this is not always the case). Thus, a risk cluster consists of all married individuals linked through the male spouse, whether living in the same compound or physically separate compounds.

Models used to analyze inter- and intra-household dynamics based upon a monogamous model may not be appropriate to the study of polygynous

household dynamics. In commenting upon differences in decision-making between monogamous and polygynous households in Tanzania, Omari (1993a: 219) concludes that the “processes of bargaining, influence, and conflict [within polygynous marriages] have characteristics that are not well explored by models developed to study monogamous couples.” Specifically pertinent to the concept of risk cluster is his observation that “[t]he need to balance the interests of several wives and their children and to integrate these into the affairs of the homestead as a whole requires specific skills and processes of negotiation while tension and jealousy between wives, and possible favoritism by the husband produce different patterns of interaction than in a monogamous relationship” (*ibid.*: 211). Additionally, the observation noted above of women being at risk of new wives coming into the family is important within the context of the HIV/AIDS epidemic. It lends weight to the notion of analyzing perceptions of risk within a population with a high rate of polygyny at the risk cluster level rather than strictly at the level of individuals or “couples.”

Research Questions

The central research question of this study is, how does gender inequality shape the embodiment—or lived experience—of risk in this population, particularly for women within marital unions. In other words, how do differences in the control over valued social and economic resources, sexuality, and reproduction affect differences in wives’ and husbands’ perception of HIV/AIDS risk and ability to reduce that risk. Specifically: are there differences in how

matched wives and husbands in monogamous and polygynous risk clusters
assess their HIV/AIDS risk and their reasons for that risk?

Chapter 3 presents the methods used to develop the data to answer these
research questions and provides a description of the setting of the study.

NOTES

¹ Seroprevalence rates provide an estimate of the percentage of people who are HIV positive at one point in time. Seroprevalence data are generally drawn from several sources such as STD clinics, women attending antenatal clinics, and blood banks. Seroprevalence data only provide an estimate of people currently infected with HIV and provide no information about the numbers who have already died or who will become infected in the future. Most of the seroprevalence data for Sub-Saharan Africa are based on women who were tested at antenatal clinics. Pregnant women are used "as a proxy for the general population" and antenatal clinic data are then extrapolated to the population level. There are many problems with estimating seroprevalence for a population based on antenatal clinic data. First, not every pregnant woman attends antenatal clinics. Second, clinic attendance varies by "age, locality, education level, parity, ethnicity, and religion—factors also likely associated with HIV status." Third, data from antenatal clinics is based on the sexually active population and may result in overestimating the extent of HIV infection in a population, especially among the youngest age cohorts. Finally, HIV infection results in reduced fertility, which may negatively skew antenatal clinic. Despite these problems, seroprevalence data "still gives a reasonable overall estimate of HIV infection in the general adult population, although they tend to underestimate HIV prevalence among women and overestimate HIV prevalence among men." (MAP 2000: 14 and 16). Seroprevalence data are distinguished from incidence data; the latter provide an indication of the number of new infections during a specified period. Incidence data are considered the best indicator of the scope of the HIV/AIDS epidemic, but are hard to come by in Sub-Saharan Africa and other nations of the South. AIDS cases refers to the numbers (or percentages) of people estimated to have transitioned from HIV infection to the constellation of diseases comprising the Acquired Immunodeficiency Syndrome. The common term used to indicate people who are both HIV infected and/or have AIDS is "people living with HIV/AIDS."

² See Fisher and Fisher (2000) for a comprehensive critical review of the following seven theoretical frameworks used to model individual level behavior change: 1) the health belief model; 2) the AIDS risk reduction model; 3) the transtheoretical model; 4) social cognitive theory; 5) the theory of reasoned action; 6) the theory of planned behavior; and 7) the information-motivation-behavioral skills model. Some of these models, such as the health belief model originated as part of other public health campaigns and have since been applied to HIV/AIDS research (*Ibid.*: 5). Many of the other theoretical frameworks were developed specifically to address the need for understanding and promoting AIDS risk reduction behaviors. While some of the models focus on determinants of behavior change (theory of reasoned action, theory of planned behavior, and some parts of the information-motivation-behavioral skills model), others add the dimension of stages of behavior change (AIDS risk reduction and transtheoretical models) (*ibid.*: 47). In the latter case, researchers argue that behavior change

consists of a series of stages. Movement between stages is not linear, i.e., it is probable that people will move back and forth between stages. In this view, it is important to evaluate the processual, staged aspects of behavior change in addition to behavior change as a "discrete outcome" (*ibid.*: 17). Also see Denison (1996) for a summary of the health belief model, AIDS risk reduction model, stages of change, and theory of reasoned action.

³ While this dissertation focuses on the consequences of the construction of risk groups and risk behaviors in the developing world—particularly Sub-Saharan Africa—a great deal has been written about the construction of the AIDS epidemic in the US. See Treichler (1989) for a cogent analysis of the consequences to women of AIDS being constructed as a largely gay male disease in the US. Briefly: during the early years of the epidemic, the focus was on the "4-H risk groups" of: homosexuals, Haitians, heroin addicts, and hemophiliacs, along with their sexual partners (whose gender was not usually specified). There was also an unspecified "other" category. A fifth "H" heterosexuals—and by extension, women were glaringly missing from this construction of risk groups. As Simmons, Farmer, and Schoepf (1996: 66) note, "[e]ssentialist notions of African and Haitian 'otherness' reinforced a hazardous tendency to conflate the outcomes of structural violence and cultural difference."

⁴ Since HIV transmission to women was not explicitly recognized during the early years of the epidemic, suspected cases in women were classified as "other" or "unexplained." Because AIDS was originally constructed largely as a gay male disease in the U.S., the clinical case definition was based on a male model and any symptoms or manifestations of HIV infection and AIDS that might be to unique to women were unrecognized. Under pressure from activists, the CDC started modifying the clinical case definition of AIDS beginning in 1986 and continuing through a series of changes to 1991. Each time that the case definition was revised, the number of AIDS cases in women increased. When the CDC's new case definition that included some manifestations of AIDS specific to women (as in reproductive tract infections) went into effect in 1992, "the case rate among women tripled as a result" (Simmons, Farmer, and Schoepf 1996: 59-60).

⁵ See Patton (1993) for a critique of the construction of the African AIDS epidemic in the media as well as scientific and social scientific discourse. Also, see Treichler (1989) for an analysis of the first world's construction of AIDS in the third world and the material and social consequences resulting from that construction.

⁶ See Packard and Epstein (1991) and Schoepf (1991) for a review and critique of the ways that social scientists—particularly anthropologists—contributed to reinforcing the idea that sexual behavior is culturally driven. The emphasis on "culture," as an explanation for sexual behavior and the heterosexual

transmission of AIDS in Africa, came at the expense of exploring how other factors shape the dynamic of AIDS in Africa. Among these factors are: war, mass migration, economic crises, political instability, historical and current patterns of male migration, etc., which may play an equal or more important role in influencing sexual behavior and thus risk and risk reduction.

⁷ The lack of attention to adolescents is no longer the case. Many countries, such as Uganda, focus a great deal of their AIDS education and prevention efforts towards educating and reducing the HIV seroprevalence rate among the youth.

⁸ Farmer (FN4) acknowledges the influence of Pierre Bordieu's book, *In Other Words: Towards a Reflexive Sociology* (Cambridge: Polity, 1990) on structure and agency in his formulation of structural violence. While Farmer does not explicitly draw upon Galtung's notion of structural violence, Galtung's formulation of the concept is included here to elucidate its meaning.

⁹ Unequal access to treatment and care in wealthy and poor countries affects survival rates; over 98% of the three million people who are estimated to have died from AIDS in 2001 resided in developing countries. HIV/AIDS is estimated to have caused 2.3 million deaths of adults and children in Sub-Saharan Africa in 2001 as compared to 20,000 in North America and 6,800 in Western Europe during the same year. Since the start of the HIV/AIDS pandemic, over 75% of the estimated 20 million people who have died from HIV/AIDS were from Sub-Saharan Africa. (UNAIDS/WHO 2001, 2000).

¹⁰ It is beyond the scope of this dissertation to go into the details of the reasons for women's increased physiological vulnerability to HIV infection. Thus, this is a vastly simplified summary of the major themes identified in overviews on this topic. For a more detailed discussion, refer to the references at the end of this section as well as Plummer et.al.'s (1994) for a discussion of the relationship between sexually transmitted HIV and STDs. Also, see Piot, Goeman, and Laga (1994) for an overview of the epidemiology of HIV/AIDS in Africa.

¹¹ "The risk of acquiring HIV from a single act of sexual intercourse is at least eight times as high from men to women as opposed to women to men" (Padian et. al 1987; DeVencenzi 1994, cited in Wingwood and DiClemente 2000: 556).

¹² See Campbell (1996: 19-20) for a brief discussion of how age-related differences in cervical cells increases younger women's risk for HIV transmission. Campbell also points out that, perimenopausal and menopausal women are at higher risk than younger women because of the increased fragility of their reproductive tract.

¹³ The efficiency of male-to-female transmission of other STDs is illustrated by the fact that women are at a 60%-90% risk of being infected with gonorrhea from

a single act of sexual intercourse as opposed to an estimated risk of 20% to 30% for female-to-male transmission (Judson 1990, cited in Wingwood and DiClemente 2000: 556).

¹⁴ See Piot, Goeman, and Laga (1994: 160-161) and Plummer et al. (1994) for an explanation of the complex interaction between STDs and HIV.

¹⁵ "Sex is a determination made through the application of socially agreed upon biological criteria for classifying people as females or males....Placement in a *sex category* is achieved through application of the sex criteria, but in everyday life, categorization is established and sustained by the socially required identificatory displays that proclaim one's membership in one or the other category....*Gender*, in contrast, is the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate to one's sex category" (West and Zimmerman 1991:14, emphasis in the original).

¹⁶ An estimated 85% of infertile women in Africa have had STDs (Faxelid and Krantz 1988, cited in de Bruyn 1992: 251).

¹⁷ The reference to anal sex as "an alternative sexual practice" of adolescent females used to protect their virginity makes specific mention of Brazil and Guatemala. While I have not seen any mention of this in reference to female youth in Sub-Saharan Africa, I include it here as part of the larger discussion about the risks associated with the expectation of virginity for women and the link with increased HIV risk.

¹⁸ See UNIFEM's (2000) *Progress of the World's Women 2000*, for a complete (and region specific) breakdown of these generalities on a global scale.

¹⁹ For the ARRM see Catania et al. (1990) and Coates et al. (1988, both cited in McGrath et al. 1993). The Baganda are the dominant ethnic group in Uganda, both historically and presently. They are members of the Bantu linguistic group and predominate in the central region of the country.

²⁰ In addition to high polygyny regimes, Ekeh (1997:4-5) defines mid-polygyny regimes as ranging from 10-20% polygyny, and low-polygyny regimes have less than 10% of all currently married in polygynous unions.

²¹ See Seidel (1993) and Carovano (1991), for succinct critiques of the problematic use of the term prostitute in HIV/AIDS discourse. Also see Booth (1998) for an enlightening discussion of the debate within the World Health Organization's Global Programme on AIDS about whether to focus policy on "good women" (mothers) or "bad women" (sex workers).

²² One of the major criticisms of Orubuloye, the Caldwells, and their colleagues' work is their uncritical selection and use of ethnographic data, without adequate recognition of the limitations of such data—whether from its dated nature or from limitations in the way the data were collected and interpreted (see LeBlanc, Meintel and Piché 1991). Additionally, in their research on sexual networking among the Yoruba they did not interview husbands and wives within the same household or more than one wife within polygynous households. They chose this strategy to allay respondents' fears about comparisons that might take place on the part of researchers if more than one household member was interviewed. They acknowledge that consequently, there is no way to crosscheck spouses' response, and even if they could cross check responses, spouses tend to keep each other uninformed about the extent of their sexual networking. Moreover, because only one wife was interviewed per polygynous household, co-wives are underrepresented. Given that the majority of women in the rural areas and over 50% of women in urban areas are in polygynous unions, their strategy of only interviewing one wife is a major limitation of the broad claims that they make. An additional limitation to only interviewing one co-wife is their implicit assumption that co-wives are interchangeable (Clignet and Sweet 1971). Finally, much of their analysis relies on men's accounts because of their assumption that in the rural areas "men's responses are more trustworthy than are women's responses for the level of sexual activity." Men reported a higher number of sexual partners than did women, which the authors view as an underrepresentation of the extent of women's sexual networking. On the other hand, the researchers assert that men underreported the extent of their sexual networking with "prostitutes" by defining them as "friends" (Orubuloye, Caldwell, and Caldwell 1994: 14-16, 18).

²³ Individuals in the survey were grouped into risk clusters based on the head of household as the index person. While never and ever married people (the latter category includes individuals who are widowed, separated, or divorced) who are heads of their own households were assigned to their own risk cluster, the analysis for this dissertation is based solely upon currently married survey participants in risk clusters where a husband and at least one wife were interviewed.

CHAPTER 3

RESEARCH METHODS AND SETTING OF THE STUDY

Introduction

I conducted the research for this dissertation in the Busoga region of eastern Uganda. In the initial sections of this chapter, I present a brief description of the geography and demography of Uganda, with a particular emphasis on Busoga, and specific information about the research site. The remainder of the chapter describes the field methods I used during two stages of research over 18 months. The first stage of research (pre-dissertation) took place over 7 months in 1994-1995 and the second stage (dissertation) was conducted during an 11-month period in 1997.¹

During the first period of research, my primary research methods were focus groups and key informant interviews conducted throughout the three districts of Busoga (Jinja, Iganga, and Kamuli). I used these methods to explore the influence of gender and economic relations on HIV/AIDS risk and risk reduction and the impact of the FAEPTI project on the communities it reached (see Appendix A for the 1994-1995 focus group guidelines). This initial stage of research provided me with a regional level understanding about both the activities of the IMAU FAEPTI Project and the issues confronting Muslims reached by the project. It also established a foundation for site selection, research design, and the development of research instruments for my second stage of research.

The second period of research involved a broad range of activities. The scope of the research design and limited resources necessitated choosing one parish (a political administrative unit) "Ghano" in Kamuli District. Ghano Parish consists of one trading center and ten villages. I chose it as a research site based on having conducted the most extensive research there during the initial period of fieldwork and having established good rapport and close contacts with members of the communities comprising the parish. All research was conducted in Lusoga. To protect the confidentiality of research participants, pseudonyms are used for the villages and trading center in the parish where the research was conducted as well as for research participants.

The University's Human Subjects Research Committee approved both stages of research. The cover letter explaining the purpose of the research and stressing confidentiality as well as the consent form (Appendices B through E) were written in Lusoga and read to potential participants.

I conducted both periods of research in collaboration with the Islamic Medical Association of Uganda (IMAU). This indigenous non-governmental organization was suggested as a possible collaborative partner during a meeting in 1994 with USAID/Kampala's Technical Advisor in HIV/AIDS. The IMAU was founded in 1988 by Muslim medical professionals and para-professionals to address unmet health and health education needs among the Muslim population of Uganda. Over the years, it has initiated and sustained a number of health-related projects, including the Family AIDS Education and Prevention Through Imams (FAEPTI) project, which began in 1992 (Wheeler 1998).²

The FAEPTI project trains imams (religious leaders), laywomen, and laymen within communities to be family-based AIDS educators called Family AIDS Workers (FAWs). The imams incorporate messages about AIDS prevention into their sermons at mosques, particularly on Fridays, when women attend services. Among other key information about AIDS prevention, the AIDS education curriculum which the imams and FAWs learn and in turn teach within the family setting specifically addresses gender and economic power relations within Muslim communities in Uganda. The curriculum stresses changing these influences on individuals' behavior by situating messages regarding the importance of change within the context of Islam (Kagimu et al. 1998; Wheeler 1998; Kagimu, Marum, and Serwadda 1995).

During an initial interview in 1994, IMAU's director expressed an interest in a collaborative study on the influence of gender and economic power relations on HIV/AIDS risk and risk reduction. The organization was also interested in the impact of their program's activities on risk-related behavior change. He introduced me to project staff who acted as guides and translators during the pre-dissertation research and facilitated entrée into the communities participating in the FAEPTI Project. We agreed that the dissertation findings would be shared with the organization and the communities, that the director and other key staff members would be consulted regarding research activities and design, and that I would not misrepresent the Muslim communities. Finally, I agreed to share the survey data set with the organization.

The vast majority of people who participated in this study are Basoga Muslims, that is, Muslims who are members of the Basoga ethnic group. Since this dissertation relies heavily on survey data, the chapter includes a summary of the demographics of the full sample of 313 people who participated in the survey, married and unmarried, giving a broad overview of the population from which the sample was drawn. I advance comparative analyses in this and subsequent chapters using data from the full sample, national level, and a recent HIV/AIDS study of Ugandan Muslims to situate demographic indicators in Uganda in general and Ugandan Muslims in particular.

“Demographics” are more than simple descriptors of a sample or individual level data. They are windows into systems of social stratification that influence the allocation of power and resources within societies. Within the context of the AIDS epidemic, there are a variety of ways that social forces may become embodied as risk, particularly for women. Gender inequality operating at the level of the household and beyond shapes differences in education, age at first marriage, age at first sex, as well as age and educational gaps between spouses, all of which may contribute to the embodiment of risk by impacting access to and control of resources as well as control over sexuality and reproduction.

While the full sample data provide a picture of the population from which it was drawn, the focus of analysis in this dissertation is the risk cluster sub-sample, which consists of spouses from risk clusters in which a husband and at least one or more wives were interviewed. It is within this sub-sample that

linkages between "demographics" and the perception and embodiment of risk will be made. Thus, I present a summary table of the risk cluster sub-sample is in this chapter and elaborate upon the sociological significance of the data in regard to the embodiment of risk in subsequent chapters.

Research Setting

Uganda is a landlocked country in eastern Sub-Saharan Africa (see Appendix F for a map of Uganda). It shares borders with Sudan to the north, Tanzania and Rwanda to the south, Kenya to the east, and the Democratic Republic of Congo to the west. Uganda has 48 districts; the three districts constituting Busoga are Iganga, Jinja, and Kamuli. The districts vary in size and area of landmass. Iganga and Jinja districts both border Lake Victoria. The source of the River Nile is in the city of Jinja where the country's only hydroelectric plant is located. Iganga is the largest district, followed by Kamuli District, and Jinja District (Government of Uganda 2000).

The most recent Ugandan census figures (2000) estimate the total population at 20.3 million. The 2000 estimates for the three districts comprising Busoga are Kamuli District, 561,500, Jinja District, 345,000, and Iganga District, 1,067,000 for a total population of 1,973,500 (9.7% of the country's total population) (Government of Uganda 2000).³ About 88.5 percent of Ugandans live in rural areas. The largest urban area is the capital city of Kampala, which has an estimated population of one million people. The Busoga districts also vary in the distribution of their rural and urban populations. The Uganda census defines "urban" as areas with populations over 1,000 persons.

The following discussion relies primarily upon data from the 1991 Ugandan census, which is the most detailed recent district-level data available.⁴ Jinja District is home to Jinja, the second largest (and formerly most industrialized) city in Uganda. Jinja District has four urban centers (including Jinja), and the most urbanized population in Busoga (30%, with 81% living in Jinja). Iganga District has ten urban centers and is classified as 4.7 percent urban (Iganga Town makes up about 45% of the district's urban population). Kamuli District is the least urbanized, at 1.7 percent; Kamuli Town accounts for about 77 percent of the district's urban population (*ibid*; Statistics Department, Ministry of Finance and Economic Planning 1992a, 1992b, 1992c).

Muslims are a minority in Uganda (11.1%); the majority of the population is either Catholic (47.2%) or Anglican (Church of Uganda, 41.6%).⁵ Historically and presently, however, the distribution of population by religion varies widely within the country. In 1991, the Eastern region (location of Busoga) had a Muslim population of 15.9 percent (Statistics Department, Ministry of Finance and Economic Planning 1994). The three districts comprising Busoga account for 62.9 percent of the total Muslims in the Eastern region. Iganga District, with 43.3 percent, has the highest percentage of Muslims, followed by Jinja and Kamuli Districts, each contributing about ten percent to the region's total Muslim population. The Muslim population in Iganga District accounts for 68.8 percent of Busoga's total Muslim population, while those in Kamuli and Jinja District each account for 15%-16% of Busoga's total Muslim population (Statistics Department, Ministry of Finance and Economic Planning 1992a, 1992b, 1992c).

The 1991 Uganda census indicates the presence of at least 46 ethnic groups in the country. The Basoga are the nation's fourth largest ethnic group, comprising 8.5 percent of the total population.⁶ The Busoga region is fairly ethnically homogenous; nearly three-quarters of the total population (71.4%) are members of the Basoga ethnic group. Of the three districts, Kamuli is the least ethnically diverse, with 84.1 percent Basoga, followed by Iganga and Jinja (66.7% and 65.3% Basoga, respectively) (*ibid.*).

Uganda is considered resource rich in terms of natural resources and is noted for its fertile soils, regular rainfall, and considerable deposits of cobalt and copper. Agriculture is the country's most important economic sector. In 1998, it accounted for 43 percent of the GDP per capita, followed by services at 40 percent and industry at 17 percent. In 1999, 82 percent of Ugandans were employed in the agricultural sector, 13 percent in the service sector, and five percent in industry. The country's major industries are sugar, brewing, tobacco, cotton textiles, and cement. Its most important export is coffee, which is the largest revenue earner. Other exports include fish and fish products, tea, electrical products, iron and steel. In fiscal year 1998 /1999, Uganda generated revenues of \$959 million and spent \$1.04 billion. In 2000, its external debt was \$3.6 billion. Uganda is reliant on economic aid and received an estimated \$1.4 billion in 2000 (Central Intelligence Agency 2001c).

In the Busoga region as throughout the rest of the country, the primary economic activity is agricultural production. Jinja District's major economic activity is manufacturing and trade (power generation, sugar industry, textile

production, iron smelting, leather tanning, and breweries) in the city of Jinja and its environs, while in the rural area of the district it is agriculture. The main crops grown in the three districts overlap somewhat and include beans, maize, millet, sorghum, cassava, bananas, sweet potatoes, groundnuts, yams, sesame, sunflower, cotton, coffee, sugar cane, and rice. Fishing on Lake Victoria is also an economic activity in Iganga and Jinja districts as is fishing on the River Nile in Jinja district (Government of Uganda 2000; Rwabwogo 1994).

As throughout all of Sub-Saharan Africa, calculations of life expectancy, morbidity, and mortality are profoundly affected by the HIV/AIDS epidemic. The life expectancy at birth in Sub-Saharan Africa has dropped from 50 years in 1990 to 47 years in 2000. The primary contributing factor is a high infant mortality rate of 91 per 1,000 live births for the region, with HIV/AIDS being the leading cause of mortality. The overall HIV prevalence rate (estimate at one point in time) of adults (15–49) in Uganda has declined significantly over the last five to ten years from a high of as much as 25%-26% to about 10%-12% in urban areas. In 2001, the estimated adult HIV/AIDS prevalence rate was 5.0 percent, compared to an adult rate of 8.3 percent in 1999. The comparable adult HIV/AIDS seroprevalence rates for 2001 in Kenya and Tanzania were 15.0 percent and 7.8 percent, respectively (UNAIDS 2002a, 2002b, 2002c). As with the rest of Sub-Saharan Africa, the HIV/AIDS epidemic continues to shape Uganda's demographics. Signs of these effects include increased overall mortality rates, higher infant morbidity and mortality rates, lower population and growth rates,

and changes in the age and gender distribution of the population that would not have been otherwise predicted (Central Intelligence Agency 2001c).

Select demographic indicators for East Africa in 2001 are shown in Table 3.1. Compared to other states in the region, Uganda has a lower life expectancy at birth and a higher mortality rate than Kenya and Tanzania. It also has a higher birth and total fertility rate along with a significantly higher infant mortality rate than either Kenya or Tanzania. Finally, Uganda has a higher percentage of people in the 0-14 year old age cohort and a lower percentage in the 15-64 cohort.

Table 3.1. Selected Demographic Indicators, East Africa: 2001			
Demographic Indicators	Uganda	Kenya	Tanzania
Population 2001	23,985,712	30,765,916	36,232,074
Life Expectancy at Birth	43.37	47.49	51.98
Birth Rate	47.52	28.50	39.65
Total Fertility Rate	6.88	3.50	5.42
Infant Mortality Rate	91.30	67.99	79.41
Mortality Rate	17.97	14.35	12.95
% Aged 0-14	51.08	41.95	44.76
% Aged 15-64	46.78	55.26	52.35
% Aged 65+	2.14	2.79	2.89
Source: Central Intelligence Agency 2001a, 2001b, 2001c (World Factbooks for Kenya, Tanzania, and Uganda). Note: Birth and mortality rates are per 1,000 population and infant mortality rate is per 1,000 live births.			

Site of the Study: "Ghano Parish," Kamuli District

Uganda's political-administrative system is based on a five-tiered structure beginning at the village level (Local Council or LC1) and moving upward from parish, to sub-county, county, and district (LC2 through 5), respectively. Each level has its own subdivisions, and elected officials at every level maintain

census counts. The selected research site, Ghano parish, consists of Muslim and non-Muslim headed households within one very active rural trading center and ten surrounding villages. An initial series of meetings were held in the parish with community and Muslim religious leaders as well as FAEPTI Project members to explain the purpose of the research, outline a preliminary research design and timetable, and most importantly, solicit their support for the project. The elected official in charge of tracking demographic data at the parish headquarters provided LC1 census data for each community in the parish. The data in Table 3.2 show the number of households and population for each location in the parish based on the 1995 LC1 census.⁷

Table 3.2 "Ghano" Parish Local Council 1 Census: 1995

Location	Number of Households	Number of Residents in each Location	Pecent of Total Population
<i>Trading Center</i>			
Ndala	299	1,357	21.1%
<i>Villages</i>			
Ibiri	112	627	9.8%
Isatu	113	680	10.6%
Ina	146	770	12.0%
Itaanu	77	499	7.8%
Mukaaga	133	817	12.7%
Musanvu	58	348	5.4%
Munaana	missing	missing	missing
Mwenda	40	222	3.4%
Ikumi	64	375	5.8%
Ikumi na'ndala	111	735	11.4%
Total Households & Population	1,153	6,430	100.0%

Source: Local Council 1 Census Data, 1995, in files of the author.

The trading center of the parish, "Ndala," slightly exceeds the Uganda Census definition of an urban area, having 299 households and a population of

1,357 (accounting for 21% of the total parish population.) The next largest location, "Mukaaga" has 133 households and its population of 817 contributes 12.7 percent to the total parish population. "Mwenda," with only 40 households and 222 people contributes the smallest percentage to the overall population (3.4%).

The data in Table 3.3 show the number of Muslim headed households in the parish, along with the number of Muslims in each location. It is based on the updated mosque census and includes corrections to that census discovered during the process of conducting the survey.

Table 3.3 Muslim Headed Households and Total Number of Muslims in "Ghano" Parish, Kamuli District: 1997

Location	Number of Muslim Headed Households	Number of Muslims in each Location	Percent of Total Muslim Population	Percent Muslims per Total Population of Each Locale
Trading Center				
Ndala	68	295	27.1%	21.7%
Villages				
Ibiri	24	155	14.2%	24.7%
Isatu	25	143	13.1%	21.0%
Ina	20	90	8.3%	11.7%
Itaanu	24	96	8.8%	19.2%
Mukaaga	15	103	9.5%	12.6%
Musanvu	6	42	3.9%	12.1%
Munaana	9	45	4.1%	NA
Mwenda	9	33	3.0%	14.9%
Ikumi	5	29	2.7%	7.7%
Ikumi na'ndala	12	58	5.3%	7.9%
Total Households & Muslim Population	217	1,089	100.0%	16.9%

Source: 1997 Mosque census update in files of author; NA indicates not applicable due to missing data from Munaana LC1 census.

As shown in Table 3.3, Muslims account for an estimated 16.9 percent of the total parish population. This figure is slightly higher than both the district (10%) and national (11%) estimates of Muslims enumerated in the 1991 Uganda Census (Statistics Department, Ministry of Finance and Economic Planning 1994; Statistics Department, Ministry of Finance and Economic Planning 1992c). Mosque Census data are, however, in keeping with the higher percentage of Muslims residing in the three districts comprising the Busoga region.

The remainder of the chapter provides an overview of the methods used to collect and analyze data.

Research Methods Used in Second Stage of Research

Due to the sensitivity of the questions asked and the importance placed on “getting the language right,” the initial step in the research process was finding a skilled research assistant. My primary criteria in choosing a research assistant was fluency in all aspects of the Lusoga language—particularly writing and speaking the form of Lusoga used in rural areas, known as “conc” (or concentrated). The research assistant I selected was a university educated female, first language Lusoga speaker who agreed to live in the parish for the *duration* of the research. The research methods that I used during the second stage are presented below in the order in which they were conducted.

Updating the Mosque Census

Imams are responsible for maintaining mosque census lists, detailing all of the Muslim-headed households and the number of Muslims in their mosque areas.⁸ The three imams in the parish had census data for 1997, but there was some missing data for a few of the villages. The imams and an assistant imam of the parish acted as guides during the mosque census update. They made introductions at each Muslim-headed household visited, thereby helping to facilitate and legitimate census data collection. Appendix G shows the type of demographic data collected during the mosque census update. Summary tables of the updated mosque census data as well as census data for the parish as a whole are presented in the final section of this chapter. In total, 212 Muslim headed households were visited in a month and a half. One hundred five male heads of households, 79 female spouses, 23 husbands and wives together, and five female heads of households were interviewed.

Focus Groups

After carrying out the mosque census update, eight focus groups were conducted—four each with women and men.⁹ A total of 75 people (33 women and 42 men) participated in the focus groups; the average group size was nine. The research assistant and the assistant imam of the trading center mosque area were trained as focus group facilitators and a female first language Lusoga speaker was trained to take notes on verbal and non-verbal side conversations and interactions during the groups. The groups were carried out in Lusoga and were taped, later translated, and crosschecked for accuracy of the translations.

The primary purpose of the 1997 focus groups was twofold: (1) to elicit discussion and solicit definitions of key terms and concepts for the survey and (2) to collect data regarding group norms about gender/power dynamics within households. A set of focus group guidelines and activities were used to explore these norms, which included household definitional issues such as how households and head of household are defined; the differences between household, house, and family; different types of households; and household membership criteria. It also included questions about linkages between polygynous households and the circumstances under which a woman is considered head of household (see Appendix H for the 1997 focus group guidelines).

Another set of questions addressed household money matters and was designed to uncover the dynamics of cooperation and/or conflict within and between linked and separate households. Focus group members were asked a series of questions about the gender division of labor for each type of crop grown in the area (subsistence only, subsistence with surplus sold, and cash); sources of income by gender and age; access and control over income; control over spending decisions; and what money is spent on. Additionally, this set of questions addressed the circumstances and extent of co-wife cooperation in financial and other matters.

Another focus group activity involved game playing—the “coffee bean exercise.” The facilitators distributed ten coffee beans to each group member. They solicited a list of the crops that were grown in the area and explained that

the purpose of the exercise was to “show effort,” that is, how much effort do men and women within each group member’s household/s contribute to producing each crop? The facilitators stated something along the lines of, “Each coffee bean represents a certain amount of effort that women and men [husbands and wives, since the terms for women/wives and husbands/men are often interchangeable] contribute to the production of each crop. If ten coffee beans equal the maximum amount of effort that goes into producing a crop from clearing the bush, to either selling or storing it, how many coffee beans does the husband contribute and how many does the wife or wives contribute?” They then demonstrated how to play the game with one of the crops from the list and wrote down the number of coffee beans that each group member assigned to husbands/wives.

To facilitate later comparisons, group members from polygynous households sat next to each other, for the purposes of evaluating how being in polygynous households impacts the gendered division of labor. The final set of questions asked group members to identify what women and men (in separate listings) define as household necessities in order to explore gendered differences in the definition of “needs.”

All of these activities generated a great deal of discussion and debate as well as a general consensus about household definitional issues. Perhaps because these issues are either not a part of everyday discussion or because it is assumed that everyone knows what a household is, the definitional issues questions generated the most blank stares from focus group members. After the

initial awkwardness and a few probing follow-up questions from the facilitators, group members warmed to the subject. The coffee bean exercise generated the most enthusiasm, with even group members who had spoken little, slapping down their coffee beans and making comments like “Me, I give myself all ten! I have never seen him around a potato mound! Can a man plant cassava?” (from the women’s groups). And from the men’s groups: “Let it be six for the man and four for the woman. Passion fruits are for the man. All ten! Have you ever seen any woman grow passion fruits?” Here the women are asserting that men contribute little or no effort to growing, tending, and harvesting food crops such as potatoes and cassava, while the men are saying that when it comes to a cash crop like passion fruit, the scale is tipped more toward men’s greater investment in labor. The access and control over income and household needs activities also generated much lively discussion.

The focus group data were analyzed using NVivo qualitative software program using grounded theory to code for emergent themes. Focus group data from both 1997 and 1994-1995 are used to provide a background on the dynamics of gender/power relations at the household level, as well as to contextualize and provide support for the analysis of the survey data.

Survey

Survey sample selection. I developed a three-tiered stratification scheme to select survey sites in the parish based on research interests and an assessment of resources. Previous studies show that both HIV seroprevalence and risk behaviors are higher in trading centers (Kagimu et. al. 1998; Statistics

Department, Ministry of Finance and Economic Planning and Macro International 1996; Barnett and Blakie 1992). Thus, I included the only trading center in the parish was in the survey sample. The ten surrounding villages were stratified based on the following criteria: distance from the trading center (near/not near), degree of concentration of Muslim-headed households (concentrated/not concentrated), and geographical size of the village (small/not small).¹⁰ While there is some concentration of Muslim headed households in the parish, in general, Muslims and non-Muslims live side-by-side within communities rather than in religiously segregated clusters. At least one village from each of the three mosque areas in the parish was included in the survey sample. The three stratification criteria are based on the combined knowledge of local key informants and knowledge about the parish gained during the process of updating the mosque census. Appendix I provides full details of the survey sample stratification criteria.

Dichotomizing the stratification criteria in this manner has the limitation of over simplification. The criteria are, however, designed to reflect the degree of social and economic integration with the trading center and the possible reinforcement of HIV/AIDS education messages taught by the FAEPTI Project. In the context of HIV/AIDS, this is especially important, because women's access to HIV/AIDS information and services and economic opportunities for earning cash, may be limited by their distance from the trading center. Similarly, reinforcement of HIV/AIDS prevention messages may be hindered or helped by the size and geographic dispersion of Muslim-headed households in villages.¹¹

The stratification criteria resulted in eight possible combinations of near/not near, concentrated/not concentrated, and small/not small. Three of the possible combinations do not exist in the parish. One village each, from four of the remaining five possible combinations were chosen to participate in the survey, with the goal of surveying 100 percent of the total eligible household members in the trading center and five selected villages. Because of time and resource constraints, it was not possible to survey the eligible participants in the fifth stratum.

The survey was household based and organized by risk clusters. Overall, 97 percent of the eligible households in the trading center and five villages participated in the study. All eligible household members in spatially concordant and/or discordant risk clusters within the selected locations were interviewed.¹² People were eligible to participate in the survey if they met each of the following criteria: age 15 and above, resident in the community for at least one year, and resident in the household for at least three months. A total of 313 of 336 eligible people (93.2%) participated; 164 females and 149 males. Only six people (1.72%) refused to be interviewed.¹³

Demographics of the full sample. Table 3.4 provides various demographics for the full sample of 313 people who participated in the survey, stratified by gender. In both the full and the risk cluster sub-sample, chi-square was used to test for statistically significant differences in the variables of interest between women and men, with a p value set at .05.

Table 3.4 Demographics of the Full Sample						
Item	Gender				Total	
	Men		Women			
	Count	%	Count	%	Count	%
Age						
15-19	23	15%	30	18%	53	17%
20-24	27	18%	36	22%	63	20%
25-29	29	19%	33	20%	62	20%
30-39	37	25%	27	16%	64	20%
40-49	10	7%	15	9%	25	8%
50 +	23	15%	23	14%	46	15%
Total	149	100%	164	100%	313	100%
Location						
Trading Center	52	35%	59	36%	111	35%
Village	97	65%	105	64%	202	65%
Total	149	100%	164	100%	313	100%
Level of education						
None	18	12%	34	21%	52	17%
Primary or Quar'an	86	59%	106	65%	192	62%
Secondary or higher	42	29%	24	15%	66	21%
Total	146	100%	164	100%	310	100%
Marital status						
Currently married	124	83%	134	82%	258	82%
Ever	3	2%	17	10%	20	6%
Never	22	15%	13	8%	35	11%
Total	149	100%	164	100%	313	100%
Marital union type						
Monogomous	81	65%	65	49%	146	57%
Polygynous	43	35%	69	51%	112	43%
Total	124	100%	134	100%	258	100%

In the full study sample, there are no statistically significant differences in the proportions of women and men in each age cohort. The age distribution is fairly evenly balanced by gender, with the exception of the 30-39 year old cohort, in which there are proportionally more men than women. The study conducted by Kagimu et al. (1998) provides a useful basis of comparison, since 95 percent of the 1,826 survey participants in the study were Muslim. In that study (which did

not disaggregate data by gender), 40 percent of the sample were ages 15-24, 28 percent were in the 25-34 year old cohort, 13 percent were ages 35-44, and the remaining 15 percent were 45 years or older. Using the same age categories, we see a similar distribution in this sample: 37 percent are 15-24, 30 percent are 25-34, 16 percent are 35-44, and 17 percent are 45 years and above.

The gender and age distributions are similar to those found in the national level 1995 DHS, with a few exceptions. In that survey of 7,070 women and 1,996 men, 19 percent of the men and 23 percent of the women were in the 15-19 year old cohort. The percentage of people in the 20-24 year old cohort is identical to this sample, by gender, and within one or two percentage points in the 25-29 year old cohort (18 % for both women and men). As in this sample, 25 percent of the men are in the 30-39 year old cohort in the DHS. The percentage of women in that cohort is nearly equal, at 26 percent and is 10 percent higher than this sample. Finally, the DHS has higher percentages of both men and women in the 40-49 year old age category; 14 percent and 12 percent, respectively. (The DHS did not interview women over the age of 49.)

Location is not statistically significant, by gender. Overall, 35 percent of the full sample lives in the trading center, which meets the definition of urban (population of over 1,000) in the 1991 Ugandan Census. The remaining 65 percent of survey participants live in the five villages that took part in the survey. The rural/urban distribution of respondents in the DHS was 15 percent and 85 percent, respectively. Comparative analyses of the education and marital

statuses of the full and risk cluster sub-samples are presented in subsequent chapters.

Demographics of the risk cluster sub-sample. In this section, I present a brief summary of the risk cluster sub-sample, which is the focus of my analysis. During the survey, everyone in the households was asked to identify the "*mwene maka*" (head of household). Men head all but ten of the 154 households who participated in the survey. Based on this information, all 313 survey participants were reclassified into their respective risk clusters as determined by household headship data. This resulted in the creation of 149 risk clusters headed as follows: 132 headed by husbands, ten by female heads of households, three by ever married men, and four by never married men. The number of risk clusters is smaller than the number of households in the sample because 17 husbands maintain more than one household in the survey area.

The next step in the process involved excluding risk clusters with either missing data or those who were headed by currently unmarried people from the analysis. In this context, missing data refers to the cases of husbands and wives whose spouses were not interviewed. Twenty-one husbands and ten wives who were interviewed without their spouses as well as all of the female headed, never and ever married male heads of household, and a few unusual cases were excluded. This resulted in reducing the number of risk clusters used in the risk cluster analysis from 149 to 102. In addition to the above exclusions, all unmarried people in households were excluded. Thus, the final risk cluster file includes only married people in linked or separate risk clusters for whom we have

matched data. By this process, the sample size for the risk cluster file is 223 (121 wives and 102 husbands).

Risk clusters are organized with the head of household as the index person. In the full sample, men headed all but 10 of the 149 risk clusters; 132 were headed by husbands (88.6%), seven were headed by unmarried males (4.7%, three ever married and four never married), and the remaining ten risk clusters were headed by ever-married females (6.7%). The norm of male-headed households is consistent with Fallers' (1965: 72) data for the Basoga showing that 85%-95% of the households were headed by males and included their "dependents", 5%-9% were headed by males living alone, and very few were headed by women living alone or with their "dependents."

In this analysis, risk clusters headed by never or ever married individuals as well as those in which only one spouse was interviewed are not included in the risk cluster sub-sample. Thus, for the purposes of analyzing data from currently married respondents, a risk cluster consists of a husband (invariably identified as head of household by risk cluster members interviewed) and a wife or wives, whether they are living in the same (spatially concordant) or different (spatially discordant) residences. The risk cluster sub-sample therefore includes only those risk clusters in which a husband and at least one of his wives were interviewed.

The relationship between the number of husbands in the risk cluster sub-sample, number of risk clusters, number of households within the 102 risk clusters, and the number of wives that the 40 polygynous husbands have

between them is shown in Table 3.5. Based on the total of 98 wives of husbands in polygynous unions, the intensity of polygyny (average number of wives per polygynous husband) is 2.45. Sixty of the 98 wives of polygynous husbands took part in the survey (61%).¹⁴

Table 3.5 1997 Risk Cluster Sub-Sample: Wives, Households, and Risk Clusters

	Number of wives	Number of households	Number of risk clusters
Monogamous husbands	62	62	62
Polygynous husbands	98	82	40
Total	160	144	102

The demographics for the 102 husbands and 121 wives who comprise the risk cluster sub-sample are shown in Table 3.6. The sub-sample consists of matched husbands and wives (i.e., a husband and his wife or wives who were interviewed). It does not include formerly married and single respondents (ever and never married), or married respondents whose spouses were not also interviewed. Ninety-six percent of the sub-sample is Muslim and 89 percent are of the Basoga ethnic group.¹⁵

Women marry at earlier ages than men, thus there are fewer men in the two younger age cohorts. The sub-sample is evenly divided between wives who are in monogamous unions and those who are in polygynous unions. As in the full sample, women have lower levels of education than men, and the geographic distribution by trading center/village is similar to that of the full sample.

Table 3.6 Demographics of the Risk Cluster Sub-sample						
Item	Gender				Total	
	Men		Women		Total	
	Count	%	Count	%	Count	%
Age						
15-19	2	2%	20	17%	22	10%
20-24	15	15%	32	26%	47	21%
25-29	24	23%	23	19%	47	21%
30-39	33	32%	23	19%	56	25%
40-49	8	8%	10	8%	18	8%
50 +	20	20%	13	11%	33	15%
Total	102	100%	121	100%	223	100%
Location						
Trading Center	36	35%	41	36%	77	35%
Village	66	65%	80	64%	146	65%
Total	102	100%	121	100%	223	100%
Level of education						
None	10	10%	25	21%	35	16%
Primary or Quar'an	63	62%	80	66%	143	64%
Secondary or higher	28	28%	16	13%	44	20%
Total	101	100%	121	100%	222	100%
Marital status						
Currently married	102	100%	121	100%	223	100%
Ever		0%		0%		0%
Never		0%		0%		0%
Total	102	100%	121	100%	223	100%
Marital union type						
Monogamous	61	60%	61	50%	122	55%
Polygynous	41	40%	60	50%	101	45%
Total	102	100%	121	100%	223	100%

A full analysis and discussion of the significance of these "demographics" as they link to the ways that gender power relations structure the embodiment of HIV/AIDS risk is presented in subsequent chapters.

Survey development and design. The survey questionnaire combines questions generated during both stages of research with modifications of the IMAU FAEPTI Project's surveys as well as portions of the 1995 Uganda Demographic and Health Survey (Kagimu et al. 1998; Statistics Department,

Ministry of Finance and Economic Planning and Macro International 1996).¹⁶ It is sub-divided into sections on risk perception, risk behavior, and risk reduction; HIV/AIDS knowledge; HIV testing; projective questions about dimensions of power and powerlessness; and gender and economic relations. Detailed demographic data were also collected, including household census data from each person interviewed in the household. Key concepts used in the survey were derived from focus groups and key-informant interviews. These concepts included the definitions of households, head of household, household membership, female-headed households, definitions and forms of marriages, terms for sexual partners, dimensions of power and powerlessness, and various aspects of gender and economic relations.

The questionnaire is written in Lusoga, the first language of the vast majority (90%) of the respondents in the parish and was administered by survey interviewers who speak Lusoga as their first language. With the assistance of Ugandan colleagues and local key informants, the survey was triple translated and evaluated for language and content to ensure accuracy and consistency.¹⁷ Care was taken at each step of the translation process to use a form of Lusoga that was appropriate to the population being surveyed.¹⁸ The questionnaire was pre-tested twice, once with key informants and once with residents of three villages in the parish who were not selected to participate in the survey. Based on the results of the pre-tests, appropriate revisions were made in the final version.

A brief note on question form and linguistic challenges. The ideal type survey is based on questions using psychometric scales that produce ordinal or interval level data. This enables a more sophisticated analysis than a survey such as the one used in my research that relies primarily on nominal data and categorical variables. The ideal type survey was, however, unachievable in the research setting due to literacy, cultural, linguistic, and resource (participants' time) constraints. This raises important theoretical and conceptual distinctions, and influenced data analysis strategies.

In the case of a written survey, respondents can move through a series of questions based on Likert scale or other psychometric items fairly quickly. Conversely, an ideal-type survey that is read to respondents does not lend itself well to questions of the form: "Some people say that having sex with many partners is a risk factor for AIDS. On a scale of one to five, with one being strongly disagree and five being strongly agree, how much do you agree with this statement?" This question would be followed by identical questions for each of the variables of interest. Such an "ideal" would require a huge amount of time to complete, even if such a strategy would yield "better" data, in terms of having exactly the same universe of responses for each survey participant.

Additionally, while the original plan had been to use four or five point Likert scales, in the early stages of survey development it became evident that it is very difficult to express the two extremes on the scales (strongly disagree and agree) in a way that makes sense in Lusoga. Thus, the four-point scale was reduced to

a two-point scale after repeatedly meeting with respondents' confusion in key informant and pre-test interviews.

Consequently, the survey follows the standard format of surveys conducted (at the time) on HIV/AIDS in international settings by the World Health Organization, the Demographic and Health Surveys, and other research in using questions related to HIV/AIDS that are largely unprompted. Questions were read to respondents and all spontaneously mentioned responses were recorded. This made for some definite challenges in coding the survey, but enabled an evaluation of the level of knowledge and responses that are often discounted as "outside the box" (or expected universe of answers).

Finally, many additional linguistic challenges arose while constructing the survey, particularly in regard to key concepts used in HIV/AIDS research. An example of this relates to the concepts of "regular partner" and "irregular partner," which are crucial tropes in HIV/AIDS research. Research from around the globe cutting across boundaries of race, class, gender, and sexuality (Pulerwitz et al. 2001; O'Leary 2000; Ssegonzi et al. 1999) shows that people are less likely to use a condom with their regular partner than with their irregular partner. During key informant interviews and survey pre-tests, it was discovered, however, that the concepts of regular and irregular partner have very limited linguistic salience in the local context. That is, they do not translate well, even though they are the terminology used in the English versions of the survey. Since this is such a crucial social and epidemiological distinction, considerable time was spent in

both formal and informal interviews and discussions trying to develop the proper language for this set of questions.

As part of survey development, people were asked about the terms used for one of the more commonly employed definitions of regular partner: "someone other than your spouse with whom you have been having sex for about the last year or more," (irregular partner includes everyone outside that category, aside from spouses and regular partners). One of the most frequent responses to the question was "*malaya*," which is the Swahili term for prostitute. This response was usually delivered with much emphasis and a short discourse about the immorality and risks involved in such behavior.

Using the term for prostitute in asking questions about condom use on a survey would create obvious problems. Further research revealed a number of euphemisms that people use for non-spousal sexual partners. Some of the more frequently mentioned suggestions were "friend," "someone who you sleep with," and "away visits" (which is a reference to football [soccer] games that are played out of town). Another suggestion that was less frequently mentioned was "*mukwano gwa ku lia*," or outside partner (literally, 'friend of the outside'). The challenge with all of these terms is that they can also be misunderstood (not all friends sleep together, for example) and a term was needed that could apply to married as well as unmarried people.

Upon further probing, it was clear that the word "*muganzi*" (plural, *baganzi*), would be universally understood as a "regular" sexual partner. *Muganzi/baganzi* means lover/s, in Lusoga. After re-hearing the definition for

"irregular partners" the key informants responded, "we call them *abantu bandi*," which literally means other people and figuratively means "everyone else." Thus, while the concepts and terminology of regular and irregular partners is an integral part of the survey and appears as such in the English version, the actual terminology used in the Lusoga survey is "lovers and others."

Survey interviewer selection and training. I recruited four survey interviewers, two males and two females, with the assistance of the IMAU. The process used for selecting survey interviewers paralleled the process finding a full-time research assistant. The one departure was that the interviews took place at IMAU headquarters in Kampala and were conducted with the assistance of my Lusoga language instructor (and the key consultant in all matters related to Lusoga), and the education director for IMAU. The strengths and weaknesses of all 14 applicants (six women and eight men, all Muslim) who applied were debated, but the final decision rested me. While IMAU FAEPTI personnel participated in the recruitment, interviewing, and training of the survey interviewers, none of the interviewers were affiliated with the organization.

Interviewer training took place over a weeklong period and was conducted by IMAU FAEPTI personnel and me. Interviewers were encouraged to propose and discuss suggested changes in the format and language used in the survey. They were trained using extensive role-playing emphasizing the importance of protecting participants' confidentiality at every step of the process, completeness and accuracy in interviewing, and maintaining a non-judgmental attitude while asking sensitive questions. Interviewers were taught to "stick to the Lusoga



script” to ensure that all the surveys were similarly administered. They were taught to record respondents’ spontaneous answers to the questions and to probe at least twice per question to determine if the respondent had anything else to mention. The thinking behind this strategy is that it is less leading than reading the answers to respondents. Survey participants’ spontaneous answers are understood to provide an indicator of the level of knowledge available to the interviewee at the time of the survey.

Survey administration. Interviewers traveled as a group to the various sites and were guided to Muslim-headed households by either the imam or the assistant imam of the local mosque area. The imam or assistant imam introduced the interviewers, explained the purposes of the survey, and asked initial screening questions to determine the number of household members who were eligible to participate in the survey. Neither the imams nor the assistant imam were present when the questionnaires were administered. Survey participants were matched with interviewers of the same gender. Interviewers were trained to conduct the interviews out of hearing range of other household and community members. If several people were interviewed in the same household at the same time, the interviews took place in separate locations. The survey was orally administered to ensure accuracy and consistency in survey completion and due to the generally low levels of literacy in the area. At the time of the survey, most people had never seen Lusoga written, and there is no standard Lusoga orthography, thus complicating the reading and writing of the

language in ways that would have negatively impacted the quality of the survey data.¹⁹

Based on their previous experience with conducting surveys, FAEPTI personnel stressed the importance of carefully supervising survey interviewers. Survey supervision consisted of reviewing completed surveys at the end of each day to check the completeness and accuracy of data collection. The interviewers were required to revisit households to re-ask any questions with missing or incorrectly recorded information. Fortunately, the need for this was very limited, since the interviewers were generally careful in their survey administration.²⁰

Survey analysis. I analyzed only a select number of survey questions. These questions are used to answer the primary research questions of how gender inequality shapes the perception and embodiment of risk in the study population, and whether there are differences in how matched spouses within monogamous and polygynous risk clusters assess their HIV/AIDS risk. The survey questions analyzed address several areas that reveal gendered differences influencing the embodiment of risk, particularly for women, including: sources of AIDS information, levels of knowledge about HIV/AIDS transmission and levels of knowledge about ways to avoid being infected. They also address condom use within marital unions, the extent of agreement with the question of whether polygyny is a risk factor for AIDS, and self-assessed HIV/AIDS risk.

The majority of the survey questions were of an unprompted nature—respondents were read the questions and spontaneously mentioned responses were recorded. No limit was set on the number of responses that could be given

to the unprompted questions. Because the data are largely of a categorical nature, spontaneously mentioned items were recoded into dichotomous variables. In order to determine the key independent variables to use in data analysis an initial set of frequencies, contingency tables, and correlation matrices were run on a select group of variables. The first set of independent variables was drawn from the literature on HIV/AIDS in Sub-Saharan Africa and qualitative data gathered during both periods of research. They included age, gender, marital status, age at first sex, age at first marriage, polygynous status, number of wives in family, wife rank, location, and the number of children that a woman had given birth to and/or a man had fathered. Also included in the initial runs were outside partner status, education, residence (trading center or village), and exposure to the project. The latter variable was defined as having listened to or talked with a trained imam about AIDS prevention and/or having been visited by a Family AIDS Worker (FAW) at least once in the last year (Kagimu et al. 1998). Of this set of variables, only gender was consistently statistically significant and is focused on in the results. Where appropriate, analyses based on some of the other independent variables are presented.

Individual level analysis. Since the majority of the survey variables are categorical, statistical significance is measured with Pearson's Chi-Square to test for differences in proportions between currently married women as a group and currently married men as a group. The composite contingency tables presented in subsequent chapters are based upon contingency tables run with the key variables for each item of interest. In the case of the variable "gender," a series

of 2 x 2 tables for each spontaneously mentioned (unprompted response), with one degree of freedom were generated. The key variable, 'levels of education' has three categories, yielding a series of 3 x 2 tables, with two degrees of freedom. The individual contingency tables were then combined into a set of tables for each question and variable of interest. Only the affirmative responses are shown in the tables. Statistically significant results with a p value of less than .05 are indicated with an asterisk. In cases where cell counts violate the assumptions of Pearson's Chi-Square test, Fisher's exact p-value was used to determine statistical significance.

Risk cluster level analysis. The risk cluster analysis is intended to move beyond the individual level and the level of the dyad in an area with a high incidence of polygyny to a comparison of husbands' and wives' answers on key issues related to HIV risk and risk reduction. Because 82 percent of the 313 survey participants are currently married and because the purpose of risk cluster analysis is to make comparisons between husbands and wife or wives' answers, the analysis presented in this dissertation is limited to currently married respondents in risk clusters in which a husband and a wife or wives were interviewed.

Everyone within a risk cluster is affected by everyone else's risk-related behavior and even though an individual (say a co-wife) may perceive herself to be at low risk because of her own behavior, she may rank herself at a higher level of risk because she has no control over her husband or her co-wife/ves.²¹ As one informant stated—and several women echoed—in various focus groups,

what the women in polygynous households share is their husband. Likewise, while they did not use this language to describe their concerns, they also share each other's risk behaviors.

Only certain questions are amenable to risk cluster analysis. In order to run a Kappa statistic, which "is a measure of observed agreement corrected for expected agreement" (Fleiss 1981, in Bennetts et al. 1999), the data must take a certain form. To achieve that form, the questions must be of a prompted nature where wives and husbands were given the same set of answer options that were read to them, thus facilitating comparisons within and between risk clusters. In this dissertation, the survey portion of the risk cluster analysis is limited to a single question about self-perceived HIV/AIDS risk. The variable for self-assessed risk is one of the few in the survey that is interval level. Respondents were asked how they ranked their HIV risk (none, small, moderate, or great).

The level of consensus or percent agreement on self-assessed risk within risk clusters is presented in Chapter 8. Computing a Kappa statistic requires matched data, in this instance, data from both husbands and wives. The risk cluster analysis and Kappa statistic elevate the analysis to the level of comparing the responses of people within the same risk cluster to evaluate the extent of their agreement on their self-assessed risk. Computing a Kappa statistic to measure the percent agreement between husbands and wives requires having only one response from a husband and one from a wife for each risk cluster.

Because this is a matched analysis, there are at least two responses from each risk cluster (husband and wife), thus meeting the requirement. In some

cases, however, there are more than two responses to the self-assessment of risk question because of polygyny. That is, some husbands in the risk cluster file have more than one wife.

To deal with this dilemma, I computed a rounded median for wives' responses. The rounded median is based on the median of the self-assessed risk of all wives in the risk cluster (on a scale of one to four, with one representing "no risk" and four representing "great risk") and then rounded to the next whole number. In instances where there are only two wives in the risk cluster, the rounded median is equivalent to the rounded mean. This results in one value for husband's self-assessed risk and one for wife or wives in each of the 102 risk clusters in the file and enables a Kappa statistic to be computed for the 98 risk clusters for which there are complete data.

The value of Kappa statistic generally ranges from 0 to 1, with one representing perfect agreement and zero representing no agreement beyond what is expected by chance alone. The general criteria for evaluating the range of Kappa is less than 0.40 poor agreement; 0.40 to 0.59 fair agreement; 0.60 to 0.80 good agreement, and greater than 0.80 excellent agreement (Cicchetti and Feinstein 1990; Feinstein and Cicchetti 1990).

In Chapter 8, I present the findings the Kappa analyses for the self-assessment of risk question for the following combinations (by comparisons of husbands and wives responses within each risk cluster): all husbands and wives; husbands and wives in polygynous unions; husbands and wives in non-polygynous unions. Calculating the rate of polygyny within the risk cluster

presented additional challenges. Risk cluster level Kappa analysis requires one report by a husband on the rate of polygyny and one report by a wife. To address this, I compared wives' reports on polygyny/non-polygyny within the 102 risk clusters selected for Kappa analysis. In the 17 risk clusters with more than one wife, the wives agreed on their polygynous status, although in some instances they disagreed on the number of wives in the family. Since the salient point is whether it is possible to compute a single variable for wives' report on polygyny within each risk cluster, and since there is perfect agreement, I computed a new variable (polygynous status according to wives), which was then assigned to each wife in the risk cluster. In combination with the preexisting variable for husband's accounts of their polygynous status (polygynous status, husbands), this new variable can be used to compute a Kappa analysis of the percent agreement on self-assessed HIV risk within each of the 102 risk clusters.

Preliminary Analysis of the Survey and Data Entry. Following the completion of the survey, my research assistant and I conducted a preliminary analysis of the data by reviewing and recording survey answers related to key questions of interest. While data were recorded for all 313 survey participants, the primary focus was on comparing answers from matched husbands and wives within risk clusters. The specific questions focused on included basic demographic data on age, marital and polygynous status, number of wives, wife rank, age married, and age of first sex. The second set of questions analyzed was related to husbands and wives' responses to questions about "lovers" and "others" (regular and irregular partners) and condom use with spouses and

outside partners. A third area of concentration was attitudes toward condom use, self-assessment of HIV risk, and HIV testing questions. I also evaluated responses to knowledge about transmission and risk reduction questions, sources of information about AIDS, and exposure to the project.

My ultimate goal was to identify themes and issues to pursue further in the follow-up in-depth interviews at the risk cluster level and to determine who would be asked to participate in those interviews. The preliminary data analysis provided a sense of the overall patterns of responses to the key survey questions related to HIV/AIDS risk and risk reduction both within and between households in risk clusters and within and across certain categories of people such as women and men, polygynous and non-polygynous, and levels of education. Initially, selected data were entered in a hand-computed spreadsheet and analyzed. Later the data were entered into SPSS by two individuals with advanced degrees in biostatistics and extensive experience in data entry for HIV/AIDS research. They entered the vast majority of the data and conducted the initial data cleaning, which consisted of running frequencies and checking for outliers. Further data cleaning was completed during survey data analysis in the U.S.

In-depth Interviews

The primary purpose of the in-depth interviews was to follow up on certain themes that emerged in the preliminary data analysis. These interviews were used as a method to explore the issue of inter- and intra household dynamics within risk clusters. A particular emphasis was on how these dynamics are

reflective of gender/power relations and their impact upon HIV/AIDS risk perception, behaviors, and reduction. The extensive summaries of households in risk clusters in several of the villages and the trading center developed during the preliminary analysis, served as a sampling frame. My goal was to interview husbands and wives in several villages and the trading center and across the spectrum of linked/separate risk clusters, education, level of knowledge about HIV/AIDS, attitudes toward condoms, and the like.

Time and resource constraints and the dampening effects of the rainy season on any research activities, however, shaped the actual selection process. The in-depth interviews took place during the last two months of the research. I made a decision to concentrate on the Muslim headed households in the trading center ("Ndala") and one of the villages furthest from the trading center ("Ina"). I had spent a fair amount of time in each locale and had developed especially good rapport with members of the Muslim community in Ina.

As it evolved, the people in the trading center were reluctant to be interviewed (particularly the husbands) and the in-depth interviews became more of a case study of the in-depth participants in Ina. There are several possible reasons why Muslims in the trading center may have been less willing to be interviewed in-depth. Among these reasons is the possibility that many of the trading center residents are involved in business and they may have felt that too much had already been asked of their time. On the other hand, the Muslims residents of Ina often spoke of how they were unable to participate in activities

because they were so far off the main road and they continued to be enthusiastic about participating in the research.

Thus, a total of 39 in-depth interviews in 11 risk clusters were conducted. Five of the risk clusters are in Ina, others are in the trading center and the villages of “Itaanu” and “Isatu.” The interviews were not taped. Questions were asked in English, translated into Lusoga, and the English translation of responses was recorded verbatim (Appendix J shows the in-depth interview guidelines). In-depth interview data were analyzed using a grounded theory approach, looking for themes that emerged in the data using NVivo qualitative software program. I incorporated insights gained from the in-depth interviews with the survey analysis in subsequent chapters to present a more complete and contextualized analysis.

To conclude, this chapter has provided an overview of the mix of qualitative and quantitative methods I used during 18 months of field research in the Busoga region of Uganda. I presented information about the research setting, research site, and basic demographics of the population of Basoga Muslims who participated in the study along with comparative analyses using national level data and research with Ugandan Muslims. Given the importance of marital relations to the embodiment of women's HIV/AIDS risk in Sub-Saharan Africa, in the next chapter I examine marital relations and other unions more closely, with an eye toward the gap between “ideal” and “practice” and its implication for the perception and embodiment of risk.

NOTES

¹ My pre-dissertation research actually comprised 11 months and included a variety of activities in addition to the seven months of fieldwork. My other data collection activities and training in 1994-1995 included Lusoga language instruction at Makerere University, attending FAEPTI Project related events and activities such as three-day long FAW training sessions, gathering background information about the HIV/AIDS epidemic in Uganda, and establishing contacts with individuals and organizations involved in HIV/AIDS activities.

² During 1994-1995, the FAEPTI Project and some of the IMAU's other HIV/AIDS education and prevention programs were funded by USAID (among other funders). By 1997, USAID's funding policies and priorities had changed and they were no longer funding IMAU's activities. IMAU's HIV/AIDS education and prevention activities are internationally recognized and in 1998 the United Nations AIDS Programme, which selects one exemplar of HIV/AIDS prevention and education programs annually, chose the IMAU as their Best Practices Case Study for the year (see Wheeler 1998).

³ A more recent estimate (mid-2001) gives a total population figure of 23,985,712 (Central Intelligence Agency 2001c).

⁴ The recently released preliminary data from the 2002 Uganda census puts the population at 24.7 million, 16 percent of whom are listed as Muslims. Since data for this dissertation was conducted in 1994 – 1995 and 1997, however, data from the 1991 national census are most relevant and they form the basis for discussion.

⁵ The U.S. Department of State's *Background Notes: Uganda* (2002) indicates that Muslims comprise 16 percent of Uganda's population. This is a higher percentage of Muslims than shown in the 1991 Census. The number of Ugandans included in the 1991 Census data on religious affiliation is, however, close to one million (945,623) less than the total population (total for Catholic, Church of Uganda, and Muslim equals 15,726, 442 versus the total population figure of 16, 671, 705) (Statistics Department, Ministry of Finance and Economic Planning 1994).

⁶ The Baganda (central region) are the country's largest ethnic group (18.8%), followed by the second ranked Bayankole and Bahima (western region, 10.2%), third ranked Bakiga (western region, 8.7%), and the fifth ranked Langi (northern region, 6.1%).

⁷ Unfortunately, the LC1 list is partially incomplete. Despite repeated attempts to obtain the information, the data from the village, "Munaana" are missing.

⁸ The IMAU FAEPTI Project administrative structure builds upon the structure of the Muslim community in Uganda. The leader of all Muslims in Uganda is His Eminence, the Mufuti, who heads the central organizing committee of all Muslims, the Uganda Muslim Supreme Council. His Eminence oversees about 33 religious leaders known as District Khadhis, who in turn each supervise about six religious County Sheiks. The County Sheiks are each responsible for 30 to 40 Imams, each of whom has a mosque (Wheeler 1998). Each mosque has a mosque area that it serves. Mosque areas can consist of a single or many communities. The imams are responsible for maintaining census data related to all the communities in their mosque area. Within the parish, there are three mosque areas, each headed by an imam. The first is based in the trading center of Ndala and serves the Muslims in the trading center, as well as eight surrounding villages: Ibiri, Isatu, Mukaaga, Musanvu, Munaana, Mwenda, Ikumi, and Ikumi na'ndala. The other two mosque areas serve one community each; Ina and Itaanu mosque areas each serve villages of the same name.

⁹ The focus groups were held in the trading center (Ndala) and in one of the villages, Ina. The groups in Ndala drew upon Muslims living in the Ndala mosque area, while the groups in Ina drew upon Muslims in the neighboring mosque areas (and villages) of Ina and Itaanu. Eighteen women and 17 men from Ina and Itaanu mosque areas participated along with 15 women and 25 men from Ndala mosque area.

¹⁰ Researchers have highlighted the complexities inherent in defining household forms, organization, and processes across cultures (Cloud 1994; Peterson 1994; Kabeer 1991). In this study the definitions of household, household membership, and head of household used are based on local definitions generated in key-informant and focus group interviews. Within the Basoga Muslim context, households are defined as "a place where there is a man and woman/women living together with or without children. Both the children and the man may not be there all the time. A household can also consists of a single man who is living alone and responsible for himself and/or a woman who has ever been married living alone or with her children." This definition is the most commonly agreed upon definition based on an analysis of the data. It was incorporated into the survey design and read to the survey participants prior to asking them about household-related demographics. Any man and woman or women who are unrelated and living together as husband and wife/wives are considered married. This definition reflects the fact that, depending on the context, the terms for man/men and woman/women are interchangeable with husband/husbands and wife/wives, respectively in the Lusoga language. Household membership is defined locally as "all people sleeping in the household, minus visitors." Head of household is defined as "the person who owns the land and built the house and/or the person who pays the rent." From a conceptual standpoint, households are defined as gendered institutions (Anderson 1993; Baca Zinn and Thornton Dill 1994). That is, it is within households that practices and beliefs about power and power relations are reproduced, with the impact of these power

relations affecting all aspects of everyday life (Acker 1992; Jiggins 1989; Wolf 1990).

¹¹ These hypothesized relationships are not explicitly addressed in this dissertation. They will be explored in future analyses of the data that will focus on evaluating the impact of program messages on levels of HIV/AIDS prevention knowledge and behavior.

¹² The concepts of "spatially concordant" (i.e., risk clusters consisting of members from the same household or compound) and "spatially discordant" (i.e., risk clusters consisting of members in different households or compounds) is adapted from the work of Ssengonzi et al. 1999.

¹³ Of the 35 people who were eligible, but did not participate in the survey: 22 were unavailable after repeated attempts; six refused; one was too physically incapacitated to participate; and no reason was noted for one person.

¹⁴ The majority of the 38 wives (68%, n = 26) who were not interviewed were disqualified; 24 because they lived outside the survey area and two because they did not meet the eligibility criteria of being married for at least three months.

¹⁵ Three risk cluster sub-sample respondents are Catholic, five are Protestant, and two are Seventh-Day Adventists. Nine respondents are from eight different ethnic groups; one each from eight separate groups and two from the ninth group.

¹⁶ Modifications of many of the questions from the IMAU FAEPTI Projects baseline and follow-up surveys in Iganga and Mpigi Districts were used, as were modifications of many of the questions used in the 1995 Uganda DHS. The most significant modification was in the language of the survey ("conc" Lusoga—see below) and in the use of local terms and concepts for key demographic, household, and sexual partner-related questions.

¹⁷ The survey was triple translated several times in both 1994 -1995 and 1997 with the assistance of colleagues from: the IMAU, the Makerere Institute of Social Research, faculty members at Makerere University specializing in the linguistic aspects of Lusoga and Social Work and Social Administration, local key-informants, and the survey interviewers.

¹⁸ While Luganda is the first language of the Baganda and the predominant language spoken in the central region of Uganda, it is not the first language of the Basoga. There are enough critical differences between Luganda and Lusoga to justify using Lusoga on that basis. Additionally, the Lusoga spoken by some of the people in rural villages is what is referred to locally as "conc" (short for concentrated) Lusoga. Basically, this means that this form of Lusoga has been less influenced by Luganda and retains some of its linguistic uniqueness.

Because not everyone speaks “conc” Lusoga, a form of Lusoga was chosen that would be somewhere in the mid-range between Lugandanized and “conc” Lusoga.

¹⁹ A Lusoga language paper had just started, so the written Lusoga was making some inroads. Since the survey, the New Testament of the Bible has been published in Lusoga.

²⁰ I did not sit in on any of the surveys because of concerns about how my presence during survey interviews might bias participants’ answers. This was a difficult decision, since a major concern was ensuring both the accuracy and the completeness of survey administration. This issue was discussed with FAEPTI Project workers and leaders at the Kampala headquarters. One of the options considered was taping some of the interviews. After further discussion, I decided against using a tape recorder because of my concern that people might refuse to be interviewed if a tape recorder was present.

²¹ The concept of risk cluster can be expanded to include the “lovers” and “others” categories, meaning that if any one member of the risk cluster has outside partners, unless they are using condoms, everyone in the risk cluster shares indirectly in that high risk behavior. I do not address this expanded definition in my dissertation, since it would require a social network methodology and analysis that I did not conduct in either round of research. I plan to address it, however, in future research.

CHAPTER 4

THE CONTESTED TERRAIN OF MARITAL RELATIONS AND OTHER UNIONS:

IDEALS VERSUS PRACTICE

Introduction

The way that gender is done within marital relations and other unions in Sub-Saharan Africa means that women are not necessarily protected against being infected by HIV, even if they remain faithful to one partner (Center for Health and Gender Equity 2004; UNAIDS 2004; O'Leary 2000). An understanding of the dynamics of marital relations and other unions is thus critical to understanding the dynamics of the HIV/AIDS epidemic. The types of gender power dynamics that influence differing degrees of control over sexuality and reproduction between women and men have a direct impact on their differing degrees of AIDS risk and ability to reduce that risk.

The idea that women who remain "faithful" will be at less risk or that women are in a position to effectively negotiate condom use with their husbands or steady male partners is belied by gender power differentials within marital relations and other unions that contribute to their risk. These gender power differentials in control over sexuality within and outside marriage mean that women have little control over their husbands' or steady male partners' sexual behavior (Blanc 2001; Schoepf 1998; Reid 1997; Rao Gupta, Weiss, and Whelan 1996; Simmons, Farmer, and Schoepf 1996; McGrath et al. 1993; Ulin 1992). Given this, deBruyn et al. (1998: 14) argue that, "marriage should be squarely acknowledged as a major risk factor for women in many societies." Indeed as

noted by Blanc and Wolff (forthcoming: 15), "[t]he experience of Uganda has shown that in high prevalence settings marriage is no protection against HIV, particularly in the presence of a strong sexual double standard and widespread polygyny."

The 2002 UNAIDS/WHO report on the global AIDS epidemic identifies gender inequality in access to valued societal resources, worsening economic conditions, and younger women marrying older men as some of the reasons why a higher percentage of younger women are infected with HIV in Sub-Saharan Africa:

Women and girls are commonly discriminated against in terms of access to education, employment, credit, health care, land, and inheritance. With the downward trend of many African economies increasing the ranks of people in poverty, relationships with men (casual or formalized through marriage) can serve as vital opportunities for financial and social security, or for satisfying material aspirations. Generally, older men are more likely to be able to offer such security. But, in areas where HIV/AIDS is widespread, they are also more likely to become infected with HIV. The combination of dependence and subordination can make it very difficult for girls and women to demand safer sex (even from their husbands) or to end relationships that carry the threat of infection (UNAIDS/WHO 2002: 18).¹

This chapter opens with a brief summary of the major themes in the literature on marital relations and other unions in Sub-Saharan Africa. Next addressed are the processual nature and complexities of these relations, women's views on polygyny, and the general characteristics of polygynous societies. This provides a context for understanding marital relations and other unions in Uganda generally, and among the Basoga Muslims who participated in this research specifically. Since Muslims comprise the study group, the final

sections focuses on Islam, marriage, and the status of women. While no literature exists specifically on Islam, marriage and the status of women among the Basoga, the final section draws upon two Masters theses from Uganda that have been written on the topic for the Baganda, an ethnic group similar to the Basoga. The authors' analyses about the complementarity and conflict between Baganda and Islamic norms regarding women's status and marriage are broadly applicable to the study population of Basoga Muslims.

Trends in Sub-Saharan Africa

The literature on marital relations, particularly polygyny, in Sub-Saharan Africa is vast. The major themes include the contested definitions, relative stability or instability, and flexible forms of marriage over the lifespan; explanations of the origins, incidence, and persistence of polygyny; and links between forms of marriage and fertility. Also documented is the emergence of "new" forms of unions within the context of changing social and economic conditions, especially within urban areas (Bledsoe, Guyer and Lerner 2000; Dodoo 1998a; Bledsoe and Pison 1994; Guyer 1994; Karanja 1994; van de Walle 1993; Garenne and van de Walle 1989; Goody 1989; Lesthaeghe, Kaufmann and Meekers 1989; Pebley and Mbugua 1989; Obbo 1987; Boserup 1985). Largely absent from this literature are women's voices, i.e., their views and experiences of polygyny (Meekers and Nadra 1995; Wittrup 1990; Ware 1979).

Historically, the majority of the literature on marital relations in Sub-Saharan Africa focuses on women, in terms of their reproductive health, with

special emphasis on fertility and reproductive decision-making (Blanc and Gage 2000). More recently, this literature has expanded to include men's experiences of different types of reproductive partnerships (including polygyny and serial monogamy), fertility preferences, and reproductive decisions either alone or as part of a broader analysis of the gendered dynamics of reproductive decision-making and fertility (Ali 2000; Anfari and Fayorsey 2000; Blanc and Gage 2000; Bledsoe, Guyer and Lerner 2000; Greene and Biddlecom 2000; Guyer 2000; Orobaton 2000; Townsend 2000; Ngom 1997). Other recent trends also include comparisons of women's and men's reproductive preferences and decision-making, with a growing emphasis on "couples" (comparison of matched partners' data) research (Becker and Costenbader 2001; Beegle, Frankenberg, and Thomas 2001; Agadjanian and Ezeh 2000; Becker 1999, 1996; Bennets et al. 1999; Bankole and Singh 1998; Biddlecom and Fapohunda 1998; Dodoo 1998a, 1998b, 1993; Timæus and Reynar 1998; Ezeh and Mboup 1997; Dodoo and van Landewijk 1996; Dodoo and Seal 1994; Ezeh 1993).

Many of the newer couples studies pay particular attention to the role of gender power differentials as an influence on reproductive health and some of the research specifically address HIV/AIDS (Blanc and Wolff forthcoming; Ali and Cleland 2001; Becker and Costenbader 2001; Miller, Zulu, and Watkins 2001; Agadjanian and Ezeh 2000; Wolff, Blanc, and Gage 2000; Wolff, Blanc, and Ssekamatte-Ssebulia 2000; Dodoo 1998a, 1998b; Blanc et al. 1996; Dodoo and Seal 1994). More often than not, however, this analysis is secondary to the focus on reproductive decision-making and fertility. The expansion to the level of the

couple, or dyad, and analysis of the role of gender power relations is commendable. When analyzing “couples” data from people in polygynous unions, however, very few of these studies move beyond the level of the dyad—or individual couples. Each polygynous union is comprised of at least two or more dyads. Polygynous unions thus constitute units with linkages between not only a husband and his wives but also between co-wives. The newer studies’ emphasis on “couples” generally lacks an analysis of interactions among co-wives as influences on reproductive health (including HIV/AIDS risk and risk reduction).

As discussed in Chapter 2, the limited amount of research that has been conducted on women’s views on polygyny shows that the reproductive decisions of women in polygynous unions may be influenced by their co-wives’ behavior. Because women in these unions compete with each other for a share of their husband’s resources, they stand a better chance of claiming a larger portion if they produce children. Thus women in polygynous unions may compete with each other to bear children (Meekers and Nadra 1995; Bledsoe 1993; Wittrup 1990; Ware 1979). In other words, their reproductive decisions are not necessarily limited to the dyad of husband/wife. The implications of this for women living in societies with a high level of polygyny in terms of its impact on the embodiment of risk are largely unexplored in the literature on marital relations in Sub-Saharan Africa. Thus, it is important to address the social patterns of marital relations in Sub-Saharan Africa, especially the fluid and staged nature of the process.

In the following discussion, emphasis is placed on how women's status and control over sexuality and reproduction as well as valued social and economic resources are impacted by social norms and practices related to marital relations and other unions, and the implications of this for the perception and embodiment of HIV/AIDS risk. Insight into women's views on polygyny is also provided.

Marital Relations as a Staged and Fluid Process

"Marriage" in Sub-Saharan Africa, as in other parts of the world, is more of a long, fluid process comprised of a series of steps rather than a single event. Marriages take several forms, including legally or religiously sanctioned unions in which couples have been through a formal ceremony and informal unions (variously referred to as "free," "cohabitating," or "consensual") in which couples have not been through a formal ceremony, but are recognized as married by others. Other types of informal unions include "visiting unions" in which one partner comes or goes and a variety of other unions, such as "outside wives." Marriage is generally characterized as less of a union between two individuals and more as a relationship between families (Aryee 1997; Bledsoe and Pison 1994; Karanja 1994; Van de Walle and Meekers 1994; Van de Walle 1993; Meekers 1992; Bledsoe 1990).

As a process, marriage may involve the exchange of symbolic gifts, paying bridewealth (often in installments), establishing a residence, and the birth of children. These events do not necessarily occur in a linear manner. The processual and fluid character of marriage means that it is difficult to define

marital status, much less pinpoint when a "couple" is married. This, in turn, can lead to disagreements on whether or not a union is formally completed. For example, a couple may be living together and have children, but may not be considered "married" because the bridewealth has not been fully paid (Bledsoe and Pison 1994: 4-5). Conversely, as with the Bakgalagadi of Botswana, "while payment of bridewealth can confirm a marriage, it does not always. But it always legitimizes children, and more than any other single act, it has the effect of defining an individual's social identity and clarifying succession to office and devolution of property" (Solway 1990: 45).

Economic decline, geographic mobility (especially migration to urban areas in search of work resulting in the separation of spouses), and rapid urbanization are contributing to new forms of unions. Increasing levels of education for some women, access to more economic resources, and the lessening of social controls, especially in urban areas also play important roles. The forms and costs of bridewealth payments are changing, with some groups now requiring part or all of the bridewealth in the form of cash. The burden on men and their families to generate the costs of bridewealth and other wedding-related costs is also increasing the number of informal unions in Sub-Saharan Africa. These unions are variously referred to as "concubinage," "outside marriages," "second office," "sugar daddy relationships," "visiting unions," and "serial monogamy" (Aryee 1997; Ocholla-Ayayo 1997; Meekers and Nadra 1995; Bledsoe and Pison 1994; Karanja 1994; Locoh 1994; van de Walle and Meekers 1994; McGrath et al 1993; Bledsoe 1990; Obbo 1987). While they are known by

a variety of names, Bledsoe (1990: 120) argues that they are “de facto polygynous templates.”

Women’s views on polygyny are largely missing from demographic and sociocultural analyses of polygyny.² This is especially true of much of the early anthropological literature on kinship, marriage, and family forms. As Ware (1979: 186) notes in her study in Nigeria with Yoruba women, “polygyny as seen from the inside was very different from the phenomenon generally described by male anthropologists.” These accounts—particularly those that rely on structuralist-functional explanations of polygyny—treat all women as though they are “interchangeable” (Clignet and Sween 1981).³ This approach is perhaps best exemplified in the statement that, “plural marriage treats women differently than men in terms of material status, but treats all women the same....” (Goody 1973: 173, cited in Wittrup 1990: 129). Representing women as equally impacted by polygyny fails to situate the analysis of polygyny within the “sex/gender system” that shapes its differential expression not only between women and men but also among women of different social statuses (Wittrup 1990).⁴

Such an approach also ignores differences between women’s backgrounds and current roles as co-wives (Clignet and Sween 1981: 450). Co-wives do not have the same degree of independence and autonomy. “The roles of co-wives are not interchangeable. In certain instances, the independence of these co-wives is wholesale, but in others it is a selective privilege that a women derives either from her assigned position in the domestic hierarchy or from her

involvement in activities that are valued by her husband or by the society at large" (*ibid.*: 463).

Most notably, viewing co-wives as interchangeable ignores differences between the types of decisions and options that women and men are faced with concerning marriage. Men's options include marrying, divorcing, and/or adding additional wives. Women are faced with a different set of marriage decisions beginning with the initial decision of whether to marry into a monogamous union or enter a polygynous union as a junior co-wife. If a woman enters a monogamous union, and the husband decides to add another wife, she may later face a decision of whether to divorce her husband or stay on as a senior co-wife. If she divorces, she will be faced with a decision of whether to remain unmarried, remarry a monogamous man, or enter a polygynous union as a junior co-wife (*ibid.*: 450). A woman may marry into and prefer to remain in a monogamous union, but may not be consulted by her husband about whether the union will become polygynous (Meekers and Nadra 1995; Wittrup 1990; Ware 1979).

Women and men thus have differing degrees of control over whether they are in a monogamous or polygynous union (Meekers and Nadra 1995; Wittrup 1990; Ware 1979). "... [I]n a society in which polygyny is fully accepted, [a woman] is constantly at risk of her husband choosing to take another wife" (Ware 1979: 188). A 1980 study found that the risk that a monogamous union will become polygynous increases with the duration of the union. The average length of time before a monogamous union becomes a polygynous union in Nigeria, for example, is five to seven years (Chonjnacka 1978: 30; see also Ware 1979). In a

more recent study of polygyny in several Francophone countries of Sub-Saharan Africa, Speizer (1999: 5) found that men who had been married between six to twenty years were more likely to state that they intended to become polygynous than men who had been married for five or less years. While the length of the first union and lower levels of education influences the intention to become polygynous, wealth influences the ability to realize that goal.

Faced with the possibility that a monogamous union may become polygynous and the fact that in much of Sub-Saharan Africa—particularly in the rural areas—a women's access to property and resources is vested through men, she may stay in (the newly polygynous) marriage. Her other option is to leave the marriage, which may involve repayment of bridewealth. If she is unable to do so, she may still be considered to be married to the man even though she has left him. Thus, many women may remain in marriages to ensure the economic security of themselves and their children (Ako 1993).

While some women identify advantages (such as economic security) to polygyny, others are either ambivalent, or state that polygyny offers them no advantages. On the one hand, polygyny may benefit women and their children at the individual level, by decreasing their workload and giving them a chance to socialize with others. On the other hand, women recognize that polygyny creates the types of structural tensions within linked domestic groups that can lead to competition between co-wives or for scarce resources (Soloway 1990: 48). Wittrup (1990: 120) argues that as a social institution polygyny can be understood as a domain of "potential conflicts" between women and men as well

as between co-wives. Eighty-five percent of women in Ware's (1979: 190)

Yoruba study, for example, identified "envy, jealousy, hate, chaos, devilishness, or murder...." as the disadvantages of polygyny.

The reality of conflict within polygynous unions is reflected in the parallel terms used for co-wives, rivals, and jealousy in some groups within Sub-Saharan Africa. Among the Luo of Kenya, for example, the term for co-wife is "*nyieka*...[which] refers to 'jealousy' and can be translated as 'my partner in jealousy' or my co-wife" (Potash 1978: 384). The word for co-wife in Yoruba is "*orogun*," which translates as "rival" or "competitor" (Ware 1979: 190). The Bakgalagadi of Botswana refer to co-wives as "*bagadikano*," or rivals while the term for polygyny, "*lefufa*" implies jealousy (Solway 1990: 48).

In Uganda, terms for co-wife among the Baganda and the Basoga also reflect this trend. The Luganda (language of the Baganda) term for co-wife is "*mukazi-muggya*," which literally translates as jealous woman and is most likely derived from "*buggya*," the word for jealousy (Kilbride and Kilbride 1990: 96).⁵ A Musoga woman who is in a polygynous union would introduce her co-wife (in Lusoga) as *mughalikwa*, which literally means, "your husband's other woman/wife." Beyond that, the term is understood to infer jealousy, since co-wives are considered rivals and competitors. Wittrup (1990: 96), who conducted research among the Mandinka of the Gambia, contends that despite social or religious sanctions that husbands should treat their wives equally and rotate their attention among wives, "[t]he everyday experience confronting each and every

woman in a polygynous marriage is of a husband committing *adultery*....”

(emphasis in the original).

Women thus identify one of the major disadvantages of polygyny as creating tensions within polygynous families—not only between husbands and wives but also between co-wives. Women compete for resources from shared husbands for themselves and their children. Husbands may show favoritism toward a new wife, which results in a lack of support for the other wife or wives and their children (Meekers and Nadra 1995; Kilbride and Kilbride 1990; Wittrup 1990; Ware 1979).

A lack of socially sanctioned steps in the marital process can contribute to disagreements between husbands and wives and between co-wives, or other members of the family about who counts as an “official wife” and who counts as “an outside wife” (Aryee 1997; Karanja 1994). The definitions and forms of unions vary between individuals and ethnic groups as well as within the same ethnic group based on socioeconomic status (Van de Walle and Meekers 1994: 57). All of these dynamics add complexity to the definitions and analyses of marriage forms in Sub-Saharan Africa, particularly as they relate to issues of sexuality and reproductive decision-making (see Meekers and Nadra 1995; Bledsoe and Pison 1994; Karanja 1994; Locoh 1994; Van de Walle and Meekers 1994; Bledsoe 1990). They also add complexity to analyses of marriage forms as they relate to HIV/AIDS risk and risk reduction (see Caraël 1994; Van de Walle 1993).

The emergence of new forms of unions such as “outside wives, girlfriends, etc.—has a number of consequences for women (Adepoju 1997; Caldwell et al. 1994; Caraël 1994; Ahlberg 1991) that impact the embodiment of risk. Commenting upon the Kikuyu in Kenya, Ahlberg (*Ibid.*: 184-185) notes that in the past the decision to add another wife to the family was made jointly by the husband and wife. Currently, many women learn that they have co-wives or their husband has mistresses through other sources. Thus husbands are now shared with unknown women. This also means that husband’s resources are stretched even more thinly among many women and their families before. Teenage pregnancies and pregnancies outside marriage have increased, as has fertility among married women and related complications. Such unions expand the sexual network for all involved and increase the risk of STD transmission, including HIV/AIDS. On the one hand, if men use condoms with their extra-marital partners, then the expanding sexual networks created by new forms of unions pose little risk to existing wives. Even if condoms were available and used with all extra-marital partners, however, “the wives of husbands infected prior to condom use would nevertheless remain unprotected” (*ibid.*: 220).

Characteristics of Polygynous Societies

“Most African men are involved in long-term relationships with more than one woman at any given moment, a situation that for the majority of African women has led to the inevitability of being in a polygynous consensual or formal union” (Adepoju and Mbugua 1997: 42). While there are a wide diversity of marriage practices and rates of different forms of marriage in Sub-Saharan

Africa, some common patterns emerge. In polygynous societies, women generally marry at an earlier age than men and there is often a significant age gap between husbands and wives. This is especially true with higher order wives (or junior wives), who may be many years younger than their husbands (Adepoju and Mbugua 1997; Bledsoe and Pison 1994; Bledsoe 1990; Lesthaeghe, Kaufman, and Meekers 1989).

Fertility preferences remain high in much of Sub-Saharan Africa (Bledsoe and Pison 1994; Bledsoe 1990). The social definition of woman centers largely on producing and raising children and women are in a better position to claim a portion of a shared husband's resources if they have children. Thus, co-wives often compete with each other in childbearing (Meekers and Nadra 1995; Wittrup 1990; Garenne and Van de Walle 1989; Ware 1979). This competition for resources among co-wives affects women's decisions about whether to use family planning or space children and highlights the need to analyze polygynous unions at a level that moves beyond "couples."

Men can increase their fertility through marrying multiple wives who bear several children a piece. The costs of maintaining multiple wives and children, however, are harder to meet in times of economic decline. Men may attempt to reduce the social and economic costs related to polygyny by "marginalizing low-status women, usually those with the least education, as outside wives and their children as outside children." In this way, an officially polygynous union may become monogamous and wives who were defined as legitimate "inside" wives

may find themselves and their children as outsiders, through the husbands' withdrawal of support (Bledsoe 1990: 115, 123).

Divorce and widowhood are common in polygynous societies; women often remarry quickly after becoming widowed or divorced. Women who remarry because of divorce or widowhood frequently remarry into already polygynous unions as junior wives. A woman who has not produced children with a man may either leave or be divorced by him and remarry someone else (again, often as a higher order wife in a polygynous union) in the hopes of fulfilling her socially sanctioned roles and statuses as wife and mother. Women are thus in some form of marital union for most of their lives (Adepoju and Mbugua 1997; Bledsoe and Pison 1994; Bledsoe 1990; Lesthaeghe, Kaufman, and Meekers 1989). Serial marriages of either women or men, following the death of a spouse are a concern within the context of the AIDS epidemic, particularly in areas with a high level of HIV/AIDS, because of the risk that new partners will be exposed to HIV (Adeokun and Nalwadda 1997). Many women in monogamous unions are those who are younger and have been married for a shorter duration (Pebbley and Mbugua 1989). "The institution that maximizes the time women spend in union, despite wide age gaps between spouses and often high rates of divorces is polygyny" (Bledsoe 1990: 117).

The rate of polygyny is usually framed in terms of two measures: incidence and intensity. The incidence of polygyny provides a measure of the number of men married to more than one wife. Intensity is discussed either as the average number of wives per polygynous man or as the number of men who

are married to more than two wives (Clignet 1970; Van de Walle 1968). Given the flexibility of marriage forms and the likelihood that many currently monogamous marriages may become polygynous, an alternative conceptualization of intensity is "...not only *whether* a man is married but *how* married he is. In this view, polygyny is not a state distinct from monogamy but simply farther along a continuum that ranges from 'not at all married' to 'intensely married'" (emphasis in the original) (Blanc and Gage 2000: 165).

The incidence of polygyny varies widely by region and by ethnic group. The rates are generally highest in West and Central Africa and lower in East and Southern Africa. About 40 percent of women in West Africa and 30-39% of women in much of Central Africa are in polygynous unions, compared to a rate of between 20%-30% in East Africa. The percentage of women in polygynous marriages is 20 percent or less in southern Africa (Lesthaeghe, Kaufmann, and Meekers 1989: 276-277). "Widespread polygyny is probably the most distinctive feature of African marriages" (Garenne and van de Walle 1989: 267). The high incidence of polygyny has persisted despite efforts on the part of both colonial and contemporary states and religious institutions to decrease or eliminate it through the enactment of legal and religious codes (Bledsoe and Pison 1994; Bledsoe 1990).

Data from a series of Demographic and Health (DHS) surveys conducted from 1990-1993 in nine Sub-Saharan African countries (Burkina Faso, Cameroon, Ghana, Kenya, Malawi, Niger, Rwanda, Senegal, and Tanzania) among men ages 20-54 shows a low of about nine percent polygyny in Rwanda

and Malawi to a high of approximately 28 percent in Senegal and Burkina Faso. The rates for Kenya and Tanzania were 11.6 percent and 14.9 percent, respectively. Calculations of the intensity of polygyny show that most polygynous men in the nine-country study are married to two wives. The number of wives that a man is married to increases, however, over his lifetime (Blanc and Gage 2000: 164-166).

The next three sections focus specifically on aspects of marital relations and other unions in Uganda.

The Ugandan Context

Marital relations and other unions in Uganda are characterized by the fluidity and staged processes discussed above. Customary practices related to the exchange of money, material goods, and the future bride's productive and reproductive labor (including her sexual services and fertility) varies by region and ethnic group. Likewise, while the general practice is for marriages to be virilocal (i.e., a wife moves into her husband's home, which may be in the same compound, or near his parent's compound), there is also variation in the rate of co-residence, in the case of polygynous unions (Olowo-Freers and Barton 1992).

Formal unions generally consist of several stages, including aspects of customary marriage following the initial stage of partner selection such as (1) an introduction ceremony, (2) the payment of bridewealth and (3) a religious or civil wedding ceremony (Kyomuhendo 1994). Alternately, customary marriages (consisting of a contract between the prospective husband and the father of his

future bride and sealed with the payment of bridewealth) and religious or civil ceremonies may occur independently of each other (Nabaitu, Bachengana, and Seeley 1994). The initial stage following partner selection is the introduction ceremony, (*okwandhula*, in Lusoga). This is the formal meeting of the two families and involves the exchange of gifts, with the man doing the majority of gift giving to members of the woman's family. The stages are not necessarily linear. For example, a man and a woman may start out living together and may not go through the formal introduction ceremony until they have been married for quite some time and have had children together. Bridewealth (the second stage) may be paid in installments, rather than all at once at the start of the marriage. Marriages are not viewed as fully legitimate, however, until bridewealth has been paid and the couple has been through the introduction ceremony (Kyomuhendo 1994).

The payment of bridewealth affects women's position within the household. In some instances in the Southwestern region, girls are married at early ages in order to finance their brother's marriages. Additionally, when a husband pays bridewealth he also contracts for the expectation of an obedient wife. Further, should a marriage end in divorce, the wife or her family will be expected to repay bridewealth. In many instances, this can act as a deterrent for wives leaving unhealthy marriages; in most cases, men gain custody of the children and women who leave forfeit their access to property (Kirumira et al. 1993).

The emphasis placed on women's sexuality and fertility is reflected in the social definition of women. Women's status as adults is defined largely by their ability to produce children. Wives who do not produce children are at risk of social ostracism and/or divorce (Kirumira et al. 1993; Olowo-Freers and Barton 1992). In Busoga and Buganda, for example, the definition of adult womanhood is not based solely on age. In Busoga, a female—no matter what age—who has not produced a child or children, is socially defined as a "*mughala*" (girl) rather than as a "*mukazi*" (woman). A woman who has never married is also referred to as a *mughala*, regardless of her age.

Men's inability to pay bridewealth due to economic decline as well as decreased parental control over marriages has contributed to a blurring of the line between women who are viewed as wives versus girlfriends (Mwaka, Mugenyi, and Banya, no date). Informal unions take a variety of forms including consensual or free unions in which the couple have not been through a ceremony, are cohabitating, and are viewed as married by friends and neighbors. Another type of informal union is known as a *mukwano*, or friendship union (also known as a visiting union) in which the couple may cohabit or one party may come and go (Davis 2000; McGrath et al. 1993; Obbo 1990). A woman may also be called—or call herself a wife—if she has produced a child and the father accepts responsibility for the child (Mwaka, Mugenyi, and Banya, no date).

Polygyny in Uganda is not unique to Muslims. As discussed in Chapter 3, an average of 30 percent of all women and 15 percent of all men in Uganda are in polygynous unions (Statistics Department, Ministry of Finance and Economic

Planning, Uganda and Macro International 1996). Commenting on polygyny, Katungulu (1993: 202) observes that,

Ugandans, like many other African peoples, accept polygyny as a traditional and customary practice. Most tribes in Uganda accept polygyny as a social need and it is considered by many as a supportive institution ...[because] at times co-wives may work together, mind each other's children and help themselves out in times of need. Contrary to this, however, is the fact that at times, polygyny is the major cause of conflicts in the home. The wives compete for income and resources each trying to find personal favours.

Men may marry additional wives for a number of reasons including as a means of increasing their status and prestige, to benefit from a larger agricultural and domestic workforce, because of suspicions that a first wife is infertile, or due to a lack of male children. Additionally, in ethnic groups where sex is prohibited during menstruation or due to postpartum taboos, polygyny ensures that men have sexual access to more than one wife (Barton and Wamai 1994; Olowo-Freers and Barton 1992). Because of the high value attached to women's socially defined role as wives and mothers and the access that women gain to social and economic resources through men, women may marry into an already existing polygynous union, rather than remain unmarried. This is especially true for widows and divorced women with children (Kyomuhendo 1994).

Multiple and conflicting marriage and family laws. Uganda has multiple systems of statutory marriage and family laws that were formulated during the colonial period. Colonial officials sought to legislate the Christian ideal of monogamous marriages, but eventually "drafted different laws and ordinances for each social group" (Kasozi 1995: 233).

Under the statutory law of Uganda, a marriage can be monogamous or polygynous. It is monogamous when contracted under the Marriage Act of 1902 and the African Marriage Act of 1903 and under the Hindu and Divorce Act of 1962.... Most Ugandan women are married under the Customary Marriages Decree of 1972 or Islamic Law. Polygynous marriages ...[are regulated] under the Marriage and Divorce of Mohammedan Act of 1906. The Legal age for a girl to marry is 16 (Kyomuhendo 1994: 18).

Under customary law, women are considered legal minors in most ethnic groups and are not granted “contractual rights in issues related to marriage” (Kyomuhendo 1994). Marriages that combine customary and statutory law can lead to problems for women. For example, in the event of a dispute over the issue of polygyny, a wife who was monogamously married under statutory law but whose husband paid bridewealth under customary practice can claim the right to a polygynous union under the latter system of marriage law. Similarly, a wife who divorces her husband under statutory law may still find herself married under customary law (*ibid.*). Many women married under customary law do not register their marriages, which can result in their being unable to claim inheritance if their husband dies (Mwaka, Mugenyi, and Banya, no date).

The heavy emphasis on pronatalism and attitudes toward women’s sexuality and fertility combined with socio-economic decline mean that many women view sexuality and fertility as a route to economic and social security. This, in turn, increases women’s health risks on a number of levels, including maternal mortality (which is estimated at 500 per 100,000 live births) and STDs (sexually transmitted diseases), including HIV/AIDS (Kirumira et al. 1993: viii-ix). This leads to a

...culturally based 'dependency' element. Women are culturally expected to depend on men for money and other necessities. Women rarely have control over the proceeds from cash crops although they spend 50% of their energy and time on them. They have limited resources to hire casual labor, to accumulate wealth, and to control their decision-making over treatment options. The resultant economic inadequacy and insecurity sometime drives women into various liaisons with men thus increasing the risk of exposure to infections and unwanted pregnancies (*ibid.*: 1).

Marital instability and divorce. Dissolution of marriages is a particular concern within the context of the AIDS epidemic in Uganda, since it generally results in partner change (Nabaitu, Bachengana, and Seeley 1994; Kirumira et al. 1993). A number of factors may either inhibit or enhance the rate of divorce. For example, inheritance rules and the amount of brideprice paid may influence whether an unhappy marriage ends in a divorce. High brideprice, as practiced among many of the northern groups, may contribute to a low divorce rate because of the obligation for the wives' family to repay bridewealth. A woman marrying into these groups belongs to her husband's clan, and she and her children will inherit through the patrilineage (Larson 1989).

On the other hand, among ethnic groups that require limited bridewealth—such as the Baganda—bridewealth is low and women remain in their father's clan even after marrying. They are able to inherit both land and property and frequently return to their father's home following the breakup of a marriage, where they may be given land and a house. In this instance, the low bridewealth and inheritance rules may contribute to a high divorce rate. Other reasons for the dissolution of marriages include infertility, polygyny, large age gaps between partners, alcoholism, lack of sexual satisfaction, neglect of economic

responsibilities, laziness, and geographic mobility separating husbands and wives, which may lead to outside partners (Nabaitu, Bachengana, and Seeley 1994; see also Barton and Wamai 1994; Olowo-Freers and Barton 1992).

Fallers (1965, 1957) has written the only ethnography of the Basoga. Based on his research from the 1950s, he contends (1965: 85 and 161) that it is quite common for wives to leave their husbands and return to their parental homes during the early years of their marriage. The line between separation and divorce in Basoga was quite blurred and Fallers (1957: 121) argues that they "are practically synonymous." "In spite of the belief in the desirability of stable marriages....and in spite of the emphasis upon formal good relations between bako [a husband and his in-laws], marriage in Basoga is quite unstable....between one-quarter and one-half of all marriages contracted end in separation, and in 90 percent of these cases there is a formal divorce with repayment of the bridewealth" (*ibid.*: 114).

Unlike some other patrilineal groups in Sub-Saharan Africa, Basoga women remain in their own clan after marriage, that is, they do not become a member of their husband's clan. The children that they bear with their husband, however, will belong to his clan. Fallers views one of the primary causes of the high rate of marital dissolution among the Basoga as due to the competing demands placed upon women due to the kinship system:

Soga marriage...is not a strong enough bond to resolve the conflict, present in any patrilineal society, between a woman's loyalty to the group into which she was born and of which she remains a member and her loyalty to the group in which she married and for which she bears children (*ibid.*: 86).

At the time that Fallers conducted his research, the common pattern of wives returning to their father's home when conflict arose between them and their husbands often led to conflict between the husband and his in-laws

...because a husband has an absolute right to require his wife's presence in his homestead. She may not even visit her parents without his explicit permission. A father who allows his daughter to stay in his house without her husband's permission is guilty of the offence known as *kutuuza omukazi*, "harbouring a wife." Divorce is easy for a man, who may simply send his wife away, but difficult for a wife. She cannot simply leave her husband, even on the grounds of severe cruelty. If she has good grounds for divorce, she should return to her father and he should immediately inform the village headman, asking him to notify the husband, and offering to repay the bridewealth. If the husband refuses to accept it, the father may then bring a suit against him, giving the wife's reasons for wanting a divorce (1957: 113-114).

Among the Baganda, women may leave their husbands (*kunoba*) and return to their natal home because of mistreatment and neglect. In these cases, the separation may be viewed as only temporary until the husband "explain[s] himself and [comes] to claim his wife" (Obbo 1993: 954). While reconciliation may occur, many marriages end after several such separations resulting in women making the temporary leave of absence, permanent. Other practices contributing to marital instability and also to increased HIV/AIDS risk among the Baganda included establishing co-wives in separate households (contributes to "adultery"), and the common practice of young women returning to their parents just before and for a few weeks after childbirth. While this practice functions as a protective mechanism for the mother's health, it also contributes to some husbands having outside partners during this period. The culture of silence that dictates household members should display good manners (*buntu bulamu*) by

not mentioning the transgression to the wife when she returns contributes to the increased transmission of HIV/AIDS (*ibid.*: 953-954).

One of the ways that Baganda and Basoga women exercise their agency to opt out of marriages altogether or to remain unmarried after widowhood or divorce is by becoming *banakyeyombekedde/banakyembekiere* (Luganda and Lusoga terms, respectively) or *bakirerese*. Traditionally, *nakyeyombekedde* (singular form) meant a rural female head of household. In the pre-colonial period, such a woman was usually over the age of 35 and had either left or been divorced by her husband. A *nakyeyombekedde* could become an independent householder by cultivating a piece of land given to her by the chief or her natal village or her husband's village in exchange for providing food, cooking, and entertainment to important visitors or during festivals (Obbo 1976: 378).

Currently the term *banakyeyombekedde* has expanded to include anyone who lives in rented rooms and is an urban female head of household. School leavers as young as 15 are referred to as *banakyeyombekedde* if they are urban heads of households residing in rented rooms. Women who have migrated to urban areas in search of income and are living as *banakyeyombekedde* may form bonds of fictive kinship and "cooperative residential and economic units" that enable them to collectivize their efforts to the benefit of all the women (and their children) (*ibid.*: 378, 382).

In contrast to *banakyeyombekedde*, *bakirerese* (singular *kirerese*) do not have their own houses. They "stay with friends, brothers, parents or lovers for varying periods of time repeatedly" and do not settle down in any one place. The

term *bakirere* is understood to mean “restless people.” “A female *kierere* nowadays is a woman who has had, perhaps, many unsuccessful marriages or has been involved in short-term concubinage relationships” (*ibid.*: 378-379). Unlike the *banakyeyombekedde*, who live independently and who “...dictate the kinds of relationships that they want to have with men,” *bakirere* are “dependent women.... In most cases, they used marriage, sexual affairs and children to gain economic goals from men” (Obbo 1980: 153, 154).

Both of these statuses are socially stigmatized. Baganda women refer to *banakyeyomekedde* as “husband snatchers” and Baganda men refer to them as “purse pinchers,” because of the costs of maintaining them. While the terms *banakyeyombekedde* and *bakirere* are still used (along with the term, “*abemizigo*”—“those with doors—working girls...” all single women living in rural or urban areas in rented rooms are now grouped together under the Swahili term for prostitute, “*malaya*” (Obbo 1976: 379).

The extent of stigmatization directed toward women living independently—particularly in the city of Kampala—has intensified within the context of the AIDS epidemic in Uganda. A recent study shows that “town women” (“*abakazi be tawuni*”) in Kampala are blamed for the spread of AIDS (Davis 2000: 1). “Town women” are viewed as prostitutes and contrasted with proper women—or married housewives (“*abakyala abatufu*”). The status of “*omukyala omutufu*” (singular form) in Kampala rests on three elements:

social life—marriage, producing children, and cultivating *empiisa* (respectability, discipline)—and marriage is central to all three. In this discourse of respectability, cleanliness, sociability, and good neighborly relations are important, but the central requirement is

marriage, or a stable, committed relationship...that demands sexual fidelity on the part of the woman. Single women are not "Proper Women." Without male control over her sexuality, the single woman is viewed as unstable, unpredictable, and immoral—"what she likes is what she does" (Ogden 1996: 176, cited in Davis 2000: 10).⁶

In summary, there are a variety of ways that sociocultural influences on gender power relations shape the embodiment of risk through the institution of marriage in Uganda and throughout Sub-Saharan Africa. The value of being married as a marker of the way that gender is done among the Basoga and the Baganda of Uganda is illustrated in the stigmatization of women who leave their marriages and remain unmarried. These women have broken with the way that gender is done and are often blamed for spreading HIV/AIDS. Since the study population is Muslim, it is critical to understand the relationship between Islam, marriage, and the status of women. The following sections address this relationship, with an emphasis on Islam, marriage, and the status of women among Baganda and Basoga Muslims in Uganda.

Islam, Marriage, and the Status of Women

There is no single, definitive interpretation of Islam (Bhutto 1998: 107) and, thus, any discussion of Islam and marriage must be framed within this realization. "Just as we have different religious sects in Islam, upholding different religious views—whether this is the Shi'is, the Sunnis, the Malakis, the Hanafis...—so too we have different interpretations with regard to the more secular aspects of the duties incumbent upon the Muslim."⁷ Bhutto (1998: 107) delineates two primary categories of Islam, "reactionary" and "progressive."

We can have a reactionary interpretation of Islam which tries to uphold the status quo, or we can have a progressive interpretation of Islam which tries to move with the changing world, which believes in human dignity, which believes in consensus, and which believes in giving women their due right .

A comprehensive discussion of Islam and marriage in Sub-Saharan Africa is beyond the scope of this dissertation. Most of the sources drawn upon fall into Bhutto's "progressive interpretation." This perspective also seems to be the primary interpretation favored and put into practice by the Islamic Medical Association of Uganda in their AIDS education and prevention programs.

The distinction between "Islamic" and "Muslim" provides a useful framework for discussing Islam and marriage. Islam is the religion, thus Islamic refers to the "essential values of the religion...." Those who practice Islam are Muslims, the practitioners of the religion (Aroukan 1984, cited in Obermeyer 1995: 370). The usefulness of this distinction, according to Obermeyer is that it "separates the ideal of the religion from its implementation by various sects and acknowledges diversity while protecting the central core of the religion from totalitarian claims."

The distinction between "ideal" versus practice is also articulated by Dahl (1997: 5), who identifies a "major and minor tradition in Muslim family life." Writing about Muslim families in a poor section of Cairo, Egypt, he notes that, "the major tradition is constituted *by Islam as a paramount code for the conduct of individuals*. This code derives from Sharia—Islamic law—with its special historical and authoritative sources of law" (emphasis in the original). This, then, is the "ideal." Islamic law, or Sharia, is based on two primary sources: the Koran

(which is considered "the highest source, since it is the result of divine revelation") and the Sunna ("the tradition left by the Prophet, i.e., all his acts and words") (*ibid.*: 32, 37).⁸

The "ideal" is contrasted with the "minor tradition" in which the code of conduct for Muslims enshrined in Sharia law is articulated and manifested in "acts, opinions, and attitudes..." at the local level (i.e., "practice").

Islam is a uniform doctrine, since *Sharia* is a norm system that is deemed to be both uniform and universal. It is universal in the sense that it applies to all Muslims no matter where they live in the world, and uniform in the sense that there is one will, and only one will – Allah's – that is expressed.

Nevertheless, in practice the major tradition is neither universal nor unambiguous. A number of local traditions have modified and differentiated the uniform doctrine, and adjusted it to their customs and conditions (*ibid.*: 12).

Commenting on the congruence or conflict between customary practices and Islamic doctrine on marriage during the introduction of Islam into Uganda, King, Kasozi, and Oded (1973: 53) note:

... Islam came into some measure of conflict and yet of congruence with traditional beliefs and practices in regard to marriage and the status of women. In traditional society a rich and powerful man could have any number of wives; their rights were of the families from which they had come and of which they were still in some sense members. Senior women of the family or group had great authority, especially over women who had not yet brought forth children. Islam insisted on the rights of woman; she was to inherit a share, she was to be legally married by the use of the idea of a contract—as long as she fulfilled her part in it she had rights. The grounds and manner of divorce were also carefully laid down. Clearly, Islam and Traditional Religion would take time to adjust, but would not come into the headlong clash produced by the Christian ideal of monogamous permanent marriage and rare divorce reluctantly granted, if at all.

There is ambivalence and thus a tension within Islamic doctrine in regard to the status of women. On the one hand, there is evidence of equality between women and men before God, and on the other, clear distinctions between the rights and responsibilities of women and men. Thus, Islamic texts—as with any religious doctrine—can contribute to increasing the oppression of women or to increasing more equal gender relations. Traditional interpretations stress the subordinate status of women and limitations upon their “freedom of choice in matters of marriage, divorce, and the custody of children” (Obermeyer 1994: 42).

In this tradition, women’s options are limited to their domestic role. ... Marriage is contracted by a woman’s legal guardian, her consent is inferred rather than formally sought, and early marriage and forced unions are not regarded as infringements on an individual’s free choice, or as unethical. Men are entitled to four wives and can repudiate their wives by uttering the divorce formula, whereas women must go through an often difficult procedure if they wish to obtain a divorce. Fathers have custody of their children after infancy, while women have no grounds in claiming custody. And although the religious sources provide no clear rule on the degree to which women should have access to equal education and employment, conservatives have favored sexual segregation in schools and opposed women’s work outside the home (Abu Zahra 1955; Rahman 1980, cited in Obermeyer 1994: 42).

In contrast, reformists argue that Islamic texts provide many examples that stress gender equality. Islam, in this view, is based upon an “essentially egalitarian ethos” that has subsequently been “distorted by patriarchal forces” (Ahmed 1986, 1992, cited in Obermeyer 1994: 42). Contemporary reformists thus argue that it is not the original precepts of Islam that have contributed to the lower status of women, but rather “misinterpretation of the Quar’an and un-

Islamic additions" (Kayunga 1993: 58). Islamist⁹ gender activists challenge the dominant Islamist discourse on gender relations, arguing that women have the right to work outside the home, to own property, and control their own wealth. "Despite the actual traditional practice... Islam does not shackle women within marriage, does not bind them to domesticity, and by allowing them a separate property entitlement, in fact makes them independent of their husbands and thus able to fend for themselves" (Maumoon 1999: 8).

Husbands are required under Islamic law to provide maintenance to their wives and to treat them with kindness. Women are allowed to insert a provision enabling them to divorce within the marriage contract (Maumoon 1999: 8). Similarly, they are allowed to insert clauses into the marriage contract protecting themselves against polygyny as well as "arbitrary divorce," and ensuring their rights of freedom of movement. Throughout history, privileged Muslim women have inserted these provisions into the marriage contract. In practice, however, many Muslim women are unaware of this aspect of marriage law and unable to implement it (Obermeyer 1995: 380).

Islamic interpretations of polygyny vary based on whether they are filtered through a conservative or reformist lens. Muslims are enjoined (in the frequently cited Qur'anic verse [Sura 4, Verse 3] to " 'marry such women as seem good to you, two, three, four, but if you fear you will not be equitable, then only one.' " Rather than being what is commonly interpreted as a justification for polygyny, this verse actually advises Muslim men to only marry one wife "since equal and just treatment of several wives is beyond the ability of any human being"

(Kayunga 1993: 58-59; see also Bhutto 1998: 110). Polygyny from an Islamist gender activist's standpoint is allowed only under "exceptional circumstances and...the husband must ask the wife's permission before doing so" (Maumoon 1999: 8).

Polygyny, rather than being the norm among Muslims, is the exception (Serunjogi 1994). For example, data from 1950-1980 in Arab Muslim countries shows that only 5-12% of men are in polygynous unions (Chamie 1986 cited in Blanc and Gage 2000: 164). The important point in Sub-Saharan Africa, however, is that polygyny existed in many of the societies prior to the introduction of Islam (and Christianity). Thus, both the practice of polygyny and the treatment of women may depart from the Islamic ideal. Indeed, Obermeyer (1995: 371) asserts that, "...societal definitions of women's roles and reproductive rights are affected more by local and international practice than by religious doctrine as such."¹⁰

Obermeyer's argument parallels Dahl's articulation of the "minor" tradition in Islam, i.e., how the practice of Islam is enacted at the local level. Drawing on qualitative data, the next section presents a brief overview of "the local tradition"—or how gender is done among the rural Basoga Muslims who participated in this study. This provides a context for understanding the final section of the chapter, which examines the complementarity and conflict between sociocultural and Islamic norms influencing the practice of marital relations and other unions, and the impact of this tension on women's status among Baganda and Basoga Muslims in Uganda.

"Doing Gender"

The way gender is done in a society shapes the allocation of power and resources in societies by essentializing and legitimating socially constructed definitions of "differences" between boys and girls, men and women (West and Zimmerman 1991 24 and 32). "Doing gender" among the Basoga is illustrated in Figure 4.1, which presents the rights and responsibilities of a Musoga girl, boy, woman, and man. It is based upon on a list drawn up by a key informant during the initial period of research. The articulation of "doing gender" in the table is representative of similar lists drawn up by another key informant and by a group of female and male community members as part of a group discussion during a Family AIDS Workers (FAW) training session, all of which are referred to in this discussion.¹¹ The list represents Basoga social norms about the rights and responsibilities of females and males at different stages of the life cycle.

Comparing the rights and responsibilities of a Musoga boy and girl reveals that boys become heirs while girls do not. Boys are entitled to own land and to build a house, while the same is not true for girls. Girls are expected to be virgins at marriage, while there is no mention of this for boys. Bridewealth that comes to families from girls' marriages should be used to finance their brothers' marriages.

Figure 4.1 Basoga Gender Norms			
Rights & responsibilities of a Musoga girl	Rights & responsibilities of a Musoga boy	Rights & responsibilities of a Musoga woman	Rights & responsibilities of a Musoga man
To get married.	To become an heir.	To be a housewife.	Head of his family.
To bring wealth out of a dowry (bridewealth).	To marry a woman out of his sister's dowry (bridewealth).	To produce children.	To marry women.
Always stay beside her mother at all times.	To help a father in his duties.	To grow food for the family.	To be the money earner and provider for family.
Helps mother in doing housework, e.g., cooking, looking after the young ones & father, fetching water.	Does not cook or help his mother as with the Musoga girl.	To look after the husband and children.	The only decision maker for his family members.
Helps mother to cultivate food & prepare it.	To own land.	Not to own land.	To own land.
Not to be in boy's/men's groups.	Is free to go anywhere if he feels like it.	Not to have money.	To look for a job.
To get a little education. If not at all, it does not matter.	Is expected to get the highest education. Priority is given to him for education.	Responsible for the purchase of household commodities such as saucepan, plates, cups & salt.	To build a home/house.
To remain a virgin until marriage.	Controls the movement of girls.	To respect the husband.	To be respected.
	To build a house.	To help her parents.	To protect his parents.
		To maintain cleanliness of the home, children, plus husband.	To pay graduated tax.
		To teach children manners.	To be strong.

The gender division of labor is reflected in the expectation that girls assist their mothers with domestic labor, while boys assist their fathers. Boys' education is prioritized over girls' and their freedom of movement is not restricted as is girls. The item "always stay beside her mother at all times" refers to a social norm that girls should stay within the family's compound for their own protection, i.e., to reduce the likelihood that they will be "conned" (talked into having sex) if they leave the compound. Similarly, the item, "controls the movement of girls" refers to brothers' responsibility to protect their sisters' virtue by keeping an eye on their movements.¹²

Turning now to the rights and responsibilities of a Musoga woman and man, the social norm that men are the head of the household (*mwene maka*) and are considered the final decision maker, is shown in the table. Men are to be respected as head of the household and are responsible for providing for the family. They are recognized as having authority (*obuyinza*) over household members and matters. Women are responsible for producing children, teaching the children proper manners, taking care of children and her husband, and doing domestic labor. Women's responsibility to produce children is linked to the social definition of woman and the importance placed on motherhood. They are also responsible for growing food for the family and purchasing basic household commodities, but they are not to own land, build a home, or have their own money. In contrast, men are expected to earn an income, own land, build a home, and pay taxes.

Another key informant, who is also a FAEPTI trainer as well as a health educator and mid-wife, made a nearly identical list of what is expected of Basoga female and male youth and adults. Her list includes the additions that a Musoga man has the authority to give household members permission to travel away from the home. Further, when he has many wives, he is the person who sets the rules governing their behavior and interaction. She also noted that a Musoga woman does not have authority (*obuyinza*) within the home.

Participants in a three-day training session during 1995 for both female and male community members to become FAWs produced nearly identical lists for the responsibilities of a Musoga woman and man during a group exercise. In addition to the items in the above table, they stated that Basoga women are responsible for being patient, forgiving, well-behaved, trustworthy, keeping family secrets, and being religious. Basoga men are responsible for the items identified in the table along with producing an heir, ensuring discipline within the home, good behavior, being forgiving, and religious.

Figure 4.2 shows the rights/freedom of a girl, boy, woman, and man in Islam. It is based on a list presented by an IMAU FAEPTI Project trainer to community members being trained as FAWs during the training session in 1995. The figure represents part of the FAEPTI Project's message to their target population about gender relations in Islam. The wording in the figure is that of the IMAU trainer.

Figure 4.2 Islamic Gender Norms		
Rights/Freedom of a Girl in Islam	Rights/Freedom of a Boy in Islam	Rights/Freedom of a Woman in Islam
Right to live.	Right to live.	
Right to be treated fairly, i.e., not to get married when still very young (12 years).	Right to be treated fairly.	A virgin girl should marry a virgin man. Right to choose whom she wants to marry.
Right to attend school, just like boys.	Right to be taught religion.	Right to decide the amount of dowry and how to spend it.
	Right to be taught all spheres of life.	Right to be prepared before marriage.
	Right to an education.	Right to be satisfied sexually.
		Right to only have sex with her husband and not with her in-laws.
		Right not to have sex during her periods.
		Right to be treated equally in a polygynous marriage.
		Right to receive adequate care from her husband in all ways.
		Right not to be divorced if she is very sick, disfigured, or has a mental disorder.
		Right to be treated well in marriage by law, e.g., to divorce her husband if there is a genuine reason & not to be accused falsely without enough evidence if her husband wants a divorce.
		Right to decide whether to remarry if widowed or divorced.
		Right to take 25% of her husband's estate if she has children and 12.5% if she is childless.
		Right to get equal pay when doing the same job as a man, to vote, and to claim her human rights if they have been taken from her.
		Right to be loved by his wife all his life. Right to have sex with his wife.
		Right to be head of the home.
		Right for his wife to give him due respect.
		Right for his wife to keep all his secrets.
		Right to be comforted by his wife, especially in times of trouble.
		Right to be corrected by his wife when
		Right for his wife to fear and love God.
		Right to see that his wife teaches the children good manners.
		Right to educate his children, both girls and boys.
		Right to be respected and looked after if he falls sick.
		Right to divorce his wife if she doesn't want to pray, fast, or practices witchcraft.
		Right to receive one-half of his wife's things when she dies.

In contrast to the list of rights and responsibilities for a Musoga girl, the list for a Muslim girl states that she has a right to an education, just like boys, who have the additional right of being taught about all spheres of life. Most of the points in the figure relevant to marital relations are addressed in the following section and are not included in the list for a Musoga woman, including: the right for a Muslim woman to choose her own marital partner; to decide on the amount of dowry; to be treated equally in polygynous marriage; to receive maintenance from her husband; and the right to re-marry following widowhood or divorce. Muslim women also have the right to earn equal pay when doing the same work as a man, and the right to a share of their husband's estate.

The implications of the way gender is done among the rural Basoga Muslims who participated in this study with regard to HIV/AIDS risk and risk reduction are explored in a subsequent chapter on power, resources, sexuality, and risk. The final section of this chapter focuses on Islam, marriage and the status of women among the Baganda and the Basoga, with an emphasis on the gap between ideals and practice.

Complimentarity and Conflict: Islam Marriage and the Status of Women among the Baganda and the Basoga

The vast majority of people who took part in this dissertation research are Basoga Muslims. There are a number of overlaps as well as differences between Basoga and Muslim marriage practices. The following discussion of similarities and differences is based upon field data as well as a MA thesis on the status of Muslim women in Uganda and another MA thesis on Islam and marriage in Uganda (Serunjogi 1994; Katungulu 1993). Both theses focus primarily on Islam,

as practiced by the Baganda. The insights they offer are, however, generally applicable to Islam as practiced by the Basoga.¹³

Serunjogi and Katungulu tend to present their analyses in terms of the “ideal” of what is set forth in Islamic law and contrast that with “practice,” i.e., how Islam, as a “paramount code of conduct” (Dahl 1997: 5) is filtered through Baganda culture and customs and enacted by Muslims at the local level. They argue that the practice of Islam by Baganda Muslims deviates in several important respects from the “ideal” set forth in Islamic law. These authors thus present Islamic law as something designed to guide behavior—and of particular relevance to this dissertation—to ensure certain rights for women. In the following discussion, therefore, the phrase “Islamic law” refers to the authors’ framing of the Sharia as the “ideal.” As viewed by the authors, deviations from the ideal that are the result of cultural influences that have distorted the ways that Baganda Muslims practice Islam as it relates to marriage.

It is somewhat difficult to classify Serunjogi and Katungulu as either “traditionalists” or “reformists.” In most instances, they can be categorized as the latter. However, while asserting that Islamic law establishes certain rights for women that extend well beyond the rights granted to women under Baganda customs, the authors often tend to take these rights at face value. In other words, they rarely question what many construe (Maumoon 1999; Memissi 1998; Dahl 1997) as the contradictions within Islamic law that grant men greater rights and control over their lives than granted to women.

This tension is well summarized by Dahl (1997: 60) in the following statement:

The message of the Koran is that women, as believers, are equal members of *al-umma* – the Muslim community – and that God weighs women's and men's actions on an equal scale as regards entry into Paradise. As legal persons women themselves received through Islam the right to own property, the right of inheritance, and the right to dispose of their property independently. But the commandments concerning these matters are themselves discriminatory. Women's right to decide for themselves is strongly curtailed through the rules of the Koran and the rest of the law relating to male precedence in marriage and private life, how his opinions and decisions take precedence over hers; how a male Muslim may marry a Jew or a Christian, whereas a female Muslim may not do so; how a husband may have several wives at the same time, whereas a wife may not have more than one husband; how women's rights of inheritance are far weaker than men's.¹⁴

Marriage as an "ideal" is considered a contract in Islamic law with specific rules set forth to guide each stage of the process: (1) partner choice; (2) betrothal (dowr may be set at this stage or after betrothal); (3) marriage ceremony; and (4) divorce. These rules also guide the behavior and protect the rights of all family members (Katungulu 1993: 1). Muslim women have the right to choose their own husband and cannot be forced to marry against their consent. A woman's consent over the choice of marital partner is required, even in the case of arranged marriages. Women have the right to set the amount of and control the Muslim dowr (dowry). Additionally, Islam stipulates that women have the right to be fairly treated by their husbands and that they cannot be inherited against their will. As with the Baganda, Muslim women have the right to receive maintenance from their husbands. They also have the right to initiate a separation leading to divorce if a marriage is unsustainable and attempts at reconciliation as guided by

Islamic teachings have failed. Women are also free to remarry after divorce or widowhood (Serunjogi: 72-77). Each of these points is discussed in more detail below.

Under Islamic doctrine, marriage is considered “a religious duty which should be embarked upon only after adequate preparation. The obligation of marriage in Islam differs from person to person in accordance to his or her physical, economic, and social capability” (Katungulu 1993: 41). Marriage is prohibited for those individuals who are not capable of fulfilling marital obligations. Capability is framed in both physical and financial terms. For example, since sex is considered part of marital rights for both women and men, impotent men should not marry. Likewise, if a man is able to satisfy sexually only one wife, he should not marry a second wife. Men or women who have communicable diseases, or other diseases or conditions that prevent them from sexual satisfaction are also barred from marrying. If a man is not financially capable of paying his prospective bride’s *mahr* (dowry), covering the costs of the marriage ceremony, and providing her maintenance as set forth in Islamic doctrine, he should not marry.

While these are the ideals of marital unions under Islam, an illustration of the gap between ideal and practice is provided by a study of 200 Baganda Muslim women, which found that while they were knowledgeable about customary marriage practices, they were not knowledgeable about Islamic marriage practices. For example, they were unaware that marriage is prohibited

under certain circumstances, i.e., it requires both physical and financial capability (*ibid.*: 49-50 and 53).

The first stage of the marital process, partner choice—particularly for women—is guided by parents or guardians in both the Baganda and Muslim marriage practices. Baganda marriage ideals stipulate that women should not find their own husbands, rather husbands are usually found for women by their parents or other relatives. Potential husbands are deemed desirable if they come from a “respectable family,” that is, if he has good virtues, good health, and is able to work hard. People are prohibited from marrying within their father or mother’s clan (Serunjogi 1994: 62-63; Katungulu 1993).¹⁵

Likewise, Muslim ideals stipulate that parents or guardians should guide and approve the selection of marital partners, particularly for women. Under Islamic ideals, partners have a choice in selection, but this is considered contingent upon parents’ or guardians’ approval. Partners do, however, have the final say in whether a marriage takes place. The guardian’s role (usually the prospective bride’s father or brother) is to select a partner and to sign the marriage contract. Marital partners should be well matched in terms of age, education, social and economic status, religion, and morals (Katungulu: 44-46).

The ideal of matching prospective marital partners’ education and age is complicated by the fact that, historically, Muslims have lower levels of education—particularly Muslim females—and higher dropout rates than other religious groups in Uganda (Serunjogi). While this situation is changing, it dates back to the marginalization of Muslims by the colonial state in Uganda. Muslims

emerged as the disadvantaged group—in comparison to Christians—in the struggle for power over control in the historically dominant kingdom of Buganda. The education of Ugandans was left to the Christian missionary schools (Kayunga 1993; Oded 1974; King, Kasozi, and Oded 1973; Carter 1965).¹⁶ “The avowedly evangelistic aims of the mission schools deterred a majority of Muslims from exposing their children to mission prosletisation” (Carter: 193).

Muslims did not have comparable mission schools: “In 1918 there were only traditional Koranic schools where Arabic and Islamic Law were taught and by 1939 there was only one full Primary School of a recognised standard. By 1944 of the £134,000 spent on Education only £213 represented grants in aid to Muslim schools” (Carter: 194). While Muslims established their own primary and secondary schools in Uganda, “[i]n 1960, only two years before Uganda gained her Independence, there were only 905 children at the Mohammedan junior secondary schools and none in Mohammedan senior secondary” (*ibid.*: 198). There were also only a few Muslim students in Mission and government senior secondary schools (Carter: 194, and 198). While the current rates of enrollment for female Muslims in secular schools have increased, their rate of completion is low and few Muslim women advance to University (Serunjogi: 115 and 121).

While the “ideal” of equal education for females is codified in Islamic law (particularly in reformists’ interpretations), until recently “many Muslim parents in Buganda denied their daughters education on the grounds of sex. They thought that women never needed education since they would be catered for by their husbands” (*ibid.*: 25). Girls may be pulled out of school early by their parents,

who want them to be married. Some parents interpreted Prophet Mohammed's admonition that girls should be married as soon as they are ready to mean that they should be married immediately after the onset of menstruation. Thus, some parents married their daughters at early ages to be in keeping with the Prophet's teachings. Currently, some Muslim men view part of a potential wife's "readiness" as having attained an education and thus are looking for that in selecting their spouse/s. Girls may also drop out of school if they become pregnant, in which case, their parents marry them to the child's father. The bias against investing in girls' education is slowly changing and some Muslim women have attained high levels of education and professional status (*ibid.*:122-124).

Presently, many Muslim youth in Uganda choose their own partners without the guidance and approval of their parents. Muslim youth who subvert the parental role in partner selection have taken partner choice as a right and ignored the Islamic system of marriage that requires the involvement of parents or guardians. "The modern understanding of Islamic marriage received acceptance from most groups of muslim youths. The Islamic teachings of free choice were conducted by young muslim sheiks [learned religious leaders] who had been informed by western practices" (Katungulu: 66-67).

Changes in parents' role in partner selection are not limited to Muslims in Uganda. Increasingly individuals are choosing their own marital partners and marrying without parental legitimation. A recent study (Mukiza-Gapere and Ntozi 1995) based on focus groups with female and male youth and elders in several

districts of Uganda reports that participants in Masaka District (largely populated by Baganda) identified three current types of marriage:

The first one is the traditional type, where parents and relatives still play a big part in selecting the marital partner, and provide guidance in their children's marriage. This type is common in rural areas and for children who have not had much education. The second type is one based on modern individual choice: these marriages start as love affairs, usually at school or places of work. Parents are informed later and then marriage follows. The third type is cohabitating: for such reasons as lack of bridewealth, which is high in some communities, young people may cohabit before marriage in the hope that the relationship will mature into a formal marriage. They noted that this approach is risky because there is no legal bond between the cohabitating individuals (*ibid.*: 203).

Islam stresses the ideal of potential marital partners getting to know each other before the marriage contract is completed. The staged nature of the contract: (1) partner choice (requiring parents' or guardian's consent and including the role of the children in partner selection), (2) betrothal and (3) marriage ceremony, is designed to facilitate this process. The second stage of the marriage process is betrothal, which follows partners choosing each other vis-à-vis the guidance of parents or guardians. In Muslim marriage, betrothal is "the rite of seeking the hand of a woman for marriage from her parents or guardians" (Katungulu: 73). It involves the prospective husband and his family and friends visiting the bride-to-be's home, to be formally introduced to each other. The potential partners discuss their marital plans and the betrothal marks their mutual agreement to be married. It is not, however, considered a contract and either party can break it off. Gift giving on the part of the prospective groom is not a required part of the Muslim betrothal ceremony. If gift giving occurs, it is supposed to happen after

the ceremony and before the wedding on an occasion at which, "the guardian or the girl announces the amount of the dowr....A period of time is agreed within which to pay the dowr" (*ibid.*: 73-75).

Muslim *mahr* (dowry) is "...wealth given to the woman by the man as part of the marriage contract....In Islam, *mahr* is a concrete sign whereby the man proves to the woman and her parents that he will be able to safeguard, feed, clothe, and meet the rising necessities after marriage" (*ibid.*: 80-81). The prospective bride sets the amount and controls the *mahr*. "According to the Quar'an (30:21) *mahr* is the pledge of true love." Anything can function as *mahr*, but cash is most common. Muslim marriages in which wives have not received *mahr* are considered invalid (*ibid.*: 81-83).

Baganda customary marriage is also a staged process, with several overlaps as well as differences from Muslim marriage as a staged process. The first stage for Baganda is selecting a partner. As mentioned earlier, traditionally partners are found for women. The second stage is called "*okwogereza*" (to ask, in Luganda) and "*okuyala*" (to visit, in Lusoga). It involves the prospective husband's initial visit to the potential bride's parents' home to ask for her hand in marriage. At this point, the groom-to-be is expected to give a gift of appreciation to his future bride. The third stage is "*okwanjula*" ("*okwandhula*" in Lusoga), or the formal introduction (betrothal) ceremony. This is the formal meeting between members of the groom's family at the home of the bride's family. At this point, the future groom's family either pays the dowry or bridewealth ("*omutwalo*") that the future bride's parents have decided upon or they promise to pay it later. The

bridewealth traditionally includes a *kanzu* (formal white robe) for the future bride's father and brother, along with a *busuti* (traditional dress of the Baganda and Basoga) for his future bride's mother and maternal aunt. It also includes things like sugar, salt, meat, and other items set by the bride's relatives as part of the bridewealth (Serunjogi: 64-65). The prospective groom also brings a large calabash of traditional beer, called *ekiya ky'omwenge*, as a gift for the ceremony (Katungulu).

Usually, the introduction ceremony and wedding ceremony are combined into one occasion to reduce the costs associated with the ceremonies and gift giving (*ibid.*: 76).¹⁷ Traditionally, at the *okwanjula* ceremony, the bride and groom promised to be mutually faithful and to live together harmoniously. The future bride's brother plays a major role in the *okwanjula* ceremony. "After the introduction the brother of the girl would ask permission from the aunt of the girl to drink from the beer which was brought by the boy's side. If he drank the beer, that would be a sign of giving away his sister to the suitor. This was the formal betrothal rite after which the girl's brother usually announce the dowry he wanted" (Katungulu: 19).

When a man pays this *mutwalo* he does not intend to buy the girl. In fact men go to be born in that family of the woman. This explains why on many introduction ceremonies the man's side says 'we have come to be born into this family'*Mutwalo* symbolises the worth of the woman in question to her husband. The two families will also develop an understanding resulting from *mutwalo*. It also serves as a certificate of marriage" (Serunjogi: 106).

The full payment of *mutwalo* thus essentially seals the customary Baganda marriage contract. Traditionally, "the term 'contact' in Uganda was

understood as commitments for the contracting of firm grounds in the relationship between the two families... The agreement was the incorporation of the bridegroom in the family of the bride" (Katungulu: 21). If the marriage ends and the wife is viewed as the cause of the dissolution, the husband and his family members who assisted with the gathering the resources to pay the bridewealth must be repaid. The bridewealth is thus also traditionally viewed as a means of discouraging females from leaving their marriages because their family will be forced to repay it. Other circumstances which can lead to the return of the bridewealth include "sorcery by the man or woman, death before wedding, pregnancy by another man before the marriage takes place, renunciation by either party for a reason or no reason, impotence of the man or incapability of the woman to play sex, and when the wife willfully denies her husband sexual intercourse" (*ibid.* 97 and 105).

According to Katungulu (*ibid.*:75-76) a "[g]reat number of Ugandan Muslims do not differentiate between the Islamic and Ganda customary betrothal because of the many similarities in both practices." The major difference is that the gifts are given after the betrothal in the Islamic practice, whereas they are given during the betrothal (or introduction ceremony) in the Baganda practice. This difference is linked to the meaning of dowry in the Islamic marriage contract and its corresponding meaning among the Baganda.

A marriage can be contracted without the immediate payment of mahr or even the mentioning of it at marriage contract. This means that at the time of contracting [the] marriage the finance aspect should be avoided.... The customary marriage contract is essentially the payment of the whole marriage bridewealth which is the factor that legalizes the Ganda marriage contract. The act of

drinking or testing the Ganda beer “omwenge” by the brother of the bride is the acceptance of giving away his sister to the prospective husband (*ibid.*: 107)

However, the prospective spouses are required to come to an agreement about the amount of the Muslim dowry before the marriage contract is made and the future bride has the right to reject any contract in which she is not guaranteed the payment of her dowry (*ibid.*: 107-108). Based on his research, Katungulu asserts that the majority of Muslims frame the marriage contract in terms of the Baganda customary system. “To the majority of Muslims in Uganda, the Islamic marriage contract is a formal process after all other customary rites have been completed (*ibid.*: 109).

Additionally, Baganda bridewealth—if it is asked for from the bride’s family—belongs to them and they are responsible for repaying it if the marriage ends. Muslim *mahr* (dowry), on the other hand, remains under women’s control and cannot be taken from her, except under certain circumstances. These circumstances include the return of the *mahr* if no marriage takes place and if a wife is unable to stay with her husband and initiates divorce proceedings then she must return part or all of the *mahr*. Otherwise, demanding the return of *mahr* is considered “unislamic.” *Mahr* is not related to purchasing women in Islam, so demanding its return is disallowed. “...Mahr is enjoined by the law merely as a token of love and respect for the bride” (Katungulu: 82, 103-106).

Since Muslim wives have the right to possess *mahr*, they no longer feel that they are excluded from the gifts that are given to her family in the betrothal/wedding ceremony. Katungulu views this as promoting greater

tolerance and stability within marriages. As a result, he notes that Baganda Muslim wives' question of "*wagula meka?*" (How much did you pay for me?) is now heard less frequently. On the other hand, some Muslims consider *mahr* as a part of customary *omutwalo* (bridewealth) and will appropriate it from the bride. Many Ugandan Muslims consider low *mahr* to be an Islamic tradition, however, both low and high *mahr* are allowed and it is up to the prospective spouses to agree on the amount (*ibid.*: 82-84 and 91-92).

Baganda Muslims complete the Islamic marriage contract either at the mosque or at the bride's parents' home in the presence of the mullah (or learned religious leader) and witnesses. The mullah performs the marriage rites and delivers the "Islamic marriage sermon," stressing the importance of marrying according to Islamic practice. He also advises the marital partners to be faithful and instructs the husband to treat his wife fairly and the wife to be obedient to her husband. Both the bride and groom sign the mullah's registry of marriages, as does the mullah himself and the witnesses. The marital partners are given copies of the marriage certificates with all the signatures (*ibid.*: 109 and 112-113).

Each partner can establish certain conditions that must be met in the Muslim marriage contract, but according to Katungulu, most Muslims in Uganda do not consider this to be important. However, a wife has the right to stipulate that her husband not marry another woman. She can also stipulate that she not be forced to share her house with another woman, or be shifted from her marital home into another dwelling. Katungulu contends that the failure to consider and

set forth conditions in marriage contracts has undermined marital stability, especially within polygynous Muslim homes (*ibid.*: 114-115).

One of the major difference between polygyny as practiced by the Baganda (and the Basoga) and as practiced under Islam is that Islam sets conditions on how many wives a man can marry and also stipulates that they must all be treated equally. In the Baganda culture, there is no upper limit to the number of wives that a man can marry (Serunjogi 1994). In contrast, Islam enjoins men not to marry other wives unless they can provide for all present and future wives equally and also sets a maximum of four wives as the number allowable in polygynous unions (Serunjogi 1994; Katungulu 1993). Additionally in Baganda culture, a husband is not required to consult with his wife or wives before bringing another wife into the family. Under Islam, husbands should tell their first wives when they plan to marry a second and the wives are expected to, “out of fear of Allah...accept willingly” (Serunjogi: 90). As discussed in the next chapter, however, few wives indicated during the in-depth interviews conducted as part of the present study that they were consulted prior to their husbands bringing home another wife.

Both Serunjogi and Katungulu argue that there is a sizeable gap between the Islamic doctrine on polygyny and the practice of polygyny among Muslims in Uganda. They highlight the need for Muslims to become better educated about and follow more closely Islamic teachings about marriage in general and polygyny in particular. According to Katungulu (*ibid.*: 214) many Muslims in Uganda consider “polygyny an Islamic right and obligation.” They contend,

however, that polygyny as practiced by Baganda Muslims does not generally follow the set of conditionalities or restrictions set forth in the Islamic teachings on marriage. Consequently, “unguided polygyny has created instability in Muslim homes in Uganda.” In contrast, Katungulu (*ibid.*:9) argues that, a close adherence to the “ideal” of marriages as guided by Islamic doctrine contributes to marital stability.

In particular, the considerations of capability—specifically, the financial aspects—that prohibit Muslim men from taking additional wives unless they can treat their present wives equally are not followed. Some Muslim men have married additional wives “without considering the socio-economic conditions prevailing [thereby] violating the ideal of Islamic polygyny” (Katungulu: 215). Additionally, some men do not treat all their wives equally, favoring some over others, “not only in love and affection, but also in the provision of marital requirements” (*ibid.*: 215).

The favoured wife may be provided with all necessary requirements leaving the other(s) without even the basic needs of the home. For instance, those favoured ones may be given good residences, most especially in towns, whereas those in rural areas are squeezed into one small house without privacy, a fundamental right of the wife....Nutritional foods such as meat, fish, and others are only a matter of accidental items in rural homes, an issue far different from the urban setting....Inequality and lack of maintenance may be sighted in the provision of clothes and medical care to wives (*ibid.*: 215-216).

Katungulu (*ibid.*: 216) argues that inequitable treatment of wives is especially prevalent in “poverty stricken polygynous homes.” Muslim men add wives in order to meet their sexual needs, without considering the requirements

and limitations set forth in the teachings of Islam. "Many wives are falsely seduced into such practices by false promises, that they will be provided with all the necessary home requirements only to reach there and find otherwise." Against the teachings of Islam, first wives are not generally consulted when the husband wants to marry another wife and potential wives may not be informed about the presence of another wife or wives (see also Serunjogi: 159-165).

The next chapter draws on both survey and qualitative data to examine marital relations and risk more broadly.

NOTES

¹ This gendered difference in the percentage of young women and men living with HIV/AIDS in Sub-Saharan Africa is also linked to women's lower level of knowledge about HIV/AIDS (as many as 80% of women in the 15-24 year old cohort are estimated to lack adequate knowledge) and to physiological factors (immature cervical cells) that increase the risk of girls and young women being infected with HIV (UNAIDS/WHO 2002: 18).

² To date only a few studies have been conducted which specifically address women's perspectives on polygyny. These include Ware's (1979) study with Yoruba women in Nigeria, Solway's (1990) work with the Bakgalagadi of Botswana, Wittrup's (1990) analysis of the Mandinka in the Gambia, and Meekers and Nadra's (1995) work with the Kaguru of Tanzania. The issue of women's attitudes toward polygyny is highly complex and the extent of women's support or disdain for the institution varies within and between regions and societies (Meekers and Nadra 1995). Education, religion, location (rural/urban), age, and socioeconomic status may influence women's views on polygyny. Women's structural position within society and within households also shapes their perspectives. Newly married wives may have a much different view than senior wives, and their views might change as they gain seniority within polygynous households. Similarly, women's views on polygyny may differ based on their statuses as mothers or mothers-in-law (Wittrup 1990: 133; see also Clignet and Sween 1981; Ware 1979).

³ See Clignet and Sween (1981: 446-451) for a critique of the acultural, ahistorical, and atemporal analyses produced by structural-functionalist approaches to polygyny. Structural-functionalism does not distinguish between the ways that an institution such as polygyny functions at the individual versus the societal level since "the parts and the totality of the sociocultural units are interchangeable..." (1981: 446) This enables structural-functionalist to expand their analyses of polygyny beyond a specific culture to consider cross-cultural and/or cross regional analyses resulting in analyses that downplay inter- and intra-cultural variation in the practice of polygyny across cultures. Examples of such variation include the number of nights that a husband spends with each wife, the extent of co-wife jealousy, and differences in the incidence of polygyny in societies where men marry more wives as a status marker of wealth versus those in which additional wives are a means of increasing wealth. Additionally, Clignet and Sween critique the assumption that taboos against sexual activity during the postpartum period that are more common in polygynous societies contribute to the decreased fertility of each co-wife. Such an assumption ignores the likelihood of inter- and intra-cultural respect for postpartum abstinence and is, again, based upon the view of co-wives as interchangeable. "...[I]t is doubtful that polygynous husbands ignore their own preferences in favor of egalitarian principles or that their co-wives are uniformly faithful " (1981: 449).

⁴ Rubin (1975) develops the concept of “sex/gender system” to analyze the ways that the categories of male/female, masculine/feminine, and sex/sexuality are culturally constructed and imbued with meaning. Inequality and oppression within specific sex/gender systems “...is not inevitable...but is the product of the specific social relations which organize [them]” (1975: 168).

⁵ A Musoga key informant who speaks both fluent Lusoga and Luganda (which are similar, yet not identical languages spoken by the Basoga and the Baganda, respectively) commented that the Kilbride’s translation of co-wife is partially incorrect. Because the word *muggya* refers to a jealous wife, it is unnecessary to add the word for woman (*mukazi*).

⁶ See Davis (2000) for an extensive discussion of the phenomenon of “town women” In Kampala, particularly about their increased stigmatization within the context of the AIDS epidemic. Davis’s discussion is limited to the urban area of Kampala; therefore, I do not go into any detail here. The significance of her study to my research, however, is in delineating the social legitimation that is attached to the status of marriage for women. Similarly—whether town woman or proper married woman—producing children “is still an essential requirement for full adulthood, full womanhood, and personhood.” Town women may increase their level of respectability through either producing “proper” (i.e., “children who will show their mother respect and support her in her old age...”) and/or adopting children of their siblings who have died of AIDS. By investing their earnings in education for these children and “produc[ing] healthy, educated children...” “town women” may be recognized and legitimated for their roles as mothers and thereby regain some respect at all levels of Ugandan society (Davis 2000: 17-18).

⁷ Sunnism and Shi’ism are “the two largest sects of Islam...” and Hanafis and the Malakis are “...two schools of thought within Sunnism....” (editor’s note FN 3 Bhutto 1998: 107). According to Trimingham (1964: 81), “East Africa is predominately Shaf’i [Sunni] since its Islam derives from South Arabia, the revival of the Hanbali school under the Wahabis not influencing that region.”

⁸ It is beyond the scope of this dissertation to go into detail regarding Islamic law. It should be noted, however, that in addition to the Koran and the Sunna “there are several other, more or less important sources [of law] in the form of legal techniques for resolving specific legal issues.... [including] *ijma* (consensus), *qiyas* (analogy), and *ijtihad* (independent juristic reasoning).” There are various schools of law that emerged after Prophet Muhammad’s death that “adjusted Islam to the social needs of local conditions... [additionally] Islamic law has also integrated into itself central elements of the pre-Islamic legal systems” (Dahl: 1997, 40 and 12). “In deriving shari’a, the various schools of jurisprudence differ in the extent to which they allow *ijihad* (the formulation of independent legal judgment), and the bases upon which such judgment can be formulated” (Obermeyer 1994: 42).

⁹ Maumoon (1999: 1) defines an Islamist as someone who “attempts to propagate and purify Islam and gets actively involved in organizations which aim to transform society along ‘Islamic’ lines.” She uses the term ‘gender activism’ to mean, “religiously based feminism.” Further, “Islamist gender activists aim to reclaim religion and find a liberation theology from within Islam. The pioneers amongst these are struggling against the patriarchal dictates of the dominant Islamist discourse” (1999: 2, 6). Islamist gender activists also challenge the misrepresentation of Islam posited in some Western feminist accounts. These accounts often paint Islam in an uncritical, ahistorical manner, casting it as monolithic and “uncompromisingly oppressive to women” (1999: 11).

¹⁰ See Obermeyer (1994, 1995) for a discussion of women’s reproductive choice under Islam. Her case study of changes in reproductive and marriage policies in Tunisia and Iran shows that “the conditions that affect women’s options are the outcome of political strategies rather than the result of implementing a religious code. Like other religious doctrines, Islam has been used to legitimate conflicting positions on gender and reproductive choice. The ways in which the ethical code of religion is translated into policies affecting women’s status has been a function of the ideology of groups in power and have been influenced by changes in the economic, political, and social spheres” (1994: 49).

¹¹ The key informant who developed the list upon which the table is based is a FAEPTI Project trainer who trains imams and community members to be Family AIDS Workers (FAWs). She is also a community health educator and medical assistant at the District level in one of Busoga’s districts. She made the list in response to this researcher’s request and as part of an ongoing discussion about the similarities and differences between gender norms as structured by the Basoga and Islam. The list represents Basoga social norms or ideals about the rights and responsibilities of females and males at different stages of the life cycle. She also commented that she did not necessarily agree with all of the items in the table, particularly those regarding Basoga norms about gendered differences in education and earning an income. The wording in the table is hers; the only changes to her list is its reformatting as a table and reordering of some of the items to facilitate comparison across the categories of female and male youth and adults.

¹² The explanation of these two items benefited from clarification provided by a female Musoga key informant in December 2002.

¹³ A guiding assumption of this section is that the way the “major” tradition of Islam is practiced at the local level (i.e., the “minor” tradition) varies within and across both regions and ethnic groups of Sub-Saharan Africa based on a complex mix of factors, including the history of the introduction of Islam into an area or region.

¹⁴ Dahl (1997: 60) also notes that evidence offered by women as testimony in court cases carries half the weight of men's and that women's testimony is not allowed in certain types of cases.

¹⁵ While this is the traditional ideal, a university educated female Musoga key informant notes that most Baganda and Basoga women find their own husbands these days. There are, however, likely differences between rural and urban settings and by level of education. The majority of women interviewed in this study stated that they did not find their own husbands, but rather than someone else—usually a male relative—played a significant role in partner selection.

¹⁶ A discussion of the history and trajectory of the three major religions in Uganda (Islam, Catholicism, and Protestantism [Anglicanism]) is beyond the scope of this dissertation. The following is a highly condensed summary of salient points related to the disadvantaged position of Muslims in colonial education policy during the early years of colonialism. Readers are referred to Kayunga (1993), Oded (1974), and King, Kasozi, and Oded (1973) for detailed overviews of Islam in Uganda. Islam was the first of the three major foreign religions introduced into the Kingdom of Buganda during the pre-colonial period. Islam was brought into the Kingdom by Arab traders traveling from the east African coast during the 1840s (Kayunga 1993). The Kabaka (king) of Buganda converted to Islam and Islam was the only foreign religion in the kingdom until the arrival of the other two major religions about 30-35 years later (Kayunga 1993; Oded 1974; King, Kasozi, and Oded 1973). While having converted to Islam, Kabaka Mutesa adopted an "instrumental and utilitarian" approach to the three religions, essentially playing them off against each other in order to fulfill his own purposes. "If Islam could further his objectives at a certain period, he adopted it. But when Christianity appeared in his country and he calculated that it could help in certain circumstances, he displayed an inclination to that faith in order to gain the support of its followers" (Oded 1974: 296). The introduction of Islam by Arab traders into the kingdom brought reading and writing to Buganda; the Kabaka and his court learned to read and write Arabic and Kiswahili from the traders. This helped establish the groundwork for the Christian missionaries who followed to gain converts. "Considering the subsequent penetration of Christianity into Buganda it would appear that reading was the prelude to the process of conversion and that Mutesa [the Kabaka] allowed the [Christian] missionaries to teach in Buganda because he wished his people to master the art of reading and writing." Increasing literacy in Arabic and Kiswahili facilitated the spread of Islam in Buganda as well as the later spread of Christianity, whose missionaries used both languages to spread their faith (*ibid.*: 93, 95). A significant difference in the diffusion of Islam and Christianity, however, was that the latter had organized missionary groups. These groups spread western education and values, while at the same time gaining converts (King, Kasozi, and Oded 1973). Prior to the formation of Uganda as a colonial British "protectorate" in 1894, Islam, Catholicism, and Protestantism struggled for control over state power within the

historically dominant kingdom of Buganda. Each of the religions "saw the control of state power as extremely important for its own survival and expansion" (Kayunga 1993: 27). A number of religious battles were waged during the 1880s-1890s. By the time of the 1900 Anglo-Buganda Agreement, Muslims had emerged in a disadvantaged position in comparison to Christians. The Anglo-Buganda Agreement dictated the terms between the colonial state and the kingdom of Buganda and impacted the re-distribution of land by the colonial state as well as chieftainships. "Since the criteria for land acquisition was loyalty to the colonial state between 1894-1900, and since during this period, Muslims had constituted an insubordinate force, very few of them were given land." Catholics and Protestants, on the other hand, were given large plots of land to "develop their clerical work." They were also given the majority of the chieftainships (Ibid.: 14-15). In addition to being marginalized in terms of land and chieftainships, Muslims were also disadvantaged in regard to colonial education policy. Ugandans were excluded from the state-run schools, which catered to Asians and Europeans. The education of Ugandans was left up to the Christian missionary schools." The Muslim community, without an established missionary group and land, could not easily set up schools. The schools set up by the missionary groups were partly converting centres. The effect of this policy was that a large number of Muslim youth who passed through the missionary schools were converted to Christianity" (Kasozi 1986, cited in Kayunga 1993: 15).

¹⁷ If it is a Christian couple, the introduction ceremony takes place and then a church wedding follows. Only wives who have been married in a church and had their marriages blessed by a priest (in what is called a 'ring marriage') are considered recognized wives. If it is a Muslim wedding, it will take place either at the bride's parents' home as part of the introduction ceremony or at the mosque.

CHAPTER 5

MARITAL UNIONS AND RISK

Introduction

For women in Sub-Saharan Africa, as elsewhere in the world, being faithful to a male partner in a marital union or stable relationship is no guarantee of reduced HIV/AIDS risk (Center for Health and Gender Equity 2004; UNAIDS 2004; O'Leary 2000). "Women's main risk for HIV and other sexually transmitted diseases (STDs) is often their male partners' sexual behavior, and negotiation of safer sex is frequently controlled by men" (Pulerwitz et al. 2001: 1650). Many women in marital unions or other stable relationships are aware of the risk posed to them by their husband's or steady male partner's behavior, and attribute their self-perceived HIV/AIDS risk to their partner's, rather than their own, behavior (Bernardi 2002; Spira et al. 2000; Kengeya-Kayondo et al. 1999; Baingana et al. 1995; Caraël 1994; McGrath et al. 1993). Married women, however, may not be aware of their husband's HIV status, as was the case with 78 percent of the wives of AIDS patients in another Ugandan study (Baingana et al. 1995: S19).

Research from Uganda (Blanc et al. 1996: 74) shows that, "[c]learly, the institution of marriage imposes more obligations on women to meet the sexual demands of their partner." It may be difficult for married women to refuse their partners sex because of the risk of separation or divorce. Given the centrality of "marriage for defining women's position in society" (*ibid.*), this chapter addresses marital relations and HIV/AIDS risk. It opens with an overview of the marital demographics for the full and risk cluster sub-samples, utilizing the former for

comparative purposes with national level data. Drawing upon both qualitative and quantitative data, the chapter closes with a discussion of the process of marital unions among the Basoga Muslims who participated in the study. Carrying through with the theme in Chapter 4, the emphasis here is on the gap between ideals and practice. Linkages are made throughout the chapter between marital unions and the embodiment of HIV/AIDS risk, particularly for women.

Marital Unions and Risk

Doing Gender: Marital "Demographics" and Risk

The vast majority of people who participated in this study are married; overall, 82 percent of the full sample is currently married (83 percent of the men and 82 percent of the women). The data in Table 5.1 show survey participants' marital status by gender within each age cohort for the full sample. The proportion of women who have been previously married is five times higher than that of men, while the proportion of men who have never been married is about twice as high as the corresponding rate for women ($p < .05$). Looking at just the 15-49 year old survey participants (who comprise 85% of the full sample), equal percentages of women and men (80%) are currently married. This compares with national data showing that 73 percent of women and 63 percent of men ages 15-49 are currently married in the DHS. The category of currently married in the DHS includes women in formal unions and those in informal unions; the latter is defined as cohabitating with the intention of a long-term relationship even if they have not been through a formal civil or religious ceremony (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 73).

Table 5.1 Marital Status by Gender within Each Age Cohort, Full Sample

Men's Marital Status within Each Age Cohort, Full Sample			
Age	Currently Married	Ever Married	Never Married
15-19 (n = 23)	13%	4%	83%
20-24 (n = 27)	85%	4%	11%
25-29 (n = 29)	100%	0%	0%
30-39 (n = 37)	97%	3%	0%
40-49 (n = 10)	100%	0%	0%
50+ (n = 23)	100%	0%	0%
Total (n = 149)	83% (n = 124)	2% (n = 3)	15% (n = 22)
p < .05			
Women's Marital Status within Each Age Cohort, Full Sample			
Age	Currently Married	Ever Married	Never Married
15-19 (n = 30)	70%	3%	27%
20-24 (n = 36)	89%	3%	8%
25-29 (n = 33)	91%	9%	0%
30-39 (n = 27)	96%	4%	0%
40-49 (n = 15)	73%	27%	0%
50+ (n = 23)	61%	30%	9%
Total (n = 164)	82% (n = 134)	10% (n = 17)	8% (n = 13)
p < .05			

Seventy percent of the 15-19 year old women in the full sample are currently married. The percentage of women who have never been married declines by more than two-thirds from 27 percent to eight percent in the 20-24 year old cohort and by age 25-29, the percentage falls to zero. This pattern holds through the 30-39 year old and 40-49 year old cohorts, with only two women reporting that they have never been married in the 50 and older cohort. The percentage of women who have been previously married increases with age (with the exception of the 30-39 year old cohort). Of the 17 women, nine are

separated and seven are widowed (missing one case). The percentage of widows increases with age; five out of the seven widows are in the two older age cohorts (the other two are in the 25-29 year old cohort).

In comparison, on a national level, only 49 percent of 15-19 year old women are currently married. There is a similar pattern of fewer women reporting having never been married with increasing age. By the time women reach the age of 30 and above, less than two percent have never been married. The percentage of women who are currently married increases steadily up to the age group of 35-39, at which point it starts to decline due to increasing widowhood and, to a lesser extent, divorce. Widowhood accounts for 16 percent of all the ever-married women ages 45-49, compared to four percent of women in that category who are divorced (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 73-74).

In contrast to the women, only 13 percent of the men in the 15-19 year old age group in the full sample are currently married. The percentage of men who are currently married increases steeply to 85 percent by ages 20-24. As with the women, by ages 25-29, the percentage falls to zero. Only three men reported being previously married (2%); one man each in the 15-19 and 20-24 cohorts indicated that he was separated, while the remaining man in the 30-39 year old age group stated that he was divorced.

On a national level, about the same percentage of 15-19 year old men (10%) are currently married. Compared to the full sample, there is a slower increase in the percentage of men who are currently married by increasing age.

The percentage increases steadily with age: by ages 20-24, 49 percent are currently married and ten years later (30-34) 89 percent are currently married. By ages 50-54, only one percent of men have never been married (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 78 and 73-74).

Age at first marriage and age at first sex. Tables 5.2 and 5.3 show the age at first marriage and age at first sex for women and men in the full sample.¹ The percentages are based on a total of 146 women and 125 men, which includes both those who are currently married and those who were previously married.² Comparing the marginals for age at first marriage for women in Table 5.2 versus those for men in Table 5.3, it is clear that men marry at later ages than women do. Whereas only one percent of the men reported marrying between the ages of 10-14, 24 percent of the women were married within those years. The proportion of men who were first married between the ages of 15-19 (38%) is approximately half that of women (70%). Nearly half (48%) of the men were first married between ages 20-24, compared to only 6 percent of the women.

Table 5.2 Women's Age at First Sex and Age at First Marriage by Percentage, Full Sample

Age at 1st marriage	Age at 1st sex			Total
	10-14	15-19	20-24	
10-14	23%	1%	0%	24%
15-19	9%	61%	0%	70%
20-24	0%	4%	2%	6%
Total	32%	66%	2%	100%

**Table 5.3 Men's Age at First Sex and Age at First Marriage
by Percentage, Full Sample**

Age at 1st marriage	Age at 1st sex				Total
	10-14	15-19	20-24	25-29	
10-14	0%	1%	0%	0%	1%
15-19	7%	30%	0%	1%	38%
20-24	1%	33%	14%	0%	48%
25-29	1%	6%	3%	1%	11%
30-34	0%	0%	1%	2%	2%
Total	9%	70%	18%	3%	100%

The marginals for age at first sex show that about equal proportions of women and men became sexually active between the ages of 15-19 (66% and 70%, respectively). A much higher percentage of women became sexually active between the ages of 10-14 (32%), than is the case for men (nine percent). By the age of 19, 98 percent of the women have become sexually active and 94 percent were first married. In comparison, 79 percent of the men have become sexually active and only 39 percent were first married. Eighteen percent of the men indicated that they first had sex by ages 20-24, compared to only two percent of the women.

In terms of the relationship between age at first sex and age at first marriage, 23 percent of the women became sexually active and were first married between the ages of 10-14, while no men fall into this category. Twice as many women (61%) than men (30%) were first married and first had sex within the age range of 15-19. Finally, 33 percent of the men compared to four percent of the women indicated that they became sexually active at 15-19 and were first married at ages 20-24.

On a national level, the median age at first marriage for women ages 20-49 is 17.5 years. By age 15, however, 30 percent of Ugandan women have begun sexual activity and by age 18, the percentage has reached 72 percent. The median age of first sex for women is about 16, which is 1.5 years less than the median age of marriage. Women in rural areas start sexual activity at a slightly earlier age than men, and women with secondary plus education are more likely to delay the start of sexual activity by an average of two years than women with no formal education. The median age of sex for men ages 25-54 in Uganda is 17.6, about one and one half years later than women. The median age for marriage for men in the same age group in Uganda is six years later than that for women (23.5 versus 17.5 years) (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 78-79).

The data in Table 5.4 show the gender and age distribution for the 223 matched husbands and wives in the risk cluster sub-sample, who are the focus of my dissertation analysis.

Table 5.4 Gender and Age Distribution, Risk Cluster Sub-Sample

	Gender					
	Men		Women		Total	
	n	%	n	%	n	%
Age						
15-19	2	2%	20	17%	22	10%
20-24	15	15%	32	26%	47	21%
25-29	24	24%	23	19%	47	21%
30-39	33	32%	23	19%	56	25%
40-49	8	8%	10	8%	18	8%
50+	20	20%	13	11%	33	15%
Total	102	100%	121	100%	223	100%

The median age for men in the risk cluster sub-sample is 31.5, while the median age for women is 25.0. As in the full sample, 15-49 year olds make up 85 percent of the sub-sample.³

Tables 5.5 and 5.6 show the age at first marriage and age at first sex for the risk cluster sub-sample for the 101 husbands and 116 wives for which there are complete data.

Table 5.5 Wives' Age at First Sex and Age at First Marriage by Percentage, Risk Cluster Sub-Sample

Age at 1st marriage	Age at 1st sex			
	10-14	15-19	20-24	Total
10-14	22%	1%	0%	22%
15-19	10%	63%	0%	72%
20-24	0%	3%	3%	5%
Total	31%	66%	3%	100%

Table 5.6 Husbands' Age at First Sex and Age at First Marriage by Percentage, Risk Cluster Sub-Sample

Age at 1st marriage	Age at 1st sex				
	10-14	15-19	20-24	25-29	Total
10-14	0%	1%	0%	0%	1%
15-19	8%	29%	0%	1%	37%
20-24	0%	33%	15%	0%	48%
25-29	1%	6%	4%	1%	12%
30-34	0%	0%	1%	2%	3%
Total	9%	69%	20%	3%	100%

The marginals for age at first marriage show a similar pattern to that of the full sample, with women marrying at earlier ages than men. The marginals for age at first sex show that while the majority of both women and men became sexually active between the ages of 15-19, no men reported becoming sexually active between the ages of 10-14, whereas 31 percent of the women became sexually active within this age cohort. Looking at the relationship between age at first marriage and age at first sex, 22 percent of the women were first married and

became sexually active between the ages of 10-14, and 63 percent were first married and first had sex between the ages of 15-19. The corresponding percentages for men are zero percent and 29 percent, respectively.

As noted in the figure on how gender is done among the Basoga who participated in this study (Figure 4.1), there is an expectation that girls will be virgins at marriage, while the same is not expected for boys. This is consistent with the literature on a sexual double standard that prescribes, (among other things) virginity for females, but not males at marriage (Mason 1994). The sexual double standard is supported by the survey results showing that the age cohort gap between becoming sexually active and first marriage is more pronounced for men than for women. While the expectation that both marital partners should be virgins at marriage is not expressed in the figure on rights and responsibilities based on Basoga sociocultural norms, Islamic norms stipulate that both partners should be virgins. Similarly, Islam stresses that girls should not be married “when they are still very young (e.g., 12 years old)” (FAW training session 1995). This is an important message that is taught by the FAEPTI Project in its AIDS education and prevention activities.

A FAEPTI Project leader stated that they encountered some of the highest levels of resistance when they encourage a later age of marriage for girls. The early age of marriage for girls is, according to this key informant, related to poverty; daughters are pulled out of school because of a lack of funds to pay for their education. Parents assert that it is better to have their out-of-school daughters married than to have them roaming around and at risk for contracting

AIDS. The project stresses that it is best for parents to keep girls in school and have them marry at later ages.

During both periods of research, focus group members and interviewees stressed that the message seemed to be getting through, i.e., that girls were now being married at later ages. Partial support for these observations is provided by the survey results showing that, at the time of the survey in 1997, a smaller percentage of currently married women in the three younger age cohorts (15-19, 20-24, 25-29) were first married between the ages of 10-14, compared to women in the three older cohorts (30-39, 40-49, 50 plus) (data not shown).

The significance of these findings is that they illustrate one of the ways that social forces—such as poverty and gender norms that may contribute to a smaller investment in girls' education than boys—may become embodied as risk. As in the rest of Uganda, women in the risk cluster sub-sample tended to marry at earlier ages than men. They also became sexually active at earlier ages. In the context of the AIDS epidemic, social norms that encourage early marriage for women mean that women's risk of exposure to pregnancy and HIV/AIDS (and other STDs) begins at early ages. Additionally, given the delay in men's average age of marriage, paired with their age at first sex, it is likely that men may have sexual partners before marriage, thereby potentially increasing their own and their future wife or wives' risk for exposure to HIV/AIDS (Kelly et al. 2003; UNAIDS/WHO 2002; Konde-Lule, Sewankambo, and Morris 1997).

Age gaps between marital partners. Many adolescent and young women in Sub-Saharan Africa are economically disadvantaged and may have sex with

older men to gain access to resources. Their ability to control their risk of HIV infection within these cross-generational sexual relationships may be limited by both their younger age in relation to their male partners and their economic vulnerability. "Older age and higher economic status are resources held by men in cross-generational relationships that allow them more power in reproductive and sexual decision making" (Luke and Kurtz 2002: 6), thus placing younger female partners at risk. For example, a study of Ugandan adolescents found that about 25 percent of women, ages 15-19 had their first sexual experience with men who were 6-20 years older than themselves (Kaijuka, Kiaja, and Loaiza 1989, cited in Konde-Lule, Sewankambo, and Morris 1997: 90). A more recent study of sexual networking among youth ages 13-19 in the Rakai District of Uganda (one of the areas in the country with the highest HIV prevalence rates) reports that 77 percent of women ages 15-19 reported partners who were older than their age cohort (Konde-Lule, Sewankambo, and Morris 1997: 94).

This age gap, and the fact that women also marry at earlier ages than men may help to explain a considerable difference in the HIV seroprevalence rate between married and unmarried women and men in that study. The overall HIV seroprevalence rate among 13-19 year olds was 3.5 percent, with sharp gender differences between women and men. The prevalence rate among women was 9.9 percent compared to a rate of 0.8 percent among men. Among both women and men the prevalence rate for unmarried youth was 3.9 percent as opposed to nearly triple the rate among married youth of 15.8 percent. The infection rate in married women was 17.2 percent, compared to that of married

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men of 5.6 percent. For unmarried women, the infection rate was 7.3 percent, as compared to one of 0.6 percent in unmarried men (*ibid.*: 95-96).

The low rate of infection in unmarried males is mainly "explained by the fact that the unmarried males are largely the youngest adolescents who are not sexually active" (*ibid.*: 95). Thus, "[m]arriage does not seem to provide a solution to HIV infection since the married persons of both sexes have a significantly higher rate of infection than the unmarried. Also the females with a very high marriage rate have a much higher rate of infection than the males, which may be attributed to their being married to older men with higher rates of infection than their age mates" (*ibid.*: 96 and 97). Another study (Glynn et al. 2001) found that 38 percent of married women ages 15-19 in Kisumu, Kenya and 34 percent in Ndola, Zambia who were four or more years younger than their husbands were HIV positive. In contrast, none of the women in the same age cohort married to husbands who were less than four years older than themselves were infected with HIV.

A recent UNAIDS/WHO AIDS Epidemic Update (2002: 18) identifies age differences between sexual partners and spouses in Sub-Saharan Africa as one of the reasons why more women than men (58% versus 42%, respectively) are living with HIV/AIDS in the region and why about twice as many women ages 15-24 have HIV/AIDS as compared with men in the same cohort. Women married to men who are three or more years older than themselves have an increased risk of HIV infection. As previously discussed, many researchers identify sizeable age gaps between husbands and wives in polygynous unions as a characteristic of

societies with a high level of polygyny. Women in these societies tend to marry early and husbands are usually several years older than their wives (Ratcliffe et al. 2002; Bankole and Singh 1998; Dodoo and Seal 1994; Ezeh 1993).

The mean age gap between husbands and wives in currently monogamous unions in the risk cluster sub-sample is 5.8 years, one year higher than what Bankole and Singh (1998: 18) report as the national median for all unions in Uganda. The age gap in monogamous unions ranges from a low of one year older ($n = 7$) to a high of 29 years older ($n = 1$). Six wives are older than their husbands and two spouses are the same age. In contrast, the mean age difference for husbands and wives in polygynous unions is substantially higher at 10.3 years. The age gap ranges from a low of one year older ($n = 1$) to a high of 37 years older ($n = 1$), with six wives who are older than their husbands. Figures 5.1 and 5.2 show the age gap in years between spouses in monogamous and polygynous unions for the cases where husbands' age exceeded wife's age (the figures exclude six cases each in monogamous and polygynous unions where wives are older than husbands).

Figure 5.1 Husband's Age minus Wife's Age in Years, Spouses in Monogamous Unions

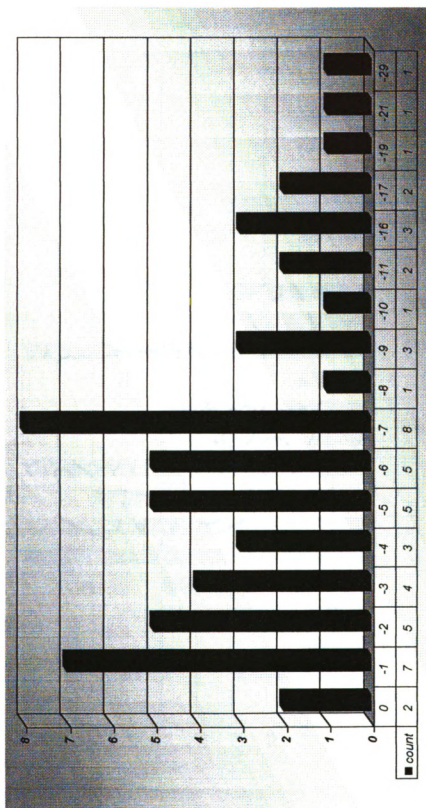
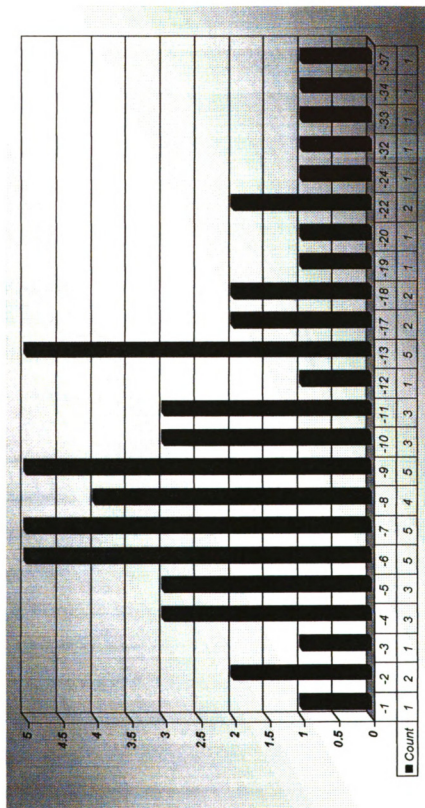


Figure 5.2 Husband's Age minus Wife's Age in Years, Spouses in Polygynous Unions



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The data in Table 5.7 show the relative age gap between spouses in monogamous and polygynous unions in the risk cluster sub-sample.

Table 5.7 Relative Age Gap by Union Type, Risk Cluster Sub-Sample

	Monogamous unions		Polygynous unions		Total	
	Count	%	Count	%	Count	%
Husband less than 5 years older	21	35%	7	12%	28	23%
Husband 5 or more years older	33	55%	47	78%	80	67%
Wife older	6	10%	6	10%	12	10%
Total	60	100%	60	100%	120	100%
*p = .009						
	Count	%	Count	%	Count	%
	Count	%	Count	%	Count	%
Husband less than 10 years older	43	72%	29	48%	72	60%
Husband 10 or more years older	11	18%	25	42%	36	30%
Wife older	6	10%	6	10%	12	10%
Total	60	100%	60	100%	120	100%
* p = .017						

The first panel shows that 67 percent of husbands in all unions are five or more years older than their wives; husbands in polygynous unions are, however, significantly more likely to be five or more years older than their spouses than are husbands in monogamous unions ($p = .009$). The second panel of the table shows the results of an analysis based on a relative age gap of 10 or more years between spouses. Using this age gap as a stratifier, 30 percent of husbands in all unions are ten or more years older than their wives. This compares to 32 percent of 1,010 "couples" in a study in Senegal in which husbands were ten or more years older than their wives (Dodoo and Seal 1994: 386). The incidence of polygyny in that study, in which the vast majority of respondents were Muslim,

was 30 percent, similar to the incidence of polygyny in the risk cluster sub-sample of 35 percent.

As expected, husbands in polygynous unions are significantly more likely to be ten or more years older than their wives, compared to husbands in monogamous unions (42% versus 18%, respectively, $p = .017$). Using the larger age gap of ten years results in the age difference between spouses in monogamous unions being more starkly divided: 72 percent of husbands in these unions are less than ten years older than their wives, compared to 18 percent who are ten or more years older. In contrast, the relative age gap distribution in polygynous unions is fairly evenly divided between husbands who are less than ten years older than their wives (48%) and those who are ten or more years older than their wives (42%).

The age gap between husbands and wives in polygynous unions is further illustrated in the risk cluster sub-sample by data showing that higher order (junior) wives in polygynous unions are more likely to be five or more years younger than their husbands than are first wives in polygynous unions or wives in monogamous unions. Eighty-two percent of higher order wives in polygynous unions are married to men five or more years older than themselves, compared to 73 percent of first wives in polygynous unions, and 55 percent of wives in monogamous unions ($p = .014$, data not shown).

Dodoo and Seal (*ibid.*: 385) hypothesize that an age gap of ten or more years between husbands and wives may increase the scope of gender inequality within families. An age gap of this magnitude between spouses may put

“women... at a significant disadvantage with respect to arrangements concerning the intrafamily allocation of resources.” Sizeable age gaps may also amplify husbands or male partners’ patriarchal power within the realms of sexuality and reproductive decision-making (Blanc and Wolff forthcoming; Timæus and Reynar 1998; Dodoo and Seal 1994). Decisions related to sexuality and reproduction—for example, whether to continue childbearing, the use of condoms, and when to resume childbearing after the birth of a child—have obvious implications for HIV/AIDS risk. Large age gaps between sexual partners are associated with a decreased likelihood that condoms will be discussed and/or used (Luke and Kurz 2002). Moreover, a recent study in South Africa (Jewkes et al. 2003) found that women in steady relationships or marriages with partners who were more than five years older than themselves were 35 percent less likely to discuss HIV with their partner than women whose partners/husbands were five or fewer years older.

Polygynous unions. Historically, the Busoga region is recognized as having a high rate of polygyny. The full sample is nearly evenly divided between women in polygynous and monogamous unions (51% and 49%, respectively), while 35 percent of husbands are in polygynous unions. These figures are comparable with Fallers’ (1965: 74) rate of 37%–59% of all Basoga marital unions as polygynous. Additionally, two other studies in rural Busoga found polygyny rates of about 44 percent for all unions (Sørensen 1992: 48; Mwaka 1990: 28, cited in Sørensen 1992: 48).

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On a national level 15 percent of the men and 30 percent of the women in Uganda are in polygynous unions. The rates of polygyny vary by region; they are highest in the eastern region (where the research took place), 37 percent for women and 22 percent for men. The fact that the research was conducted with Muslims probably accounts for the higher percentage of polygyny in this data set. The rates for women in the other regions are 32 percent in the northern region, 27 percent in the central region, and 23 percent in the western region. Rates for men in the northern, central, and western regions are 12 percent, 11 percent, and 14 percent, respectively (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 74-75).

There are gender and age differences in the percentages of women and men in polygynous unions. The differences are statistically significant ($p < .05$) for men as a group, but not for women as a group. In the full sample, women are more likely to be in polygynous unions at earlier ages than men. Thirty-eight percent of the currently married women ages 15-19 are in polygynous unions, whereas none of the three men in the same age group are in polygynous unions. By ages 25-29, 63 percent of all currently married women are in polygynous unions, compared to 14 percent of currently married men. There is a large increase in the proportion of men in polygynous unions in the 30-39 year old cohort to 75 percent, while 65 percent of women in that age group are in polygynous unions. The percentage of both women and men in polygynous unions declines in the 40-49 and 50 and above cohorts; 46 percent of the women ages 40-49 and 40 percent of the men are in polygynous unions and 50 percent

of women ages 50 and above along with 39 percent of men in the same cohort are in polygynous unions.

On a national level, 17 percent of 15-19 year old women are in a polygynous union and the percentage increases steadily in each five-year age cohort until it reaches a high of 41 percent among women ages 35-39, at which point it begins to decline. The number of men aged 15-19; in polygynous unions was too small to compute in the 1995 DHS, however, only three percent of men in the 20-24 year old cohort is in polygynous unions. By ages 25-29 12.5 percent are in polygynous unions. The percentage drops between the ages of 35-39 to about 12 percent and reaches its highest level at age 50 and above, when 30 percent of men are polygynously married (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 74-75).

As with the national data, the percentage of women and men in polygynous unions is approximately the same for those living in rural versus urban areas. Slightly more women in the villages are in polygynous unions than in the trading center (54% versus 47%, $p < .05$), while the reverse is true for men (49% polygynous unions in the village compared to 51% in the trading center, $p < .05$). Nationally, 30 percent of women living in rural areas are in polygynous unions, compared to 28 percent in urban areas. The corresponding percentages for men in rural and urban areas are nearly identical 15.5 percent and 15 percent, respectively (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 73-74; see also Kirumira et al. 1993).

Sixty-five percent of women with no formal education in the full sample are in polygynous unions, compared with 43 percent of the women with primary or Quar'anic education, and 72 percent of women with secondary or higher education ($p < .05$). The apparent bimodal distribution of polygynous status by education may be due to the smaller numbers of women with no formal and secondary or higher education ($n = 26$ and 18 , respectively), compared to those with primary or Quar'anic education ($n = 90$). In contrast to the women, there are no statistically significant differences in the proportions of men in polygynous unions by educational level. There is a pattern of increasing incidence of polygyny with higher levels of education: 27 percent of currently married men with no formal education are in polygynous unions compared to 35 percent with primary or Quar'anic education, and 40 percent with secondary or higher education.

Nationally, higher levels of education for women show a negligible effect on whether they are in polygynous unions. Thirty-two percent of women with no formal education are in polygynous unions compared to 27 percent of women with a secondary or higher level of education. Among men, 13 percent of those with no formal education are in polygynous unions as opposed to 16 percent with secondary or higher education. The sample of men in the DHS was much smaller than the sample of women, which may account for the difference (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 73-74; see also Kirumira et al. 1993).

In addition to being asked about age at first marriage and age at first sex, all currently married survey respondents were asked about the number of wives (or, in the case of women, number of co-wives) in the family. In creating a variable for polygynous status, it was necessary to assign a single value to each husband and wife in risk clusters. All wives in polygynous risk clusters agreed that they have co-wives, but sometimes disagreed about the number of co-wives. The important point in creating the variable, however, was that they agreed on polygynous status. During the survey and in-depths, it became evident that wives are often knowledgeable about their husbands' other wives, some of whom may not be claimed as wives by the husband. Thus, since the difference between husbands' and wives' accounts on polygyny is only a matter of one less monogamous and one more polygynous union reported by wives, wives' accounts form the basis of the polygynous status value assigned to all spouses within the risk cluster sub-sample. Therefore, the percentage of wives and husbands in polygynous and monogamous unions reported in this study are based on wives' reports. Wives are evenly divided among those in monogamous and those in polygynous unions, while 40 percent of the husbands are in polygynous unions.

The data in Table 5.8 show the level of concurrence about polygynous status among husbands and wives within risk clusters. A Kappa statistic of .80 and above is considered excellent agreement (Cicchetti and Feinstein 1990; Feinstein and Cicchetti 1990).

Table 5.8 Level of Concurrence on Polygynous Status as Reported by Husbands and Wives within 102 Risk Clusters

	Polygynous status as reported by husbands		
Polygynous status as reported by wives	Monogamous	Polygynous	Total
Monogamous	59	2	61
Polygynous	3	38	41
Total	62	40	102
Kappa = .90, $p < .05$			

As shown in the table, there is a 90 percent level of agreement on polygynous status among the spouses in the risk cluster analysis ($p < .05$).

This level of agreement on polygynous status compares to a Kappa statistic of 0.65 (65%) found by Schopper and Doussantousse, and Orav (1993) among 392 couples in a rural district of northwestern Uganda (considered a good level of agreement). In that study, 66 percent of both partners in couples stated that they were in a monogamous union while 20 percent of both partners in couples stated that they were in a polygynous union. In cases of disagreement, women were more likely to report having co-wives (i.e., say that they were in polygynous unions) than were men (12% versus 2%). The higher level of agreement on polygynous status in the current study may be linked to the fact that the sample is 96 percent Muslim. Polygyny is sanctioned among Muslims and co-wives are generally known to each other. In their study of changing marital relations in the age of AIDS conducted in six districts in Uganda, Mukiza-Gapere and Ntozi (1995: 206) report that female elders in focus groups stated that among Muslims all "wives are official and are known to each other,

unlike the practice among non-Muslims who have [an official wife as well as] other wives secretly.”

The data in Table 5.9 show the number of co-wives reported by wives within each age cohort as a percentage. The likelihood that women will be in polygynous unions increases with age, up to the latter two cohorts, where it begins to decline. The majority (58%) of the 60 wives in polygynous unions have one co-wife, 30 percent have two co-wives, and the remaining 12 percent have three or more co-wives.

Table 5.9 Number of Co-wives by Wives' Age Cohort, Risk Cluster Sub-Sample

Number of co-wives	0	1	2	3+	% in polygynous unions within each cohort
Wives' age cohort					
15-19 (n = 20)	65%	30%	5%	0%	35%
20-24 (n = 32)	59%	28%	9%	3%	41%
25-29 (n = 23)	39%	39%	22%	0%	61%
30-39 (n = 23)	39%	26%	17%	17%	61%
40-49 (n = 10)	50%	20%	10%	20%	50%
50+ (n = 13)	46%	23%	31%	0%	54%
Total (n = 121)	50%	29%	15%	6%	50%

Information about the number of wives reported by husbands within each age cohort by percentage are shown in Table 5.10. Most men are in monogamous unions until the ages of 30-39 when the percentage of men in polygynous unions increases dramatically. The large increase in men in polygynous unions in this age group may be linked to the fact that it is a ten-year, rather than a five-year age cohort. However, nearly one-third (32%) of the husbands in the risk cluster sub-sample are in this cohort. The majority (67%) of the 40 husbands in polygynous unions have two wives, 23 percent reported three

wives, and the remaining 10 percent have four or more wives (three husbands have four wives and one has five wives).

Table 5.10 Number of Wives by Husbands' Age Cohort, Risk Cluster Sub-Sample

Number of wives	1	2	3	4+	% in polygynous unions within each cohort
Husbands' age cohort					
15-19 (n = 2)	100%	0%	0%	0%	0%
20-24 (n = 15)	87%	13%	0%	0%	13%
25-29 (n = 24)	88%	8%	4%	0%	12%
30-39 (n = 33)	30%	58%	9%	3%	70%
40-49 (n = 8)	63%	12%	12%	13%	37%
50+ (n = 20)	55%	15%	20%	10%	45%
Total (n = 102)	61%	27%	9%	4%	39%

Two of the features of societies with high levels of polygyny (defined as 20 percent or more of husbands in polygynous unions) are that older men tend to marry younger women and that women who are widowed or divorced tend to remarry quickly, often as higher order (junior) wives in already polygynous unions. It is likely, therefore, that during her lifetime, a woman may be in a polygynous union (Ezeh 1997; Adepoju and Mbugua 1995; Bledsoe 1990). Support for the observation that monogamous unions may become polygynous and the reverse, is provided by comparing wives' responses to two related survey questions: current number of wives (recoded as co-wives, above) and current wife rank. Nearly a quarter (24%) of the 118 wives for whom there are complete data gave answers revealing an apparent gap between their wife rank and the number of wives in the family. The data in Table 5.11 show the rates of discrepant responses between current number of wives and current wife rank as reported by wives, stratified by polygynous status.

Table 5.11 Gaps in Wives' Reports of Current Number of Wives in Union and Wife Rank by Polygynous Status, Risk Cluster Sub-Sample

Monogamous	Number of discrepant repsonses in age cohort	Percent
15-19 (n = 13)	4	31%
20-24 (n = 19)	6	32%
25-29 (n = 8)	3	38%
30-39 (n = 9)	5	56%
40-49 (n = 5)	2	40%
50+ (n = 6)	4	67%
Total (n = 60)	24	40%
Polygynous	Number of discrepant repsonses in age cohort	Percent
15-19 (n = 7)	0	0%
20-24 (n = 12)	0	0%
25-29 (n = 13)	2	15%
30-39 (n = 14)	1	7%
40-49 (n = 5)	1	20%
50+ (n = 7)	0	0%
Total (n = 58)	4	7%

Eighty-six percent (24 out of 28) of these discrepant responses came from wives in "currently monogamous unions" who indicated that while they are currently the only wife, they are higher order wives. The proportion of all wives in currently monogamous unions who gave discrepant responses was 40 percent. Eleven out of the 24 wives who stated that they were the only wife in the family ranked themselves as second wife (46%), five (21%) ranked themselves as third wives, six as forth wives (25%), and two as fifth wives (8%). In all instances of discrepant responses, wives indicated that the other wives had left either before or after they came.

Several of the 24 wives stated that while they are currently in a monogamous union, when they began their current marriage, they married into

an existing polygynous union. Comparing their age at the time of the survey with age at first marriage, and age at which they married their present husband (data not shown) revealed that nine (37%) of the wives were in a remarriage (one in the 25-29 year old category, three in the 30-39 year category, two in the 40-49 year old category, and three women ages 50 and above).

Marital Union Process among the Basoga Muslims Who Participated in the Study

The marriage process for the Basoga Muslims who participated in this research also consists of several stages discussed in Chapter 4 (partner selection, introduction ceremony, payment of brideprice and/or dowry, and marriage ceremony). Both husbands and wives in in-depth interviews were asked how they met their spouse/s and what steps were involved in the marriage process. Generally, their responses parallel the discussion in Chapter 4, yet there are also a few differences. The following describes the similarities and differences, drawing upon both survey and qualitative data, which are analyzed in the section which follows.

Overall, the cultural and religious expectation that parents or other intermediaries play an important role in the initial stage of partner selection—for women, in particular—is reflected in women's phrasing of how they met their spouses. "My brother [or sister] is the one who got him for me," was a common response. One husband's comments reflect the important role of intermediaries in finding marital partners: "We met at her father's place. In the way that I was brought up... someone had to go and get me a wife. I couldn't go by myself. It was my brother-in-law [her brother] who contacted her. He came for me at my

home and took me to her father's place. When we got there, we saw each other. She liked me and I liked her." Other husbands met their spouses during the course of their work or in passing them along the road as the women were fetching water.

After the partners had met, the prospective husband wrote a letter to his future bride's parents expressing his interest in their daughter and asking "to be born into their family." In most instances, this led to the negotiation of brideprice (second stage); the prospective bride's father replied with the terms of bridewealth—although this was not always the case. In a few interviews, respondents indicated that bridewealth is "unislamic", in that it involves buying the woman. One husband's statement reflects this view

In a rightful marriage, you write a letter to the girl's parents, which is asking for permission to go and introduce yourself. They also reply to the letter and allow you. Then you go in the presence of the parents and introduce yourself to all the people and her people. And then you do anything else that they require you to do.... There are some people who sell their children. They ask for goats, cows, kanzus, and busutis. Those people haven't followed the discipline of the religion because the Islamic religion doesn't allow you to sell your daughter.

Another man explained the marriage arrangements for one of his wives in this manner:

I wrote a letter and she took it to her parents... and her father said "first of all, I want to meet my son-in-law to be." When I went there, her father saw me and said, "the girl is there, me, I won't refuse [to allow the marriage]." Her father also said, "except there are two important points that I want to tell you. The first one is that I want you to be tested with the machine [pre-marital HIV test]. The second one is that I won't give you my daughter unless you get married first, and then you take her." I also agreed and did those requirements. Afterwards, she told me the date of the introduction ceremony.

home and took me to her father's place. When we got there we saw each other. She liked me and I liked her." Other husbands met their spouses during the course of their work or in passing them along the road as the women were fetching water.

After the partners had met, the prospective husband wrote a letter to his future bride's parents expressing his interest in their daughter and asking to be born into their family. In most instances, the letter to the negotiation of betrothal (second stage) the prospective bride's father replied with the betrothal phdweasith—although this was not always the case. In a few interviews, respondents indicated that phdweasith is "unnecessary" in that it involves paying the woman. One husband's statement reflected this view:

In a rightful marriage, you write a letter to the girl's parents, which is asking for permission to send and introduce yourself. They give you reply to the letter and allow you to then you go to the presence of the parents and introduce yourself to all the people and her people. And then you do anything else that they require you to do. There are some people who sell their children. They ask for goats, cows, chickens and butchies. Those people have followed the discipline of the religion because the Islamic religion doesn't allow you to sell your daughter.

Another man explained the marriage arrangements for one of his wives in

this manner:

I wrote a letter and she took it to her parents. And her father said "I want to meet my son-in-law to be." When I went there, my father was me and said, "the girl is there, me. I won't refuse to give the marriage." Her father also said, "except for the two important points that I want to tell you. The first one is that I want you to be tested with the marriage [or-marriage] test. The second one is that I want to give you my daughter because you get married first and then you take her." I said, "I will do as you say and I will be the best to the introduction ceremony."

Then you go and the introduction ceremony took place and I got married. They don't even disturb you because you have brought everything. The other letter, which the parent (father) writes specifies, "I want a goat, *kanzu*," anything that he desires, he can put in that letter. There's no law that says a Muslim has to ask for things and then you can take his daughter. You just get those things as a parent.

In response to a question about whether her husband paid bridewealth, the wife referred to above stated, "... He didn't pay brideprice as such. He gave things like a busuti [traditional dress for women], *kanzu* [formal, long white robe for men], and a goat for the *duwa* [Muslim ceremony]. *Busutis* for the mothers and *kanzu* for the father...the *duwa* happens on the night that he takes you back to his place."

Women indicated that they either wrote a letter or otherwise communicated to their prospective grooms about the amount of "*amawali*" (the local term used for the Muslim dower) that they wanted to receive. Women generally understood that the amount of *amawali* was theirs to determine and keep. They articulated the purpose of *amawali* in different ways. One wife described *amawali* as "like a bride price that you set for your husband when he is going to take you. Because when you separate you must give those things back." She said that the practice of *amawali* is unique to Muslims, and that in her case, she asked for money only. Several other women understood it as a gift from their future husband that "shows he is your husband." Another wife stated that she did not really know the purpose of *amawali*, just that it was done in the past and continues in the present.

Nor was there any set amount that women asked their future husbands for as *amawali*. One woman asked for and received 10,000 shillings (about ten U.S. dollars at the time of the interview). Another woman asked for the same amount, but when the man said that he could not manage that much, she accepted 5,000 shillings. Yet another woman asked for 1,500 shillings. In every case, women and men stated that if the marriage ends, the woman is responsible for repaying the *amawali*. This seemed to factor into the amounts that were set for some of the women, especially since a number of respondents indicated that women were responsible for doubling the amount of *amawali* that they would be responsible for repaying if the marriage ended.

Once the amount of *amawali* and/or bridewealth had been settled upon, the husband and his family and friends traveled to the bride's parents' home for the combined *okwandhula* (introduction) and wedding ceremonies (third stage). One male elder who acted as a key informant stated that formal Muslim marriage takes two forms among the Basoga Muslims in the area. The first, called "*kadaali*," takes place in one of two ways: a marriage at the mosque or a marriage at home in front of a large group of people. The second form, "*waziiko*" can take place anywhere and only involves the man, woman, woman's father ("*muko*") and the imam. An imam who was a key informant also gave the same distinction between the two forms of marriage as practiced by Basoga Muslims.

During the survey, each currently married respondent was asked about the type of marriage ceremony they had been through. The preliminary analysis of their responses revealed sizeable differences in matched husbands and wives'

reports of marriage type. The reasons for these differences emerged during the follow-up in-depth interviews. All of the spouses stated that they were married in one of the two forms of Muslim marriage. The imam performed the ceremony and read the *duwa* (or blessing), after which there was generally feasting, and sometimes *mataali* (Muslim drumming reserved for special occasions), and then the newly married couple returned to the husband's home.

While the distinction between *kadaali* and *waziiko* forms of Muslim marriage was generally expressed in the same manner by the husbands as by the elderly male key informant, wives voiced a different understanding of the distinction. This gendered difference is best articulated in the following response: "I understand *kadaali* as being dressed as a bride, with a veil. It is the veil that we call *kadaali*. So, I had a *kadaali* marriage at home. To me, *waziiko* means married without a veil." Only one wife mentioned being married in a mosque and she called that a "ring marriage," (a similar term is used for Christians who are married in a church ceremony). Similarly, only one person (a woman, who along with her spouse has secondary plus education), mentioned that after being properly married by the imam, they received a marriage certificate.

While the in-depth interview participants were all married in Muslim ceremonies, there are a number of forms of informal marriage as well, which are not limited to Muslims. One such form is called "*gula akasepiki*" which literally means "buy a small cooking pot" and figuratively refers to a couple living together as married, but without the benefit of a socially sanctioned marital process. The second form is called "*kawundo kakubye ku ddirisa*," which literally means a "bat

knocking on the window." Figuratively, the play on words connotes either a man or a woman knocking on a window at night to signal their arrival to their partner in a clandestine manner. The partners in such a marriage are living together as married, but as with other informal unions, the marriages are viewed as private and unrecognized, according to one elderly male key informant. Serunjogi (1994: 154) comments that some Muslims attribute *kakubye ku ddirisa* to the high bridewealth (or *mutwalo*) and other marriage-related expenses that men and their families must come up with as part of the formal marriage process. Such arrangements subvert the Islamic doctrine related to the marriage process, particularly the dictum that a girl must be married with the consent of her parents.

Respondents emphasized the importance of the introduction/wedding ceremony in legitimizing a marriage. While some people are considered married, if they have not been through the introduction/wedding ceremony, they will not be formally recognized as married by the woman's parents. The fluidity of marital unions and the ways that a non-recognized union can become recognized was articulated by one husband in response to a question about different types of marriage:

- There are some people who will find a woman and con her [talk her into having sex], and take her home. After the boy takes her, he will go and tell her parents, "I'm the one who took your daughter." Then the girl's parents will tell him what they require of him. After that, they will tell him, "we the parents are coming to visit your home, so go back and prepare." And they visit. So he would look good in the face of the parents because he'd told them, "I'm the one who took your daughter," and he had done everything that they had told him to do.

The data in the following tables summarize the results of specific questions asked of the currently married survey respondents who are the focus of the risk cluster analysis about whether bridewealth was paid (and if, so how much), whether they had been through an introduction ceremony, and the type of marriage ceremony they had been through. Marriage type was recoded into Muslim (*kadaali* or *waziiko* marriage) or cohabitating. Husbands were asked the marriage questions about each of their wives. The findings for husbands' responses to the marriage questions for the 100 husbands for which there are complete data ("adjusted n husbands") are shown in Table 5.12. The "adjusted n wives" of 153 is based upon the 60 wives of monogamous husbands and 93 wives of polygynous husbands for which there are complete data. The adjusted n of 153 total wives is used to calculate the percentages in the table, and the adjusted n of 93 wives in polygynous unions is used to calculate the adjusted intensity of polygyny (2.3%).

Table 5.12 Husbands' Responses to the Marriage Questions, Risk Cluster Sub-Sample

	Monogamous	Polygynous	Total
Adjusted n husbands	60	40	100
Adjusted n wives	60	93	153
Adjusted intensity of polygyny	NA	2%	2%
Through introduction ceremony	87%	79%	82%
All of brideprice paid	65%	66%	65%
Part of brideprice paid	3%	2%	3%
None of brideprice paid	32%	32%	32%
Muslim marriage	87%	89%	88%
Cohabitating marriage	13%	11%	12%

The vast majority of husbands report going through the introduction ceremony with each of their wives, with a slightly higher percentage of men in currently monogamous unions giving this response. About two-thirds of husbands report that they paid all of the brideprice for each of their wives, while nearly one-third report that none of the bride price was paid. Close to 90 percent of husbands report that they married their wives in Muslim ceremonies.

The data in Table 5.13 show wives' responses to the marriage questions. All percentages are based upon the 118 wives for whom there are complete data.

Table 5.13 Wives' Responses to the Marriage Questions, Risk Cluster Sub-Sample

	Monogamous	Polygynous	Total
Adjusted n wives	60	58	118
Through introduction ceremony	80%	70%	75%
All of brideprice paid	70%	64%	67%
Part of brideprice paid	3%	0%	2%
None of brideprice paid	27%	36%	31%
Muslim marriage	67%	64%	65%
Cohabiting marriage	33%	36%	35%

Seventy-five percent of the wives reported going through the introduction ceremony. As with the husbands' reports, more wives in monogamous unions reported going through the introduction ceremony than wives in polygynous unions. Slightly more wives in monogamous unions reported that all of the brideprice was paid, while the reverse is true for wives in polygynous unions, who were slightly more likely to report that none of the brideprice was paid. About two-thirds of the wives reported that they were married in Muslim ceremonies.⁴

Finally, very few women said that they were consulted when their husband wanted to marry another wife. Those few who were consulted indicated that there

was not much that they could do about it if they disagreed, because the husband is the "*mwene maka*" (head of household) and, as such, has the authority to make that decision. Women in focus groups also emphasized this point. This indicates a gap between the "ideal" in Muslim marriage where wives should be consulted before another wife is brought into the family and the actual practice of polygyny by the Basoga Muslims who took part in this study.

Ideals versus Practice

The similarities and differences between the ways that people articulated marriage practices as they understood and experienced them and as set forth in Islamic doctrine highlights the ways that religion is filtered through culture (or the "minor tradition"). For example, as shown in the tables, the majority of currently married husbands paid bridewealth, despite what Islam says—and what a few in-depth respondents mentioned—about bridewealth being "unislamic." Additionally, women's comments about the distinctions between *kadaali* and *waziiko* marriage and the depth of their knowledge about the purpose of *amawali* (Muslim dowry) may be a reflection of both the ways that culture and religion interact as well as women's general level of knowledge about Islam. While Muslim men are discouraged from marrying non-Muslim women, marriages across religions (whether Muslim or Christian) do occur in Uganda. In Basoga culture, it is expected that a woman will take her husband's religion upon marriage. During both periods of research, women who converted to Islam because of marriage stated that they were taught about the religion by their husbands. Several of the women who were interviewed had converted to

Islam, and this may have impacted their level of knowledge about what Islam has to say regarding Muslim dowry.

The ways that women framed the meaning of Muslim dowry may also be strongly influenced by Basoga cultural norms about bridewealth. This is reflected in the wife's statements above, that *amawali* (dowry) is a type of bridewealth. In this case, she is articulating *amawali* in terms of Basoga culture, rather than strictly in terms of the Islamic meaning of dowry. Women's low level of education also makes it unlikely that they have read Koranic verses and teachings of the Prophet Mohammed related to dowry. The same explanation may help to explain differences in the ways that women and men defined *kadaali* and *waziiko* marriage. Men, who generally have higher levels of education than women, generally followed the distinction as framed by the imam and an elderly male informant. Women, on the other hand, tended to distinguish the types of marriage based on whether or not they wore wedding attire.

Finally, while Islam sanctions that wives should be consulted before another wife is brought into the family, wives indicated that they are generally not informed about the addition of a co-wife. The addition of another wife to the union has the potential for generating increased conflict within the union. As one woman stated in a focus group during 1997, and all group members agreed: "He brings another wife and forgets about, ignores you... all the peacefulness and cooperation between you and your husband disappears. The new wife will try to do anything to make sure that you leave the home." The characterization of

relations between co-wives as marked more by conflict than by cooperation was a consistent theme in the in-depth interviews and focus groups with women.

This view is summarized well in the following statement from a focus group with women in the trading center:

When this man brings another wife, he begins treating the new wife as the best and mistreating the first wife or even ignoring her. So this creates bad feelings between the two women. You can have a house with five wives and there is no cooperation between the wives. All of them cooperate with the husband, but none of them cooperate with each other.

Some of the women in this focus group pointed out that the extent of cooperation among co-wives depends upon how the husband handles introducing the new wife. While there was not strong agreement on this, one of the more highly educated women in the group (she had completed S4, [four out of six years of secondary education] and teacher's training college) stated that,

It depends on whether your husband unites you. When he brings a young wife into the household and says to her, "do you see that lady? I have been together with her through hard and good times and therefore I do not want you to despise her." Therefore, when a young wife's child falls sick, she will go to the eldest wife for help. If their husband does not have money at the time, she will give that young wife money for treating that sick child.

Other wives in the group insisted that the level of conflict between co-wives is such that the husband will establish them in separate residences because "the only thing that those two women have in common is that they share the same husband...there can never be harmony among them. The only thing that brings them together is that man." A wife who is in a currently monogamous union, but who knew that her husband had had three wives before he married

her and had seen four other wives come and go during her marriage, commented that polygyny creates tensions within the home. Specifically, "Sometimes the man misbehaves and is always bringing wives who then go away.

Misunderstandings happen between the co-wives and there is always quarreling. Some co-wives go to witchcraft because they want the others to leave so she can have the husband all to herself."

Additionally, the majority of women in focus groups and interviews asserted that the addition of a new wife to the family stretches already scarce resources even thinner. "Especially now with the economic situation in Uganda, we are not getting enough things. The little that you get would have been enough for one wife and now it is shared with many people. And people's sources of income are the one that spoils people's homes. Because [one wife] will think that the [other wife] is the one being given enough things. And the second wife would also think that the other wives are getting the good things. And it contributes to jealousy and decreases co-wife cooperation."

Husbands in in-depth interviews and focus group were aware that wives were generally opposed to the addition of another wife in the union. Husbands were asked whether they consulted their wives before bringing another wife into the family. One husband who is currently in a monogamous union, but who may add another wife if resources allow, commented that he would tell his wife if he planned to bring another wife into the union. If she objected, he would explain his reasons, emphasizing the advantages, i.e., that they would have twice as much labor, which would allow them to grow more crops and thus increase

household resources. He asserted that she would come to see his point, "according to the way the discussion would go and we would come to an agreement." When asked what would happen if his wife disagreed and insisted that she did not want a co-wife, he commented, "Then I would just bring her [the new wife], because I am the head of the household. I have tried to discuss it with her and she refuses, so I would do what I want to do, because in this world, I am not the first man to get another wife."

While the gap between the ideal (Islam stresses that wives should be consulted before husbands add another wife to the union) and practice (wives asserted that they are rarely, if ever consulted) is wide, one of the primary messages of the FAEPTI Project—that men should not marry another wife unless they could treat all of their wives equally—seemed to be getting through to the target population. During both periods of research, people frequently commented that one of the primary signs of behavior change was that men were marrying fewer wives. This is reflected in one wife's comment during an in-depth interview: "Now things have changed in the world. You can no longer bring another wife. You used to be able to, but now you can't.... People's lives have changed. People are sick. Every person must stay in the state that they are in and stay faithful."

It is possible that the Basoga Muslim women who participated in this study may not be fully informed about their rights under Islam. This is reflected in the comments of a sheik (Islamic scholar), who is an integral part of the FAEPTI Project. "Women in Basoga Muslim society do not know their rights [as

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Muslim women]....The culture of the Basoga says that women do not have any say. The husband says do/don't. Even if it is her right, she will keep quiet. Men overpower women." His observation reinforces Obermeyer's argument (1994), discussed above, about local practice having more of an influence on women's status than religion alone.

Other FAEPTI Project leaders also asserted that Muslim women often do not know their rights and that there is also a conflict between what Basoga culture has to say about gender relations and what Islam has to say. The cultural influence often sets the tone for interactions between women and men, rather than the reverse. There seemed to be general agreement among the key informants that most Muslims in Uganda do not have an in-depth knowledge of Islam. Additionally, the project found that since men teach women about the religion, they might not have taught them what Islam says about women's rights

We talked with some Muslim scholars [in Uganda] and found that some of the rights were being hidden by the men. The sheiks [learned men] either did not know about them or were just bringing out information that was to the advantage of men's rights. For example, they were teaching that it was permissible to have four wives, but it was not qualified [i.e., that Islam allows restricted polygyny based upon the ability to treat all wives equally]. Since we are passing information through religious channels, we try to bring out what the Koran has to say to certain groups, like women. We want them to start knowing their rights, so they can help themselves.

In response to a question about how Muslims responded to the effort to inform women about their rights under Islam, he stated:

The women were very glad. Those who we talked to were glad that they had learned their rights. And the men who knew about these rights said of course, we couldn't reveal all this when they already

had so many wives. So, some men were deliberately not revealing women's rights. Others just weren't revealing out of ignorance. It was from their training. Even the more highly learned ones, the training for imams favored practices that benefited men.

When asked about whether men were resistant to change, he commented that, "They didn't know very much...they were still at least somewhat protected by culture. Religion can [be used to create] change, but culture is a roadblock."

Another FAEPTI Project leader key informant stated:

Men are dominant. They are taught to dominate. Men are supposed to teach their wives everything about the religion so that their wives learn about Islam. If women learned the Koran well they would be at peace and they would know their rights. Men don't want to teach women because they want to remain dominant. We teach women about their rights...that a woman doesn't always have to be without money, that she can work and raise, for example, goats. Those are some of the Koranic instructions. Even in the Arab world, men respect their wives.

The comments by FAEPTI project leaders reflect more of a "progressive" rather than a "reactionary" approach to gender relations. As noted previously, progressive Islam "believes in giving women their due rights," whereas reactionary Islam upholds the status quo (Bhutto 1998: 107). Importantly, many of the leaders of the FAEPTI Project have attained higher levels of education (several have university degrees and/or post-graduate education), which may influence their views on Islam. Their comments do, however, reflect the project's emphasis on re-teaching both women and men about gender relations—particularly women's rights—as interpreted through this particular lens on Islam.

Implications of Findings

There are several significant implications of the findings, summarized here and discussed in more detail in Chapter 8. First, it reinforces the material presented in Chapter 4 about the fluidity of marital relations and adds another layer of complexity. Just as all polygynous unions started out as monogamous unions, these findings point to the strong likelihood that up to 40 percent of the partners in currently monogamous unions may have been in polygynous unions in the past. In other words, the distinction between monogamy and polygyny is less clear-cut than the dichotomy implies. Speizer (1995: 537) suggests that rather than the usual marriage dichotomy of monogamy/polygyny, marital relations in Sub-Saharan Africa should be framed in terms of a "marriage trichotomy." Husbands can be sub-divided into those who are "truly monogamous" (those in currently monogamous unions who intend to remain with one wife), "potentially polygynous" (those in currently monogamous unions who intend to take another wife or wives), and "currently polygynous" (those with two or more wives).

This research suggests that it might be worthwhile to add a forth category of "formerly polygynous." In other words, the results of this study reinforce and contribute to the view of marital unions in Sub-Saharan Africa as fluid and situated along a shifting, multidirectional continuum (Blanc and Gage 2000). The implications of this for married women's risk of HIV can be extrapolated from a recent study (Halton et al. 2003: 97) of women's risk for herpes simplex 2 (HSV2) in a polygynous rural Gambian population. In that study, the odds of

women being infected with HSV2 were greatly increased for women in currently monogamous unions married to formerly polygynous men; women whose husbands intended to marry another wife; and women in currently polygynous unions. The authors conclude that, "Much transmission of HSV2 in this setting occurs within marriage where opportunities for personal protection are limited."

Second, the dissolution of marriages is a concern within the context of the HIV/AIDS epidemic because it involves partner change. In this regard, Adekun and Nalwadda (1997: 49) classify polygyny as a form of serial marriage, which they define as

... participation in a sequence of regular partnerships or unions. By this definition, males in polygamous unions are involved in the practice of serial marriages in that they go through the formation of regular unions more than once in their lifetime and are often involved in more than one such union at a time. In the case of females, serial marriage takes the form of a transition from first to second and subsequent unions within a monogamous or polygynous framework.

In their research on serial marriages and AIDS in the Masaka District of Uganda (one of the districts most heavily impacted by the epidemic), Adekun and Nalwadda found that a remarriage rate of close to 40 percent was usually due to spouses' death from AIDS. The surviving spouses' remarriage increases the likelihood of partners' exposure to HIV infection in subsequent unions: "the transition of individuals from one union to another establishes a formal sexual network through which the epidemic is propagated" (*ibid.*: 64 and 50).

Finally, the *apparent* gap between wives' reports of the current number of wives in the family and wife rank highlights the importance of asking both

questions and comparing responses, rather than relying on wife rank data alone. Wives in this sub-sample appear to understand their wife rank in terms of when and where they entered. A wife who married a man with four previous wives will call herself fifth wife, regardless of the current number of wives in the family. If she is in a "currently monogamous" union and her husband brings in another wife, the new wife will consider herself the sixth wife. Likewise, wives in currently polygynous unions will retain their wife rank regardless of whether the union remains polygynous and adds wives, or becomes monogamous. On a methodological and analytical level, this creates challenges for comparing, for example, self-assessed risk by wife rank.

The next chapter extends the findings of this chapter to examine the interplay between the distribution of power and resources, as structured by the way that gender is done among the Basoga who participated in this study, and how this shapes the perception and embodiment of risk within marital unions.

NOTES

¹ Respondents were asked about their age when they began their first marriage (which may or may not have been their current marriage) as well as the age at which they first had sex. A sizeable number of respondents were unable to give an exact age, but gave an age range. In order to make full use of the data, all respondents' answers were recoded as age ranges. Thus, it is not possible to provide an exact median age at first sex and age at first marriage, as done in the DHS data. However, the median age range for women's first marriage and first sex is 15-19; the median age range for men's first sex is 15-19, while the median for their age at first marriage is 20-24.

² The total of currently and previously married women equals 151, however, the data set is missing complete data for five of these women, thus the adjusted total of 146.

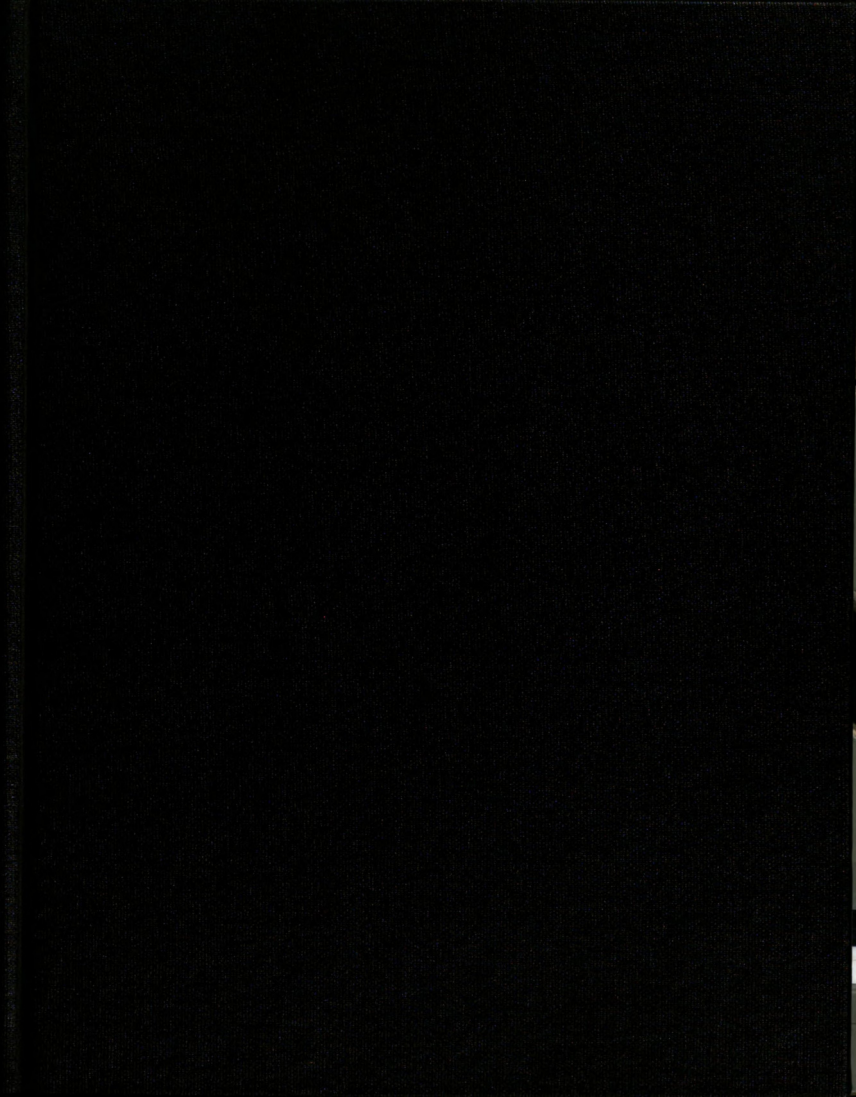
³ The small number of men in the 15-19 and 20-24 year-old cohorts is due primarily to the differences in age at first marriage for women and men. Men generally marry at later ages than women and thus there are fewer married men in these two age groups. The apparent imbalance in men and women in the 50 and above cohort is due to the absence of ever married women from the risk cluster sub-sample. That is, since the risk cluster sub-sample does not include anyone but matched husbands and wives, these women were not included in the sub-sample.

⁴ Notably, the data in Table 5.13 do not include information from the 38 wives in polygynous risk clusters who were not interviewed for the survey, which most likely accounts for the differences in percentages reported in husbands' and wives' responses to the marriage questions (husbands were reporting about all of their wives).

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**BEYOND DYADS: THE PERCEPTION AND EMBODIMENT OF HIV/AIDS RISK
AMONG MUSLIMS WITHIN MARITAL UNIONS IN RURAL UGANDA**

VOLUME II

By

Teresa A. Swezey

A DISSERTATION

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CHAPTER 6

POWER, RESOURCES AND RISK

Introduction

This chapter continues the discussion of how gender is done among the Basoga Muslims who participated in the study. The first section examines the allocation of power and resources within households as shaped by the way gender is done. The second section expands upon this discussion to examine how gendered differences in two areas of resource allocation (education and access to and control over income) may differentially influence the embodiment of risk for women.

Gender Power Dynamics within Households

Once women marry, they join their husband's household. A consistent theme during focus groups and in-depth interviews in 1997 was that it is men who form households and men who are considered head of the household. A woman's comment during a focus group with village women is representative of the views expressed in other groups and interviews, "The man is the head of the household because he is the one who built the house and brought you into that household." Or, as one husband stated during an in-depth, "head of household means that I am the one who started the home and brought in this companion." Unmarried women are socially expected to remain either in their father's or their brother's homes. This applies equally to never married and ever married women.

Further, men were generally identified as the head of the household even if they were rarely there. In response to a question about headship if a husband

is working several hundred miles away and only makes it home several times a year, there was general agreement in both women's and men's focus groups that the man is still the head of household. In that instance, his wife is considered the "caretaker" of the household, while the man is away, but he retains authority and is recognized by his wife and others as the household head.

There were, however, a few dissenting voices in the focus groups, who asserted that while men may be the *de jure* head of household, women are—or should be called head of household on a *de facto* basis. While these voices were few and far between, it is worth noting that they exist. This exchange between village women in a focus group reveals that while social norms exist about who can be called head of household; at least some women assert that it is women who should be designated as such:

Woman A: *The man is head of household because he has the authority over everything in the household. He is in charge. He is the boss, the owner of the home, and is responsible for supplying the household needs.*

Woman B: *No! The owner of the household is a woman because he will bring you from your house and leave you there with all the household needs. He will not cook or converse with visitors. He will just sit there and it will be up to you to prepare refreshments for the guests.*

Woman C: *Still, they will ask if the head of household is around even if you are there.*

Woman D: *It is true that the head of household is a man but the greatest part of responsibility for the household is for the woman, because the woman is responsible for cooking and taking care of visitors. The husband cannot manage without his wife.*

[general discussion and agreement among most of the group members]

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The man is the head of the household because he built the house and pays the taxes. Even if you work, he is the head of household.

Women in a trading center focus group expressed similar views and also commented upon the reversal in the gender order during the rare instances when a woman builds her own house, which she heads and a man later comes to live there as her husband:

Woman A: If a woman builds her own home and a man comes to live there as her husband, then the woman is the head of household because the man will have become a woman in respect to her...the woman will control the man.

Woman B: But the man has the final say so, because all the responsibility was made for the man.

Woman C: It is meant to be that way, because even when a woman does something, the man claims he did it. If you buy a goat, he can say that it belongs to him.

Woman D: Woman was created to be controlled by man. He brought you into the house, so you have to be submissive, or else both of you will act like a man in the home.

Woman E: But it is not uniform. There are some homes where the woman is listened to and her opinion counts and others where the man controls everything.

Woman D: That is because he brought you into his home.

Woman F: It would be good if women were the head of household because they are the ones who organize everything in the home, but we are controlled by men.

The extent of disagreement over the social meaning of head of household was voiced even less in men's than in women's focus groups and interviews. The following discussion occurred during a group with men in the trading center:

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Man A: *I think that the head of household is a woman because we men are not always around. Everything in the household is for the wife.*

Man B: *Yes, whatever is at the household is for the wife.*

Man C: *It depends; sometimes a woman can be head of household. There are some people who get tired of marriage very quickly. She then decides to get her own money in order to be independent. Those women are called nakyeombekiere. After which she gets a man who she will rule herself. She marries that man and instead becomes the husband.*

[laughter]

Man D: *No! Women cannot be head of household because when a person is looking for a household he will say, 'where is the road that takes me to Mr. so and so's place?' If he is shown the path then he will ask again, 'is this the path which leads me to so and so's place?' He will mention the man's name even if that man has two or three wives. But he will never mention a woman's name as owner of the household, even if he knows it. It is upon that basis that I say that a household belongs to the man.*

Man E: *For me, I think that a woman can be head of household....A woman can have her own household. You may go and visit her and then tell someone that I am coming from Khasifa's household.*

[Facilitator: What makes her the head of that household?]

Man E: *You may find that she has got young children that she is looking after.... About five of them. These children may be from a previous marriage and she is the one to look after them. She builds her house and decides to live with them.*

Man F: *For me, I think that it is the man who is mainly head of the household. This is because I have never seen any woman bring two men to sleep in one house!*

The excerpted material from focus groups and interviews suggest possible ways that "doing gender" serves to produce and reproduce the social system and allocation of power and resources (West and Zimmerman 1991: 33). One of the

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clearest illustrations of “doing gender” in the above examples is the way participants in the focus groups and interviews described the establishment of households and allocation of household headship, with its associated authority. Likewise, as illustrated in the above examples and observed in the field, the language related to marriage arrangements reveals the gendered basis of norms regarding marriage. While the Lusoga language is not gendered (i.e., there are no gender markers or gendered verbs) the language used to describe marriage arrangements comes close to being gendered. In discussions of marriage, typically women are constructed in the passive sense while men are constructed in the active sense: women are gotten, men get women; women are brought to the home, men bring women to their home; women are married by men, men do the marrying.

The subversion of “doing gender” is evident in participants’ comments about the (rare) woman who builds her own home and lives there either alone or with her children. Such women are referred to as *banakyeombekiere*. These are generally women who have been previously married and who may have children whom they are responsible for from that marriage. They may be widows or they may have left their marriages. In such a case, she is generally recognized as being the head of that household. As noted above, in that instance, she is independent and sets her own rules. Another social category of women who have broken with the usual way of doing gender is called *nakyekuluma*, that is, a woman who has left her husband. Women who live alone without a husband are viewed as playing the role of the man. *Nakyeombekiere* may “marry” men and if

they do so, a prevalent perception is that, “*nakyeombekiere* have finished our men.” If a man comes to live in her house as her husband, that represents a symbolic reversal of the gender order—the woman marries the husband and symbolically, she becomes the “husband” while he becomes the “wife.”

It is interesting to compare the ways that focus group participants described the social construction and practice of gender relations with Fallers’s description of gender relations as practiced by Basoga at the household level among during his research in the 1950s, particularly in relation to household organization, headship, and gender power dynamics. “The typical Soga homestead houses a single family consisting of the male homestead head, his wives and children, and perhaps an odd kinsmen or two from outside the simple family circle. It rarely contains more than one married male” (1965: 71-72). A very similar situation held in 1997 as did the average of five household members noted by Fallers.

Fallers noted that, while women put in more work hours to keep the homestead functioning, men have more authority over homestead resources.

This inequality is considered within the ideal pattern of distribution of authority between male and female roles. The man is the centre of authority within the homestead and its representatives in dealings with the outside world. He must be free to travel to the trading centre and sit around the beer pot with friends gossiping and discussing village affairs. The ‘good woman’ on the other hand, is one who works hard around the house, bears children, and does not endanger her virtue by going out unescorted... (*ibid.*: 78).

Fallers’s observations about men’s authority and inequality within the household parallel some of the focus group members’ comments above about gender relations as practiced by the Basoga 50 years later. This is not to imply

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that gender norms are static or that the Basoga are a society “fixed in time.” Rather it highlights aspects of continuity in the ways that “doing gender” is articulated by the Basoga across time. A woman’s status as a “dependent” of either her father or their husband is captured in Fallers’s observations that:

In terms of Soga values, a woman is in many ways, incapable of being an independent social person...If she is married, a woman should reside with and be under the authority of her husband. If she is unmarried, she should remain in her father’s homestead and under his control. If she is widowed, she should either reside as a dependent of her son or else marry her husband’s successor (*ibid.*: 118).

Fallers’s observations are largely consistent with my observations that unmarried women resided with either their father or brothers, with some of the widowed women also residing with their adult sons. The exception to Fallers’s statement is his reference to widow inheritance (a widow marrying her husband’s successor). By and large, widow inheritance is now rarely practiced among the Basoga Muslims who participated in this research. Only two out of the 124 currently married men in the full sample were married to an inherited wife. Within the context of the HIV/AIDS epidemic in Uganda, widow inheritance as a cultural practice has been discouraged as part of AIDS education and prevention efforts.

While it is rare for women to form female-headed-households, as indicated above, Basoga social norms frame such actions as a social anomaly. Fallers observes that, “[a]ccording to traditional Soga norms, a woman must live as a dependent of her father or guardian or of her husband. There is no social role for women living alone or as the head of the homestead” (Fallers 1957: 120). The social expectation that unmarried women—whether ever or never married—will

conform with the ways gender is done in Basoga society is reflected in the low numbers of female headed households in the full sample. Only ten of the 154 households included in the survey are “officially” headed by women (6.5%).

Forms of Power

The excerpted material from focus groups and interviews highlights the imbalance of power and authority within households. In most cases, both women and men assert that authority (*obuyinza*) rests with the head of the household, who is nearly always identified as “*omusadha*” (the man). *Obuyinza* can be understood as power over the behavior of household members and matters and power over final decisions within the household. This “power over” extends to control over resources as well as control over the realms of sexuality and reproductive decision making that may influence the embodiment of risk, including decisions related to AIDS risk reduction such as condom use, pre-marital testing, and whether another wife is brought into the family.

Yet, within the ways that gender is done among the Basoga Muslims, there are other forms of power. One of these is embodied in the concept of ‘*okusendasenda*,’ which means to use one’s persuasive abilities to alter the outcome of a situation in your favor. In the context of the AIDS epidemic, a woman might try to take some control over reducing her AIDS risk by attempting to persuade her husband to use a condom—using either direct or indirect means. Since the people who participated in this research were intensively educated by the IMAU FAEPTI Project as well as Ugandan AIDS prevention messages, they were well aware of the use of condoms for AIDS risk reduction. Several women

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in in-depth interviews stated that a wife who is concerned about her AIDS risk might take a direct approach by saying that it is wise, in this age of AIDS, to use a condom, so that they can stay alive for their children. Alternately, a wife may adopt an indirect approach to AIDS risk reduction through condom use, by framing it in terms of wanting to use condoms as a means of birth spacing. Of course, the way that a wife introduces this topic as well as her timing is likely to influence the outcome. Several people commented that a wife stands a better chance of successfully negotiating condom use with her husband if she does not bring it up at the last minute. A wife's attempt to persuade her husband to use condoms may run up against the cultural and religious norm that men are the final decision makers within households. Or as one woman stated in a focus group, "a wife can persuade or negotiate, but she cannot rule her husband."

Another form of power includes the notion of "ability," as in being able to act (*obusobozi*). The notion of *obusobozi* as a kind of power comes close to the sociological notion of agency. When expressed as "*nsobola*" (I am able) it embodies the concept of the capacity to act on one's own behalf, while its negation, "*tisobola*" indicates constraints on taking such action. In discussions with women about AIDS risk reduction, these constraints are often voiced in terms of social structural factors shaping gender inequality. In other words, one of the ways that risk becomes embodied is via "doing gender," which shapes the inequitable distribution of power and resources. The tension between the ability to act and constraints on taking action is critical to understanding why knowledge

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about ways to reduce one's HIV/AIDS risk is an important, but not necessarily sufficient precursor to taking steps to do so.

The following sections expand upon the above discussion about how gender is done among the rural Basoga Muslims who participated in this study by addressing how the distribution of power and resources in two realms—education and income—may impact the embodiment of risk for women.

Education

Gendered Educational Differences

“The educational differences between females and males are among the most significant indicators of gender inequality” (Riley 1997: 10). Level of education may shape the embodiment of risk by influencing the types of AIDS information people are able to access as well as their knowledge about HIV/AIDS risk and risk reduction. Educational differences may also affect the extent of women's control over sexuality and reproduction; level of education is recognized as a proxy for the level of control over fertility decisions (Blanc 2001). Gendered differences in education may impact the number and types of income generating activities that women are able to access, and thus the extent of their economic dependence on men. Each of these areas is explored in turn in the following discussion.

There are sizeable gaps in females and males' level of education both among the Basoga Muslims who participated in this study and on the national level. Respondents in the present study were asked detailed questions about their levels of education and the data were recoded into a tri-level educational

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variable to allow comparisons with other data on education in Uganda. The aggregate results of the tri-level variable are shown in Table 6.1 and are further contextualized with the results of a more stratified age/gender analysis (seven-level education variable, data not shown).¹

Table 6.1 Education and Gender, Full Sample						
	Men		Women		Total	
	Count	%	Count	%	Count	%
None	18	12%	34	21%	52	17%
Primary or Quar'an	86	59%	106	65%	192	62%
Secondary or higher	42	29%	24	15%	66	21%
Total	146	100%	164	100%	310	100%

Primary education includes P1-P7 (primary one through seven). Lower level secondary education includes S1-S4 (secondary one through four) while upper level includes S5-S6 (secondary five through six). According to key informants, Quar'anic education follows a curriculum similar to secular primary-level education (P1-P7), with the added component of Muslim religious education. Respondents who reported Primary and/or Quar'anic education were recoded into the new variable Primary or Quar'an. Kagimu et al. (1998) use an identical educational variable in their analysis of the impact of IMAU's FAEPTI Project in Uganda.

Nearly twice as many women have had no formal education and slightly more than twice as many men have had at least some secondary education ($p < .05$). Forty-eight percent of the 42 men who reported a secondary education have had higher secondary education and/or gone on to skilled trades school; only one respondent (male) out of the 313 attended university. In comparison, only 21 percent of the 24 women who reported secondary education have had

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higher secondary education. The mean level of education for the sample is Primary or Quar'an ($p < .05$).

The majority of people in this category have had some primary or Quar'anic education, as opposed to having completed primary or Quar'anic school, (77% of the men and 79% of the women have had some primary or Quar'anic education, while 23 percent of the men and 21 percent of the women have completed this level of education).

The percentage distribution for education are similar to those found by Kagimu and his colleagues' study of the impact of the Family AIDS Education and Prevention through Imams Project, which targeted Muslims (1998). While the authors did not disaggregate their data by gender, they use an identical scale: of the 1,826 respondents, 22 percent had no formal education, 58 percent had Primary/Quar'an, and 20 percent had a post-primary education. On the national level, there is wide variation in the educational level of women and men by region. Gendered educational differences show a similar pattern on a regional and national level as those shown in Table 6.1 above. Data from the DHS shows that in the eastern region (location of the research site) 12 percent of the men and 30 percent of the women have no formal education, 65 percent of the men versus 58 percent of the women have primary education, and 23 percent of men compared to 12 percent of women have secondary plus education. The aggregate pattern across all regions shows that more than twice as many women as men have had no education (12% versus 31%, respectively) and nearly twice as many men as women have had secondary plus education (25% men and 14%

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women) (Statistics Department, Ministry of Finance and Economic Planning, Uganda and Macro International 1996: 21).

The data in Table 6.2 provide information about the level of education for the risk cluster sub-sample, stratified by gender.

Table 6.2 Education and Gender, Risk Cluster Sub-Sample

	Gender					
	Men		Women		Total	
	n	%	n	%	n	%
Education						
None	10	10%	25	21%	35	16%
Primary or Quar'an	63	62%	80	66%	143	64%
Secondary or higher	28	28%	16	13%	44	20%
Total	101	100%	121	100%	222	100%

As shown, women are twice as likely to have received no formal education and twice less likely to have secondary or higher level of education than men ($p < .05$). The mean level of education for the risk cluster sub-sample is at least some Primary/Quar'an. This includes those who have completed some or all of P1-P7 (Primary 1 through Primary 7).

The vast majority of respondents (78%) within this category have had some Primary or Quar'anic education, rather than having completed that educational level. Proportionally more women than men (82% as opposed to 71%, respectively) have had some Primary or Quar'anic education. The same pattern holds for the remaining 22 percent of respondents who have completed Primary or Quar'anic school (18% women and 29% men). Close to two-thirds (64%) of those classified as having a secondary plus education have had some secondary school (some or all of S1-S3). This includes proportionally far more women (81%) than men (50%). Only three of the sixteen women (19%) with

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secondary education have attained a higher secondary education (some or all of S4-S6) compared to 50 percent of the men (data not shown).

Social norms that emphasize early marriage for females and place a high premium on women's reproductive capacities may contribute to parents not investing as much in girls' education (Ezeh 1997). Relatedly, Ezeh (1997: 5 and 7) comments that the level of polygyny in an area affects the educational level of all women—whether in polygynous or monogamous unions. Classifying Kenya's regions into three levels of "polygyny regimes": high (more than 20% of currently married women in polygynous unions), mid (10%-20% polygyny), and low (less than 10%), Ezeh found that as the level of polygyny increases, gendered differences in education increase. Thirty percent of women in high polygyny areas had no formal education, compared to 25 percent in mid-polygyny areas, and 10 percent in low polygyny areas. Because males' educational levels tend to stay fairly constant across different polygyny regimes, women's lower levels of education in high polygyny regimes is not due to a lack of access to formal education in these areas. Rather, it is due to "reproductive norms that constrain most of women's reproductive years in childbearing." Using Ezeh's classification scheme, Uganda as a whole as well as the risk cluster sub-sample would be classified as a "high polygyny regime." Thirty percent of the women in Uganda and 50 percent of the women in the risk cluster sub-sample are in currently polygynous unions and this may contribute to lower levels of education for females.

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Educational level is often used as a proxy for the extent of women's control over sexuality and reproduction, including the use of contraception. Women with higher levels of education are reported to have greater control over their sexuality and reproduction, are more likely to use contraception, and more likely to discuss their fertility preferences with their partners (Becker and Costenbader 2001; Blanc and Wolff forthcoming; Wolff et al. 2000a, 2000b; Blanc et al. 1996), all of which have implications for the embodiment of HIV/AIDS risk. As hypothesized by Becker and Costenbader (2001: 123), "[b]etter educated women may have more status in the household, and, therefore, have greater autonomy to speak openly with their husbands about their contraceptive preferences." The relative educational difference between partners also plays a role in fertility preferences. In a study of Ghanaian couples' attitudes towards family planning Ezeh (1993: 166) found that wives' attitudes toward contraception were dependent on both their own as well as their husbands' level of education. However, while husbands' higher level of education predicted wives' favorable attitudes toward family planning, the reverse was not true; husbands' contraceptive attitude was dependent on their own level of education alone.

Couples research from Uganda shows that women with higher levels of education report greater control over fertility decisions, and are significantly more likely to discuss condom use with their partners and/or use condoms with their partners (Blanc and Wolff forthcoming; Wolff et al. 2000a, 2000b; Blanc et al. 1996). Increasing level of education was a powerful predictor of both women's and men's sense of control over fertility decisions. As education increased, the

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percentage of respondents agreeing with the statement "The number of children that I will have with my partner depends mostly on what my partner wants, not on what I want" decreases. While the association between increased level of education and increased sense of control over fertility decisions was significant for both women and men, it was a more powerful predictor for women than for men. Sixty-nine percent of women with no formal education agreed with the statement as opposed to 32.5 percent of men with no formal education. At the other end of the educational spectrum, only 22.1 percent of women with lower secondary education (S1-S4) and 10.4 percent with upper secondary education (S5-S6) agreed with the statement, as opposed to 11.8 percent of men with lower secondary and 4.2 percent of men with upper secondary education (Wolff et al. 2000a: 127).

Data from the same study showed that women with a secondary or higher education expressed greater control over their ability to negotiate sex with a regular partner. Women with this level of education were approximately four times more likely than women with no formal education to state that they had greater or equal control over whether or not to have sex. They were also about twice as likely to score above the median on an attitudinal scale concerning the circumstances in which a married woman can refuse to have sex with their husbands. Moreover, women with a secondary or higher level of education were six times more likely to state that it is not difficult for them to discuss sex with their partner compared to women with no formal education (Wolff et al. 2000b: 313 and 317).

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A secondary or higher level of education also was a significant predictor of both women and men in the above study having ever discussed condom use with their current partners. Women with this level of education are five times more likely and men are 22 times more likely to have discussed condom use with their current partner than individuals with no formal education. Relative differences in education also influence the likelihood that current partners have discussed using condoms. "For men, relative to having a partner with the same level of education, having a partner with higher education increases the odds of discussing condom use; being the partner with higher education has no effect. For women, having a partner with two or more levels of higher education has a positive effect on discussion while all other categories are not significant." Similarly, a secondary plus education significantly predicts "ever use" of condoms. "Women with a secondary education are more than ten times more likely and men are six times more likely to report ever using a condom with their partner than are those with no education" (Blanc et al. forthcoming: 13 and 14).

Further implications of the gender gap in education on the embodiment of risk may include differences in the number and types of AIDS information sources utilized, levels of knowledge about HIV/AIDS transmission, and ways to avoid HIV/AIDS. Gendered differences in education may also influence the number and type of income generating activities that women and men are able to engage in. Each of these areas is addressed below.

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Sources of AIDS Information

The data for a prompted question about sources of AIDS information are shown in Table 6.3. Each item on the list was read to respondents and they were asked whether it served as a source of information about AIDS. The items in this and subsequent contingency tables are rank ordered from highest to lowest total percentage of responses. All data are drawn from the risk cluster sub-sample.

Table 6.3 Prompted sources of AIDS information by gender, risk cluster sub-sample						
Item	Gender				Total (N = 223)	
	Men (N = 102)		Women (N = 121)			
	Count	%	Count	%	Count	%
Imam/Sheik/Kadhi	92	90%	95	79%	187	84%*
Radio	94	92%	91	75%	185	83%*
Friends and neighbors	93	91%	88	73%	181	81%*
Family AIDS Worker	80	78%	81	67%	161	72%*
Newspapers/pamphlets	55	54%	28	23%	83	37%*
Television	63	62%	20	17%	83	37%*
TASO programs	56	55%	24	20%	80	36%*
Public posters	63	62%	15	12%	78	35%*
Local government workers	41	40%	19	16%	60	27%*
Children	41	40%	10	8%	51	23%*
School teacher	18	18%	10	8%	28	13%*
*p < .05						

All of the sources show statistically significant gender differentials; women were more likely to report fewer sources of AIDS information than men. The mean number of sources of AIDS information for women is four, while for men it is seven. The top four sources of AIDS information are imam/sheik/kadhi (Muslim religious leaders, project related), radio, friends and neighbors, and Family AIDS Workers (FAWs, project related). These four sources also have some of the smallest gender differentials in the proportions of women and men reporting that they receive information from them. Seventy-nine percent of women and 90

percent of men said that they receive information from imam/sheik kadhi and nearly equal percentages (75% and 92%) reported radio as a source of AIDS information. Friends and neighbors were identified as a source of information by 73 percent of the women and 91 percent of the men, while 67 percent of women and 78 percent of the men cited FAWs as a source of AIDS information. The high percentage of friends and neighbors reported as AIDS information sources is consistent with recent national level findings from Uganda of the importance of information circulated within social networks as one of the primary sources of AIDS information (Hogle et al. 2002).

Lower levels of education for females may contribute to the embodiment of risk by limiting their ability to utilize printed materials about HIV/AIDS prevention. Information sources related to literacy show a much wider gender differential. Twelve percent of women versus 62 percent of men identified public posters as a source, and 23 percent of women as opposed to 54 percent of men reported newspapers/pamphlets as one of their information sources. The AIDS Support Organization (TASO) sponsors radio programs, presents dramas, and publishes written material and posters related to AIDS prevention. Only 23 percent of women, as compared to 57 percent of men identified TASO activities as one of their information sources.

Table 6.4 expands upon this by showing the results of sources of AIDS information by highest level of education.

Table 6.4 Prompted sources of AIDS information by highest level of education, risk cluster sub-sample										
Item	Highest level of education								Total (N = 221)	
	None (N = 34)				Primary or Quar'an (N = 143)				Secondary or higher (N = 44)	
	Count	%	Count	%	Count	%	Count	%	Count	%
Radio	28	76%	118	83%	40	91%	184	83%	184	83%
Imam/Sheik/Kadhi	27	79%	123	86%	36	82%	186	83%	186	83%
Friends and neighbors	23	68%	117	82%	40	91%	180	81%	180	81%
Family AIDS Worker	20	59%	107	75%	33	75%	160	72%	160	72%
Newspapers/pamphlets	4	12%	40	28%	39	89%	83	38%	83	38%
TASO programs	1	3%	55	38%	24	55%	80	37%	80	37%
Television	2	6%	52	36%	28	64%	82	37%	82	37%
Public posters	4	12%	43	30%	31	70%	78	36%	78	36%
Local government workers	7	21%	35	24%	17	39%	59	26%	59	26%
Children	4	12%	28	20%	18	41%	50	22%	50	22%
School teacher	0	0%	16	11%	12	27%	28	13%	28	13%

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As shown in Table 6.4, sources of AIDS information are associated with level of education, which in turn, is associated with gender. As noted previously, men have higher levels of education than women; women outnumber men by a factor of two among those with no formal education and twice as many men as women have attained a secondary or higher level of education. As expected, as education increases the percentage of respondents reporting literacy-related AIDS information sources increases. Twelve percent of those with no formal education reported newspapers/pamphlets as a source, compared to 28 percent with primary education, and 89 percent with secondary or higher education. Similarly, 12 percent of respondents with no formal education identified public posters as an AIDS information source, compared to 30 percent with primary education, and 70 percent with secondary plus education.

Respondents were asked a follow-up question designed to identify not whether they received information from a particular source but rather, which source of AIDS information they relied upon the most. Table 6.5 shows the results, stratified by gender. Because of the low cell counts in most of the cells, Pearson's chi-square is not reported for the table. Forty percent of respondents identified project-related sources (imam/sheik/kadhi and FAWs) as their primary source of AIDS information, followed closely by radio (38%).

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Table 6.5 Most important source of AIDS information by gender, risk cluster sub-sample						
Item	Gender				Total (N = 221)	
	Men (N = 102)		Women (N = 119)			
	Count	%	Count	%	Count	%
Radio	42	41%	43	36%	85	38%
Family AIDS Worker	23	23%	23	19%	46	21%
Imam/Sheik/Kadhi	15	15%	28	24%	43	19%
Friends and neighbors	6	6%	18	15%	24	11%
Newspapers/pamphlets	4	4%	1	1%	5	2%
Television	3	3%	2	2%	5	2%
TASO programs	1	1%	0	0%	1	0%
Local government workers	0	0%	1	1%	1	0%
School teacher	0	0%	1	1%	1	0%
Other sources	9	9%	1	1%	10	5%

These sources combined accounted for 78 percent of responses related to the most important source of AIDS information. The fact that project-related sources are among the top three most important sources of AIDS information cited by respondents, shows the impact of the FAEPTI Project in the survey area.

Eleven percent of respondents identified friends and neighbors as their most important source of AIDS information, with more than twice as many women as men reporting this. Newspapers/pamphlets are cited as the most important source of AIDS information by only two percent of respondents. The contrast between Tables 6.4 and 6.5 also shows that while respondents may identify multiple sources of AIDS information (including literacy-related sources), in this study population, they rely most heavily on verbally communicated information about AIDS education and prevention.

Knowledge of HIV Transmission Modes

Responses to an unprompted question about HIV transmission. First addressed are the results of an unprompted question about modes of HIV transmission, stratified by gender. As shown in Table 6.6, while only one of the

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items is statistically significant it is important to note that the percentage of respondents mentioning incorrect modes of transmission is extremely low (zero to three percent). Conversely, the table reveals a high level of correct knowledge about sexual intercourse as the major mode of HIV transmission in Uganda; nearly 90 percent of both women and men spontaneously mentioned it. A substantial percentage of people also mentioned two other modes of transmission, sharing needles/piercing instruments (60%) and sharing razor blades (42%).

Table 6.6 Unprompted knowledge of HIV transmission by gender, risk cluster sub-sample

Item	Gender				Total (N = 223)	
	Men (N = 102)		Women (N = 121)			
	Count	%	Count	%	Count	%
Sex	88	86%	104	86%	192	86%
Sharing needles/piercing instruments	65	64%	68	56%	133	60%
Razor blades	47	46%	46	38%	93	42%
Sex with many partners	19	19%	25	21%	44	20%
Contact with infected blood	26	25%	19	16%	45	20%
Mother to child (vertical transmission)	12	12%	12	10%	24	11%
Sharing cups and plates	9	9%	3	2%	12	5%
Sex with prostitutes	2	2%	5	4%	7	3%
Kissing	4	4%	1	1%	5	2%
Breast feeding	2	2%	2	2%	4	2%
Mosquito bites	1	1%	1	1%	2	1%
Circumcision	0	0%	2	2%	2	1%
Ablution of the dead	1	1%	1	1%	2	1%
Touching	0	0%	1	1%	1	0%
Homosexual sex	1	1%	0	0%	1	0%
Witchcraft	0	0%	1	1%	1	0%
* p < .05						

* p < .05

The risks of infection associated with having multiple partners and through contact with infected blood were mentioned by 20 percent of the respondents. Aside from "sex" as a mode of transmission, slightly fewer women than men mentioned each of these modes. Mother-to-child (vertical) and breastfeeding

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were only spontaneously volunteered by 11 percent and two percent of the respondents, respectively.

Circumcision of male infants and ablution of the dead are two practices that are unique to Muslims. In the past, several babies were circumcised at the same time using the same razor blade, creating a risk of infection for all the babies if one was infected with the virus. The FAEPTI project has emphasized the importance of sterile razor blades and “one baby, one blade” as part of their HIV/AIDS curriculum and prevention efforts (Kagimu et al. 1998). Only one percent of the survey participants spontaneously mentioned circumcision as a way that HIV is transmitted. It is possible, however, that the 60 percent of respondents who mentioned razor blades may have felt that by identifying this mode they had addressed circumcision as a mode of transmission.

Ablution of the dead is related to the Muslim practice of the imam and relatives of the same gender bathing the body prior to burial (Kagimu et al. 1998). Traditionally, this was done with either bare hands or a cotton covering. The project has taught the importance of using latex gloves to perform this ritual as a means of reducing possible risk of HIV transmission. One percent of survey respondents spontaneously mentioned ablution of the dead as a way that HIV is spread.

The association between levels of education and unprompted knowledge of HIV transmission is shown in Table 6.7.

Table 6.7 Unprompted knowledge of HIV transmission by highest level of education, risk cluster sub-sample

Table 6.7 Unprompted knowledge of HIV transmission by highest level of education, risk cluster sub-sample										
Item	Highest level of education									
	None (N = 35)		Primary or Quar'an (N = 143)			Secondary or higher (N = 44)			Total (N = 222)	
	Count	%	Count	%	%	Count	%	Count	%	%
Sex	29	83%	119	83%		43	98%	191	86%*	
Sharing needles/piercing instruments	16	46%	80	56%		37	84%	133	60%*	
Razor blades	9	26%	60	42%		24	55%	93	42%*	
Sex with many partners	9	26%	33	23%		2	5%	44	20%*	
Contact with infected blood	3	9%	28	20%		14	32%	45	20%*	
Mother to child (vertical transmission)	3	9%	14	10%		7	16%	24	11%	
Sharing cups and plates	1	3%	8	6%		3	7%	12	5%	
Sex with prostitutes	2	6%	3	2%		2	5%	7	3%	
Kissing	0	0%	2	1%		3	7%	5	2%	
Breastfeeding	0	0%	3	2%		1	2%	4	2%	
Mosquito bites	0	0%	1	1%		1	2%	2	1%	
Circumcision	1	3%	0	0%		1	2%	2	1%	
Abilution of the dead	0	0%	1	1%		1	2%	2	1%	
Touching	0	0%	1	1%		0	0%	1	0%	
Homosexual sex	0	0%	0	0%		1	2%	1	0%	
Witchcraft	1	3%	0	0%		0	0%	1	0%	
* p < .05										

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As expected, as education increases the percentage of people identifying correct modes of transmission increases. There are statistically significant differences in the proportions of respondents mentioning sex, sharing needles/piercing instruments, sharing razor blades, sex with many partners, and contact with infected blood as modes of transmission by level of education. These differences are most likely related to gender differentials in levels of education; women's lower levels of education may shape their embodiment of risk by contributing to their generally lower levels of knowledge about HIV transmission. Sexual transmission was mentioned by 83 percent of those with no formal and primary education, whereas close to 100 percent (98%) of those with secondary or higher education gave this response.

The differences in proportions are more pronounced in the other statistically significant items. Forty-six percent of respondents with no formal education mentioned sharing needles/piercing instruments, compared to 56 percent of those with primary and 84 percent with secondary plus education. Twenty-six percent of respondents with no formal education, 42 percent with primary, and 55 percent with secondary or higher education mentioned sharing razor blades. Nine percent of survey participants with no formal education reported contact with infected blood as a way that HIV is transmitted, compared to 20 percent with primary and 32 percent with secondary or higher education. A surprising finding is that the single exception to the pattern of increasing mention of correct responses with increasing levels of education is "sex with many

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partners," where the pattern is reversed. Twenty-six percent of respondents with no formal education and 23 percent with primary education gave this response as opposed to 5 percent with the highest level of education.

Responses to prompted questions about HIV transmission. Gendered educational differences are also reflected in many survey participants' responses to a series of prompted questions about HIV transmission, and these differences have implications for women's embodiment of risk. Respondents were asked the prompted (yes/no) type questions about various items related to HIV transmission. To reduce possible bias, these questions were asked after the unprompted transmission questions and were scattered throughout the survey. Table 6.8 shows the results of the prompted HIV transmission questions by gender.

Table 6.8 Prompted knowledge of HIV transmission by gender, risk cluster sub-sample						
Item	Gender				Total (N = 223)	
	Men (N = 102)		Women (N = 121)			
	Count	%	Count	%	Count	%
Sex with HIV positive person	102	100%	119	98%	221	99%
Asymptomatic period	98	96%	102	84%	200	90%
Sex without a condom	99	97%	101	83%	200	90%
Sex with anyone	77	75%	119	98%	196	88%
Mother-to-child	94	92%	101	83%	195	87%
Circumcision	64	63%	62	51%	126	57%
Breastfeeding	49	48%	67	55%	116	52%
Ablution of the dead	59	58%	44	36%	103	46%
Sex when condom used correctly	19	19%	8	7%	27	12%
* p < .05						

Overall, 99 percent of respondents stated that it is possible to be infected with HIV through having sex with an infected person. While the results are not statistically significant, it is socially significant that nearly equal percentages of

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women and men know that sex with an HIV infected person is a risk factor for AIDS. The embodiment of risk for women, however, may be impacted by their lower levels of knowledge for the majority of prompted HIV transmission questions. These differences reached statistical significance for the questions of whether it is possible for a healthy looking person to be infected with the HIV virus (asymptomatic period) and whether having sex without a condom is a risk factor for HIV transmission. Women are also statistically less likely to say that HIV can be transmitted through circumcision and ablution of the dead.

While only a small percentage of survey participants indicated that it is possible for HIV to be transmitted when a condom is used correctly, the difference in proportions between women and men's responses is statistically significant. It is interesting that the trend toward more men than women giving "correct" responses to prompted HIV transmission questions is reversed here, with more men than women stating that it is possible for HIV transmission to occur when a condom is used correctly. Seven percent of the women, as opposed to 19 percent of the men answered "yes" to this question (in this case, a "yes" response is an incorrect answer).

In only two instances did women answer "yes" more often than men did. A slightly higher percentage of women than men stated that it is possible for HIV to be transmitted through breastfeeding (although the difference in proportions is not statistically significant). The only other item in which women were more likely to answer "yes" than men, is the question about whether it is possible to be infected with HIV by having sex with anyone (i.e., not necessarily someone who

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is infected with the HIV virus). Ninety-eight percent of the women and 75 percent of the men answered in the affirmative to this question. Technically, the “correct” answer to this question is “no.” However, given the high level of HIV seroprevalence (percentage of people estimated to be HIV infected at one point in time) at the time of the research, and the high level of awareness about the existence of an asymptomatic period, the education and prevention message of the FAEPTI curriculum is that everyone is at risk of infection. It is thus not surprising that 88 percent of the risk cluster sub-sample gave a “yes” response to a blanket question about the sexual transmission of HIV.

Table 6.9 displays the results of the prompted HIV transmission questions by education. As expected, as education increases, the proportion of people giving the “correct” response increases. The educational differences in responses to the prompted HIV transmission are driven largely by women's lower levels of education, particularly the fact that twice as many women have had no formal education as men and half as many have had secondary or higher education. These differences reach statistical significance for the questions about the asymptomatic period and whether it is possible to be infected with HIV by having sex without a condom.

Table 6.9 Prompted knowledge of HIV transmission by highest level of education, risk cluster sub-sample									
Item	Highest level of education								
	None (N = 35)		Primary or Quar'an (N = 143)		Secondary or higher (N = 44)		Total (N = 222)		
	Count	%	Count	%	Count	%	Count	%	
Sex with HIV positive person	34	97%	142	99%	44	100%	220	99%	
Asymptomatic period	27	77%	130	91%	42	96%	199	90%*	
Sex without a condom	24	69%	133	93%	42	96%	199	90%*	
Sex with anyone	32	91%	125	87%	38	86%	195	88%	
Mother-to-child	28	80%	124	87%	43	98%	195	88%	
Circumcision	17	49%	76	54%	32	73%	125	57%	
Breastfeeding	12	34%	79	56%	25	53%	116	53%	
Ablution of the dead	14	40%	66	47%	22	51%	102	47%	
Sex when condom used correctly	7	20%	13	9%	7	16%	27	12%*	
* p < .05									

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Knowledge of Ways to Avoid HIV/AIDS

Table 6.10 shows the results of an unprompted question about ways to avoid HIV transmission, stratified by gender.

Table 6.10 Unprompted knowledge of ways to avoid HIV transmission by gender, risk cluster sub-sample						
Item	Gender				Total (N = 223)	
	Men (N = 102)		Women (N = 121)			
	Count	%	Count	%	Count	%
Use condoms	62%	61%	61	50%	123	55%
Abstinence	50	49%	51	42%	101	45%
Zero grazing (be faithful)	37	36%	64	53%	101	45%
Avoid unsterilized equipment	30	29%	30	25%	60	27%
Don't have many sex partners	21	21%	24	20%	45	20%
Don't share razor blades	11	11%	3	2%	14	6%
Avoid infected blood	4	4%	2	2%	6	3%
Don't have sex with prostitutes	1	1%	3	2%	4	2%
Limit alcohol consumption	3	3%	0	0%	3	1%
Follow religion	1	1%	0	0%	1	0%
Consult traditional healer	0	0%	0	0%	0	0%
Don't kiss	0	0%	0	0%	0	0%
Don't have homosexual sex	1	1%	0	0%	1	0%
* p < .05						

As with the unprompted HIV transmission question, women were less likely to mention most ways of avoiding AIDS—with one notable exception. Forty-five percent of the sub-sample mentioned one of the Ugandan terms for faithfulness (“zero grazing”), but women were more likely to give this response than men (53% compared to 36%). Although the results are not shown here, zero grazing was the only statistically significant result when the data were analyzed by polygynous status. A total of 45 percent of respondents mentioned this, with those in monogamous unions more likely to do so than those in polygynous unions (53% and 36%, respectively).

More than half (55%) of the respondents mentioned using condoms, with women being less likely to give this response than men are (50% and 61%,

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respectively). Slightly fewer women than men mentioned abstinence (42% versus 49%), but the difference is not statistically significant. Twenty-seven percent of the respondents mentioned avoiding unsterilized equipment used for injections and 20 percent mentioned limiting the number of sexual partners. About equal proportions of women and men gave these responses, although the results are not statistically significant.

As shown in Table 6.11, with one exception there are no statistically significant differences in the proportions of respondents who mentioned specific ways to avoid HIV transmission by highest level of education. The single exception showing an increased percentage of responses by increased education is "use condoms." Thirty-one percent of respondents with no formal education, 55 percent with primary, and 77 percent with secondary or higher education mentioned this method of avoiding HIV transmission. Notably, the statistical significance for this item is most likely related to fewer women mentioning it than men and the gendered differentials in education discussed above. Likewise, the lack of statistical significance for zero grazing is probably related to the higher percentage of women who mentioned this as a means of avoiding AIDS and the fact that women have lower levels of education than men do.

Table 6.11 Unprompted knowledge of ways to avoid HIV transmission by highest level of education, risk cluster sub-sample									
Item	Highest level of education								Total (N = 222)
	None (N = 35)		Primary or Quar'an (N = 143)		Secondary or higher (N = 44)				
	Count	%	Count	%	Count	%	Count	%	
Use condoms	11	31%	78	55%	34	77%	123	55%*	
Abstinence	18	51%	65	45%	18	41%	101	45%	
Zero grazing (be faithful)	15	43%	65	45%	20	45%	100	45%	
Don't use unsterile equipment	7	20%	41	29%	12	27%	60	27%	
Don't have many sex partners	5	14%	30	21%	9	20%	44	20%	
Don't share razor blades	1	3%	10	7%	3	7%	14	6%	
Avoid infected blood	1	3%	4	3%	1	2%	6	3%	
Don't have sex with prostitutes	0	0%	3	2%	1	2%	4	2%	
Limit alcohol consumption	0	0%	2	1%	1	2%	3	1%	
Follow religion	0	0%	1	1%	0	2%	1	0%	
Consult traditional healer	0	0%	0	0%	0	0%	0	0%	
Don't kiss	0	0%	0	0%	0	0%	0	0%	
Don't have homosexual sex	0	0%	0	0%	1	2%	1	0%	
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Gendered differences in education may also contribute to the embodiment of risk by influencing the number and types of income generating activities that women are able to engage in. "Women's access to and control over independent economic resources are crucial elements of their position in the gender hierarchy" (Agadjanian and Ezech 2000: 429). Respondents were asked a series of detailed questions during the survey about their sources and types of income. Table 6.12 shows the number of reported income sources stratified by gender.

Table 6.12 Number of income sources by gender, risk cluster sub-sample						
Number of income sources	Gender				Total	
	<i>Men</i>		<i>Women</i>			
	Count	%	Count	%	Count	%
0-1 sources	14	14%	38	31%	52	23%
2-3 sources	44	44%	68	56%	112	50%
4-5 sources	29	29%	14	12%	43	19%
6-11 sources	14	14%	1	1%	15	7%
Total	101	100%	121	100%	222	100%
*p < .05						

Consistent with the literature (UNIFEM 2000; Statistics Department, Ministry of Finance and Economic Planning, Uganda and Macro International 1996), women are significantly more likely to have fewer sources of income than men are.² Table 6.13 displays the reported number of income sources by highest level of education and shows that, as education increases the number of sources of income increases.

Table 6.13 Number of income sources by highest level of education, risk cluster sub-sample								
	Highest level of education							
	<i>No formal education</i>		<i>Primary or Quar'an</i>		<i>Secondary or higher</i>		<i>Total</i>	
Number of income sources	Count	%	Count	%	Count	%	Count	%
0-1 sources	13	38%	36	25%	3	7%	52	24%
2-3 sources	20	59%	66	46%	25	57%	111	50%
4-5 sources	1	3%	31	22%	11	25%	43	20%
6-11 sources	0	0%	10	7%	5	11%	15	7%
Total	35	15%	143	65%	44	20%	221	100%
*p < .05								

Individuals with no formal education are significantly more likely to have 0-1 income sources compared to those with higher levels of education. Since twice as many women as men have no formal education and twice as many men as women have secondary or higher education, these findings are reflective of gender inequality in education, which affects individuals' total number of income sources. This may contribute to the embodiment of risk for women by increasing the likelihood that they are economically dependent on men. Women's economic dependence on men and more limited access to and control over income may increase their AIDS risk by creating a situation in which a woman who feels that her husband is not providing for her adequately may "go with a man" to get the things that she wants or needs. This is discussed more fully in the subsequent section on poverty (*obwavu*) and admiration (*okwegomba*), which are two of the major explanatory themes identified by research participants as contributing to women's HIV/AIDS risk.

The next table shows the results of a prompted question about types of income by gender. The list of sources was generated during focus group discussions. Respondents were read the list and asked whether they got money

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from each of the items listed. They were allowed to identify all their income sources.

Table 6.14 Types of income sources by gender, risk cluster sub-sample						
	Gender					
	Men (n = 101)		Women (n = 121)		Total (n = 222)	
Item	Count	%	Count	%	Count	%
Sell food crops	64	63%	96	79%	160	72%*
Sell cash crops	65	64%	62	51%	127	57%*
Trader/business	56	55%	36	30%	92	41%*
Make bricks	37	37%	5	4%	42	19%*
Handicrafts	4	4%	30	25%	34	15%*
Shop keeper	13	13%	11	9%	24	11%
Hired help in gardens	14	14%	4	3%	18	8%*
Builder	13	13%	1	1%	14	6%*
School teacher	10	10%	1	1%	11	5%*
Knock stones	10	10%	2	2%	12	5%*
Carpenter	9	9%	0	0%	9	4%
Bodaboda (bicycle taxi)	6	6%	0	0%	6	3%
Hotel (sell cooked food)	3	3%	4	3%	7	3%
Tailor	3	3%	3	3%	6	3%
Sell shoes	6	6%	0	0%	6	3%
Driver	5	5%	0	0%	5	2%
Dig pit latrines	4	4%	0	0%	4	2%
Hair salon	0	0%	3	2%	3	1%
Sell clothes	2	2%	0	0%	2	1%
Other sources of income	27	27%	6	5%	33	15%
No sources of income	3	3%	10	8%	13	6%

*p < .05

The majority of respondents earned their money from the sale of food and/or cash crops. There are gendered differences, however, in the proportions of women and men who reported these income sources. Women were much more likely to report the sale of food crops, while men were more likely to report the sale of cash crops (e.g., coffee, cotton, rice) which generally bring more money than the sale of food crops. The apparent distinction between food crops and cash crops as sources of income, however, is not as clear-cut as it first seems. Consistent with Sørensens' (1992) research in the Iganga District of Busoga, all

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crops are considered potential crops for selling, depending on the circumstances (e.g., whether there is a food or cash shortage within the household, availability of markets and market prices, etc). In the study area, women may sell traditional food crops such as groundnuts and greens and/or a portion of what are considered "both" crops (i.e., crops that are grown for food with the surplus being sold such as maize and beans).

In focus groups during 1997 participants were asked to name the crops that were grown in their area and identify the crop was a food (i.e., those that were rarely if ever sold), cash, or both crop (i.e., food crops generally grown by women that may be sold for if there is enough surplus). Relatively few crops were identified as strictly food crops. There were gendered differences, however, in the number of crops identified by type. Whereas women identified a higher number of crops as food crops and/or both crops, men identified a higher number of strictly cash crops than did women. For each cash or both crop grown in their household, focus group participants were also asked who (men or women) got the money for the crop and who decided how it was spent. With few exceptions, men were identified as the people who both get the money and decide how it will be spent from cash crops. Both women and men also indicated that, in the majority of instances, men also have greater access to and control over the funds from the sale of both crops. Most wives stated that their husband's control over income earned within the household was related to his status as *mwene maka* (head of household).

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Husbands' status as *mwene maka* is related to gender power dynamics within households. That is, the way that gender is done among the Basoga Muslims who participated in the study affects the allocation of resources, power, and risk. In most cases, there is a one-to-one relationship between the person who gets the money from the sale of a crop and the one who decides how that money will be spent. Differences in women and men's access to and control over income from agricultural production within risk clusters and its relationship to people's perceptions of risk are discussed more fully in the next section.

Obwavu (Poverty) and Okwegomba (Admiration)

Two interrelated concepts that emerged as strong themes in both periods of research concerning the embodiment of risk—especially for women—are poverty (*obwavu*) and admiration (*okwegomba*). As discussed previously, the allocation of power and resources is shaped by one of the “ideals” of the ways that gender is done among the Basoga: women are not to have their own income. Husbands are expected to, “be the money earner and provider for the family.” In this instance, sociocultural and religious norms structuring how gender is done overlap, in that Muslim men are expected to provide maintenance to their wife/ves and family.

One woman framed the link between women's economic insecurity and dependence on their husbands and HIV/AIDS risk in the following manner:

What has brought this problem [of AIDS risk] for women is that most of us do not have any kind of work to bring in some money to maintain ourselves. Then we have our husbands who can't solve our problems, yet they are the ones who we depend on. So this brings *okwegomba* [admiration]. You see other women looking nice and you want to look the same. It is very easy to fall into the

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trap of going with a man to get the money to buy the things that you admire, such as skin cream... It is better if women found a way to earn their own money and stopped depending on their husbands for everything.

Her statement is representative of many similar comments made in focus groups and interviews during both periods of research. Both women and men identified *obwavu* and *okwegomba* as two of the major reasons that women are at risk for HIV/AIDS. Within the context of the AIDS epidemic, "*okwegomba*" means to admire someone or something so much that you place yourself in risky situations in order to get the person and/or thing that you admire. The issue of *okwegomba* and poverty was often phrased in terms of men admiring women and women admiring things. This was further explored during the in depth interviews by asking whether women just *okwegomba* things or whether they also *okwegomba* men and whether men also *okwegomba* things. Most men and women asserted that men generally admire women, and women admire the things that a man might be able to provide for her. A married woman may admire a man in this way because she feels that her husband is not providing her the things that she needs. As stated by one woman, "By the time that some women admire men, they already have their own husbands who are not providing [things like soap, Vaseline, and sugar] for them. So they see this man who can provide for them and help them with their problems, so they go with that man." Another woman observed that a woman who gets a "*mukwano gwa kulia*" (outside partner) to provide her with the nice things that she wants such as skin cream

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and maybe a nice dress “doesn’t know that the person giving her all those things is actually killing her [exposing her to AIDS].”

Married women’s limited access to and control over their own income is articulated in the following comment from a sheik who is an instrumental member of the FAEPTI Project: “traditionally in Busoga, women were dependent on their husbands for everything. Even when they work together, the men can cheat and women get nothing....We are teaching that women have to have something to do to make money.” In response to a question about how women earning their own money would affect the gender/power dynamics between husbands and wives, he framed the division of responsibility and authority within the household in the following manner: “Men are the head of the home and women are the ministers. They need to sit together and discuss things, develop a plan about how to get money and for other things like how to pay school fees. They need to make a proper plan for development.”

Women earning and controlling their own income through income generating activities (IGAs) was a fairly new development among the Basoga Muslims who participated in this study. Prior to the teachings of the FAEPTI Project, people indicated that few women had their own group IGAs, i.e., some women may have earned some money individually from selling crops, but they had not formed IGA groups. The FAEPTI Project encouraged women to start and/or expand income generating activities and likewise encouraged men to allow their wives to do so. FAEPTI’s message was framed within Islamic teachings about a woman’s right to earn and control her own income. The

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thinking was that, if women had their own income, they would lessen their AIDS risk because they would be more likely to have money to buy the things that they admire rather than seeking an outside partner to get that money for those things. Finally, women could contribute to the well being of the family through helping to pay for school fees and household necessities.

In response to the project's message, many women had started IGAs of one sort or another, including making handicrafts and selling surplus food and/or both crops for cash. By 1997, for example, five Muslim women had, with the permission of their husbands, started to sell agricultural produce in the trading center's market. In the words of one of the women's husbands, these women were considered "test cases," that is, since this was a first, they were under a great deal of scrutiny by other Muslims who were eager to see whether this significant break with how gender is done would impact their behavior. The notion of these women working in the market being a "test case" is summed up well by the following comments from a FAEPTI Project leader: "traditionally in Busoga, men have a misconception. They have a feeling that if they let women go look for money, then the women are going outside the marriage to look for money...that they will get the money from fornicating....Now, in the 1990s, if men let women go look for money, if she goes back to the husband with money that she has earned, then he can be very happy."

The idea of women earning their own incomes generated considerable debate in the focus groups with men. The following discussion in a village men's

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focus group in 1997 reflects this debate among men regarding the wisdom of allowing women to earn their own money:

Man 1: *If you allow a woman to earn her own money then she won't respect you.*

Man 2 (an elder): *No! her money can help out the family when there are no funds. If you ask her for some money, she can give you some.*

Man 1: *There are very few women who will give money. When you ask them, they will just pretend that they don't have any money.*

Man 2: *You have to con her—you have to put her in the right mood, show her some love and then she'll give money.*

Man 3: *Women can use the money to cater for the family.*

Man 1: *And then she asks you what contributions you're making to the family and calls you useless, since she has to dress herself [pay for her own clothing]! Women should stay in the home and work in the garden. You can give her some money, but you should control the funds.*

Man 2: *My friend, you will solve more problems if you let the woman work. She can pay school fees, for example from the money that she gets.*

As noted in the previous section, women do earn some money from the sale of food/both crops, but they may not control those earnings. In this regard, a woman who is a FAEPTI Project leader explained that, while she is primarily responsible for everything related to growing crops, when she sells the things that come from her garden, she has to tell her husband, so that he decides how the money is going to be used. The money can be used to buy essential commodities, pay school fees, and sometimes it is spent on food when the garden cannot produce enough food for the family. She further explained that

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Sharia law (part of the Islamic system of jurisprudence) states that it is husbands' right and responsibility to decide on how money is spent. Among the Muslims, she said, husbands also control the land and wives have to ask for permission to plant anything on the land or to use the land at all. Many women stated that even if they plant crops that they might earn some income from, they do not have ready access to funds of their own if it has been a bad year (e.g. a drought) or if the crops have not yet matured.

Women in both the trading center and the villages had formed several IGA groups in response to the project's messages stressing the importance of women working together collectively to empower themselves through poverty reduction. Women's IGA group activities included handicrafts (making mats and table cloths), brick making, growing and selling vegetables such as cabbage, tomatoes, and dodo (greens), and rearing poultry. The women named their groups *"Kykolera Obwavu, Omuntu Agetta Manhi"* (What You Would Do When You Are Poor, Some People Would Call It Strength), *"Gema Kumwino"* (Uphold One Another), *"Bwidha Mpola"* (They Come Slowly), and *"Tugezeku"* (Let Us Try).

The following interchange with a woman during an in-depth interview is representative of others given by many other women in focus groups and interviews about the relationship between poverty, okwegomba, and women's risk reduction through forming IGAs:

Q: What do you think puts women at risk for AIDS here in your village?

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A: Sometimes women want Vaseline, skirts, and a busuti [traditional dress], but their husbands aren't buying them these things, so it leads them to go and contract AIDS.

Q: You've said that women need money and that poverty is a risk factor for AIDS. Some people say that IGAs for women help to reduce their risk of AIDS. Do you think that women's IGAs help to reduce their risk of getting AIDS?

A: Yes. The idea came from the teachings of the project. We decided to make mats to get money because if we planted something but it has not yet grown, you can't sell it. When you make mats, you can get some money.

Q: What do you think the relationship is between poverty and women's AIDS risk?

A: It's because she [a woman] is poor, that's why she starts thinking of admiring things. So, she sets her heart on getting a man to get those things. So, to avoid this, we put our projects, which help us to get money.

In most instances, women's IGA groups were formally structured, with elected officers and a charter. They were often developed around the concept of "burial societies," in which each group participant was required to donate an agreed upon amount of money at every meeting (usually weekly or biweekly). The collected funds are then distributed to group members on a rotating basis. If, for example, there are eight women in the group, and 500 shillings (about 50 cents at the time of my research in 1997) is collected from each group member on a weekly basis, then each member will receive 4,000 shillings every eight weeks. In some instances, the women opened individual and/or joint bank accounts, to bank their money and establish credit. This was particularly the case with women's groups in the trading center, but much less so with IGA groups formed by women in the villages.

The reality of IGAs as a means for women to earn income seemed, in part, to be shaped by whether women lived in or near the trading center. Women in the villages furthest from the trading center, for example, did not travel to the trading center often. This is reflected in the following statement from a woman during an in-depth interview:

The women in this village don't usually go to the trading center. If they go, they usually go on Thursdays [the day that the weekly market is held] to buy clothes for their children. You can even spend a few months without going there and most women only go once in a while. Women usually leave their homes to go to the mosque here in the village. In the past, we used to go to the trading center, to the mosque there. They also go to the trading center in case of disease. If their children are sick, or they themselves are sick. And even then, sometimes they don't go to the trading center.

In contrast, she stated that men from her village made frequent (often daily) trips to the trading center. Women from these villages also rarely traveled to the next town where the banks were located. Whereas some of the women's groups in the trading center were part of FINCA (The Foundation for International Community Assistance), a microcredit lending system based on village banking groups, none of the women in the villages furthest from the trading center were a part of FINCA. The FINCA system is a very structured system that requires that group members be trained in how a village banking system dedicated to loaning relatively small amounts of money for microenterprises operates. Members are required to open an account with a bank and each member is required to have a certain amount of money in that account. In the case of one of the women's groups in the trading center, their initial deposit was 20,000 shillings (about US \$20 in 1997). After their FINCA

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training, each group member was given a loan of 75,000 shillings. They were required to repay that loan at a rate of 6,200 shillings over a period of 16 weeks. While 5,300 shillings went to FINCA to repay the loan, the remaining 950 shillings is deposited into the borrower's account, so that after 16 weeks they have paid off their loan and built a savings of 15,200 shillings. FINCA members are required to meet every week, make their payments on time or be assessed a penalty of 2 percent at the end of the 16-week period if the loan has not been repaid, and to respect the rules and by-laws of the FINCA group.

While expressing an interest in expanding their IGAs, women in the villages furthest from the trading center seemed to view the rules and regulations of FINCA as an obstacle. In discussions and interviews, they generally viewed the idea of each member contributing even 200 shillings a week (about 20 cents in 1997) into a group fund as a goal that would be difficult to achieve. They tended to earn smaller amounts of income from their IGAs and used the collected funds to purchase supplies for their group activity, such as palm leaves and dye for mat making, with some of the money remaining in the group fund. Unlike the women in the trading center, those living in the villages furthest from the trading center lacked a market for their group's products (mats, handicrafts, etc.). They identified this as one of the major obstacles to their "development." That is, even if they made many mats, they lacked ready access to a market to sell them. They also identified another obstacle as limited funds to buy "medicine" (i.e., pesticide) for cash crops such as cabbage. Without an adequate supply of medicine, crop yield was low and women thus earned little or no income from

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their collective efforts. Finally, both women and men in these villages asserted that the government sponsored loan program called *entandikwa* (a Luganda term meaning a beginning and figuratively translated as “push” of capital to encourage the further development of small enterprises) did not reach as far as their villages.

Despite some of the challenges encountered, women in both the villages and the trading center insisted that the money they earned from their income generating groups was theirs to control. This statement by a woman in an in-depth interview is typical of others made by women in interviews and focus groups: “The money that a woman earns from her project is all hers. The man leaves it for you, because you are the one who has been part of the project.” For many women this was in contrast to the money that was earned from the sale of agricultural produce from their gardens, which husbands might retain a greater extent of control over. While husbands may have expressed ambivalence about women earning and controlling their own income (as expressed in the excerpt above), some of the husbands had set aside part of their land for the women’s groups to grow produce.

Men had also started IGAs in response to the project’s AIDS prevention messages. These groups focused on raising money to uplift their families’ well-being and in particular, provide their wives with the things that they need so that they were less likely to get outside partners. The project’s messages to men about the need to reduce poverty and okwegomba are articulated in the following comments by a woman who is a project leader:

We taught the men that the only way that they can stop their women from admiring is to look after them. That's it.... If a man is to look after you and your children then you are free to say no to whoever is trying to con you without any hesitation. ... The man is responsible for providing everything in the home and the woman has no right to sell or give out anything in that home. So that's why you find that everything that takes place in that home, the woman has to wait for the man to make the decisions and then he gives her a share of something. The man is responsible for his wife such that she doesn't admire anything outside the home.

Men's IGAs included projects such as raising chickens, making bricks, and a jaggery group (a group to produce and sell brown sugar). The origin, purpose, and activities of the latter IGA were explained by one of the group's members during an interview in 1997:

The FAEPTI Project taught us that we had to be united together in groups... As you've seen, we have very low incomes here, which means that our homes are not easily sustained. We decided to start growing sugar cane and started the project. The reason that we squeeze sugar cane, cook the juice, get brown sugar and sell it is so that we can get money to help in the homes. Now there is a big difference between before and after we started the project regarding our households... Before we used to wake up in the morning and we [men] were idle. Now we are able to pay school fees for our children, dress our wives and children, and maybe buy a shirt or pair of pants for ourselves.

During both periods of research, women and men consistently asserted that people acting on their admiration had declined. They attributed this to the increased knowledge about AIDS and AIDS prevention that they had gained from the project, such as the importance of not having outside partners. They also cited the role that IGAs for women played—whether individual or collective. Women could earn money through individual efforts such as making mats or tablecloths and/or their group efforts. The following excerpt from an in-depth

interview is typical of responses given by other women regarding the relationship between the decline in okwegomba and IGAs:

Q: *What does okwegomba mean?*

A: [laughs] *For example, in the past, if a woman felt that she really needed to have money, she'd decide, 'ah let me get an outside partner so that I can get that money.'*

Q: *Why doesn't that woman have money in the first place?*

A: *Because she has nothing to do to get that money. These days, since we were taught, we know how to make money. We make mats, sell them, and get money.*

Q: *Do you mean that you get enough money from mats so that women no longer get outside partners to get money?*

A: Yes.

Even if women earned small amounts of money, it was under their control and it enabled them to buy the things that they admired, so they would be less likely to go with outside partners to get those things. In this way, their embodiment of risk was reduced. It is possible that the women who participate in the IGAs may benefit as much from the collective empowerment of working together as a group to improve their socioeconomic status as they do from the (sometimes small) amounts of money that are earned. A theme that emerged in the in-depth interviews was that the groups provide an opportunity for the women to get together and discuss their situation as well as reinforce risk reduction behavior. Women asserted that even if a women's group has earned very little income from, for example making mats, "if we realize that everyone is admiring things, we sit down and decide to divide the little money that is there."

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Husbands also recognized the value of women's IGA groups for advancing women's collective status and keeping them out of potentially risky situations. This is exemplified in a husband's comment that the women in IGA groups "are not those women who are going to collect firewood or fetch water and during that time maybe become promiscuous. So when they are in their projects, they usually think about the future, about how development will come about, about improving their homes and educating their children." Another husband commented, "in these projects when women are together without any man involved, their thoughts are not on other things. Like they are not thinking about men, they only focus on the group's activities."

Husbands acknowledged the importance of women earning and controlling their own income. This is reflected in a husband's comment on the role of women's IGAs in reducing women's AIDS risk:

As for women's projects, they help them in this way...because a woman doesn't have the things that she wants [such as Vaseline, nice clothes, etc.] it forces her to get outside partners....Now, in getting those outside partners, she gets AIDS. Now, if she has this project, she will get these things from the project. The project will have saved her from having outside partners. That is how the project has helped women....And also we men have learned that we have to set some money aside to give to your wife to keep, because you never know what she will admire when you are not there. She has to have some pocket money, so that if she admires something, she can buy it.

To summarize, this chapter has shown that the way gender is done among Basoga Muslims impacts the distribution of power and resources within households and society. Females, while not powerless, are in a disadvantaged position in regard to education and control over income, which has implications

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for their HIV/AIDS risk. The next chapter extends the discussion of gender power dynamics to the realm of power, sexuality, and risk.

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¹ The seven level variable ranges from: no formal education, some primary education, completed primary, some secondary education, higher secondary, and skilled trades. Primary education includes P1-P7. Secondary education includes S1-S4 and higher secondary, S5-S6.

² The apparent concentration of women in the 2-3 sources of income category is due to more women than men saying that they have two, rather than three sources of income.

CHAPTER 7

POWER, SEXUALITY, AND RISK

Introduction

This chapter continues the analysis of the relationship between the embodiment of risk and how gender is done among the Basoga Muslims who participated in this study. The focus of the chapter is on how doing gender shapes differential degrees of control over sexuality and risk for women and men. One of the ways that gender inequality contributes to the embodiment of risk is through a sexual double standard that effectively gives men greater freedom as well as control over sexuality and reproduction. This sexual double standard is present in most societies and while manifesting in different ways in different societies, may include the expectation that women, but not men, be virgins at marriage. Once married, women are expected to remain faithful to their husbands, while men's multiple partnerships—whether formal or informal—are sanctioned (Mason 1994).

"The sexual double standard is an important indicator of the normative precedent for decision making power about sex within marriages and other stable unions" (Wolff, Blanc and Gage 2000: 304). Within the context of the AIDS epidemic, the sexual double standard means that the primary HIV/AIDS prevention messages of mutual monogamy, abstinence, partner reduction, and condom use may be of little use to women who have limited control over their sexuality, reproduction, and risk (Rao Gupta, Weiss, and Whelan 1996; see also Campbell 1995; Reid 1992; Bledsoe 1990). The implications of what has

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become known as the “ABC” (abstain, be faithful, condom use) approach to HIV/AIDS prevention for women’s embodiment of risk are discussed in this chapter.

Control over Sexuality and Reproduction

Women’s control over their sexuality and reproduction was explored during focus groups in 1995 and in-depth interviews during 1997. The following quotes illustrate women’s limited control over their sexuality, reproduction, and risk as well as the sexual double standard. “Being a wife means being in a man’s home. The man is free to go anywhere and the wife has no right to say anything. He comes back late and if he wants sex, a wife can’t refuse. If she does, she’ll face it rough, get beaten.” In response to a follow-up question about what a wife in that situation can do, she responded that she may resist the first time that such an incident occurs, but if she is beaten, she will let her husband have sex with her. Another woman noted, “for us Muslims, our men have so many women that we realize that if we talk with the husbands it may be the only way to fight getting AIDS.... or maybe the woman leaves the home. If a woman is in the home, she has to do what the man says.” Yet another wife stated, “As a married woman in my husband’s home, I don’t move out [have extra-marital partners], but men move out and women find themselves infected.”

To further assess women’s control over their sexuality and reproduction women were asked questions about decision-making processes and negotiation during in-depth interviews in 1997. Generally, women indicated that the final decision about how many children to have was up to the husband, since he is the

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mwene maka (head of household). Within the context of how gender is done among this rural Basoga Muslim population, this means that husbands are granted greater decision-making power in most realms including sexuality and reproduction. This is illustrated in the following response from a wife in regard to what her husband would do if she told him that she wanted to space her children: "If I told him that I wanted to give birth to a child and then rest a bit and he says, 'no, give birth all in one go, then rest when you are finished' then I have to do that. I have to agree because he is the one who controls me."

It is important to note that while the majority of women interviewed indicated that their husbands had final decision-making power over their reproductive choices, some women's responses showed that they were not completely powerless in this regard. In cases of disagreement over the number of children to have or child spacing, some women stated that they would suggest to their husbands that they space their children and/or limit their family size to the present number so that they can adequately care for the children that they already have. In this instance, they would couch their desire to control their own fertility in terms of the family being better positioned to care for all of the children if they limited their family size (e.g., pay for school fees and health care). This approach is reflected in a wife's statement: "We'll discuss it and come to an agreement that, let's give birth to the number of children that we can manage and educate. I know that if I told him in that way, he cannot refuse." Her statement is reflective of similar comments made by other wives who broached the topic in this manner.

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A number of wives indicated that if their husbands wanted a larger family than they did, they would use birth control without their husband's knowledge. During in-depth interviews, two wives stated that they were using contraception secretly. The covert use of contraception raises the issue of a husband's response if a couple is having sex and the wife is not getting pregnant. In response to a question about this, one of the wives who was using contraception covertly stated, "he'd just get another wife, since I've stopped producing children." Women's actual or planned covert use of birth control is consistent with the literature on reproduction in Sub-Saharan Africa (Becker and Costenbader 2001; Biddlecom and Fapohunda 1998; Blanc et al. 1996). Additionally, a nurse mid-wife working at a family planning clinic in the town nearest to the research site stated during an interview in 1997 that about 50 percent of women receiving contraception from the clinic were doing so without their husband's knowledge.

Other wives stated that if they were unable to come to an agreement with their husbands over the number of children, then they would threaten separation and/or leave their marriages. As stated by one wife in response to a question about whether she felt she had any power to influence her husband's decision in this regard, "Yes, I can tell him, if you don't allow these four children [her ideal family size] then we will separate." If no agreement could be reached, wives stated that they would leave their marriages and return to their parent's home. Wives leaving marriages is a fairly common practice among the study population; 28 percent of the wives interviewed in the survey stated that they were in unions in which other wives had left, and 85 percent of the wives reporting this were in

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currently monogamous unions. On the one hand, a woman leaving her marriage because of disputes over ideal family size or other reasons may be viewed as an example of exercising her agency and some extent of control over her life. On the other hand, the high premium placed on women being married makes it likely that women who leave their marriages will remarry. Within the context of the HIV/AIDS epidemic, “marital mobility”—of both women and men—is a concern because of the risks associated with partner change in an area with a fairly high level of HIV prevalence (Adekun and Nalwadda 1997).

Both women and men were also asked about their views on condoms as a means of family planning within marriages. As with other research from Uganda and Sub-Saharan Africa (Blanc and Wolff forthcoming; Ali and Cleland 2001; Ssengonzi et al. 1999; Blanc et al. 1996; Bassett and Mhloyi 1991), respondents indicated that condoms are associated with having outside partners. Thus, introducing condoms into a marriage is problematic. The issue of mistrust and concerns about accusations of infidelity was raised repeatedly by women as an obstacle to discussing, much less using condoms within their marriages. One woman who was pregnant and the mother of three children stated that she wanted to stop having children after her next birth. She discussed it with her husband, who told her that she could stop childbearing and wanted her to have a tubal ligation. She, however, was afraid of having the operation because of what she had heard from other women about it negatively impacting their overall health.

She had first learned about condoms as part of the FAEPTI project lessons and understood their uses for both family planning and AIDS/STD prevention. She wanted to bring up the possibility of using condoms for family planning, but was afraid to do so with her husband. Her statements in the following exchange reflect the realities of the way that gender is done and how that impacts women's control over sexuality and reproduction.

Q: So what would happen if you brought up the topic of using a condom for family planning?

A: I'm scared, because he will tell me, 'you were taught and I was taught. You should have waited for me and seen the way that I would have reacted to what I was taught.'

Q: So, if you bring it up before he does, then you are being disrespectful?

A: Kyoka [in this instance, this means 'what a question!'], yes! He would say, 'this woman is difficult! I was taught and she was taught. She should look up to me.' He might even suspect me, because I haven't been playing sex with him after a certain point in my pregnancy.

The gap between knowledge about condoms as a means of family planning and/or AIDS prevention and women's power to control their own sexuality, reproduction, and risk is further illustrated in her comment that, "...there is no way that I can buy condoms and bring them home and tell my master, let's start using them."

After her first in-depth interview, this woman stated that she continued thinking about how she wanted to stop having children, but did not want to have her tubes tied. Even though she was afraid to broach the topic of using condoms as a form of family planning with her husband, she "became very courageous

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and determined” and decided to discuss it with him. She chose to do so on a day when his sister, whom he is very close to, was visiting. When asked why she discussed it with her sister-in-law present, she replied that her husband and his sister were very close and that her husband respects his sister’s views. Thus, “when his sister is talking about something, he takes it as something that is very serious.”

She gave this account of how she started the conversation:

We were just conversing and I told him, ‘me, I’m tired of having children.’ We also talked about the condom issue. I told him that I really wanted to stop having children....Then he asked me why I wanted to stop having children and I told him that we have a very difficult time ahead of us. There’s going to be a famine, so I want to stop and feed the ones that are here and pay school fees for them.

In response to a question about how her husband reacted to the idea of using condoms she replied: “He didn’t react in a very bad way because we were three people—me, my husband, and my sister-in-law. It was as if I was talking with my sister-in-law and saying that I was tired of having children.” After hearing her reasons for wanting to stop childbearing her husband gave his permission, telling her that she must be serious about it, since she had raised the issue a number of times. She reported that he agreed to use condoms, but was also uncertain that he would keep to the agreement.

She also explained that part of the reason why she wanted to stop having children was that she suspected that her husband wanted to get another wife. “I can’t manage the way that man behaves! First of all, when he gets another wife, he starts ignoring you....I have seen that with all three of the wives that he has

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brought so far." She chose to have her sister-in-law present for moral support on this issue. Prior to raising the issue of using condoms for family planning with her husband, she explained her concerns with her sister-in-law: "I told her that when he gets another wife, he starts ignoring you. You have to feed the children and clothe them. So, I want to stop having children since he is going to get another wife."

Her comments are consistent with the literature on women's views of polygyny in Sub-Saharan Africa presented in previous chapters. That is, women's decisions about reproduction are not always limited to the level of the dyad in polygynous unions. In this case, at least part of her decision is based on her knowledge that once her husband gets another wife, his resources will be stretched even further and he will decrease the amount of support that he presently provides for her and her children. Her story also illustrates the linkages between the way that gender is done among Basoga Muslims and women's access to resources via producing children.

Additionally, some wives noted that husbands in polygynous unions who suggest condom use to their wife/ves as a means of family planning may be viewed as trying to limit one wife's fertility in favor of allowing the other/s to have children. Since women gain access to resources for themselves and their children through producing children, husbands in polygynous unions may face opposition from their wives if they try to limit family size at the level of the dyad. This is reflected in the following exchange during an in-depth interview with a wife in a polygynous union:

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Q: *How many children do you want?*

A: *About six.*

Q: *How many does your husband want?*

A: *I can never know how many he wants and he can never know how many he wants because he has many wives. He can't say to one wife, 'you stop giving birth,' because that wife would say, 'he has refused me to have children.' So it is difficult for him to decide. He can tell me to have four children and yet I want six. And then another wife can say, 'why is he refusing me to give birth when one has four children and I only have three?' So it is difficult for him to decide.*

Q: *So are you saying that there is competition between wives to give birth to children?*

A: *[laughs] the important thing is that when one sees the other is going to have a child, she also wants to have a child.*

Q: *Why's that?*

A: *Because all the time you are thinking that the one who has the most children will be the owner of the household.*

Husbands also mentioned that wives are resistant to the use of condoms as a form of family planning. This is illustrated in the following excerpt from an interview during 1997:

Q: *If you get to the point where you feel that you have enough children with your wife, how would you feel about using condoms as a method of family planning with her?*

A: *I would begin by discussing with her that it is better if we stopped having children. But it requires that she just stops. That would be better.*

Q: *How would she do that?*

A: *Maybe go and get her tubes cut. Or, if there are any pills that she could take, she could stop forever.*

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Q: How would she react if you brought up the topic of using condoms for family planning?

A: She wouldn't agree to using condoms for family planning. For example, if you haven't been around, she might think that you want to use condoms because you have heard something bad about her. She would be very surprised. Unless a woman is very educated, most don't want to stop having children.

Q: How about if your wife brought up the idea of using condoms for family planning?

A: I would ask her why. Then she would first give me a very good explanation. I might allow, if I really think about it.

Q: What's a really good explanation?

A: She might tell me that she wants to pause in having children so that we can plan for these children that we already have. We need to plan how we will educate them and how we will build a house. Then, after doing all those things, we can start having more children.

The following sections address three of the primary AIDS prevention messages, which are embodied in the "ABC" approach to prevention: abstinence, be faithful, and condom use.

Control over Risk: As Simple as "ABC?"

"A": Abstinence

Recent data from Uganda contends that the expansion of the ABC approach to include "D", i.e., a delay in the initiation of sexual activity has been successful in delaying the age at which adolescents have their first sexual encounter.¹ This, in part, accounts for the significant downward trend in HIV/AIDS prevalence in Uganda where prevalence declined by more than 50 percent during the 1990s (Greene 2003; Hogle et al. 2002; USAID 2002). As reflected in

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the opening quotes of this chapter, however, abstinence is not a particularly relevant message for women in marital unions, because of gender power dynamics making it difficult for women to refuse their husbands sex.² Additionally, sociocultural expectations and the value placed upon women as wives and mothers may make it difficult for women in marital unions to abstain from sex. The high premium placed on producing children may also make abstinence an impractical prevention message within the context of the lives of women who are in their reproductive years (15–49).

Partial support for the limited relevance of abstinence as a prevention message for people in marital unions (particularly for women of reproductive age) is provided by the survey results. While 45 percent of the risk cluster sub-sample (42% of women and 49% of men, see Table 6.10) mentioned abstinence as one of the ways to avoid becoming infected with HIV/AIDS only 12 percent (n = 15) identified abstinence as one of the reasons why they ranked themselves at no/small risk for HIV/AIDS. These results are gender and age specific and are statistically significant by age cohort. Eighty percent of those who gave “abstain” as one of the reasons why they ranked themselves at no/small risk of getting AIDS are in the 50 and above age cohort. Eleven out of the 15 people (73%) who gave “abstain” as a response are women, and eight of these 11 women are age 50 or above (73%). The remaining three women are over the age of 30 (two are in the 30–39 cohort and one is in the 40–49 cohort). All four of the men who gave abstinence as a reason for self-assessing their risk as none or small are in the 50 and above cohort, and three out of four of these men are in currently

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monogamous unions in which their wives are also in the same age group and indicated that they are abstaining. Fifty-five percent of the eleven wives who indicated that they are abstaining are in polygynous unions (data not shown). The results of the self-assessed risk question are discussed more fully in Chapter 8, which presents the risk cluster analysis.

Further insight into the importance of women's marital status on their control over sexuality and risk is provided in a recent study conducted at the dyad level with people in marital unions in two districts of Uganda (Blanc et al. 1996). This study found that women's rights of refusal to have sex with their male partners are dependent upon context and marital status. Respondents were asked whether married and unmarried women were able to refuse sex in a variety of circumstances. "Almost half of the sample does not feel that a married woman's desire to avoid pregnancy warrants her refusal to have sexual relations with her husband. An alarming finding is that fully one in four men and women believe that a woman cannot refuse sex with her partner if she knows that he has AIDS" (*ibid.*: xxi).

Blanc et al. found that domestic violence is considered less of a justification for a married woman's refusing her husband sex than is the husband's failure to support her economically. Forty-five percent of men and 49 percent of women perceived a woman as justified in refusing to have sex with her husband if he beat her, compared to 49 percent of men and 59 percent of women who said that she has refusal rights if he is not supporting her economically. In contrast, higher percentages of men and women (63% and 60%, respectively)

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indicated that an unmarried woman has the right to refuse sex if her partner beats her, while 56 percent of men and 72 percent of women stated that she is justified in refusing if her partner fails to support her economically (*ibid.*: 72). "Overall, women believe an unmarried woman has greater rights than a married woman to refuse sexual relations with her partner in all but three...conditions...that is, if she is menstruating, if her partner is drunk, and if her partner is having sex with outside woman" (*ibid.*: 73).³

Focus group discussions with women in their study revealed that, when threatened with the possibility of separation or divorce, married women might feel less able to refuse sex because of the "importance of marriage for defining a woman's position within society." Wives may also feel obligated to meet their husband's sexual needs if they are threatened with the possibility that he will add another wife to the family unless they acquiesce. "Clearly, the institution of marriage imposes more obligations on women to meet the sexual needs of their partners" (*ibid.*: 74).

"B": Be Faithful (Zero Grazing)

The second component of the ABC message is "be faithful," which is referred to as "zero grazing" in Uganda. This concept also refers to partner reduction for those individuals with multiple partners and essentially translates as sticking with the partners that you already have. Within the context of polygynous unions, it means staying within the union. The FAEPTI Project's approach to "be faithful" focused on discouraging extra-marital sexual partners and reducing the number of sexual partners for those who are unmarried (Kagimu et al. 1998).

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This approach was nicely summarized by a trainer during training for the project's Family AIDS Workers: "If a man has four wives and gets AIDS from outside his marriage, then he infects all four women. One of the women might go outside the marriage and infect another man with four wives of his own, leaving a total of nine people infected. So we teach that people should stay within their marriages or stick with the partners that they already have."

The proscription that sexual relations are to be confined to marriage was also emphasized by imams: "At the mosque we emphasize the punishment that one gets after playing sex with someone who is not your legal wife." Since the risk cluster sub-sample is limited to currently married respondents, the following discussion is limited to respondents' comments about reductions in extra-marital sexual partners.

Participants in focus groups and interviews stated that the project's message about staying within marital unions had influenced behavior change within the communities reached by the project. In response to questions about concrete signs of behavior change in this regard, respondents noted that both women and men had decreased or stopped having sexual partners outside marriage. Respondents spoke about this in both general and specific terms. The following comment is typical of others given in focus groups and interviews: "it seems that since the project taught us about the risk of getting HIV/AIDS from outside partners now almost everyone is sticking with his/her partner." Others stated that they were "sticking to their husband or wife/ves." The survey results presented in the previous chapter (Table 6.10) raise the interesting question of

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whether women are internalizing the “be faithful” message more than men are. As shown in that table, there are statistically significant differences in the proportions of women and men who spontaneously mentioned zero grazing as one of the ways to avoid becoming infected with HIV; 53 percent of the women in the risk cluster sub-sample, as opposed to 36 percent of the men gave this as a response.

There was also a consensus that, in response to the project’s message that husbands were responsible for treating all of their wives equally, husbands were marrying fewer wives. Imams (religious leaders) reported that they, “try to make it clear to people that the maximum number of wives that a man is allowed to marry is four. But you can only marry up to four if you are able to treat them all equally. It is not a sin to have only one wife. The question you should ask yourself before adding another wife is: are you living with them all equally? If not, then you are sinning.”

All currently married respondents were asked whether they had regular and/or irregular partner/s (lovers and others, respectively). Lovers were defined as “a person (other than your spouse/s) with whom you have been having sex for about the last year or more.” Others were defined as “anyone else other than your lover/s and spouse/s with whom you have been having sex within the last year.” Very few respondents (9% of the risk cluster sub-sample, $n = 19$) reported outside partners; 17 percent of 100 husbands and 2 percent of 121 wives. Forty-seven percent of the husbands with outside partners ($n = 8$) are in currently monogamous unions and 53 percent are in currently polygynous unions. This

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represents 13 percent of all husbands in monogamous unions and 22 percent of all husbands in polygynous unions in the sub-sample. Two of the eight husbands in monogamous unions have more than one irregular partner; one husband stated that he had two irregular partners and the other reported three such partners. One of the nine husbands in polygynous unions with outside partners reported having two irregular partners.

The two wives who acknowledged outside partners each reported one partner apiece. The wife in a polygynous union reported an irregular partner and the wife in a monogamous union reported a regular partner. The low percentage of women reporting outside partners is consistent with other research from Sub-Saharan Africa showing that women are less likely to report outside partners. This is probably due to social sanctions against women engaging in extramarital relations, much less acknowledging them (see for example, Orubuloye, Caldwell, and Caldwell 1994: 21).

"C": Condom Use

Condom recognition and knowledge of use. The "C" of the ABC message refers to condom use. Consistent and correct condom use is one of the key HIV/AIDS risk reduction messages. As was shown in Table 6.10, however, there are statistically significant gendered differences in the proportions of women and men who mentioned condoms as a way to avoid becoming infected with HIV. Men were more likely to give this as a response than were women (61% and 50%, respectively). To measure the level of knowledge about condoms within the study population all survey respondents were shown a wrapped condom (still in

the package) and asked to state what it was. Eighty-nine percent of the respondents in the risk cluster sub-sample recognized the condom. There were statistically significant differences, however, in the proportions of women and men who identified a wrapped condom; women were less likely to recognize the condom than were men (83% and 95%, respectively).

There were also statistically significant differences in the percentages of respondents who recognized a condom by age cohort: 82 percent in the 15-19, 100 percent in the 20-24, 98 percent in the 25-29, 91 percent in the 30-39, 78 percent in the 40-49, and 67 percent in the 50 and above cohorts identified the condom. The likelihood that respondents recognized a condom increases with increasing level of education. Seventy-four percent of those with no education, 89 percent with primary education, and 98 percent with secondary or higher education identified the condom (data not shown).

Condom identification is also statistically significant by the number of reported income sources; the likelihood that respondents will identify a condom increases with an increasing number of income sources. Seventy-nine percent of those with 0-1 sources identified the condom, compared to 90 percent with 2-3 sources, 93 percent with 4-5 sources, and 100 percent with six or more sources (all but one of the 14 survey participants in the latter category are men). There are no statistically significant differences in condom recognition by location (trading center or village), polygynous status, or exposure to the prevention project (data not shown).

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When the data are analyzed separately for women and men, age remains statistically significant for both women and men, but education is only significant for women. Sixty-seven percent of women with no formal education recognized the condom, compared to 86 percent with primary, and 94 percent with secondary or higher education. The corresponding percentages for men are much closer, which probably accounts for the lack of statistical significance (90% with no formal education, 93 percent with primary, and 100 percent with secondary or higher education). In contrast, reported number of sources of income is no longer significant when women are analyzed separately. The statistical association between number of income sources and condom recognition remains when men are analyzed separately. Seventy-nine percent of men with 0-1 sources of income identified the condom, compared to 98 percent with 2-3 sources, 97 percent with 4-5 sources, and 100 percent with six or more sources (data not shown).⁴

About two or three days into the administration of the survey, the survey interviewers reported their impressions that respondents' high level of condom recognition may have been due to the placement of the question after a series of condom use questions. The interviewers suggested that another survey question be added, asking respondents who recognized a condom whether they knew how to use one. Because the question was added part way into the survey, it was, unfortunately, not asked of all respondents. However, data exists for 83 percent (162 of 196) of the respondents in this sub-sample who identified a condom. The following results are based upon that number.

Fifty percent of those who identified a condom stated that they knew how to use one. Women were statistically less likely to say that they know how to use a condom than were men. Thirty-four percent of women (n = 28) said they knew how to use a condom, compared to 66 percent of men (n = 53).⁵ Age, location, and polygynous status are not statistically associated with knowledge of condom use, but knowledge of condom use increases with increasing levels of education. The educational gradient is fairly steep—particularly from those with no formal education to those with secondary or higher education. Thirty-percent of respondents with no formal education who identified a condom stated that they knew how to use it, compared to 44 percent with primary education and 76 percent with secondary or higher education. Given that women were less likely to state that they knew how to use a condom, the educational gradient is probably linked to women's lower levels of education (data not shown).

As with condom recognition, the likelihood that respondents will state that they know how to use a condom increases as the number of reported income sources increases. Thirty-one percent of those with 0-1 sources, as opposed to 47 percent with 2-3 sources, 62 percent with 4-5 sources, and 85 percent with six or more sources indicated knowledge of condom use, and the results are statistically significant. These findings are probably influenced by the fact that women reported fewer sources of income than men did. Finally, unlike the case with condom recognition, knowledge of condom use is statistically associated with exposure to the FAEPTI Project. Fifty-four percent of those who stated that

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they knew how to use a condom had been exposed to the project compared to 24 percent who had not been exposed to the project (data not shown).

Condom use with outside partners. While the small number of respondents who stated that they had outside partners ($n = 19$) precludes statistical tests of significance, the pattern of responses regarding whether they used a condom for the last sex with their outside partner is consistent with the HIV/AIDS literature. That is, condom use was higher with extramarital than marital partners and it was highest with irregular partners. Eighty percent of the husbands (four out of five) who stated that they had irregular partners, reported condom use during their last sex with an irregular partner. In three instances, condoms were used for STD/AIDS prevention and in one case, a condom was used for birth control. In contrast, only 33 percent of the 12 husbands who reported regular partners stated that they used a condom last time. In all cases, condoms were used for STD/AIDS prevention. Of the two wives who reported outside partners, the wife who indicated that she had a regular partner stated that a condom was used for STD/AIDS prevention, while the wife who reported an irregular partner stated that no condom was used.

Condom use within marital unions. A consistent theme in the HIV/AIDS literature (Center for Gender and Health Equity 2004; Blanc and Wolff forthcoming; Pulerwitz et al. 2001; Rivers and Aggleton 1999; Ssengonzi et al. 1999; de Bryun et al. 1998; McGrath et al. 1993) as well as during both periods of fieldwork is that condom use within marital unions is low. One of the reasons for this is that it is often difficult—especially for women—to introduce the topic of

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condom within the context of marriage. Both women and men asserted that condoms were viewed as being used primarily with outside partners rather than within a marriage. Due to this, introducing a condom into a marriage may raise the issues of mistrust and an implied accusation of infidelity.

Women reported that wives who are concerned about their AIDS risk weigh the possible consequences of suggesting condom use such as being accused of infidelity and/or losing their access to land “to dig on” for themselves and their children. In such situations, wives may decide to remain silent. Women also stated that since it is difficult for wives to sexually abstain, the only prevention option that a wife who was worried enough about her AIDS risk to consider suggesting condom use to her husband may have is to leave the marriage altogether.

Some wives indicated that they would adopt an indirect approach to introducing a condom into their marriage if they were concerned about their AIDS risk because of their own, their husband's or their co-wife/ves' behavior. This is exemplified in the following statement: “Since I am young and still producing, if I am breastfeeding I can say that I don't want another child. If I'm straightforward, he will refuse.” Husbands also recognized that wives who are worried about their AIDS risk may use an indirect approach and, as with the wives' comments, husbands stated that timing is everything. This is exemplified in a husband's statement that a wife would be unsuccessful if she “tells the husband directly, ‘you are misbehaving and we should use condoms.’ In that case, he will refuse and may become angry with her. But if she has had a birth, she can use the path

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and say, 'let's use condoms to space our children and wait for this child to grow.' Then he will agree."

Husbands may also adopt an indirect approach to suggesting condom use within their marriage, as reflected in a wife's observations during an in-depth interview:

Now, there are married people—like those men who work from a faraway place—who can get a friend there. When he gets his girlfriend, back here in the village, you don't know about that. Yet, he treats you the same. And sometimes, your husband's girlfriend dies. Now, there is no way for him to tell you, 'my dear wife, I'm infected.' So what he does is tell you, 'let's use a condom so that we can make sure that we plan for our children. Because right now, I don't know what happens here. I don't know which people are deceiving you.

In this example, the husband frames his concern about infecting his wife with HIV in terms of using a condom for child spacing, so that they can look after the children they already have. He also implies a shift in responsibility for the reason to use condoms to the wife, since he does not know her behavior when he is away from work.

When asked about whether his wife could suggest using condoms because of concerns over her husband's behavior while he is away at work, this respondent replied: "She cannot. She is afraid that her master will start suspecting that she has outside partners." Asked what options a woman in this situation had, she said that most women would remain silent. When probed whether there was anything at all that a wife could do to reduce her HIV/AIDS risk in that situation, she continued to insist that most wives would not suggest using condoms to their husbands. As noted above, this was also a consistent

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theme voiced by other women during in-depth and key informant interviews, many of whom stated that the only option left in that situation was for the wife to leave her husband's home and return to her parent's home.

While very few women would suggest condom use in this scenario, the women being interviewed did give the example of a woman she knew that "used her husband's tricks." In this case, although the wife was very concerned about her AIDS risk because of suspicions about her husband's behavior while he was away from home for work, rather than suggesting condom use she chose a different approach. When her husband wanted to have sex, "she was very patient and courageous and played a trick on her husband saying, 'ah my friend, now I am too old to play sex. Let me retire from those things.'" The husband in this case, responded by ordering his wife to return to her parent's home. She, however, refused, saying, "I'm staying here to look after my children. Let me build a house nearby and if you want, you get other wives." According to the woman who was re-telling the story, "the man tried all of his tricks until he defeated the woman. He beat her three times, up to the point of death. Finally, the woman took her children and went back to her parent's home." This account highlights how the way gender is done contributes to the embodiment of risk for women: men are the head of the household and have authority over most realms. It also reinforces the discussion above about the challenges married women face in implementing "abstinence" as an AIDS prevention strategy.

The association of condoms with promiscuity (i.e., as used primarily with outside partners) is also reflected in some women's objections to distributing

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condoms to men on the grounds that doing so will promote adultery. This issue was raised in a strident manner by a group of women being trained as Family AIDS Workers (FAW) in 1995. Following instruction about proper condom use as part of the training, condoms were distributed to the women and men who were being trained as FAWs. The woman reacted to condoms being given to the men by saying "No, don't give them condoms! Doing so will encourage them to commit more adultery!"

Wives' concern about condom distribution promoting adultery was also evident during a discussion with a female Family AIDS Worker during 1997. She stated that the women she taught were afraid to ask their husbands to use condoms because "as soon as you bring up the topic, the man becomes tough and starts accusing you of being with another man outside the marriage." In response, she spoke with the men about using condoms and distributed condoms to them because they stated that they wanted to use condoms for child spacing. Their wives "got annoyed with us because they felt that by distributing condoms we were encouraging their men to go outside marriage." When asked whether she thought that the condoms were used within or outside marriage she replied that there was no way for her to know. The complexities of using condoms within the context of marriage are well summed up in her observation that she suspected "the men would tell us lies to get the condoms by telling us that they were for child spacing and yet the women would tell us that the condoms were spoiling their men."

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A few wives interviewed during 1997 stated that they would be able to discuss condom use directly with their husbands. Their comments usually took the form of a hypothetical statement: "if I become worried about AIDS then I will ask him to use condoms. Since we have been educated about AIDS, then he will not refuse." Further probing revealed, however, they had the same concerns as the other wives interviewed about being accused of having outside partners if they suggested condom use. When asked whether they had ever suggested using condoms for family planning purposes (less of a potentially volatile issue than suggesting them for AIDS prevention) each of the women responded with a resounding "no!" This highlights the gap between the ideal and reality. In an ideal world, wives who are concerned about their AIDS risk are able to suggest using condoms to their husbands. Again, in an ideal world, husbands are likely to agree because they have been educated about AIDS. In reality, however, the way that gender is done as well as the association of condoms with extramarital partners creates major challenges for women putting the ideal into practice.

This is reflected in the following exchange with a woman who is a Family AIDS Worker regarding the options available to a wife who is worried about her AIDS risk, but is faced with her husband's refusal to use condoms:

Q: So what does a woman in that situation do to protect herself from AIDS?

A: ...unless she leaves his home. If she is still in his house, it is impossible.

Q: Why is that?

A: Because he has authority over everything, beginning from the woman to everything else in the home. He has to make the final decision.

Q: So, if a woman is still in her husband's home and she is very, very worried about her AIDS risk, then there is nothing for her to do?

A: Yes, she can do nothing at the time, because if you refuse while you are still in the home, he will tell you that you have some men who are influencing you. So, the understanding between husband and wife is not there. So, before you even decide to leave the home, he will tell you to leave.

Q: Since you were trained as a FAW, what would you tell a woman in that situation?

A: I would tell her, 'you have children and you think that your husband is going to infect you. So in order to stay alive and look after the children, it would be better for you to separate from your husband. That way, you can work and look after the children instead of staying and getting infected and leaving the children behind.

Q: How do you think a wife would respond to that advice?

A: The one who acts on my advice would be the one who is so worried about leaving her children behind. And the other one would be the one who just said, 'if it's dying, we're already dead anyway.'

The foregoing discussion based on qualitative findings helps to contextualize the following survey responses drawn from questions about condom use within the context of marital unions. During the survey, currently married respondents were asked whether they used a condom for the last sex with their spouse. The rate of condom use within marital unions in the risk cluster sub-sample is low; 5 percent of 217 survey participants (n = 12, seven wives and five husbands) said 'yes.' This compares with an overall rate of condom use with extramarital partners in the risk cluster sub-sample of 53

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percent (8 out of 17 men and 2 out of 2 women stated that they used a condom for their last sex with an outside partner). The low rate of condom use within the context of marriage is consistent with findings in the HIV/AIDS literature (Ali and Cleland 2001; Ssengonzi et al. 1999; Brockhoff and Biddlecom 1998; de Bruyn et al. 1998).

For example, a study in the Masaka district of southwestern Uganda (Ssengonzi et al. 1999: 20) found an identical rate of condom use in spousal unions. Respondents who stated they used a condom with their spouse were asked a follow-up questions about the reason/s why a condom was used. While the small number of respondents precludes statistical tests of significance, the differences in respondents' answers by gender are interesting. Four out of the seven wives stated that they used a condom for STD/AIDS prevention, compared to one out of the five husbands. In contrast, three of the husbands reported using a condom for child spacing purposes versus only one of the wives. Finally, two wives and no husbands stated that they used a condom for birth control purposes.

Survey participants who indicated that they did not use a condom for their last sex with their spouse were asked a follow-up question about their reasons for non-condom use. The results are shown in Table 7.1.

Table 7. 1 Unprompted reasons why no condom used during last sex with spouse by gender, risk cluster sub-sample

Item	Gender				Total (N = 205)	
	Men (N = 93)		Women (N = 112)			
	Count	%	Count	%	Count	%
Respondent trusts spouse	46	49%	23	21%	69	34%*
Condoms only used with outside partners	19	20%	7	6%	26	13%*
Uneducated about condoms	8	9%	18	16%	26	13%
Spouse dislikes condoms	1	1%	22	20%	23	11%*
Spouse wants children	8	9%	4	4%	12	6%
Condoms are too expensive	3	3%	5	4%	8	4%
Don't know where to get condoms	0	0%	9	8%	9	4%*
Condoms not available here	2	2%	4	4%	6	3%
Afraid to ask spouse to use a condom	2	2%	3	3%	5	2%
Respondent wants children	4	4%	1	1%	5	2%
Respondent dislikes condoms	0	0%	3	3%	3	1%
Condoms are difficult to use	0	0%	2	2%	2	1%
Respondent doesn't trust condoms	0	0%	0	0%	0	0%
Religion forbids condoms	0	0%	0	0%	0	0%

* p < .05

As shown in the table, the most frequently cited reason for not using condoms was that the respondent trusted their spouse; about one-third of respondents gave this as a reason. There is a statistically significant difference, however, in the percentages of husbands and wives who mentioned trust. Wives were over twice less likely to mention trust than husbands (21% and 49%, respectively).

The results of the analysis of reasons by education, exposure to the project (whether respondents had spoken with an imam, FAW, or listened to an imam speak about AIDS in the mosque within the past year), and polygynous status in relation to trust being cited as a reason for the non-use of condoms within marital unions bear mentioning here. There were statistically significant differences in the proportions of respondents who gave trust as a response by

educational level, although the pattern is somewhat hard to discern. Twenty-one percent of those with no formal education ($n = 7$) mentioned this, compared to 31 percent with primary education ($n = 40$), and 16 percent of those with secondary or higher education ($n = 7$). In terms of the variable, exposed to prevention project, trust was the only reason mentioned that was statistically significant. Respondents who had been exposed to the project were more likely to identify trust as a reason than were the non-exposed survey participants. Thirty-eight percent (66 out of 172) of respondents exposed to the project mentioned "trust" as a reason for not using condoms with their spouse versus nine percent (three out of 33) who were not exposed to the project.

While "trust" was the most frequently mentioned response by husbands and wives, the second most frequently identified reason for wives was their spouses' dislike of condoms. The difference is statistically significant; wives were twenty times more likely to cite their spouse's dislike of condoms than were husbands. During the survey analysis, it became evident that a number of 'other' reasons why condoms were not used fell into a category that could be termed "condoms are only used with outside partners." These responses were recoded into that variable with the results showing that wives are less likely to give that response than husbands (6% and 20%, respectively). This was also the single statistically significant response category when the data were analyzed by polygynous status. Respondents in monogamous unions were slightly more than twice as likely to give this as a response as were those in polygynous unions.

Sixteen percent ($n = 18$) of those in monogamous unions and seven percent ($n = 6$) in polygynous unions mentioned this as a reason (data not shown).

A second new variable that was added during data analysis was the response "uneducated about condoms." A total of 13 percent of survey participants gave this as a response, with close to twice as many wives as husbands mentioning it. The remaining statistically significant finding relates to the difference in the number of wives and husbands who indicated that they did not know where to obtain condoms; eight percent of the wives as opposed to no husbands gave this response.

The silences regarding reasons for non-use of condoms within marriages provide insights into factors that were not mentioned as obstacles to their use. While not statistically significant, it is socially significant that religion, distrust and/or dislike of condoms, cost of condoms, fear about asking a spouse to use condoms, and respondent's desire to have children were either not identified or very infrequently mentioned.

Currently married respondents who indicated that they did not use a condom for their last sex with a spouse were also asked whether their spouse had ever suggested using a condom. The low rate of condom use within the context of marital unions is reinforced by the finding that only 13 percent (15 wives and 13 husbands) stated that their spouse had ever suggested using a condom. Because of nearly equal numbers of wives and husbands giving this response, the results are not statistically significant. It is interesting to note, however, that as education increases, the percentage of respondents indicating

that their spouse had suggested condom use also increases. Three percent of those with no formal education gave this response, compared to 13 percent with primary, and 20 percent with secondary or higher education (data not shown). Research in Uganda has shown that higher levels of education are positively associated with an increased likelihood that women within marital and stable long-term unions will have discussed and/or ever used condoms with their partner (Blanc and Wolff, forthcoming).

The percentages of survey participants who stated that their spouse had ever suggested a condom also generally decreases with increasing age. Nineteen percent of those who stated that their spouses had ever suggested using a condom are 15-19, 17 percent 20-24, 11 percent 25-29, 12 percent 30-39, 11 percent 40-49, and 6 percent 50 and above. Finally, about equal percentages of survey participants in monogamous and polygynous unions gave an affirmative response to this question (13% and 12%, respectively, data not shown).

To summarize, this chapter has shown that the way gender is done among Basoga Muslims limits women's control over their sexuality, reproduction, and risk. My findings support other research (Center for Health and Gender Equity 2004; Weiss, Whelan, and Rao Gupta 2000) showing the limited relevance of the "ABC" approach to HIV/AIDS prevention for women within marital unions. Most women find it difficult to raise the issue of HIV/AIDS prevention with their husbands because of the possible consequences of doing so (e.g., accusations of infidelity, becoming dispossessed from the household

and so on). Support for the value of expanding the lens of analysis from couples to the "union" level is also provided in this chapter. Consistent with the literature on women's views of polygyny (Meekers and Nadra 1995; Bledsoe 1993; Wittrup 1990; Ware 1979), women in polygynous unions may consider the number of children their co-wife/ves have produced when making their own reproductive decisions. The next chapter presents the results of the risk cluster analysis on self-assessed HIV/AIDS risk and the analysis of polygyny as a risk factor for HIV/AIDS.

NOTES

¹ See the May 2003 issue of the *AIDS and Anthropology Bulletin* (The Newsletter of the AIDS and Anthropology Research Group, Volume 15, Number 2) for discussion and critiques of overly simplified attributions of Uganda's "success story" to the "ABC" approach.

² It should be noted here, however, that Islam allows a woman to refuse her husband sex if she is menstruating or ill (Serunjogi 1994; Katungulu 1993).

³ This study also found differences in patterns of responses by gender, rural/urban location, and by district for many of the situations related to when married and unmarried women are entitled to refuse their partners sex.

⁴ The chi-square statistic for condom recognition by age cohort and number of sources of income is impacted by the small cell counts resulting from the high level of condom recognition in most of the age cohorts and number of income sources categories.

⁵ The small number of women who stated knowledge of condom use precludes analyzing them separately.

CHAPTER 8

BEYOND DYADS TO RISK CLUSTERS

Introduction

This chapter presents the findings on study participants' views about polygyny as a risk factor for AIDS as well as the individual and risk cluster level analyses of self-assessed HIV risk. The focus on polygyny is not intended to imply that Muslims are at greater risk for AIDS because polygyny is officially sanctioned in Islam. Indeed, a long-term longitudinal study (Carpenter et al. 1999: 1087) on HIV transmission within marriages in the rural district of Masaka, Uganda with sero-discordant partners (one partner HIV positive, the other HIV negative) found that the rates of new infection "for non-Muslims were significantly higher than those of Muslims for men...and women...."¹

Another longitudinal study conducted in the neighboring Rakai District (Gray et al. 2002, 2000: 2379) reported that Muslim men (particularly those aged 20-29) were at a much lower risk of being infected with HIV than non-Muslim men. The authors suggest several factors (in addition to the nearly universal circumcision of Muslim men as opposed to a 3.7 percent rate in Non-Muslim men) that may account for the lower prevalence and incidence of HIV among Muslims: polygyny (which "may provide a closed sexual network..."), abstinence from alcohol use among Muslims, and hygienic practices related to religiously prescribed washing after sex as well as before daily prayers.²

Yet another study conducted in Uganda (Macintyre, Brown, and Sosler 2001) found that Muslims were more likely to report behavior change than

members of other religious groups. Similarly, a study conducted in rural Senegal (Lagarde et al. 2000) found that Muslims were significantly more likely than non-Muslims to say that they had already become or were planning to become faithful as a way to protect themselves from AIDS. In contrast, a different study conducted in a rural area of Senegal with a high rate of polygyny (Spira et al. 2000: 553), found that being Muslim produced mixed results in terms of adopting preventative attitudes toward AIDS. On the one hand, "Islam was associated with a higher rate of preventative attitudes [toward AIDS risk] among women, in that Muslim women reported communication about AIDS at higher rates than women of other religions." On the other hand, Muslim men were less likely to adopt preventative attitudes toward AIDS risk than men of other religions were. Respondents of any religion who considered themselves to be strongly religious were also less likely to change their HIV/AIDS risk related attitudes and behaviors than those who did not characterize themselves as strongly religious.³

The practice of polygyny is not limited solely to Muslims in Uganda. While Muslims accounted for only about 11 percent of the country's population in the 1991 Census, an estimated 30 percent of all women were in currently polygynous unions (Statistics Department Ministry of Finance and Economic Planning 1994).⁴ Polygyny is not, in and of itself, necessarily a risk factor for AIDS at the individual level, if all spouses stay within the marital union. It becomes a potential risk factor for all spouses if any one of them has extramarital partners with whom they have had unprotected sex outside the union (Morris and Kretzschmar 2000 1995; Berkley 1994; Caldwell et al. 1994).

Morris and Kretzschmar (2000: 4 and 5) identify concurrent partnerships (i.e., partnerships “that overlap in time”) as one way that the HIV/AIDS epidemic has spread rapidly in Sub-Saharan Africa. For analytical purposes, they identify two types of concurrent partnerships: long-term (marriages) and short-term (all other sexual relationships). Having more than one partner at a time contributes to the spread of the epidemic because:

First, from the virus-eye view, there is less time lost after transmission occurs waiting for that partnership to dissolve, or between the end of one partnership and the beginning of another. Second, the effect of partner sequence on exposure risk is reduced. Under serial monogamy, each partner increases the risk of infection to a subject, so earlier partners are less likely to be exposed to an infected subject than later ones. If partnerships are concurrent, much of the protective effect of sequence is lost. Earlier partners remain connected to the subject, and are exposed when the subject becomes infected by a later concurrent partner. And finally, concurrency has a critical effect on the “connected component,” the number of persons in the population that are directly or indirectly connected at any point in time. Under sequential monogamy, the maximum size of the connected component cannot exceed 2. Under concurrency, by contrast, the maximum size of a connected component can become quite large: individuals have partners who are themselves connected to others, these others are again connected to additional persons, and so on. Concurrency creates a large, loosely structured, constantly shifting web of connected persons in a network, enabling an infectious agent to spread rapidly and pervasively (*ibid.*:4).⁵

The network aspect of polygynous unions means that all partners are linked to each other through a complex web of sexual, economic, and social relationships. Polygynous unions thus consist of linkages between two or more “dyads” that do not exist in isolation from each other. Yet more often than not, they are analyzed in this manner in the existing “couples” research on reproductive health and to a much lesser extent, HIV/AIDS research in Sub-

Saharan Africa. Analyses of "couples" data that includes people in both monogamous and polygynous unions may be restricted to only monogamous "couples" because of the difficulties inherent in analyzing data from a husband and more than one of his wives. Alternately, if people in polygynous unions are included in a study, researchers may restrict the analysis to husbands and only one of their interviewed wives, or they may count a husband and each of his interviewed wives as a "couple" (Dodoo 1998b). Other researchers have adopted a more extreme approach, as exemplified in a study conducted with urban male factory workers in Tanzania (Pool et al. 1996: 207) in which polygynous unions were reclassified as single partnerships "for convenience" if respondents reported being faithful to their spouses.

In other words, co-wives and their husband are rarely considered as a "unit." In couples studies focusing on AIDS, limited attention is paid to how the interactions and relationships between everyone in the union impacts concerns about AIDS risk and risk reduction. While sexual behavior occurs at the dyadic level, the limited research on women's views of polygyny in Sub-Saharan Africa suggests that women in polygynous unions may consider their co-wives' reproductive behavior when deciding on whether or not to have another child (Meekers and Nadra 1995; Bledsoe 1990; Ware 1979). Given this, it seems reasonable to expand the lens used to analyze assessments of HIV/AIDS risk within marital unions to ask whether concerns about co-wives' behavior influence the HIV risk assessments of women in polygynous unions.

The purpose of this chapter is to demonstrate the utility of moving beyond the level of the dyad in HIV/AIDS research in Sub-Saharan Africa as a framework for better understanding the perception and embodiment of risk for women within marital unions. The first section presents respondents' perceptions of polygyny as a risk factor for AIDS. This is followed by the analyses of self-assessed HIV/AIDS risk by gender and type of marital union. Next presented are the findings from the risk cluster analysis, with an emphasis on differences in self-assessed risk among spouses in monogamous and polygynous risk clusters. The chapter closes with a discussion of the findings.

Perceptions of Polygyny as a Risk Factor for AIDS

Qualitative Findings

Polygyny as a risk factor for AIDS emerged as a consistent theme in focus groups and interviews during both periods of research. Many of the reasons offered for why polygyny is considered a risk factor are linked to "doing gender" and reflect the themes identified in previous chapters: an imbalance of power within marital unions and its consequences for the embodiment—or lived experience—of risk for women. Both women and men framed polygyny as a potential risk factor in terms of "trust/mistrust" (concern about their spouse/s' and/or co-wife/ves behavior), the possibility that a new wife added to the union might be infected, and challenges for men in treating all their wives equally, which might lead to one or more of the wives seeking outside partners. Many women also expressed concerns about the possibility that even if they remained

"faithful" within their polygynous union, their co-wife/ves might have outside partners, thereby increasing their risk.

The way gender is done may contribute to women's sense of increased HIV/AIDS risk if they feel that they are unable to control their husband's or co-wife/ves behavior or to object to their husbands taking another wife. As one woman in a focus group, echoing others, reported, "Myself, I can stick with my husband and stay home and be faithful, but there is no way that I can force my husband or co-wife to do the same." In a similar vein, another woman in a polygynous union maintained that, "polygyny is not a very good thing in this time of AIDS. The way you behave is not the way that the others [in the union] behave....you can never know where the disease came from."

Yet another wife in a polygynous union stated, "I don't like polygyny because among the many [in the union] that's where you will find the sick one. Now we are living in bad times when you have to protect yourself from the disease." Husbands also expressed awareness that co-wives may not trust each other as the following excerpt from a focus group shows: "Those co-wives may be eating together and cooking out of the same pot, they may be sharing the same food, but they do not trust each other."

Women's sense of risk may increase if they feel that they are unable to object to their husband's adding another wife to the family. Because of the imbalance of power and authority within marital unions, the decision to bring another wife into the family rests with the husband. Wives in both currently monogamous and currently polygynous marriages insisted that they had little, if

any, control over whether another wife was brought into the union. They are rarely consulted about the addition of another wife. "Even if a wife disagrees with the husband bringing another wife, he will just do so anyway because he is the *mwene maka* (head of the household). The wife can't say no." Moreover, wives who voice objections to a new wife being brought into a union may run the risk of being abandoned. "You can't refuse because the husband has all the authority in the household. He may decide to hide her [the new wife] far away....He will say, 'I have left the household for you.' Then he will leave you there in the cold."

Women in Sub-Saharan Africa identify one of the major disadvantages of polygyny as the potential for tension within polygynous unions—between not only husbands and wives but between co-wives. Women may compete for resources for themselves and their children from a shared husband. A husband may show favoritism toward a new wife, resulting in a lack of support for his other wife, or wives and their children (Meekers and Nadra 1995; Kilbride and Kilbride 1990; Wittrup 1990; Ware 1979). Further, as noted in Chapter 7, women are aware of the link between "producing children" and gaining access to resources. In fact, wives may become resentful if their husband suggests that they use condoms as a form of family planning. This is especially the case if their co-wives already have more children than they do or if their co-wife/ves continue to bear children while they are being asked/told to use condoms as a method of contraception.

This tension between co-wives engendered by the production of children has implications for condom use within marital unions as a form of HIV/AIDS prevention. People were taught by the FAEPTI Project about the use of condoms

for HIV/AIDS prevention; however, very few wives suggest condom use to their husbands for this purpose. As a wife in a polygynous union observed, "They [FAEPTI] taught us, but we are two wives. Even if I suggested that we should use condoms that way and he agreed, he might go to the other wife and she wouldn't agree because she would say that they [husband and her co-wife] are trying to prevent me from having children, so she wouldn't use them."

The value of moving beyond dyads is also reinforced by another frequently cited reason for why polygyny is considered a risk factor for HIV/AIDS, i.e., the challenge of treating all wives equally (emotionally, materially, and sexually). While this equality is the ideal under Islam, a gap exists between ideal and practice. The likelihood that adding another wife to the union will result in some wives being neglected sexually is well summarized in the following statement from one of the most highly educated male survey respondents: "Men like [sexual] variety, so they have many wives along with outside partners....In the end, they forget or neglect some of their wives as far as sex is concerned."

Wives who are unhappy about the addition of another wife to a union may choose to leave the union. As indicated in Chapter 5, a fairly high percent of wives left their marital unions in the risk cluster sub-sample. According to wives' reports, as many as 40 percent of partners in currently monogamous unions may have been in polygynous unions in the past. This highlights the fluidity of marital unions along a shifting continuum of currently monogamous, currently polygynous, intending to become polygynous (Speizer 1995), and a possible forth category that should be added to Speizer's marriage trichotomy, i.e.,

formerly polygynous. The high percentage of “currently monogamous” marital unions that were likely polygynous at some point in the past is a concern within the context of the AIDS epidemic because it involves partner change (Adekun and Nalwadda 1997).

Wives leave unions for a number of reasons. For example, the entry of a new wife into a union may create conflict, prompting the departure of some wives. As women in a focus group concurred, “Wives leave their marriage when a new wife comes and makes life so miserable that you go back home.” Moreover, they may leave “because of a lack of patience with their husband’s irresponsible and unbearable behavior, such as their husbands admiring other women outside the marriage.” In this case, the respondent was referring to husbands acting on their admiration and having extramarital partners.

If a wife is concerned about her husband’s or co-wife/ve’s behavior as an influence on her HIV/AIDS risk, she may decide not to address this issue with her husband out of fear of rejection, accusations about her own behavior, or being forced to leave the home. In fact, most women agreed that, “If a wife is worried about her co-wife or husband’s behavior in regard to her risk of getting AIDS, she cannot talk with them about it. The only thing she can do is leave the home.” Nevertheless, several women insisted that even if they wanted to leave their marriage and return home because of concerns over their husband’s or co-wife/ves’ behavior, they would choose to remain because they would be worried about the welfare of their children if they left the marital union.

Wives were asked whether co-wives ever communicated with each other directly if a situation arose where a woman was concerned about her co-wife's "slippery" (i.e., risky) behavior. The consensus was that wives do not generally communicate their concerns to each other. If they decide to express their concerns, they will talk with their husband, who may or may not discuss the issue with the co-wife. Given that, women weigh the risks of broaching the subject with a husband against the potential risk of rejection and/or being forced to leave the home, many women may choose to remain silent about their concerns.

The above discussion provides a context for understanding why polygyny is viewed as a risk factor for AIDS. I have shown how the way that gender is done influences the perception and embodiment of risk and highlighted the importance of moving beyond the level of the dyad. In the section, which follows, I draw on quantitative data to explore these themes further.

Quantitative Findings

When asked whether they agreed or disagreed that polygyny is a risk factor for AIDS, almost two-thirds (63%, $n = 140$) of the 223 people in the risk cluster sub-sample agreed that it was (data not shown). There were no statistically significant differences in the proportions of respondents agreeing by gender, age cohort, self-assessment of risk, polygynous status, or education. Nevertheless, the results by educational status show that the percentage of respondents agreeing that polygyny is a risk factor as levels of education rises. Seventy-one percent of those with no formal education agreed, compared to 62 percent with primary education and 59 percent with secondary or higher

education (data not shown). While the reasons for the differences are unknown, it may be that as education increases, blanket agreement with a question about polygyny as a risk factor for AIDS decreases. In other words, perhaps individuals with higher levels of education are more likely to recognize that polygyny itself is not a risk factor for AIDS, but rather the potential risk is associated with any member of the risk cluster having unprotected sex outside the union.

When asked why they agreed that polygyny was a risk factor, people responded in a variety of ways, and their responses were highly gendered (see Table 8.1).

Table 8.1 Unprompted Reasons Why Polygyny is a Risk Factor for AIDS by Gender, Risk Cluster Sub-Sample

Item	Gender				Total (N = 140)	
	Men (N = 61)		Women (N = 79)			
	Count	%	Count	%	Count	%
Can't trust all your wives	38	62%	0	0%	38	27%
Can't trust husband	3	5%	0	0%	3	2%
Can't trust co-wives	2	3%	69	87%	71	51%
Difficult to treat wives equally	18	30%	28	35%	46	33%
NB: N refers to those who agreed that polygyny is a risk factor for AIDS; * p < .05						

The most frequently mentioned reason (51%) was 'can't trust co-wives,' which was mentioned almost exclusively by women, (87% versus 3% of men, $p = < .05$). In contrast, only men identified 'can't trust all your wives' as a reason (62%). About equal percentages of women and men (35% and 30%, respectively, $p = < .05$) stated that it is 'difficult to treat all wives equally; this was the second most frequently cited reason why polygyny is considered a risk factor for AIDS.

While a gendered pattern exists, with only men citing mistrust of wives, and women (with the exception of two men) identifying mistrust of co-wives as reasons for why polygyny is a risk factor AIDS, women and men appear to be

united in citing wives as the problem. On the one hand, this is a somewhat paradoxical finding, given the concerns about husbands' behavior that were raised by women. After all, women reported that, "As married women in the man's home, we do not move out [travel outside the home], but men move out and women find themselves infected." Further, they insisted that "Generally women have no power over their risk, because they can stay home and be faithful, but they cannot rule their husbands and force them to stay home."⁶

On the other hand, as shown in previous chapters, there was also a fair amount of wife blaming on the part of both women and men with regard to why women have extramarital partners. While husbands' inability or unwillingness to meet all of their wife/ves' emotional, sexual, and material needs was cited as a reason why wives have outside partners and thus may bring AIDS into marital unions, the men who are those outside partners were curiously absent from the discourse on blame. These contradictions may be related to a sexual double standard (that is not unique to Muslims, but is found throughout most societies) that is more likely to sanction men's, but not women's, extramarital relationships (Mason 1994). Another possible reason for the difference between the concerns raised by wives about their husbands' behavior as an influence on their risk and this particular survey finding may be linked to the type of data collection method used. Women may have been more comfortable speaking about their concerns during the in-depth interviews, focus groups, and informal conversations than in the formal, highly structured survey setting.

When the data are disaggregated by type of union, (see Table 8.2) the results suggest that respondents in monogamous and polygynous unions hold different views on the potential risks posed by co-wives and the challenge to treating all wives equally as reasons for why polygyny is a risk factor for AIDS.

Table 8.2 Unprompted Reasons Why Polygyny is a Risk Factor for AIDS by Type of Marital Union, Risk Cluster Sub-Sample

Item	Type of Union				Total (N = 140)	
	Monogamous (N = 72)		Polygynous (N = 68)			
	Count	%	Count	%	Count	%
Can't trust all your wives	21	29%	17	25%	38	27%
Can't trust husband	2	3%	1	1%	3	2%
Can't trust co-wives	28	39%	43	63%	71	51%*
Difficult to treat wives equally	29	40%	17	25%	46	33%*
NB: N refers to those who agreed that polygyny is a risk factor for AIDS; * p < .05						

Similar percentages of men in monogamous (29%) and polygynous (25%) unions mentioned, "can't trust all your wives" as a reason. Women in polygynous unions were more likely (63%) to cite "can't trust co-wives" than were those in monogamous unions (39%, $p = <.05$). In contrast, people in monogamous unions were more likely (40%) to identify challenges in treating all wives equally as a risk factor for AIDS than are those in polygynous unions (25%, $p = <.05$).

An explanation for this seemingly paradoxical finding includes the possibility that individuals in currently monogamous unions may be less supportive of the idea that it is possible to treat all wives equally than people in currently polygynous unions. As previously discussed, wives in monogamous unions were opposed to the possibility of a new wife entering a union because of the increased tension that often results, which may also explain the findings (17 women in monogamous unions gave this as a response versus 11 women in polygynous unions, data not shown). Twice as many men in monogamous

unions mentioned challenges to treating all wives equally as a reason why polygyny is a risk factor for AIDS as men in polygynous unions (12 versus six, respectively, data not shown). Perhaps men in monogamous unions view treating all wives equally as more of an issue than men in polygynous unions.

To summarize, the findings presented in this section support the qualitative findings showing that polygyny is considered a risk factor for AIDS. The majority of people in the risk cluster sub-sample (63%) hold this view. Respondents' reasons for why polygyny is a risk factor are highly gendered. Only men mentioned, "can't trust all your wives" as a reason and all but two of the people giving "can't trust co-wives" were women. Moreover, the findings reveal differences in responses by type of marital union. Women in polygynous unions are more likely than those in monogamous unions to mention "can't trust co-wives," and respondents in monogamous unions are more likely than those in polygynous unions to mention "difficult to treat all wives equally." The next sections present the individual level analyses of self-assessed risk by gender and polygynous status.

Self-Assessed HIV/AIDS Risk

Self-Assessed HIV/AIDS Risk by Gender

Respondents were asked to assess their risk of 'getting AIDS' based on a four-point scale (none, small, moderate, and great). Table 8.3 shows the results of that analysis by gender. While the results are not statistically

significant, a slight majority (57%) of respondents rank themselves at no (22%) or small risk (35%), with small risk being the most frequently cited risk level.

Table 8.3 HIV Risk Self-Assessment by Gender, Risk Cluster Sub-Sample

Item	Gender				Total (N = 218)	
	Men (N = 101)		Women (N = 117)			
	Count	%	Count	%	Count	%
Risk level						
No risk	19	19%	29	25%	48	22%
Small risk	43	43%	34	29%	77	35%
Moderate risk	20	20%	26	22%	46	21%
Great risk	19	19%	28	24%	47	22%
Total respondents	101	100%	117	100%	218	100%
Reasons for no/small risk						
One partner	25	40%	46	73%	71	57%*
Abstain from sex	4	6%	11	17%	15	12%
Mistrust spouse	7	11%	4	6%	11	9%
Use condoms	6	10%	2	3%	8	6%
Limited number of partners	7	11%	0	0%	7	6%*
No homosexual sex	0	0%	0	0%	0	0%
No blood transfusions	0	0%	0	0%	0	0%
No injections	0	0%	0	0%	0	0%
Reasons for mod/great risk						
Spouse has multiple partners	0	0%	31	57%	31	33%*
Mistrust spouse	15	38%	15	28%	30	32%
Do not use condoms	3	8%	15	28%	18	19%*
Mistrust co-wives	0	0%	10	19%	10	11%*
Resp. has multiple partners	2	5%	0	0%	2	2%
Injections	1	3%	1	2%	2	2%
Homosexual sex	0	0%	0	0%	0	0%
Blood transfusions	0	0%	0	0%	0	0%
* p < .05; calculation of percentages for no/small risk based on N = 62 for men & N = 63 for women; mod/great N = 39 for men & N = 54 for women						

The percentage of men (43%) ranking themselves at small risk is noticeably greater than the percentage of women who assessed their risk as small (29%).

Overall, 62 percent of husbands and 54 percent of wives in the sub-sample ranked themselves as at no or small risk. These percentages are considerably lower than national level data from the 1995 Uganda DHS (Statistics Department Ministry of Finance and Economic Planning and Macro International 1996: 154

and 155), which showed that 85 percent of currently married men ranked themselves at no/small risk compared to 62 percent of currently married women.

About equal percentages of women (22%) and men (20%) in my study assessed their risk as moderate, while slightly more women (24%) than men (19%) ranked their risk as great. These findings differ from responses to a nearly identical question asked in the 1995 Uganda DHS. In that study, currently married women were more likely to assess their risk of getting AIDS as moderate or great than were men. Twenty-four percent of currently married women in the 1995 DHS considered themselves at 'moderate' risk and 14 percent assessed their risk as 'great' compared to ten percent of currently married men who evaluated their risk as 'moderate' and five percent who considered themselves at 'great' risk (*ibid.*).

Table 8.3 also shows respondents' reasons for considering themselves at no/small or moderate/great risk. The second panel of the table shows the results for those who said that they had no/small risk of getting AIDS. The most frequently cited reason (57%) for both women and men was having only one partner, and women were far more likely (73%) to identify this as their reason than were men (40%, $p = <.05$).⁷ Men were more likely to mention 'limited number of partners' as a reason than women ($p = <.05$).

The number of sexual partners that a spouse has also was a factor in the reasoning of those who believed themselves at moderate or great risk of AIDS. "Spouse has multiple partners" (33%) was the most frequently mentioned reason for respondents ranking themselves at moderate/great risk ($p = <.05$). Moreover,

this response is highly gendered, i.e., only women (57%) gave this as one of their reasons. The wording of the English version of the response category "spouse has multiple partners" translates as "my husband/wife has sex with many people" in the Lusoga version. Thus, it includes both spouses and outside partners. The high percentage of women who gave this as a reason may be explained by the fact that 50 percent of the women in the sub-sample are in polygynous unions. As might be expected, only women mentioned "mistrust co-wives" as one of the reasons for their moderate/great risk ($p = <.05$). Finally, women were more likely (28%) than men (8%, $p = <.05$) to mention not using condoms as a reason for being at moderate/great risk.

In sum, a slight majority of the risk cluster sub-sample (57%) assess their risk in the two lower risk categories; 62 percent of the husbands and 54 percent of the wives ranked themselves at no/small risk. Respondents—particularly men—in this study appear to perceive themselves as at greater risk than respondents in the 1995 Uganda DHS (85% of married men and 62% of married women assessed their risk as no/small). The most frequently mentioned reasons for assessing risk as no/small or moderate/great were highly gendered. Women were more likely than men to mention having only one partner as a reason for their no/small AIDS risk than men. Women were also more likely to mention "spouse has multiple partners" as the reason for their moderate/great risk than men. This finding is not surprising given that 50 percent of the women in the risk cluster sub-sample are in polygynous unions. The next section presents the findings on self-assessed risk by type of marital union.

Self-Assessed HIV/AIDS Risk by Type of Marital Union

The results of the self-assessed HIV risk question by type of marital union are shown in Table 8.4.

Table 8.4 HIV Risk Self-Assessment by Type of Marital Union, Risk Cluster Sub-Sample

Item	Type of Union				Total (N = 218)	
	Monogamous (N = 120)		Polygynous (N = 98)			
	Count	%	Count	%	Count	%
Risk level						
No risk	36	30%	12	12%	48	22%
Small risk	46	38%	31	32%	77	35%
Moderate risk	24	20%	22	22%	46	21%
Great risk	14	12%	33	34%	47	22%
Total respondents	120	100%	98	100%	218	100%*
Reasons for no/small risk						
One partner	55	67%	16	37%	71	57%*
Abstain from sex	9	11%	6	14%	15	12%
Mistrust spouse	4	5%	7	16%	11	9%*
Use condoms	4	5%	4	9%	8	6%
Limited number of partners	2	2%	5	12%	7	6%*
No homosexual sex	0	0%	0	0%	0	0%
No blood transfusions	0	0%	0	0%	0	0%
No injections	0	0%	0	0%	0	0%
Reasons for mod/great risk						
Spouse has multiple partners	4	11%	27	49%	31	33%*
Mistrust spouse	15	39%	15	27%	30	32%
Do not use condoms	4	11%	14	25%	18	19%
Mistrust co-wives	3	8%	7	13%	10	11%
Resp. has multiple partners	0	0%	2	4%	2	2%
Injections	1	3%	1	2%	2	2%
Homosexual sex	0	0%	0	0%	0	0%
Blood transfusions	0	0%	0	0%	0	0%
* p < .05; calculations of percentages for no/small risk based on N= 82 for monogamous & N = 43 for polygynous; mod/great N = 38 for monogamous & N = 55 for polygynous						

The first panel of the table reveals that respondents in polygynous unions are significantly more likely to assess their risk as moderate (22%) or great (34%) while those in monogamous unions are more likely to rank themselves at no (30%) or small (38%) risk ($p = <.05$).

The second panel of Table 8.4 shows respondents' reasons for ranking themselves at no/small risk by type of union. As might be expected, respondents in monogamous unions (67%) were more likely to cite 'one partner' as a reason for assessing their risk in the categories of no or small than were those in polygynous unions (37%, $p = <.05$). Men in polygynous unions were more likely than those in monogamous unions to state that they were at no/small risk because they have a limited number of partners (only men gave this as a response, p). Moreover, people in polygynous unions were more likely to identify "mistrust of spouse" as a reason for assessing their risk as no/small (16%) than were people in monogamous unions (5%, $p = <.05$).

The third panel of the table provides respondents' reasons for ranking their risk at moderate or great. The only statistically significant result is "spouse has multiple partners," which was mentioned by women only (see Table 8.3). Women in polygynous unions were significantly more likely to cite this as a reason (49%) than were women in monogamous unions (11%, $p = <.05$). This finding is consistent with 50 percent of the women in the risk cluster sub-sample being in polygynous unions.

To summarize, the findings from this section show that people in polygynous unions are more likely than those in monogamous unions to assess their HIV risk as moderate/great. As expected, respondents in monogamous unions cited having only one partner as a reason for considering themselves at no/small risk more frequently than respondents in polygynous unions. In contrast, respondents in polygynous unions were more likely to mention "mistrust spouse"

as a reason why they were at no/small risk than were those in monogamous unions. While the results were not statistically significant, a higher percentage of people in monogamous unions identified mistrusting their spouse as a reason for assessing their risk as moderate/great than people in polygynous unions. Higher numbers of women in monogamous unions and men in polygynous unions gave "mistrust spouse" as a reason for their moderate/great risk assessment; 11 of the 15 people in monogamous unions who gave this as a response are women. In contrast, 11 of the 15 people in polygynous unions who gave "mistrust spouse" as a reason are men (data not shown).

Finally, people in polygynous unions were much more likely than those in monogamous unions to say that they were at moderate/great risk because their "spouse has multiple partners." This response was highly gendered. Only women gave this response, which is consistent with half of the women in the risk cluster sub-sample being in polygynous unions. This particular finding suggests that women in polygynous unions may be more concerned about the extra-dyadic basis of such unions as influences on their HIV/AIDS risk than men in polygynous unions.

Risk Cluster Analysis

Self-Assessed HIV/AIDS Risk within Monogamous and Polygynous Risk Clusters

Wives (as a group) and husbands (as a group) assess their HIV risk within monogamous and polygynous risk clusters differently ($p = <.05$). These results are shown in Table 8.5. While the results are shown at the individual level (218

respondents), they provide a critical background to the presentation of the data for the 98 risk clusters for which there are complete data that follows.

Table 8.5 Comparison of Wives and Husbands' Self-Assessed Risk within Group and by Type of Marital Union within Risk Clusters

	Self-Assessed Risk									
	None		Small		Moderate		Great		Total	
Wives	Count	%	Count	%	Count	%	Count	%	Count	%
Wives in polygynous unions	8	14%	15	26%	15	26%	20	34%	58	50%
Wives in monogamous unions	21	36%	19	32%	11	19%	8	14%	59	50%
Total	29	25%	34	29%	26	22%	28	24%	117	100%
* chi-square $p < .05$										
	Self-Assessed Risk									
	None		Small		Moderate		Great		Total	
Husbands	Count	%	Count	%	Count	%	Count	%	Count	%
Husbands in polygynous unions	4	10%	16	40%	7	17%	13	32%	40	40%
Husbands in monogamous unions	15	25%	27	44%	13	21%	6	10%	61	60%
Total	19	19%	43	43%	20	20%	19	19%	101	100%
* chi-square $p < .05$										

The first panel of Table 8.5 displays the results of wives' assessment of their HIV risk by type of union. Wives in monogamous risk clusters are more likely to consider themselves in the lower risk categories of none (36%) and small (32%) than are wives in polygynous risk clusters (14% and 26%, respectively). Put another way, wives in polygynous risk clusters are about 2.5 times less likely to assess themselves as at no risk of HIV infection than are wives in monogamous risk clusters. Not surprisingly then, wives in polygynous risk clusters are significantly more likely to assess their risk as moderate (26%) and great (34%) than are wives in monogamous risk clusters (19% and 14%, respectively). In short, wives in monogamous risk clusters are about 2.4 times less likely to assess their risk as "great" than are wives in polygynous risk clusters.

The second panel of the table shows a similar pattern of responses for husbands in monogamous and polygynous risk clusters. Husbands in monogamous risk clusters are more likely to assess their risk as none (25%) and small (44%) than are husbands in polygynous risk clusters (10% and 40%, respectively). As with wives, husbands in monogamous risk clusters are about 2.5 times more likely to report that they are at no risk of HIV infection than are husbands in polygynous risk clusters. As expected, then, husbands in polygynous risk clusters are more likely to say that they are at moderate (and about 3.2 times less likely to classify themselves at the other end of the scale (great risk). A slight majority of husbands in monogamous risk clusters assessed their risk as moderate (21%) compared to husbands in polygynous risk clusters (17%). Husbands in polygynous risk clusters were much more likely, however, to state that their HIV risk was great (32%) than were husbands in monogamous risk clusters (10%). In other words, husbands in polygynous risk clusters were 3.2 times more likely than those in monogamous risk clusters to rank their risk as "great." Thus, both husbands and wives in polygynous risk clusters are more likely to rank themselves at great risk than are spouses in monogamous risk clusters.

Table 8.6 presents the same data in a different format focusing on the relationship between the percentages of wives and husbands in each risk category who ranked themselves at a particular risk level and their status as members of monogamous or polygynous risk clusters. The percentages presented in this table were calculated using the count for each level of risk

(bolded in the table) and the number of wives (or husbands) in monogamous and polygynous risk clusters who assessed their risk at that level. The first panel of the table shows that 72 percent of the wives who assessed themselves at no risk of contracting HIV/AIDS are in monogamous risk clusters.

Table 8.6 Comparison of Wives and Husbands' Self-Assessed Risk by Type of Marital Union within Risk Clusters and within Risk Level

	Self-Assessed Risk									
	<i>None</i>		<i>Small</i>		<i>Moderate</i>		<i>Great</i>		<i>Total</i>	
	Count	%	Count	%	Count	%	Count	%	Count	%
Wives										
Wives in polygynous unions	8	28%	15	44%	15	58%	20	71%	58	50%
Wives in monogamous unions	21	72%	19	56%	11	42%	8	29%	59	50%
Total	29	25%	34	29%	26	22%	28	24%	117	100%
* chi-square p < .05										
	Self-Assessed Risk									
	<i>None</i>		<i>Small</i>		<i>Moderate</i>		<i>Great</i>		<i>Total</i>	
	Count	%	Count	%	Count	%	Count	%	Count	%
Husbands										
Husbands in polygynous unions	4	21%	16	37%	7	35%	13	68%	40	40%
Husbands in monogamous unions	15	79%	27	63%	13	65%	6	32%	61	60%
Total	19	19%	43	43%	20	20%	19	19%	101	100%
* chi-square p < .05										

The gap between wives' assessment of their risk narrows considerably in terms of those who ranked themselves as at small risk, with 56 percent of the wives in monogamous risk clusters assigning themselves at this risk level versus 44 percent in polygynous risk clusters. The pattern is reversed at the two higher levels of risk, with a higher percentage of wives in polygynous risk clusters assessing their risk as moderate (58%) or great (71%).

The second half of the table shows the results for the husbands. As with the wives, the vast majority (79%) of husbands who ranked themselves at no risk are in monogamous risk clusters compared to only 21% of the husbands in polygynous risk clusters assessing their risk at this level. Whereas proportionally

few wives in monogamous risk clusters assessed their risk as moderate, the reverse is true for husbands in these risk clusters. Sixty-five percent of the husbands who evaluated their risk as moderate are in monogamous risk clusters, compared to 35 percent who are in polygynous risk clusters. Finally, more than twice as many husbands who ranked their risk as great are in polygynous risk clusters (68%, versus 32% of husbands in monogamous risk clusters).

To summarize, the data presented in this section demonstrate that wives and husbands in polygynous risk clusters are more likely to consider themselves at moderate/great risk of getting AIDS than their counterparts in monogamous risk clusters. The next section provides the findings of the risk cluster analysis on level of agreement about self-assessed risk, by risk cluster type.

Percent Agreement on Self-Assessed Risk within Risk Clusters

Level of agreement within all risk clusters. Table 8.7 presents the results of the level of concurrence on self-assessed risk within the 98 risk clusters for which there are complete data. The percentages of risk clusters in which there is agreement between spouses on their risk assessment are shown on the diagonal and are highlighted in gray. The counts for each cell are not included in the table to facilitate the reading and interpreting of results. Significance was tested using chi-square, with the probability level set at .05. The Kappa statistic, which measures for the level of agreement adjusted for chance is also included in the following tables. The methods used to create values for computing a Kappa statistic were presented in Chapter 3. To review the range of agreement indicated by a Kappa: a Kappa of less than 0.40 is considered a "poor" level of

agreement, 0.40-0.59 is "fair", 0.60-0.80 is "good", and greater than 0.80 shows an "excellent" level of agreement.

In this analysis, the Kappa statistic provides insight into the level of agreement among spouses in monogamous and polygynous risk clusters on self-assessed HIV risk. As discussed in the final section of this chapter, the level of agreement on self-assessed risk within risk clusters may be an indicator of the level of communication about risk behaviors among partners within marital unions. The level of agreement on self-assessed risk may also have implications for the risk reduction behaviors implemented by spouses within risk clusters.

Table 8.7 Percent Agreement on Self-Assessed Risk in 98 Risk Clusters

	Wives' Self-Assessed Risk				
	<i>None</i>	<i>Small</i>	<i>Moderate</i>	<i>Great</i>	<i>Total</i>
Husbands' Self-Assessed Risk					
<i>None</i>	8%	4%	3%	4%	19%
<i>Small</i>	12%	17%	8%	5%	43%
<i>Moderate</i>	5%	5%	6%	3%	19%
<i>Great</i>	0%	3%	7%	8%	18%
<i>Total</i>	25%	30%	25%	20%	100%
n = 98; Kappa = 0.19, p < .05					

The overall level of concurrence (or agreement) within all 98 risk clusters on self-assessed risk is 39 percent.⁸ The Kappa statistic of 0.19 (19%) is statistically significant and shows that there is a "poor" level of agreement among spouses within risk clusters on their self-assessed HIV risk. The highest level of agreement occurs among spouses within risk clusters who agree that they are at small risk of contracting HIV/AIDS (17% of all risk clusters). This higher level of agreement may be driven by the higher percentages of spouses who ranked themselves at small risk at the individual level (35%) compared to the other

levels of risk, which range from 21%-22% (see Table 8.4).⁹ Equal percentages of spouses (8%) agree that their HIV risk is at either end of the scale, while six percent agree that they are at moderate risk. In cases of disagreement, the instances in which husbands feel that they are at greater risk exceed (32%) the cases in which wives feel that they are at greater risk (27%).¹⁰

The 38 percent level of agreement in this study is similar to that found in the 1995 Uganda DHS (37%), which is based on 1,099 married couples as the unit of analysis (the DHS does not provide a Kappa statistic). A higher percentage of spouses in the DHS agreed that they were at no (10%) or small (23%) risk, and lower percentage agreed that they were at moderate (2%) or great risk (2%) compared to the spouses in this study. In contrast to this study's findings, in the DHS a higher percentage of wives (45%) in the DHS considered themselves to be at greater risk than husbands (18%). The DHS provides no information about whether their "couples" data includes "couples" in polygynous unions (Statistics Department, Ministry of Finance and Economic Planning and Macro International 1996).

An additional difference between the data from this dissertation (which is based on the risk cluster as the unit of analysis) and the 1995 DHS data is that the latter are drawn from couples residing in the same household, while this study is based on data from both co-resident and non-coresident spouses. Along with sample size, these factors may help account for some of the differences in level of agreement on self-assessed risk between husbands and wives in the two

studies. The DHS data are not further disaggregated into monogamous and polygynous "couples."

In summary, the Kappa statistic shows that there is a "poor" level of agreement among spouses in the 98 risk clusters for which there are complete data. At this level of analysis (all 98 risk clusters), the highest level of agreement within risk clusters is among those spouses who agree that they are at small risk (17%) for HIV infection. In cases of disagreement on risk, a slightly higher percentage of husbands considered themselves to be at greater risk than their wives (32% and 27%, respectively). In the next section, the results of the percent agreement analysis are further disaggregated by polygynous and monogamous risk clusters.

Level of agreement by monogamous or polygynous risk clusters. Table 8.8 displays the results within 39 polygynous risk clusters.

Table 8.8 Percent Agreement on Self-Assessed Risk in 39 Polygynous Risk Clusters

	Wives' Self-Assessed Risk				
	<i>None</i>	<i>Small</i>	<i>Moderate</i>	<i>Great</i>	<i>Total</i>
Husbands' Self-Assessed Risk					
<i>None</i>	0%	3%	3%	5%	10%
<i>Small</i>	10%	15%	8%	8%	41%
<i>Moderate</i>	0%	3%	10%	5%	18%
<i>Great</i>	0%	5%	13%	13%	31%
<i>Total</i>	10%	26%	33%	31%	100%
n = 39; Kappa = 0.16, not significant					

Looking first at the totals, while equal percentages of wives and husbands in polygynous risk clusters assessed themselves at no risk (10%), a higher percentage of husbands (41%) than wives (26%) ranked their risk as small. In contrast, the gap (15%) is reversed with regard to the percentages of wives and husbands within polygynous risk clusters who ranked themselves at moderate

risk (33% of wives and 18% of husbands). Equal percentages of spousal partners (31%) assessed their risk as great.

According to the Kappa statistic, there is a poor (16%) level of agreement on self-assessed risk within polygynous risk clusters. The results are not statistically significant, probably due to low counts in many of the cells. As shown in the table, the level of agreement on self-assessed risk within polygynous unions is slightly skewed toward the high risk categories (23% for moderate/great versus 15% for none/small). The highest single level of agreement (15%) among spouses within polygynous risk clusters is within the risk category of small risk. The next highest level of agreement is great risk, with 13% of spouses within polygynous risk clusters agreeing that are within the highest level of risk. In contrast, no marital partners in polygynous risk clusters agree that they are at no risk of getting AIDS. Ten percent agree that they are at moderate risk. In cases of disagreement, similar percentages of wives (32%) and husbands (31%) assessed their risk as greater. The highest level of disagreement is within the polygynous risk clusters where wives considered themselves at moderate risk and husbands considered themselves at great risk (13%).

Table 8.9 shows the percent agreement within 59 monogamous risk clusters.

Table 8.9 Percent Agreement on Self-Assessed Risk in 59 Monogamous Risk Clusters

	Wives' Self-Assessed Risk				
	<i>None</i>	<i>Small</i>	<i>Moderate</i>	<i>Great</i>	<i>Total</i>
Husbands' Self-Assessed Risk					
<i>None</i>	14%	5%	3%	3%	25%
<i>Small</i>	14%	19%	9%	3%	44%
<i>Moderate</i>	9%	7%	3%	2%	20%
<i>Great</i>	0%	2%	3%	3%	10%
<i>Total</i>	36%	32%	19%	14%	100%
n = 59; Kappa = 0.17; p < .05					

Comparing the totals in this table to those in Table 8.8 reveals that more spouses in monogamous risk clusters assess their risk as none (36% of wives and 25% of husbands) or small (32% of wives and 44% of husbands) compared with spouses in polygynous risk clusters (10% of wives and husbands assessed their risk as none, and 26% of wives along with 41% of husbands considered their risk as small). About equal percentages of husbands in monogamous (20%) and polygynous risk clusters (18%) consider their risk at moderate. In contrast, fewer wives in monogamous (19%) assess their risk at moderate compared to wives in polygynous risk clusters (33%). Not surprisingly then, fewer wives and husbands in monogamous risk clusters consider their risk at great (14% and 10%, respectively) than wives and husbands in polygynous risk clusters (33% and 31%, respectively).

Whereas spouses in polygynous risk clusters tend to agree that they are at high risk (23% agreed that they are at moderate/great risk), spouses in monogamous unions are more likely to agree that they are in the low risk (33% agree that they are at none/small risk). The Kappa statistic (0.17) shows a poor level of overall agreement among spouses in monogamous risk clusters on self-

assessed risk, and the results are statistically significant ($p = <.05$). As with spouses in polygynous risk clusters (15%), the highest single level of agreement is among spouses who consider themselves at small risk of HIV infection (19%). The next highest level of agreement is among spouses who said that they are at no risk of becoming infected (14%). This is in contrast to the second most common level of agreement in polygynous risk clusters in which 13% of spouses agreed that they are at great risk of HIV infection.

In cases of disagreement, the instances where husbands feel they are at greater risk (35%) than their wives exceeds the reverse scenario, where wives feel that they are at greater risk than their husbands (25%). This is in contrast to polygynous risk clusters in which nearly equal percentages of wives (32%) and husbands (31%) considered themselves to be at greater risk than their spouses. The highest level of disagreement is in risk clusters where wives consider themselves at no risk and husbands view their risk as small (14%). This represents a similar a pattern (albeit at the opposite end of the self-assessed risk scale) to the highest level of disagreement among spouses in polygynous risk clusters, where 13 percent of wives felt they were at moderate risk, while their husbands felt they were at great risk.

To summarize, when the data are disaggregated by type of marital union, the Kappa statistic shows that there is a poor level of agreement of self-assessed HIV risk within monogamous and polygynous risk clusters. Moreover, where agreement on self-assessed risk exists, spouses in monogamous unions tend to agree that they are at no/small risk, while spouses in polygynous unions agree

that they are at moderate/great risk. One possible reason for these differences may be related to the fact that 70% of the co-wives in polygynous unions are not co-resident and this may contribute to increased perceptions of risk among spouses in polygynous unions. Under the Islamic ideal, husbands are supposed to divide their time equally between their wives. Most husbands achieve this; of the 55 wives in polygynous unions for which there are data, only 33 percent reported that their husband spent seven nights a week at their compound (this percentage approximates the percentage of husbands who keep their wives in the same compound). Of the remaining wives, 14 percent reported that their husband never stays at their place, 20 percent stated that he stays 1-2 nights per week, 31 percent indicated that the husband is there 3-4 nights a week and 5 percent reported that he stays 5-6 nights a week.¹¹

To analyze the possible association between husbands' full time residence with wives and wives' self-assessed risk, the variable for co-residence was recoded into a dichotomous variable (husband does/does not stay seven nights per week) and the four-level self-assessed risk variable was recoded into two levels (none/small and moderate/great). Nearly two-thirds (61%) of the wives in polygynous risk clusters whose husbands stay with them seven nights a week ranked themselves at no/small risk. In comparison, only 33 percent of the wives in polygynous risk clusters whose husbands stay with them less than seven nights a week ranked themselves in the lower risk category (the difference nears statistical significance at $p = 0.052$). Moreover, the percentage of wives in polygynous risk clusters who ranked themselves at no/small risk is similar to the

percentage of wives in monogamous risk clusters who ranked themselves at no/small risk (68%). Other possible reasons for the difference in self-assessed risk among spouses in monogamous and polygynous unions are presented in the following section, along with a discussion and summary of the findings about polygyny as a risk factor for HIV/AIDS.

Discussion

Perceptions of Polygyny as a Risk Factor for HIV/AIDS

I argued above that researchers need to move beyond the level of the dyad when they study HIV/AIDS in Sub-Saharan Africa, particularly when studying risk and risk reduction within marital unions. To the best of my knowledge, HIV/AIDS research in Sub-Saharan Africa (including the more recent couples research) rarely, if ever, addresses respondents' views on whether polygyny is a risk factor for AIDS. A limited number of studies have analyzed spousal differences in self-assessed HIV/AIDS risk (see for example, Statistics Department Ministry of Finance and Economic Planning and Macro International 1996). These analyses do not, however, extend to whether there are differences between husbands and wives in monogamous and polygynous unions on their self-assessed risk at the individual—much less at the risk cluster (or all interviewed marital partners within each monogamous or polygynous unions analyzed as a unit)—levels. Part of this may be due to questions about polygyny and HIV/AIDS risk either not being asked or not being analyzed and reported. It is also linked to the challenges of analyzing data from a husband and more than one of his interviewed wives.

One of the reasons why polygyny as a risk factor for AIDS and possible differences in risk perception among partners in monogamous and polygynous unions has yet to be addressed is related to the challenges of defining marriage in Sub-Saharan Africa. As discussed in Chapter 4, the multiple forms, flexibility, and staged nature of marital unions and other relations in Sub-Saharan Africa often makes it difficult to pinpoint whether a "couple" is "married" and whether the marriage is recognized socially, legally, and/or religiously. For example, in their evaluation of the impact of the FAEPTI project on Muslims in Uganda, Kagimu et al. (1998) did not analyze the marital status and type of marital union data because of respondents' inconsistency in responding to the marital status questions during their baseline and follow-up studies.

Additionally, Kagimu and his colleagues cite variations in the definition of marriage in Uganda, i.e., some people in long-term relationships consider themselves married while others do not, and the lack "of local terms which are universally interpreted in the same way" as a reason for not analyzing those data. Further, while they asked about risk perception related to polygynous status, their data analysis revealed that respondents were confused about the meaning of the questions, thus those data were not reported. Their decision not to focus on the type of marital union (i.e., monogamous or polygynous) was also influenced by the FAEPTI Project's emphasis on stressing the risks associated with casual partners and extra-marital partners. "Imams and Family AIDS Workers encouraged married men and women not to engage in extra-marital sex, and for those not married, to reduce the number of sexual partners" (*ibid.*). Within this

framework, the FAEPTI curriculum stressed that, “[r]isks associated with polygamy... could be made less risky by maintaining marital fidelity, or as it is expressed locally, ‘sticking to’ one’s spouse or spouses’.”

In contrast to Kagimu et al. (1998), this study considered respondents’ self-reports as acceptable indicators of marital status and the type of marital union. The Kappa statistic of 0.90 (90%) showed that there is an “excellent” level of agreement among marital partners on whether they are in a currently monogamous or currently polygynous union. This justifies analyzing polygyny as a risk factor for AIDS along with differences in self-assessed AIDS risk within monogamous and polygynous risk clusters.

While Kagimu et al. did not ask specific questions in their baseline or follow-up studies on the impact of the FAEPTI project on the target population of Muslims, they do present data from focus groups showing that,

[b]oth men and women thought that attitudes about polygamy were changing both with the threat of AIDS and the difficult times facing Uganda. Women also tended to mention “avoiding disorganisation in the home” as an explanation of why a man would not take a second wife (*ibid.*).

The qualitative and quantitative findings of this study, which was conducted about two years after the FAEPTI project began in the study area, appear to support their focus group findings.

Survey respondents’ answers to a question about whether polygyny is a risk factor for AIDS provides insight into general perceptions (rather than individual reasons) about why nearly two-thirds (63%) of the risk cluster sub-sample viewed polygyny is a risk factor for AIDS. In this analysis “mistrust”

emerged as a gendered predictor; only husbands mentioned "can't trust all your wives" as a reason, while only wives identified "can't trust co-wives." The quantitative findings are supported by qualitative data showing that wives are concerned about the possible effects of their co-wives' behavior on their risk. When the data are further disaggregated by type of union, wives in currently polygynous unions were more likely than wives in currently monogamous unions to cite "can't trust co-wives" as one of their reasons. While this finding is not an indicator of individual wives' perception of polygyny as an influence on their HIV risk, it may reflect the concerns of women in currently polygynous unions.

Distinct from wives' responses, husbands in currently monogamous and currently polygynous unions are about equally likely to identify "can't trust all your wives" as a reason why polygyny is a risk factor for AIDS. In contrast to the highly gendered nature of the "can't trust wives" and "can't trust co-wives responses," roughly equal percentages of husbands and wives mentioned "difficult to treat all wives equally" as a reason why polygyny is a risk factor for AIDS. This was another major theme that emerged during qualitative data collection. A higher percentage of spouses in monogamous unions than in polygynous unions, however, gave this as one of their reasons. Husbands are curiously absent from the unprompted survey responses to the question of why polygyny is a risk factor for AIDS. In other words, both wives and husbands seem to identify wives as one of the reasons why polygyny is a risk factor for AIDS. This may be consistent with a sexual double standard that sanctions men having outside partners but proscribes against such a practice among women.

Women's comments during focus groups and in-depth interviews highlight the imbalance of power within marital unions and the way that it affects their perception and embodiment of risk. As stated in previous chapters, women—whether in monogamous or polygynous unions—felt that they have a limited ability to control their sexuality, reproduction, and risk. The association of condoms with outside partners makes it difficult for both women and men to suggest their use within the context of marriage. Men's greater control over sexual decision making means that it is especially difficult for women to suggest condom use. These challenges are amplified within polygynous unions.

The links between risk, the meaning of producing children for women's social status and socioeconomic security, and competition among co-wives came through clearly in the qualitative data and reinforce the importance of framing analyses at the "union" (or risk cluster), rather than the "couple" level. Dynamics within polygynous unions may create additional obstacles to condom use—either as a means of fertility regulation or risk reduction. As one of the wives in a polygynous union stated, "all the time you are thinking that the one with the most children is the one who will be the owner of the household." According to women, a husband in a polygynous union who suggested condom use to one wife is likely to face resistance if she feels that he is trying to keep her, but not her co-wife/ves, from producing children.

Moreover, a woman is aware that even if she managed to convince her husband to use a condom (or was convinced by him to use one), there was no guarantee that her co-wife/ves would agree to use condoms, particularly if the

co-wife/ves felt that condom use was being suggested as a way to control their fertility. This is consistent with other research from Sub-Saharan Africa on competition in childbearing among co-wives in polygynous unions to gain equal or greater access to their shared husband's resources (Blanc and Gage 2000; Wolff, Blanc, and Ssekamatte-Ssebuliba 2000; Meekers and Nadra 1995; Bledsoe 1993; Wittrup 1990; Ware 1979). Men in focus groups conducted in two districts of Uganda (Blanc and Gage 2000: 170-171) observed that women in polygynous unions compete in childbearing and construe attempts to regulate their fertility as a sign that they are no longer loved.

Additionally, women in focus groups and in-depth interviews indicated that even if they remained monogamous within a polygynous union (i.e., faithful to their husband), they might still be at risk due to a lack of control over their husband's and/or their co-wife/ves' behavior. Women's comments during focus groups and in-depth interviews also revealed the gap between the ideal and practice of Muslim marriage. While the Islamic ideal is that wives should be consulted before another wife is brought into the union, women said that it is very rare for a husband to discuss the addition of another wife with his current wives. The way that gender is done among Basoga Muslims (i.e., the husband is the head of the household and thus has authority over most realms), conditions women's to believe that they cannot object to the addition of another wife. The finding that about one-third of both husbands and wives identified the difficulty of treating all wives equally as a reason why polygyny is a potential risk factor for AIDS also highlights the gap between ideal and practice.

Women's concerns about the risk of infection within polygynous unions is supported by research conducted in the rural Rakai District of Uganda by Morris and Kretzschmar (2000: 26) which found that concurrent partnerships (whether spousal or non-spousal) have "played a significant role in the spread of HIV." In their study, the majority (84.6%) of concurrent partnerships were spousal, (although the term includes both spousal and non-spousal partnerships). Men in their study (14%) were more likely than women (1%) to report concurrent partnerships on the day of the interview. "This is largely because when women do have concurrent partnerships both partners are not spouses, in contrast to men, so the period of overlap is shorter" (*ibid.*: 7).

Based upon their modeling of the impact of concurrent partnerships on amplifying the HIV/AIDS epidemic Morris and Kretzschmar found that:

[t]his level of concurrent partnerships could raise the size of an epidemic by about 26% over a five year period when compared to a population with the same total number of partnerships practicing sequential monogamy. Increasing either the partnerships or the concurrency separately we find that concurrency seems to have the larger potential impact. The average number of new cases [of HIV/AIDS] rises 90-347% under the concurrency scenarios, compared to 30-100% in the partnership scenarios. Increasing both the partnerships and the concurrency, we find a much larger non-additive effect, with the average number of new infections rising from 113-713%. The results suggest that slightly higher levels of behavioral risk on these variables could have easily produced an epidemic two to three times larger than that predicted by current behavior, and that most of this effect will be due to concurrency (*ibid.*: 23-24).

Polygyny—as a form of concurrent partnership—has been identified as a risk factor for AIDS in some studies (Caldwell et al. 1994; Caraël 1994). In contrast, Gray and his colleagues (2000) suggest that polygyny may pose less

risk for HIV infection because polygynous unions constitute “closed networks.” Their observation, however, is only valid if all spouses within a polygynous union stay within the union. It also ignores the fluidity of marital unions (e.g., the addition of new wives—whether through formal or informal polygyny). In fact, a recently published study based on an analysis of 1989-1990 data from Lusaka and Kampala (Caraël, Ali, and Cleland 2001: 84) found that women who were in polygynous unions had higher levels of risky behaviors (e.g., non-regular partners) than women in monogamous unions. While the authors observe that this finding is counterintuitive to the expectation that being in a polygynous union would “be protective against the health risks of casual relationships,” they suggest that urban settings may encourage the practice of men having “outside wives” i.e., informal polygyny. In this situation, men may “not take on the obligations that are traditionally attached to a polygamous marriage. Couples continue to take other partners for economic necessity or prestige.”

A more recent study (Auvert et al. 2001a: S26) in two low HIV prevalence cities (Cotonou, Benin and Yaoundé Cameroon) and two high HIV prevalence cities (Kisumu, Kenya and Ndola, Zambia) found “no association between concurrent partnerships and HIV risk at the *individual* level, and neither were concurrent partnerships more prevalent in the two high HIV prevalence cities than the two low HIV prevalence cities” (emphasis added). This study and a companion study that included Dakar, Senegal in addition to the other four cities (Lagarde et al. 2001) has been critiqued for concluding that concurrent relationships (as measured by level of concurrency at the time of the interview)

are not a *major* determinant on the rate of HIV transmission, but only one of many factors—both behavioral and biological—influencing HIV epidemics in the five cities. As noted by Gorbach and Holmes (2003: iii21), “While this study provides important data that questions the role of concurrency in driving HIV epidemics, it is limited by temporal ambiguity thereby associating current sexual behavior with a disease that may have been acquired years earlier.”

Moreover, while concurrent partnerships may not be associated with increased risk at the *individual* level there may be an increased risk at the level of the partnership

Expanding the concept of risk from a focus on the individual to one on partnerships can help to improve understanding of both behavior and disease. This is because the risk for acquiring STIs/HIV for the individual results from not only his or her own concurrent partnerships and behaviors but also from his or her partner’s practice of concurrency. An individual’s partner may have concurrent partners who belong to high STI/HIV-prevalence sexual networks, which may inadvertently increase the risk to the individual who is several steps removed from the high risk networks (Morris 2001, cited in Gorbach and Holmes 2003: iii22).

Evidence that polygynous unions do not always remain closed (i.e., “protective”) is provided by a recent study conducted in Oyo State, Nigeria, with Yoruba men (Lawoyin and Larsen 2002). This study found that both monogamous and polygynous men had extramarital partners (the majority of whom were “steady girlfriends,” and some of whom later became another wife). Polygynous men, however, in both urban and rural areas, were “more likely to have concurrent partnerships (the other wife/wives)... and more likely to be in high-risk partnerships” during their wives’ pregnancies and post-partum

abstinence. Moreover, "[p]artner mixing (with long-term regular partners such as wives and steady girlfriends) and short-term partners (casual [partners] and commercial sex workers), in the absence of protected sex are known to amplify HIV spread. Partner mixing was generally worse in polygamous marriages" (*ibid.*: 61). Of course, it bears repeating that spouses within an HIV-free polygynous union who remain within the union are at less risk of HIV infection than spouses within a monogamous union who each have extramarital partners.

Self-Assessed HIV/AIDS Risk

Bernardi (2002: 17) sums up risk perception as "a compromise between what people know and what they want to know." She identifies three potential influences on HIV risk perception, which provide a useful framework for the following discussion on self-assessed risk at the individual and risk cluster levels:

a) Knowledge of the mechanisms of HIV spread: risk perception is dependent on the capability to assess the relationship between behaviour and the modes of transmission of the virus....

b) Behavioural control and actual behaviour: individual risk perception depends on the individual's perceived control of her capability to take preventative measures against the infection and, of course, on actual behaviour. Risk self-assessment is the product of one's knowledge (whether correct or not) and of the "riskiness" of one's behaviour. Depending on one or the other of these two factors, perceived risk may or may not be accurate compared to actual risk....

c) Social networks: individual risk perception is dependent on the perception of risk held by other members of her personal network (ibid.: 5, 6, and 7, emphasis in the original).

As shown in Chapter 6, the study population has a high level of (correct) knowledge about the primary mode of HIV transmission in Sub-Saharan Africa (i.e., sexual transmission).

The issue of individuals' sense of perceived control over their ability to influence a reduction in their HIV risk clearly comes into play in the discussion of why polygyny is a risk factor for AIDS as well as women's (in particular) self-assessed risk. Consistent with other studies from Sub-Saharan Africa (Bernardi 2002; Spira et al. 2000; Kengeya-Kayondgo et al. 1999; Mukaire and Kalikwani 1997; Baingana et al. 1995; Caraël 1994; McGrath et al. 1993) women attributed at least part of their risk perception to their husband's behavior. As summed up (to a chorus of agreement) by a woman in a polygynous union, married women in the trading center discuss their AIDS risk and resolve to be faithful and "even to try to use condoms within the marriage." Another woman added, "But even if we say that we will be faithful, the men will not necessarily act the same way, so it is useless."

Even women in monogamous unions were concerned as the following quote illustrates, "I am worried that maybe I might become infected—maybe my husband will infect me—but as for my own behavior, no I am not worried." Women's concerns over their husbands or steady male partner's behavior as an influence on their HIV risk were also prominent in a study conducted at a family planning clinic in the Busoga District (Mukaire and Kalikwani 1997:23). Over half of the women in that study considered themselves to be at risk of getting

HIV/AIDS; of these women, 93 percent attributed their risk assessment not to their own behavior but to their partner's sexual behavior.

As shown above, husbands and wives in polygynous risk clusters are more likely to consider themselves at moderate/great risk of becoming infected with HIV than spouses in monogamous risk clusters. A surprising finding was the identification of "mistrust" of spouse or co-wives as one of the reasons why people rank themselves at a particular risk level.¹² Such mistrust was mentioned by proportionally more respondents who ranked themselves at moderate/great risk than at no/small risk. On an individual level, mistrust of spouse was mentioned most frequently by men who ranked themselves at moderate/great risk (38% men versus 28% women, though not statistically significant).

Respondents in monogamous unions also mentioned mistrusting their spouses as a reason for their self-assessed moderate/great risk of getting HIV more often than respondents in polygynous unions (39% and 27% respectively), although these results were not statistically significant. This raises the question of whether respondents in monogamous unions are more concerned about their spouses having outside partners than respondents in polygynous unions.

I have argued for the need to move beyond the level of dyads (and individuals) when analyzing HIV/AIDS data from populations with a high level of polygyny. A central research question was whether there are differences in self-assessed AIDS risk among spouses in monogamous and polygynous risk clusters. Both the qualitative and quantitative findings presented in this chapter highlight the utility of expanding analyses beyond the level of the dyad. At the risk

cluster level of analysis, there are significant differences in self-assessed risk in monogamous and polygynous risk clusters. First, there is a poor level of agreement overall within all the risk clusters on self-assessed risk. Second, members of polygynous risk clusters are more likely than those in monogamous risk clusters to rank themselves at moderate/great risk and the level of agreement on self-assessed risk is skewed toward these higher risk categories.

Bernardi's observation about personal networks as an influence on risk perception finds support in this study. Both the qualitative and quantitative findings indicate respondents' awareness of the network-like or linked structure of relations within polygynous risk clusters as an influence on their self-assessment of risk. It is likely that respondents in polygynous risk clusters are assessing their risk not only in terms of dyads (wife/husband) but also in terms of how the behavior of other members of the risk cluster impacts their risk. There are a number of possible explanations for why spouses in polygynous unions perceive themselves to be at greater risk than spouses in monogamous unions. Given the high level of agreement on polygynous status within unions, it is likely that wives in polygynous unions know of each other's existence. This knowledge of a sexual network beyond the level of the dyad may contribute to an increased perception of risk in polygynous unions. This possibility is supported by findings from a study of female partners of AIDS patients in Kampala, Uganda (Baingana et al. 1995: S18), which found that women in customary marriages (which are often polygynous) had a higher perception of HIV risk than did women in civil marriages or cohabitating unions.

Another possible explanation for the perceived high risk among spouses in polygynous risk clusters may be related to the fact that the majority of spouses in polygynous risk clusters are not co-resident. As discussed in previous chapters, 70 percent of the wives in polygynous risk clusters live in separate locations. This may contribute to concerns among spouses about the activities of their husband/wife/ves or co-wife/ves. Indeed, during focus groups in 1997, some of the women in polygynous unions commented that they are worried about their HIV risk, because they do not know where their husbands spend most of their nights and whether they use protection.

While every attempt was made to conduct follow-up in-depth interviews with spouses in co-resident and non co-resident polygynous risk clusters, I was only able to interview spouses in one co-resident risk cluster. The observations of the three co-wives in this risk cluster are, however, worth noting. In separate interviews, each of them said that they felt that they were at risk by being in a polygynous union, but they also felt that their risk was reduced by having all the wives in the same compound. One of the wives commented, "I want us all to be in one house, so I can know when the husband is out of the house. He might say that he is going to the co-wife's place, but he is actually going elsewhere. If we are all in the same place, then we know where he is at." She went on to say, "when you are all in the same house, everyone watches everyone else's movements, so you can't do anything, because it will be reported to your husband."

One of her co-wives similarly observed, "I feel safe, because we are all in the same place....Those people who put their wives in separate places, when their husband goes away, the wife will decide to bring another man. But here we are in the same place and that can help us to keep track of each other's movements." In the absence of comparable data, it is unclear how representative these women are of their counterparts.

The spouses in this particular risk cluster were unusual in that they were all quite young; it is unusual for a young man to have three wives. The co-wives were also unusual in the extent of their cooperation in keeping an eye on their husband's activities. Each stated that if they are concerned about their husband's movements (e.g., if he has been coming home late), then the co-wives will sit down together as a group and discuss their concerns. Then when their husband returns, they will discuss the issue with him. As one of the co-wives stated, "We all sit down when we are going to talk with him, and even if it one person who does all the talking, the very fact that we are all listening is the most important thing." In fact, on occasions of such discussions, they accepted his explanations for coming home late because "he rarely tells lies."

While the experiences and views of spouses within one risk cluster are not generalizable to the entire study sample, some support for the possible link between co-residence and perceived HIV risk is provided by a study that drew on data from the 1993 Kenya Demographic and Health Survey (KDHS) (Brockerhoff and Biddlecom 1998). In the KDHS, "rural women whose husbands or partners do *not* co-reside with them are more likely to both perceive themselves at risk of

HIV/AIDS in general and to perceive themselves at risk in relation to behaviors of their husbands or partners.” The authors’ interpretation of this finding highlights the embodiment of risk for married women: “These results can be interpreted as supporting the argument that HIV/AIDS will move into the currently lower HIV-prevalence areas by way of migrant husbands who return to their wives and have unprotected sex” (*ibid.*: 20).

Additionally, a recent study conducted in Kenya (Bernardi 2002) with a sample that had a 30 percent rate of polygyny, found that women whose husbands were frequently absent from the compound were more concerned about their HIV risk than women whose husbands were regularly present in the compound. Studies conducted in Nigeria (Lawoyin and Larsen 2002; Orubuloye, Caldwell and Caldwell 1994b), found that wife/ves or steady female partners who were not co-resident with their husband/steady male partner were more likely to have outside partners, especially in rural areas.

Given the fact that marital unions may change from monogamous to polygynous (and back again), what are the implications of the lower self-assessment of risk in monogamous risk clusters? In other words, are spouses in monogamous unions underestimating their risk? Wives in both monogamous and polygynous unions seemed to recognize the network-like aspect of polygynous unions (at the economic, social, and sexual levels). During focus groups, wives in monogamous unions were strongly opposed to the possibility of their marriage transitioning from monogamous to polygynous, although most of them said that

there was little, if anything, they could do to prevent their husband from adding another wife to the union.

The low estimates of perceived risk within monogamous unions may be linked to a potentially false sense of security, i.e., being in a monogamous union equates with monogamous behavior. Kamaya et al. (1997: S 63) note a useful distinction between monogamous marriage versus monogamous behavior (i.e., the two are ideally, but not necessarily, identical). It is possible that spouses in currently monogamous unions assess themselves at low levels of HIV/AIDS risk because they assume that their partners are practicing monogamous behavior.

A final point to consider based on the risk cluster analysis is the poor level of agreement on self-assessed AIDS risk within risk clusters. To review: the Kappa statistic showed that level of agreement on self-assessed risk within all 98 risk clusters was only 19 percent. The level of agreement within polygynous risk clusters was tipped toward the higher levels of risk (moderate to great) but also was poor. Similarly, spouses in monogamous risk clusters had a poor level of agreement on their risk, but the results were skewed in the opposite direction (no or small risk). Couples research on fertility preferences, contraceptive use, and reproductive decision making (Blanc and Wolff forthcoming; Ratcliffe et al. 2002; Becker and Costenbader 2001; Miller, Zulu, and Watkins 2001; Ezeh and Agadjanian 2000; Wolff, Blanc, and Ssekamatte-Ssebuliba 2000b; Bankole and Singh 1998; Dadoo 1998a, 1998b; Ezeh and Mboup 1997; Becker 1996; Blanc et al. 1996; Bankole 1995; Ezeh 1993) provides a context for understanding this low level of agreement. These studies have revealed that a lack of agreement (or

concurrence) between couples is not unusual. For example, the 1995 Uganda DHS found that wives' perception of their husband's approval of family planning was accurate only 49 percent of the time, while husbands' perception of their wife/ves' approval of family planning was accurate 58 percent of the time. In both instances, the Kappa statistics indicated poor agreement (13% and 16%, respectively) (Macro International 1996, cited in Becker 1996: 296).

These studies have also found that lack of concurrence is often based on limited spousal communication about reproductive matters (including the use of condoms for family planning and/or HIV/STI prevention). Increased levels of education (particularly for women) predict a greater likelihood of discussion and couple negotiation about these matters. Becker and Costenbader (2001: 123) suggest that, women with higher levels of education may have more status within the household than their less educated counterparts and may feel more empowered to discuss their contraceptive preferences openly with their husbands. In a study conducted in Malawi, Miller, Zulu and Watkins (2001: 171) found that women's status (as reflected by level of education) and autonomy (as reflected by women's freedom of movement, i.e., the ability to "travel without their husband's permission") are positively associated with spousal agreement on family planning and AIDS. Moreover, the extent of "agreement ... on spousal discussions (concerning ideal family size, family planning, and AIDS) also depends on how each spouse defines 'discussion.'" One spouse may believe that a discussion occurred, while the other disagrees (*ibid.*: 164).¹³ Findings from a study conducted in Uganda show that even when couples agree that a

discussion about AIDS or family planning took place, the imbalance of power within marital unions may translate into a lopsided "discussion" dominated by the husband's views and preferences (Wolff, Blanc, and Ssekamatte-Ssebuliba 2000).

A study conducted in Bangkok, Thailand (Bennetts et al. 1999) also found that limited spousal communication was a factor in the low level of agreement between HIV positive pregnant women and their husbands on questions related to risk perception, risk behavior, HIV testing, discussion of HIV, and knowledge of spouses' outside partners. The findings showed that wives were misinformed about the extent of their husbands risk behaviors and "more women than men reported that the husband had had an HIV test. This illustrates a lack of open and clear communication or a misunderstanding between husbands and wives as to what constitutes an HIV test." The authors suggest that the low level of agreement is likely related to husbands hiding their risk behaviors from their wives as well as Thai social norms regarding communication about sex, which are characterized by "discretion and silence" (Maticka-Tyndale et al. 1994, cited in Bennetts et al. 1999). They conclude that, "[t]his lack of understanding between husbands and wives regarding male partner risk behavior poses a serious challenge to HIV prevention among couples... If wives do not understand the risks to which their husbands are exposing them, condom use, as well as other prevention strategies will pose problems" (*ibid.*).

All of these findings provide a context for understanding the poor level of agreement on self-assessed HIV risk within risk clusters. Moreover, the low level

of agreement raises the question of possible implications for the AIDS risk reduction steps implemented by spouses within risk clusters. The FAEPTI Project encouraged open spousal communication about all matters, including HIV/AIDS, but the survey did not include any questions about spousal communication on HIV/AIDS risk. I did, however, explore spousal communication during the in-depth interviews via questions about decision making over agricultural production, money, and reproductive matters (including condom use for family planning and HIV/AIDS prevention).

Both wives and husbands stressed the importance of "discussing and agreeing" on matters of importance such as which plants to crop, how money should be spent, and reproductive decision making. A commonly repeated response to questions about how decisions were arrived at was, "we sit together and discuss and agree." When asked to define "discussion" a wife in a polygynous union responded that, "discussion means that you have a very good marriage because you agree with your husband." Her response was echoed by other wives during the interviews. Further probing revealed that "discuss and agree" generally means that it is the husband's point of view or preferences that are agreed to. This is related to the gender dynamics within households and risk clusters, including the fact that husbands are recognized as the *mwene maka*, or head of household and thus have the final decision-making power in most realms. In other words, "discuss and agree" is the ideal that people strive for but, as indicated in previous chapters, wives often find it difficult to raise the issue of HIV/AIDS prevention with their husbands and rarely, if ever discuss this with their

co-wife/ves. This may contribute, in part, to the low level of agreement on self-assessed risk within risk clusters. As in other studies, women's education may play a role in whether husbands and wives discuss HIV/AIDS prevention. During in-depth interviews, the few women who had completed higher levels of education spoke of discussing HIV/AIDS risk and risk reduction with their spouses more often than women with lower levels of education.

In the next chapter, I discuss the major findings and limitations of this study, suggestions for future research, and the theoretical and substantive contributions of the research.

NOTES

¹ This longitudinal project (the Medical Research Council General Population Cohort) has followed 10,000 people residing in 15 neighboring villages in rural Masaka District, Uganda since 1989. It, along with the Rakai Project conducted in a neighboring district of Uganda, is one of the few research studies in Sub-Saharan Africa able to provide incidence (number of new cases during a specified time period) as well as prevalence (number of cases at one point in time) HIV/AIDS data over an extended period of time. The authors observe that the lower incidence rates in Muslim men may be linked, in part, to male circumcision, which has been hypothesized as a protective factor for HIV transmission; all of the Muslim men in the study were circumcised compared to about 10 percent of the non-Muslim men. They do not—at least in this article—extend the discussion of what accounts for the significantly lower rates of new infections among Muslim women and men in their study beyond this finding (Carpenter et al. 1999: 1087). Another group of researchers who have conducted a long-term longitudinal study in the neighboring Rakai District (Gray et al. 2002; Gray et al. 2000) suggest that several factors related to being Muslim (in addition to nearly universal circumcision among Muslim men) may contribute to lower HIV incidence rates among Muslims. Other researchers dispute the potentially confounding influence of religion on the effect of male circumcision on lower HIV prevalence and incidence. For more on the debate over the protective role of male circumcision, religion, and other sociocultural factors that may influence HIV risk see Abebe et al. (2003), Halperin et al. (2002), Auvert et al. (2001a, 2001b), Weiss et al. (2001), and Weiss, Quigley and Hayes (2000).

² Gray et al. (2000) also found that circumcised HIV negative men (Muslim and non-Muslim) in serodiscordant couples (where the female partner was HIV positive) had a significantly lower seroconversion rate than uncircumcised men. Additionally male circumcision also played a protective role in serodiscordant couples where the female partner was HIV negative and the male partner was HIV positive.

³ In their study in rural Senegal, Lagarde et al. (2000: 2032) similarly concluded that there was a negative association between religion and adopting preventative behaviors. Respondents who considered religion very important in their lives were less likely to adopt preventative behaviors.

⁴ The most recently available Uganda Demographic and Health Survey (Macro International 2002: 75) provides a slightly higher figure of 33 percent of all currently married women in polygynous unions.

⁵ See Ssengonzi et al. (1999) and Robinson et al. (1999) for further discussion of the role of concurrent partnerships in HIV transmission. As noted by Robinson et al., short-term concurrent partnerships play an important role in the rapid spread

of HIV during the early stages of an HIV epidemic. In the latter stages of an HIV epidemic, however, long-term concurrent partnerships between serodiscordant partners also play an important role.

⁶ Additionally, as shown in Table 8.4, slightly more than a quarter (28%) of the wives who ranked their HIV risk as moderate/great gave responses indicating that they mistrusted their spouse as one of their reasons.

⁷ No further comparisons with 1995 Uganda DHS data on respondents' reasons for assessing their risk as no/small or moderate/great will be made because of the differences in sample size between the two studies. Slightly more than 3,100 currently married women and 1,000 currently married men took part in the 1995 DHS. While the risk assessment question used in this dissertation was nearly identical to the DHS question, the smaller sample size and small cell counts in many of the response categories do not justify a comparative analysis.

⁸ Becker and Costenbader (2001: 126 N1) prefer the term "concurrence" over "agreement" because the latter implies "communication and consensus between partners...[and] couples' reports could also be the same simply by chance."

⁹ The statistical significance of the level of agreement varies by whether the risk assessment levels are analyzed based on the original four-level risk scale, or whether the scale is collapsed into a two-level scale (lower/higher). Becker (1996: 294-295) notes that the chance that spouses will concur is "influenced both by the number of response categories and by the marginal distribution of responses for each partner. Chance agreement is highest if only two possible responses can be given to a question and if the distribution is skewed and it is lowest if many categories are given with responses uniformly distributed between them."

¹⁰ These percentages were calculated by summing the instances where wives and husbands within risk clusters disagreed on their HIV risk (i.e., none/small, none/moderate, none/great, small/moderate, small/great, and moderate/great for husbands' and wife/ves' values).

¹¹ Collapsing the number of nights that husbands stay with their wives obscures wide variation in wives' reports on this: 11 percent reported never, 4 percent one night per week, 16 percent two nights, 22 percent three nights, 9 percent four nights, 2 percent five nights, 4 percent six nights, and 33 percent seven nights (n = 55).

¹² This finding has not emerged in other studies as a pre-determined survey answer category (i.e., part of the expected range of responses).

¹³ In addition to asking about family planning and AIDS, the Malawian study asked couples a series of questions about the ownership of certain household

items. They found that husbands and wives agreed more on the household ownership questions than on the family planning and AIDS questions. In other words, "[h]usbands and wives close association with each other..." leads to closer agreement about the ownership of household items than issues related to family planning use or discussions about family planning and/or AIDS. Miller, Zulu, and Watkins (2001) suggest that, "...the discrepancies between husbands and wives responses [on reporting ownership of household items] are due in part to differences in their perceptions of the interview process and appropriate strategies to follow in responding to questions." They also note the importance of recognizing respondents' agency within interviews. They argue that when asked questions about the ownership of household items, women and men use gendered strategies in responding. Men (who tended to report a greater number of household items) are concerned to present themselves as good providers. Women present themselves to the interviewer as in need of assistance and thus reported fewer household items. Miller and her coauthors conclude by noting that, "...the interaction between gender and reporting is sensitive to the particular topic and the regional context. In our data, family planning and AIDS are particularly sensitive topics, and we suggest that such differences might be related to women's status in each region or to political party affiliation, or to other contextual differences" (*ibid.*: 171 and 172).

CHAPTER 9

CONCLUSION

Introduction

The primary research question I addressed in this dissertation is how the social construction and practice of gender relations affects the perception and embodiment—or lived experience—of HIV/AIDS risk, particularly for women in marital unions. Individuals learn gender norms and are rewarded or sanctioned based upon the extent to which they practice (or “do”) gender according to dominant norms. Specifically, using both qualitative and quantitative methods I examined (1) how doing gender among Basoga Muslims impacts access to and control over valued social and economic resources as well as control over sexuality and reproduction, (2) the way inequitable distribution of resources and control over sexuality and reproduction affects the perception and embodiment of risk, and (3) the different way matched wives and husbands in monogamous and polygynous unions assess their HIV/AIDS risk and their reasons for that risk. I also discussed perceptions of polygyny as a risk factor for HIV/AIDS as a sub-set of the third research question.

Marital partners in polygynous unions are linked to each other through complex, multi-dimensional networks. To address these connections and produce data to answer the above questions, I developed the risk cluster concept as an analytical and methodological tool. This concept attempts to move beyond the level of individuals and dyads (or couples) to compare matched husbands and wives’ responses to key issues related to HIV/AIDS risk and risk reduction.

A risk cluster consists of all the marital partners within a union, whether living in separate or linked households. A linked household is one in which a husband has wives living in more than one compound (or house).

The risk cluster concept emerged out of research participants' comments about inter- and intra-household dynamics concerning HIV/AIDS risk and risk reduction. These dynamics centered on the social, economic, and sexual linkages between marital partners. While sexual behavior occurs at the level of the dyad, study participants acknowledged that partners within polygynous unions share each other's risk-related behavior.

In this chapter, I summarize my major findings. I also present the theoretical and substantive contributions of my research as well as its limitations and I offer suggestions for future research.

Summary of Major Findings

Educational (and income) differences are often used as proxy measures of women's status within societies and power within relationships (Blanc 2001). The way that gender is done among Basoga Muslims means that women have lower levels of education and fewer sources of income than men. While the level of correct knowledge about HIV transmission and ways to avoid transmission was fairly high in the study population, women's more limited access to resources (i.e., education and income) often contributed to the embodiment of HIV risk. Women reported fewer sources of AIDS information than men, particularly literacy-related sources such as newspapers and printed posters. As

education increased, the number of AIDS information sources (including literacy-related sources) rose. Additionally, as education increased, levels of knowledge about HIV transmission and the percentage of respondents mentioning condoms as a way to avoid becoming infected with HIV grew.

Further, education and reported income sources rose in tandem. Women's economic vulnerability (i.e., their more limited access to and control over income) was identified by both women and men as one of the major risk factors for HIV/AIDS. Similarly, both women and men stated that the initiation of income generating projects for women had contributed to a reduction in women's economic vulnerability (and their AIDS risk) because women were able to earn and control their own income.

Large age gaps between marital partners (which are common in areas of Sub-Saharan Africa with high levels of polygyny) may amplify women's HIV/AIDS risk by decreasing the likelihood that they will be able to take steps to reduce their risk. The mean age gap between husbands and wives in currently monogamous unions in the risk cluster sub-sample was 5.8 years. The gap between spouses in polygynous risk clusters was considerably higher, 10.3 years. Adolescent wives are especially at risk of being infected by their husbands "as marital relationships are associated with more frequent sexual intercourse and greater exposure to infection as well as decreased likelihood of condom use" (Luke and Kurz 2002:17).

The single statistically significant response mentioned more frequently by women than by men as a way to avoid HIV infection was "zero grazing" (the 'B' in

the ABC message, i.e., be faithful). Fifty-three percent of the women in the risk cluster sub-sample mentioned this, compared to 36 percent of the men. This finding suggests that women have internalized the “B” faithful message to a greater extent than men have.

The way that gender is done also limited women’s control over their sexuality, reproduction, and risk. Both women and men articulated the different forms of power they experience and use—whether in the realm of sexuality, reproduction and risk, or other realms of their daily lives—as highly gendered. Indeed, men are recognized as the *mwene maka* (head of household) and, as such, are accorded power and authority (*obuyinza*) over most realms, including sexual and reproductive decision making. Some women found ways to gain greater control over their HIV/AIDS risk through indirect means (e.g., suggesting condom use for child spacing when the underlying motivation was related more to HIV/AIDS prevention). Others mentioned attempting to persuade or influence (*okusendasenda*) their husband to use condoms. In these instances, wives who attempted to persuade or influence their husbands to use condoms were likely to encounter resistance because of cultural and religious norms that granted men final decision making power. As women in a focus group stated, “a wife can persuade or negotiate, but she cannot rule her husband.”

Women also frequently responded to questions about HIV/AIDS risk reduction in terms of the notion of the ability (*obusobozi*) to act on AIDS prevention messages. *Obusobozi*, as a form of power, is similar to the sociological notion of agency. When expressed as *nsobola* (I am able), it implies

the ability to act on one's own behalf. The negation, *tisobola*, indicates constraints on an individual's ability to act. Women revealed that these constraints often were social structural (e.g., women's poverty). In other words, the way that gender was done, which produces differences in the distribution of power and resources, contributed to the embodiment of risk for women. As voiced by women in a focus group, "*abakazi bazira buyinza okubakuba basdha*" (women do not have the power to rule men).

The value of producing children for women's social status and socioeconomic security was a challenge for women's risk reduction within marital unions, and this challenge was amplified for women in polygynous unions. Consistent with other research from Sub-Saharan Africa (Meekers and Nadra 1995; Bledsoe 1990; Wittrup 1990; Garene and Van de Walle 1989; Ware 1979), one of the ways that women gained access to resources was by bearing children. Women in polygynous unions competed in child bearing to gain greater access to resources for themselves and their children from their shared husband. In other words, women considered the number of children that their co-wives had when making their own fertility "decisions." Thus, a polygynous husband's request for condom use (whether for HIV/STI prevention or for family planning purposes) was likely to be met with resistance if a wife felt that she was being asked to limit her fertility while her co-wife/ves were not.

Women seemed aware that their husbands had other wives. Moreover, one of the surprising findings was the excellent level of agreement on polygynous status within risk clusters, a level of agreement that has not been found in other

studies. A second surprising finding was that wives and husbands had different understandings of wife rank. When asked to provide details about the marriage arrangements with each of their wives, husbands listed them in order from most to least senior (e.g., first through third). Wives, on the other hand, understood their wife rank in terms of when and where they entered. The vast majority of wives (86%) who gave discrepant responses indicating a potential gap between current polygynous status and wife rank were in "currently monogamous" unions.

For example, a wife who classified herself and was classified by her husband as in a "currently monogamous" union, but knew that her husband had three wives before her, often gave her current wife rank as "fourth," while her husband was more likely to list her as his first and only wife. Similarly, a woman in a currently polygynous union with two other co-wives, who knew that the three wives before her had left, would list herself as fourth wife. Her co-wives, in turn, were most likely to rank themselves as their husband's fifth and sixth wives, respectively.

Currently monogamous unions may become polygynous and may have been polygynous in the past. The intensity of polygyny (number of wives in a polygynous union) varies over time. Wives in polygynous unions in effect calculated intensity in terms of the total number of wives their husband had ever married, rather than the current number of wives in the union. Husbands, on the other hand, tended to calculate intensity in the present, rather than the past tense.

Many women who were concerned about their AIDS risk indicated that leaving their marriages was one of the few options available to them if they were concerned about their AIDS risk, nevertheless, they felt unable to address the issue with their husbands. Partner change—in the form of wife leaving or husbands bringing in new wives—is considered a risk factor for HIV/AIDS. Partner change—whether in the past or planned partner change, as in the intention to add another wife in the future—also increases the embodiment of risk for other STIs for women within marital unions (Adeokun and Nalwadda 1997; Nabaitu, Bachengana and Seely 1994).

Consistent with the literature on HIV/AIDS in Sub-Saharan Africa, wives were concerned about their husband's behavior as an influence on their risk (Kengenya-Kayondo et al. 1999; Caraël 1994; McGrath et al. 1993). In addition, one of the major findings of this study was that wives in polygynous unions were concerned about the possible influence of their co-wife/ves' behavior on their risk. Thus, a wife in a polygynous union was likely to rank her risk as low because of her own behavior, but elevate her risk to a higher level because of concerns about her husband's and/or co-wife/ves' behavior. This is a new finding in the research on HIV/AIDS risk perception within marital unions.

Another significant finding, not reported in other research, is that the majority of participants (nearly two-thirds) considered polygyny a risk factor for HIV/AIDS. The reasons for this were discussed in Chapter 8 and are encapsulated in the statement from a woman in a focus group: "the way you behave is not the way that others [in the union] behave..." Moreover, "mistrust"

was a gendered predictor for why polygyny is a risk factor: only men identified mistrusting wives and all but two of the people who identified mistrusting co-wives were women. In contrast to the highly gendered responses related to “mistrust,” about equal percentages of women and men mentioned that polygyny is a risk factor because it is difficult to treat all wives equally in a polygynous union. Only three participants out of 140 (all men) identified untrustworthy husbands as one of the reasons why polygyny is a risk factor for AIDS.

In fact, men were largely absent from the discourse of responsibility and blame. In other words, a fair amount of woman blaming was used to explain why people within communities are at risk for HIV/AIDS. For example, while both women and men identified *obwavu* and *okwegomba* (poverty and admiration) as two of the major reasons why women have outside partners, the men who are those outside partners are generally missing from the discussions. The discourse focused primarily on women bringing infection into the union, thus placing the burden and blame on women, rather than on articulating men’s shared responsibility for HIV transmission. The perception of women as going outside marital unions and the absence of men from much of the discussion about this may be linked to a sexual double standard that sanctions men’s multiple partnerships—whether formally or informally—but proscribes against women having multiple partners.

At the individual level, a slight majority (57%) of respondents assessed their HIV/AIDS risk as no/small, and assessments were highly gendered. Women were more likely than men to mention, “only have one partner” as a reason for

considering themselves at no/small risk. Women were also more likely than men to identify “spouse has many partners” as a reason for considering themselves at moderate/great risk.

When the findings were disaggregated by marital union type, individuals in polygynous unions were more likely than those in monogamous unions to consider themselves at moderate/great risk. Moreover, women in polygynous unions were more likely than those in monogamous unions to mention, “spouse has many partners” as a reason for their moderate/great risk. This finding is not surprising given that 50 percent of the women in the risk cluster sub-sample were in currently polygynous unions. It does, however, reinforce the importance of moving beyond the level of dyads in HIV/AIDS research.

To the best of my knowledge, this study may be the first to pose an analytical and methodological framework for moving beyond the level of the dyad in HIV/AIDS research in areas of Sub-Saharan Africa with high levels of polygyny. The findings of the risk cluster analysis showed that there was a poor level of agreement within all risk clusters on self-assessed risk. Moreover, spouses in polygynous risk clusters were more likely than those in monogamous risk clusters to assess their HIV risk as moderate/great. Where agreement on self-assessed risk did occur, it was skewed toward the higher risk level of moderate/great in polygynous risk clusters, while it tended toward the lower level of none/small in monogamous risk clusters.

Theoretical Contributions

The findings from this dissertation support and expand upon other research showing the fluidity of marital relations and other unions in Sub-Saharan Africa. Monogamous unions may become polygynous and polygynous unions may become monogamous. Moreover, partners in polygynous unions—whether formal or informal—are linked to each other through complex webs of social, economic, and sexual networks. We need to move beyond the level of couples (or dyads) when conducting research on HIV/AIDS in areas of Sub-Saharan Africa with high levels of polygyny and adopt a broader frame of analysis than provided by individual level or couples research. My findings also suggest that a fourth variable of “formerly polygynous” could be added to Speizer’s (1995) marriage classification of men’s marital status in Sub-Saharan Africa as currently monogamous, currently polygynous, and intending to become polygynous.

Moreover, my finding that the dynamics between co-wives influence women’s sexuality, reproduction and risk, suggests that we need to expand West and Zimmerman’s concept of doing gender to include gender relations among women as well as between women and men. Responses related to “mistrust” were highly gendered. Relationships among women are as important to understanding the dynamics of power as are relations between women and men.

My research also suggests that we need to expand our thinking about the notion of power. While men are recognized as having “power over,” some

women do find ways to try to reduce their HIV/AIDS risk through both direct and indirect means. In this sense, they show that even in the face of a structured set of constraints that is shaped, to a large extent, by the gender order, they are able to exercise their agency. In this regard, empowerment for women may consist of finding room to maneuver within the way that gender is done.

In fact, my findings indicate that a reconceptualization of the concept of empowerment is necessary. As shown in this study, taking collective action (as in forming income generating groups) is also an important component of women's empowerment. Not only did women state that they had greater control over income earned from income generating activities than from the sale of their food crops, they also benefited from meeting together as a group and offering mutual support. Participating in a group income generating activity provides women with the opportunity to discuss their situation as well as support each other's efforts to reduce their HIV/AIDS risk.

Substantive Contributions

The importance of examining women's HIV/AIDS risk within marital relations and other unions is gaining increasing attention. A growing body of research shows that the majority of "sexually transmitted HIV infections in women occur either inside marriage or in relationships women believe to be monogamous" (UNAIDS Press release February 2, 2004). The findings from this study contribute to and expand upon this research. While the practice of gender varies across societies, the balance of power in sexual decision making as well

as other realms is usually tipped toward men. In spite of this, until very recently, HIV/AIDS prevention efforts have been directed primarily toward women, who are often least empowered to protect themselves against infection, particularly within the context of marriage. While some women managed to take steps to reduce their HIV/AIDS risk, the major theme that emerged was the constraints women within marital unions faced in taking such action. In other words, understanding the tension between the ability to act and constraints on taking action is critical to understanding why knowledge about ways to reduce one's HIV/AIDS risk is an important, but not necessarily sufficient, first step in acting on prevention messages.

My findings support other research showing that AIDS prevention for women—especially within marital unions—is not as easy as “ABC” (abstain, be faithful, condom use). The success of Uganda's efforts in reducing both prevalence and incidence is attributable to expanding the “ABC” approach to emphasize:

... ‘D’ for delayed sexual activity—this message seems to get through to young people better than abstinence. With financially independent married women more likely to report abstaining from sex, the ABC...Delay continuum was extended to ‘EF’: Empowerment of women through Financial independence. Beyond ABC activities, Uganda also delivered care, provided testing, involved people who had HIV/AIDS in service delivery, and engaged in advocacy and stigma reduction activities (USAID 2002: 8, emphasis in the original).¹

An addition to the “E” in alphabet approach to AIDS prevention might be “Education” (Empowerment/Education). Levels of knowledge about HIV transmission, ways to avoid becoming infected, and the likelihood of discussions

among marital partners such as about HIV and condom use are all associated with level of education—particularly for women (Blanc and Wolff forthcoming; Wolff et al. 2000a, 2000b; Blanc et al. 1996).

Although my study was not designed as a formal evaluation of the Islamic Medical Association of Uganda's Family AIDS Education and Prevention Through Imams (FAEPTI) Project, it does provide insight into this unique, faith-based effort to address some of the gender-based risk factors for HIV/AIDS. The FAEPTI Project's approach to HIV/AIDS prevention is part of a larger movement among Muslims in Uganda called the AIDS Jihad. This Jihad (or holy struggle) is directed at harnessing the power of religion in Muslims' lives to affect risk reduction behaviors. The Project suggests that following religious beliefs allows both women and men to gain increased control over their HIV/AIDS risk. In this regard, the FAEPTI curriculum promotes the replacement of cultural practices that may contribute to increased HIV/AIDS risk—such as unrestricted polygyny, early withdrawal of girls from school, early age of marriage for girls, and women not earning their own income—with practices influenced by religious teachings that could contribute to risk reduction. In particular, the project teaches women's rights under Islam and project leaders assert that religion can be a force for changing practices that put people at risk. The project acknowledges, however, that "culture is a roadblock."

IMAU models women's empowerment by involving "women at every level of its AIDS education activities. The Imam is required to have a female as well as a male assistant and Family AIDS Workers (FAWs) are comprised of equal

numbers of men and women" (Wheeler 1998: 27). Women are also highly visible in positions of responsibility and authority within the organization. The lens of Islam through which the IMAU FAEPTI Project frames gender relations discourages men from marrying other wives unless they can treat those they already have equally and encourages fidelity. It also encourages girls' education, which may lead to a later age of marriage and contributes to women's empowerment.

Moreover, the project uses a range of messages from the Koran and Sharia to encourage behaviors that can reduce risk, and while it is clear that many of these messages have been acted upon, many women continued to feel that they are at risk for HIV infection. Given the different (and gendered) types of power that women and men experience and use, it may be helpful for the IMAU FAEPTI Project to further reinforce the influence of gender power relations on HIV/AIDS risk reduction. In other words, the project may want to facilitate brainstorming sessions during HIV/AIDS educator training sessions as well as open community discussions about the constraining and enabling factors that women and men face in implementing risk reduction messages. Imams could also address gender power relations as part of the HIV/AIDS prevention messages they present to people attending mosque.

The project may also want to consider revising its HIV/AIDS education curriculum and working with the imams to address the overall low perception of HIV/AIDS risk, as well as the differences in perceived risk in monogamous and polygynous risk clusters. The project could address the possible underestimation

of risk by members of monogamous risk clusters by encouraging discussion during HIV/AIDS educator training sessions about the reasons for changes in marital unions, possible ways to mediate “marital instability,” and by emphasizing the risks associated with partner change.

The high level of perceived risk (moderate/great) among members of polygynous risk clusters may be related to the low level of communication and cooperation among co-wives as well as the norm of keeping co-wives in separate residences. Working with the imams and community members, the project might address this by developing a curriculum module designed to stimulate discussion about why polygyny is viewed as a risk factor and ways that members of polygynous unions can work together to increase communication and reduce their risk.

The project may also want to address the issue of mistrust that emerged as a major reason why polygyny is considered a risk factor for HIV/AIDS. Women were identified as the source of the problem and men were largely missing from the assignment of blame. The absence of men from the discourse of blame highlights the need to develop a means of addressing joint responsibility of men as well as women in HIV transmission and prevention. Encouraging men to take responsibility and encouraging open discussion of the responsibility for HIV/AIDS risk at the community level and in training sessions are possible strategies that the project could adopt.

As previously noted, the FAEPTI project encourages open communication among spouses within marital unions yet, as shown in this study, a number of

obstacles stand in the way of achieving that goal. In light of this, the project may also want to consider revising its curriculum to emphasize increased communication among *all* members of marital unions (husbands and wives as well as co-wives). The low level of agreement among spouses in risk clusters on self-assessed HIV/AIDS risk was likely related to low levels of communication about risk-related behaviors within marital unions. Low levels of communication, in turn, may contribute to an under or overestimation of risk as well as a decreased likelihood that risk reduction strategies will be discussed, much less implemented.

As in other studies, condom use is associated with outside partners and it is very difficult for marital partners (particularly women) to raise the issue of condom use as a means of HIV/AIDS prevention with their husbands. The project may want to consider developing ways to facilitate open discussion of the calculus of risk that women consider in weighing whether to suggest condom use to their husbands (i.e., being accused of infidelity or being dispossessed). Moreover, the project may also want to re-emphasize that condom use within marriage is a sign of caring for one's spouse as well as an act of mutual responsibility that will enable marital partners to reduce their risk and contribute to the well-being of all members of the marital union and their children (through reducing the chance that one or more marital partners will be infected with HIV/AIDS and eventually die). Further, the fact that more women than men mentioned being faithful as a means of avoiding HIV infection suggests that the project may want to reinforce that prevention message for men.

Finally, the importance of income generating activities (IGAs) for women as a means of economic empowerment contributing to risk reduction and the project's emphasis on girls' education needs to be recognized and reinforced. Study participants identified the initiation of women's IGAs in response to the project's teachings as a key factor in reducing women's HIV/AIDS risk. Given the challenges identified by women in the villages furthest from the trading center in benefiting from their IGAs (e.g., few opportunities to market their produce or handicrafts and challenges in organizing and sustaining group IGAs), the project may want to hold a workshop with these women (perhaps in association with FINCA or other microcredit organizations) aimed at addressing their capacity building needs. Lastly, women's low level of education is associated not only with fewer income sources, but also with fewer sources of AIDS information, a lower level of knowledge about condoms and condom use, and lower levels of knowledge about HIV transmission and prevention than men. This highlights the continued importance of the project's emphasis on parents keeping their girls in school.

Limitations of the Study

This study has some limitations, including the cross-sectional research design, which precludes an analysis of change over time. The generalizability of the findings is also somewhat limited. The study sample included rural Basoga Muslims who had been reached by an intensive faith-based HIV/AIDS education and prevention program. While the findings are probably generalizable to other

rural Basoga Muslims, my findings show that the way gender is done is affected not only by religion but also by ethnicity. Indeed, the findings revealed that there was often a gap between the ideal of gender set forth in Islam and the reality as it is shaped by culture and manifested at the local level. Variations in the way gender is done across religions and ethnic groups may limit the generalizability of the findings. Differences in the way that gender is done within urban and rural areas may also limit the findings. A further limitation is that while this study provides a great deal of contextual information about the various meanings of power and differences in the types of power generally attributed to and used by women and men, the survey instrument did not include specific items to measure gender power dynamics within marital unions.

Suggestions for Future Research

The findings from this study suggest that researchers studying HIV/AIDS risk and risk reduction within marital unions in Sub-Saharan Africa should move beyond the level of the dyad in their research design and analyses. Moreover, the risk cluster approach provides an expanded framework for HIV/AIDS education and prevention programs to address the realities of HIV/AIDS risk and risk reduction within marital unions. Recognizing that the perception and embodiment of risk occurs at a level beyond the dyad—particularly for women in polygynous unions—provides an opportunity for designing HIV/AIDS education and prevention programs that incorporate this recognition into intervention efforts.

While the network aspect of polygynous unions emerged as an analytical theme in this dissertation, I did not formally examine social and sexual networks. The results and methods of recent studies on social and sexual networking (Bernardi 2002; Bühler and Kohler 2003; Smith 2003; Morris and Kretzchmar 2000, 1995; Ssengonzi et al. 1999; Orubuloye 1997; Pickering et al. 1997; Orubuloye, Caldwell, and Caldwell 1994a, 1994b; Obbo 1993; Serwadda et al. 1992; Orubuloye, Caldwell, and Caldwell 1991) provide a framework for formally exploring the role of social and sexual networks in HIV/AIDS risk perception and risk reduction behaviors within risk clusters during future research. Ssengonzi and his colleagues' (1999) framework of spatially concordant (living in the same location) and spatially discordant (living in separate locations) partnerships will be especially useful for further investigating the possible relationship between increased risk perception in polygynous risk clusters and the practice of keeping co-wives in separate (spatially discordant) residences.

Finally, my findings also document the efforts of an intensive-faith based HIV/AIDS education and prevention program to address gender-based inequalities that contribute to women's increased HIV/AIDS risk. This area of research may be of interest to other researchers in the field of HIV/AIDS education and prevention, particularly in light of recent studies showing the mixed effects of religion on HIV/AIDS risk and risk reduction (Takyi 2003; Lagarde et al. 2000; Spira et al. 2000). An aspect of future research, which I hope to conduct in collaboration with the Islamic Medical Association of Uganda, will explore the

relationship between the intensity of religious beliefs, preventative behaviors, and perceived HIV/AIDS risk.

NOTES

¹ Uganda's success is also attributable to a strong commitment at the national level to AIDS education and prevention as well as to the importance of "locally driven community-based approaches to facilitating behavior change." Uganda also adopted a multi-sectoral approach to HIV/AIDS education and prevention and involved religious leaders in prevention efforts (USAID 2002: 8).

APPENDIX A

1994-1995 Focus Group Guidelines

NB: Each of the questions was probed for aspects of gender and economic power relations, if appropriate. Women, men, and youth were all asked about their own and the other groups.

A. Questions to assess participants' views on the scope of HIV/AIDS and availability of AIDS education and prevention-related resources in their communities

1. Do you think that AIDS is a problem in your community?
2. How much of a problem?
3. Why is AIDS a problem?
4. Do you know many people with AIDS?
5. Before the FAWS or imams visited, did you think AIDS was a problem?
6. Are there other projects in the community to fight AIDS?
7. Where can people in the community get help if they have someone with AIDS in their family? What can they do?
8. Who can people in the community talk to about AIDS?
9. Whom do you feel comfortable talking with if you want to learn more or are worried about AIDS?

B. Questions to assesses people's risk perceptions

1. What kinds of things put women/men/youth at risk for AIDS in your community?
2. Who is most impacted by AIDS? Women, men, the youth, or everyone? Why?
3. What puts women/men/youth at higher risk?
4. Is polygyny a risk factor for AIDS? Why?
5. Why do women/men go outside marriage?
6. Do you think that women/men/youth are worried about getting infected with HIV?
7. If they aren't worried, when do they start worrying?

C. Questions to assess people's attitudes towards prevention

1. What can women/men/youth do to prevent AIDS?
2. Are women/men/youth able to reduce their risk of AIDS? Why or why not?
3. What are some of the reasons that people might find it hard to protect themselves from AIDS?
4. What is the best way to prevent AIDS?

5. Why would someone want to use condoms?
6. Do women/men use condoms mostly inside or outside marriage?
7. What does a wife/husband think if their spouse introduces a condom into a marriage?
8. Do women buy condoms?
9. What do you think when you see a woman with a condom in her handbag?
10. Do you think other community members feel the same way? Why or why not?
11. What can the community do to fight AIDS?

D. Questions to assess participants' responses to the project

1. What did you think when the FAWS first visited your homes?
2. Why did you think they were visiting?
3. How did the FAWs teach you?
4. What did they teach you?

E. Question requesting questions

1. Do you have any questions or concerns that you would like to ask or discuss?

APPENDIX B

1997 English Cover Letter

Greetings. My name is Teresa Swezey and I am from Michigan State University in the United States of America. I am conducting research here in Uganda regarding AIDS prevention behaviors. I am particularly interested in how you feel about the problem of AIDS and about people's ability to protect themselves from getting AIDS.

I am asking you to participate in the focus group or interview today in order to try to learn more about the problem of AIDS and its transmission in Uganda. Your participation today should involve about an hour of your time. What you will be able to tell me will help me to more fully understand the problems that you and others may be encountering in your life, in living with AIDS in Uganda.

If after talking with me today, you have any questions concerning this research, or if you would just like to talk with someone further about the things that we talked about today, I would be happy to meet with you again to answer any questions that you may have. You may also contact the IMAU staff, who will be happy to talk with you as well. Both IMAU and I can be contacted at the address listed below.

I want to thank you for agreeing to talk with me today. Your input is very important to our understanding of people's experiences with living with AIDS.

Respectfully,

**Teresa Swezey
Ndala [pseudonym] Trading Center**

**NB: Islamic Medical Association of Uganda's address in Kampala:
Saidina Abukabar Hospital (along Bakuli-Nakulabye road)**

APPENDIX C

1997 English Consent Form

Before I agree to be a part of this study, I understand that I should think about each of the following points. If I understand and accept them, then I will agree to participate in this research.

- 1. My participation in this research is completely voluntary.**
- 2. If I decided not to take part in this research, it will not affect my relationship with the IMAU project.**
- 3. If I have any questions or concerns over the research being conducted, or my involvement with the research, or about AIDS in general, I may contact the researcher or the IMAU at the address on the letter that will be given to me today.**
- 4. What I say during the interview or focus group will be kept completely confidential and my responses will not be linked with my name in any way.**
- 5. I may decide not to participate in the research at any time, even after the focus group or interview has begun.**
- 6. Once the interview or focus group has begun, I can decide that I do not want to answer any questions that I might be shy about answering.**
- 7. My participation will involve about an hour of my time today.**
- 8. I will not receive payment of any kind for my participation in this research.**

I have understood and accept each of the above points.

**SIGNATURE:
MALE OR FEMALE:**

**DATE:
AGE:**

**TO BE COMPLETED BY PROJECT STAFF:
CENSUS HOUSEHOLD NUMBER:**

LOCATOR HOUSEHOLD NUMBER:

APPENDIX D

1997 Lusoga Cover Letter

Mbalamwisa inho,

Amaina gange ninze Teresa Swezey. Nvira mu Michigan State University eyo mu America. Ndhikola okunonekereza kubulwaire bwa Siriimu n'engeri yokubwewala mu ghano mu Uganda. Nsingiria erala kwenda kutegeera engeri gyemuwuliramu kigemegana nekizibu kino ekya Siriimu, n'obusobozi bw'abantu okwekinga obutafuna Siriimu.

Ndikusaba wenigire mu kibina oba mubyenja okubuza olwa leero, mweyongere okwega kubigemagana kukizibu kino ekya Siriimu n'engeri gyagemamu abantu oba gyasasanamu mu Uganda. Okwenigiramukwo olwaleero kwidha kutwala sawa ndala oba ibiri kubiseera byo. Byonasobola okunkobera bidha kunamba okwongerera okutegeera ebizibu ewe nibaino byemulikwagana mubulamu bwaimwe, mu kulwanagana ni Siriimu mu Uganda.

Bwonomala okwogeera ninze olwaleero nga oli n'ebibuzo ebigemagana ku kunonenkereza kuno oba nga oyenda okweyongerera okwogeraku kubintu byetwoegeire ku leero, ndakusanuka okwaganana niwe omulundi ogundi, nkwiremu ebibuzo byonaba nabyo. Oyinza n'okwebuza kubantu abakola mukitongole kya IMAU (Islamic Medical Association of Uganda). Nze awalala ni IMAU osobola okututusaku obubaka bwonabwona nga okozesa endagiriro eyo eri ghansi.

Nenda okukwebaza olwo kwikiriza okwogera ninze olwa leero. Byotukobeire bikuulu inho kubanga tweyongeire okutegeera engeri abantu gyebabawo n'obulwaire buno obwa Siriimu.

Abaisamu ekitibwa,

**Teresa Swezey
Ndala Trading Center [pseudynom]**

**NB: Islamic Medical Association of Uganda's address in Kampala
Saidina Abukabar Hospital (along Bakuli-Nakulabye road)**

APPENDIX E

1997 Lusoga Consent Form

Nga nkaali kwikiriza kwegaita ku kusoma kuno, ntegeire nti ntekwa okulowooza ku bulimutwe gwebikulu nga bwebiraganwaku. Bwemba nga ntegeire era nga mbikiriza, awondhakuba nga ndikiriza okwetaba mu kunonhereza kuno.

1. Okwebata kwange mu kunonhereza kuno kwonakwona kwa kyendheire.
2. Buti bwemba nga nsazzewo obutegaita mu kunonhereza kuno, tikidha kutabula knolagana yange ni IMAU project.
3. Bwemba nga n'ebibuzo oba obwelalikirivu mukononhereza okulikukolebwa, oba kukwetaba kwange mu kunonhereza kuno, oba Siriimu okutwaliza awalala, nninza okwebuzaku kwoyo alikukola kukunonhereza kuno oba IMAU ku ndagiriro erimu egya okumpebwa ola leero.
4. Byenakoba mu kukuzibwa oba mulukungana bidha kukumibwa nga byakyama era n'okwiramumu tikwidha kwefananiriza liina lyange mu'negri yonayona.
5. Nhinza okusalawo obutetba mu kunonhereza kuno esaawa yonayona wairenga olukungaana oba okubuzibwa kunabanga kutandise.
6. Kasitanga ebibuuzo oba olukungaana lunatandhika, nhinza okusalawo nti tiyenda kwiramumu bibuuzo byonabyona bwempuliranga ngemebwa enonhi okwiramumu.
7. Okutabagana kwange kwidfakutwaala entangama ya saawa ndhala oba ibiri kubiseera byange leero.
8. Tidha kufuna mpeera buli mutwe gwe ebikula nga bwebighereibwa eitale.

Ntegeire era naikiriza mutwe gwe ebibukulu nga bwebighereibwa eitale.

OMUKONO GWO:
MALE OR FEMALE:

DATE:
AGE:

TO BE COMPLETED BY INTERVIEWERS:

CENSUS HOUSEHOLD NUMBER (CHHNUM):
LOCATOR HOUSEHOLD NUMBER (LHHNUM):

APPENDIX F Map of Uganda

Map scale: 1 cm = 66 km
Source: NCQIA SB UNEP-GRID Sioux Falls



APPENDIX G

1997 Data Form, Mosque Census Update

- 1. Date?**
- 2. Name of head of household?**
- 3. Who was interviewed?**
 - a. male head of household:**
 - b. wife/ves:**
 - c. both husband and wife/ves:**
 - d. female head of household:**
 - e. other person (who):**
- 4. Location of Home?**
 - a. Block?**
- 5. Rent or own?**
- 6. Length of time at present location?**
- 7. Married?**
- 8. Length of marriage?**
- 9. Type of marriage?**
- 10. Number of wives/co-wives?**
- 11. Wives Muslim or non-Muslim?**
- 12. Number of wives living at this location?**
- 13. Any other homes?**
 - a. Location/s?**

14. Sources of income?
 - a. Primary way husband gets money?
 - b. Secondary way husband gets money?
 - c. Primary way wife/ves get money?
 - d. Secondary way wife/ves get money?
15. Household demographics:
 - a. number of women?
 - b. number of men?
 - c. number of girls (under age 15)?
 - d. number of boys (under age 15)?
16. Contact with the FAEPTI Project
 - a. Heard of FAEPTI?
 - b. Visited by FAWS?
 - c. Number of visits?
 - d. Date (approximately) of last visit?

APPENDIX H

1997 Focus Group Guidelines

NOTE: Items listed in the charts are for illustrative purposes in this appendix and are drawn from data generated during the focus groups.

HOUSEHOLD DEFINITIONAL QUESTIONS

1. How are households defined here?

- **PROBE:** What are the differences between household, house, and family?

2. What are some of the different kinds of households?

(PROMPT: For example, How does a household that's just starting out with a young married couple [no other wives yet], and maybe a few children who are not yet in school, differ from another household with a middle-aged man, several wives, and school age children?)

- **PROBES** (Try to get about three or so ideal types/categories of households):
 - What if a man has two wives in a compound, each with their own house? Does that mean that they are in the same household?
 - What if a man has two wives and they are living in two different places? Does that mean that they are one household or two?
 - Are there ever households made up of single men and/or women? What do you call that kind of household?
 - If someone owns a compound and has grown up men and their families living in several houses on that compound then is that one household? Why?

3. Who counts as a member of a household?

- **PROBES:**
 - Does a household equal sleeping in the same house, eating together or both? What about households where some of the children spend the night at another house (say their grandparents')? Whose household do they belong to?

- How long does someone have to be in the household to count as a member?
- Do people who are in boarding schools count as household members?

4. How is head of household defined?

- **PROBES:**

- Can a woman ever head a household? In which situations? What do you call the head of that household?
- Refer to the above household scenario and ask whether a man with two wives in two different places is head of both households.
- If a man is rarely at home and the woman is the one who makes the daily decisions about the household, then who is the head of the household?
- What if a woman buys some land, builds a house of her own and later on, a man comes and takes her as a second wife. Then who is the head of that household?

HOUSEHOLD MONEY MATTERS

Now we would like to ask you about how women and men interact within and between households.

1. Who decides how money is earned and spent and under what circumstances?

- **PROBE:** Refer to the earlier types of households

- Do people within a household each control their own money or do they pool their money all of the time/sometimes/never?
- Under what circumstances do they have separate or shared money?
- If there are three wives in the same house and their husband leaves them a certain amount of money for the household, how will they arrange their finances?
- Do co-wives living in separate/the same household ever cooperate? In what circumstances?

- For example, if one of the wives has a very sick child but doesn't have any money and the other co-wife has some money can the first co-wife ask the other one for money? Will the one who is asked give the money? Why or why not?

ECONOMIC ACTIVITIES:

1st CHART

1. What are the different ways that women, men, girls, and boys get money in your community?

PROBE: Ask them to list the way that each social category gets money and make lists

Make a chart that looks like this:

ACTIVITIES	WHO DOES ACTIVITY?	WHO GETS MONEY?	WHO CONTROLS MONEY?
growing coffee	women and kids	men	men
mat making	women	women	women

2nd CHART

1. Ask which crops are grown in the community, who has primary responsibility, and who helps in the garden (ask for specifics re: women, men, girls and boys)

CROP NAME	CROP TYPE	PRIMARY RESPONSIBILITY	WHO HELPS?
matooke	B	W	B, G
coffee	C	M	W, G, B

NB: F = food crop; FS = food for sale; C = cash crop; B = both; A = all; W = women, G = girls; B = boys;

3rd CHART

1. Based on the above chart, ask the following questions for each of the crops: Who gets the money? Who decides how it is spent? Husband spends it on? Wife/ves spends it on?

Make a chart that looks like this:

CROP NAME	WHO GETS MONEY?	WHO DECIDES HOW IT'S SPENT?	HUSBAND SPENDS ON?	WIFE/VES SPEND ON?
cabbage	W, M	W with M's consent	other wives' needs	school fees & household needs

GENDER DIVISION OF LABOR:

4th CHART

1. Who is most responsible for each of these activities related to growing, processing, harvesting, and marketing crops and who helps?

Make a chart that looks like this and use abbreviations, above:

ACTIVITIES	WHO'S MOST RESPONSIBLE?	WHO HELPS?
clearing bush		
land preparation		
planting		
watering		
weeding/pruning		
applying fertilizer		
harvesting		
carrying crops from garden to home		
sorting and grading		
seed selection and preservation		
preparing crops to eat/sell		
storage		
transporting crops to market		
marketing (who transacts sale)		

COFFEE BEAN EXERCISE (Allocation of effort to agricultural production):

5th CHART

1. Count out and distribute 10 coffee beans to everyone in the group. Explain that each coffee bean represents a certain amount of effort that women and men (husbands and wives) in their households contribute to the production of a crop. If 10 coffee beans equal the maximum amount of effort that goes into producing a crop, from clearing the bush to either selling or storing it, how many coffee beans does the husband in the household contribute and how many does the wife/ves? (In the case of unmarried participants, explain that it is okay for them to put down all the beans if they want on their side).

Demonstrate this game by starting with one of the crops that is grown locally, such as maize. Role-play as you assign a certain number of coffee beans to the husband and wife. Explain why you are giving the man so many versus the woman.

Try to have the focus group participants in polygynous marriages sit next to each other so we can keep track of differences by polygyny/non-polygyny.

Use the list of crops that they came up with and write down the number of coffee beans given for women and men for each crop on a chart.

HOUSEHOLD NEEDS:

6th CHART

1. Make a chart with women on one side and men on the other. Ask participants to first identify what women view as household needs and then ask them to list what men view as household needs. After they've finished listing one side of the chart, cover it up while they are listing items for the other side of the chart.

WOMEN	MEN
match box	land
soap	another wife
school fees	school fees
clothes for the kids	sugar
jewelry	radio cassette recorder

APPENDIX I

1997 Survey Sample Stratification and Combinations

Distance of Villages from Trading Center	Degree of Concentration	Village Size	Mosque Area	Village/s in Stratum	Participated in Pre-test or Survey?
NN	C	S	Ina & Itaanu	Ina & Itaanu	Survey: Ina & Itaanu
NN	C	NS			
NN	NC	S			
NN	NC	NS	Ndala	Ibiri, Mwenda & Ikumun'andala	Survey: Ibiri
N	C	S	Ndala	Munana	Pre-test: Munana
N	C	NS	Ndala	Ikumi & Musanvu	Pre-test: Musanvu Survey: Ikumi
N	NC	S			
N	NC	NS	Ndala	Isatu & Mukaaga	Pre-test: Mukaaga Survey: Isatu

NB: The notations NN, N, C, NC, S, NS indicate: not near, near, concentrated, not concentrated, small, not small, respectively; bold font indicates that the stratum does not exist in the parish.

- Distance from the trading center (near/not near):** Villages classified as near are approximately a mile or less from the trading center. Villages classified as not near are anywhere from a mile to three or four miles from the trading center.
- Degree of concentration of Muslim-headed households (concentrated/not concentrated):** Villages classified as concentrated are characterized by Muslim-headed households either adjacent to each other in clusters or at a very short walk (five to eight minutes) between clusters. Villages classified as not concentrated are characterized by Muslim-headed households at a distance of a 5-20 minute bicycle ride between some households.
- Village size (small/not small):** Based on local informants', interviewers', and this researcher's assessment of geographic size.

APPENDIX J

1997 In-depth Interview Guidelines

NOTE: These questions were modified based on whether a husband or wife was interviewed and whether they were in currently monogamous or polygynous unions.

1. **BACKGROUND/HISTORY:** We'd like to know more about your life history, or the story of your life. Can you tell us about your life up to this point?

PROBES:

- Where are you from in Uganda?
 - From Busoga or somewhere else?
- Can you tell me something about the family that you grew up in?
 - How many children (girls/boys)?
 - What rank were you in the family?
 - Did you come from a polygynous family?
- How far did you go in school?
 - What subjects did you like?
 - What were your educational or job/work goals?
 - If you dropped out, when and why?
- What did you do between stopping school and getting married?
 - Stayed at home?
 - How long was it between stopping school and getting married?
 - Did you have a job or a way to earn money?
 - If so, did you control the money that you earned?
 - What did you spend it on?

MARRIAGE PROBES:

- How did you meet your husband?
- How old were you when you got married?
- Had you ever been married before?
- What types of marriage arrangements?
 - Parents' reaction?
 - Introduction and brideprice?
 - Pre-marital HIV testing? Conducted and concerns?
- What do you think about polygyny?
 - Is it a 'good thing,' a 'bad thing,' why?
 - If marrying into an already polygynous family:
 - Why did you marry into a polygynous family?
 - What did you know about the family that you were marrying into?
 - What were your co-wife's reactions when you arrived?
 - Aside from the wives who were there when you married into the family, did your husband have any wives before them?

- What happened to those wives? Did they leave? If so, why?
- If marrying into a currently monogamous union:
 - Do you know if our husband had any wives before you married him?
 - If so, what happened to those wives? Did they leave? If so, why?
- Has your husband added another wife or wives to your family since you married him?
 - Does your husband discuss with you and/or your co-wives about his plans to bring home another wife?
 - What are your feelings about his bringing more wives into the family?

2. FAMILY PLANNING DECISIONS:

- How many children do you have now? (girls/boys)
- How many children do you want?
 - How many children does your husband want?
 - If you and your husband ever had a disagreement over how many children to have, what would you do?
 - How would your husband respond if he wanted more children and you said you wanted to wait a while and space your children?
- Do you use family planning?
 - If yes, which method and why? If not, why not?
 - If yes, does your husband know that you are using it? If not, can you say something about why he doesn't know?
- If from a polygynous family: in deciding about the number of children that you want, do you think about the number of children that your co-wives have produced?
 - If, in three years, each of your co-wives has two or three children, but you only have one, what will happen?
 - If, in three years, you have two or three children, but your co-wives haven't produced any children, what will happen? (Designed to get at the possible influence of co-wives on women's fertility behaviors, the ideal number of children, and whether a new co-wife might be added to the family.)

3. GENDER AND ECONOMIC POWER RELATIONS WITHIN HOUSEHOLDS:

- What are the main sources of income in your household?
- Co-wife cooperation and/or conflict:
 - Do you all dig in the same garden?
 - If separate gardens, why?

- Do you work together in the gardens, or is each wife independent?
- In what circumstances do/would you help each other?
- Is each of you responsible for growing food and cash crops for the family's use?
- Who decides what's planted in the gardens?
 - Source of inputs?
 - If there is a disagreement, who decides what to plant?
 - What crops did YOU grow last growing season? How was that decided?
- In your household who is responsible for each stage of the crop production process—from clearing the land to either selling or storing the crop?
 - Does it vary by crop type?
- In your household how do you decide on the allocation of responsibilities such as fetching water, childcare, cooking, compound maintenance, etc.?
- Who takes care of marketing the crops?
 - Is everyone responsible for selling their own?
 - Who handles transport, selling, etc.?
 - Does it vary by crop type?
- Who actually gets the money?
 - If you sell crops from your own garden, do you keep the money or give it to your husband?
 - What do you do with the money that you get from selling crops?
 - What do your husband and/or co-wives do with their money?
 - How about your co-wife/ves?
- Do you pool your money or keep separate accounts?
- How do you decide on allocating money for household things that everyone uses such as salt, sugar, matchbox, etc.?

4. HIV/AIDS RISK AND RISK REDUCTION:

- What are some of the things that put people here in your community at risk for AIDS?
 - What puts women at risk?
 - What do you see as the most important risk factor for women?
 - What are some other reasons why women are at risk?
 - What puts men at risk?
 - What do you see as the most important risk factor for men?
 - What are some other reasons why men are at risk?
- What can people do to reduce their risk?
 - What can women do to reduce their risk?
 - What can men do to reduce their risk?

- **Were you and/or your husband tested before you were married? Why or why not?**
 - **Are you concerned about your own risk of AIDS? Why or why not?**
 - **What is your major concern?**
 - **Do you feel that you can control your risk of HIV infection? Why or why not?**

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