LIVING WITH GLOBALIZATION:
THE INTERSECTION OF INTIMATE PARTNER VIOLENCE AND HIV
TREATMENT IN UGANDA

by

MARGARET SUSAN WINCHESTER

Submitted in partial fulfillment of the requirements
For the degree of Doctor of Philosophy

Department of Anthropology
CASE WESTERN RESERVE UNIVERSITY

January 2011
We hereby approve the thesis/dissertation of

Margaret Susan Winchester

candidate for the _______ Ph.D. ________ degree *.

(signed)  Janet W. McGrath

(Chair of the committee)

Jill Korbin

Eileen Anderson-Fye

Patricia Marshall

(date) 05 August 2010

*We also certify that written approval has been obtained for any proprietary material contained therein.
In loving memory of JPW
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>4</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>5</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>6</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>8</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>9</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td></td>
</tr>
<tr>
<td>1.1 Framing the subject</td>
<td>11</td>
</tr>
<tr>
<td>1.2 Problem statement/ objectives</td>
<td>11</td>
</tr>
<tr>
<td>1.3 Significance</td>
<td>14</td>
</tr>
<tr>
<td>1.4 Chapter Overview</td>
<td>16</td>
</tr>
<tr>
<td>CHAPTER 2: BACKGROUND/ LITERATURE REVIEW</td>
<td></td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>18</td>
</tr>
<tr>
<td>2.2 Defining globalization</td>
<td>19</td>
</tr>
<tr>
<td>2.3 Theorizing globalization and HIV</td>
<td>23</td>
</tr>
<tr>
<td>2.4 Domestic violence research</td>
<td>37</td>
</tr>
<tr>
<td>2.5 Intersection of HIV and domestic violence</td>
<td>56</td>
</tr>
<tr>
<td>CHAPTER 3: THE UGANDAN CONTEXT</td>
<td></td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>61</td>
</tr>
<tr>
<td>3.2 Contextualizing research in Uganda</td>
<td>62</td>
</tr>
<tr>
<td>3.3 HIV in Uganda</td>
<td>77</td>
</tr>
<tr>
<td>3.4 Domestic violence in East Africa</td>
<td>83</td>
</tr>
<tr>
<td>3.5 Fieldsite 1: Urban Kampala</td>
<td>86</td>
</tr>
<tr>
<td>3.6 Fieldsite 2: Peri-urban Mbarara</td>
<td>87</td>
</tr>
<tr>
<td>3.7 Summary</td>
<td>88</td>
</tr>
<tr>
<td>CHAPTER 4: METHODS</td>
<td></td>
</tr>
<tr>
<td>4.1 Overview</td>
<td>89</td>
</tr>
<tr>
<td>4.2 Sampling procedures</td>
<td>90</td>
</tr>
<tr>
<td>4.3 Data gathering procedures</td>
<td>94</td>
</tr>
<tr>
<td>4.4 Data Analysis procedures</td>
<td>97</td>
</tr>
<tr>
<td>4.5 Scope and Limitations</td>
<td>101</td>
</tr>
<tr>
<td>4.6 Ethical Considerations</td>
<td>102</td>
</tr>
<tr>
<td>CHAPTER 5: POLICY ENVIRONMENT</td>
<td></td>
</tr>
<tr>
<td>5.1 Overview</td>
<td>104</td>
</tr>
<tr>
<td>5.2 Current and pending policy in Uganda</td>
<td>105</td>
</tr>
<tr>
<td>5.3 Views on government</td>
<td>115</td>
</tr>
<tr>
<td>5.4 Summary</td>
<td>123</td>
</tr>
<tr>
<td>CHAPTER 6: SERVICE PROVISION</td>
<td></td>
</tr>
<tr>
<td>6.1 Overview</td>
<td>125</td>
</tr>
<tr>
<td>6.2 Medical providers</td>
<td>126</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

Table 1- Policy and service-related interviews by site and gender  
Table 2- Codes for narrative data  
Table 3- Demographic characteristics of clinic sample  
Table 4- Women’s health  
Table 5- Marriage Practices  
Table 6- Partner characteristics  
Table 7- Gender vignette responses  
Table 8- Acceptability of physical violence  
Table 9- Views on women’s ability to refuse sex  
Table 10- Overall perceptions of gender equality scale  
Table 11- Economic practices  
Table 12- Economic assessment of assets  
Table 13- Controlling behavior and verbal violence  
Table 14- Physical and sexual violence  
Table 15- Factors associated with types of violence and overall violence  
Table 16- Effects of violence  
Table 17- Responses to violence  
Table 18- Formal help seeking in response to violence
LIST OF FIGURES

Figure 1: WHO Typology of Violence 40
ACKNOWLEDGMENTS

Over the past six years, countless individuals and institutions have supported my work and inspired me in Cleveland and in Uganda. To all of them, mentioned here or not- I am unendingly grateful. This work was sponsored through a National Science Foundation Doctoral Dissertation Improvement Grant (DDIG#0823287) and write up was partially supported through the Richard B. Zdanis fellowship from Case Western Reserve University.

Firstly I thank all of the women in this study for their openness, understanding, and humor. I am honored to have been so welcomed so intimately into your lives and am truly inspired by your daily strength and resolve. My research assistants in the field, Sheila Irene Kisakye and Judith Namanya are both exemplary young researchers who gave me fresh insight, invaluable daily assistance, and challenged me with their own questions. I look forward to being colleagues in the future and thank you both for your patience.

To my committee members, Drs. Janet McGrath, Jill Korbin, Eileen Anderson-Fye and Patricia Marshall- thank you for your guidance, understanding, inspiration, and exemplary scholarship. Your own work and support motivates me in my own. In particular, Dr. Janet McGrath has served as an advisor, mentor, and strong support over the past six years.

In Uganda, the Center for Social Science Research (CeSSRA) team has acted as resources and supporters for the past several years. I am grateful to know all of you and honored to work with you. Dr. David Kaawa- Mafigiri, Dr. Charles Rwabukwali, Judith Birungi, Florence Namutiibwa, Amina Nalwoga,
George Ssendegye and Emily Kyarikuna- thank you all for your encouragement, your patience with my questions, and tireless work. Jenny Zabel in Cleveland has assisted in data analysis, and general organization- without which I would be lost. Thank you! To the patient and accommodating staff at the Joint Clinical Research Centre (Kampala), ISS Clinic (Mbarara), and the Center for Domestic Violence Prevention, thank you for your welcome and support.

I am grateful to all of my friends in Uganda who have over the past seven years welcomed me and helped me to build a home there. Particular thanks to Alex Q. Matovu, Phoebe Sullivan, and Alex Kintu for their friendship, insight, love, and support. I am grateful to my colleagues at Case Western Reserve University. My fellow graduate students are an inspiration and I am so lucky to have such supportive, brilliant, and exemplary colleagues and friends.

And lastly, thank you to the Winchesters (yes, all of you)- in particular my ceaselessly supportive and patient parents- for your strength, humor, love, and support.
LIST OF ABBREVIATIONS

ABC- Abstinence, Be Faithful, Condom use
AIDS- Acquired Immunodeficiency Syndrome
ARV- antiretroviral
CD4- T-lymphocyte bearing CD4+ receptor
CEDAW- Convention for the Elimination of All Forms of Discrimination against Women
CFPU- Child and Family Protection Unit
CHOGM- Commonwealth Heads of Government Meeting
CPS- Central Police Station
DV- domestic violence
EAISR- East African Institute for Social Research
HAART- highly active antiretroviral treatment
HIV- Human Immunodeficiency Virus
HRAF- Human Relations Area Files
IMF- International Monetary Fund
IPV- intimate partner violence
ISS- Immune Suppression Syndrome
JCRC- Joint Clinical Research Center
LC- local councilor
MUST- Mbarara University of Science and Technology
NGO- nongovernmental organization
NIECO- new international economic order
NRM- National Resistance Movement
PEPFAR- President's Emergency Plan for AIDS Relief
SAP- structural adjustment programs
STI- sexually transmitted infection
TASO- The AIDS Support Organization
TRIPS- Trade-related Intellectual Property Agreement
UDHS- Uganda Demographic and Health Survey
UNAIDS- Joint United Nations Programme on HIV and AIDS
VAW- violence against women
VCT- voluntary counseling and testing
VAAW- violence and abuse against women
WB- World Bank
WHO- World Health Organization
WTO- World Trade Organization
Living with Globalization: The Intersection of Intimate Partner Violence and HIV Infection in Uganda

Abstract

by

MARGARET SUSAN WINCHESTER

Intimate partner violence (IPV) and HIV treatment intersect as synergistic vulnerabilities for women. This study examines how women in two regions of Uganda live with and respond to both issues in the context of globalization, including the perspectives of policy makers, service providers, and HIV positive women. Women in Uganda have few formal means of dealing with IPV, and even where services are available, they may choose not to seek help or disrupt their relationships. Most women who seek help do so informally, through family or local and religious leaders. Providers also have limited ability to assist women because of a lack of resources and the limited legal sanctions available. Legal sanctions for responding to women’s needs are in transition, but currently limited in their effectiveness.

All of the women in this study are already living with HIV and enrolled in treatment. Those who face or have experienced violence are faced with another set of challenges. IPV frequently occurs in conjunction with economic difficulties, alcohol use, and polygamous marital practices within a home. Women only have legal rights for maintenance in formal marriages, but many are in informal or polygamous partnerships.
Women in this study are part of an emerging era of HIV, in which HIV can be lived with as a chronic disease. Globalization impacts their daily experiences through the availability of life-saving treatment. In this context women’s concerns are frequently outside the purview of health. They have a previously unknown luxury of being able to “not worry” on a daily basis about maintaining their health. Economic concerns are of the utmost importance and when women are deprived of resources from their partners in acts of economic violence they are more likely to seek assistance than when experiencing physical or sexual violence.

This work contributes to the anthropological literature on globalization and health, HIV, and IPV. Women’s experiences of both HIV and intimate partner violence in the Ugandan context are mitigated by global processes, local politics, service provision, cultural ideologies and interpersonal relationships.
CHAPTER 1: INTRODUCTION

1.1 Framing the subject

In an era of globalization and increased interconnectivity, health and healthcare access and outcomes remain disparate across the globe. The perpetuation of these disparities highlights the need for focused studies of the local patterning of globally created and locally experienced inequities. HIV/AIDS has reached pandemic proportions, spread across fault lines of social inequalities and poverty and, increasingly, women have been disproportionately affected and infected (eg. Farmer et al. 1996; Gupta and Weiss 2009; Dilger 2009). This study examines one facet of women’s experiences living with HIV, the role that intimate partner violence has played in how women experience care and seek help, and in their overall approaches to survival. Contextualized within Uganda’s policy environment and available services for women, this study shows how women are viewed as patients, clients, and subjects, in addition to presenting the women’s voices themselves. It is informed by and contributes to the medical anthropological literature on globalization and health.

1.2 Problem Statement/ Objectives

This research explores women’s experiences of living with HIV in two regions of Uganda. Women’s double vulnerability in maintaining HIV treatment and experiences of intimate partner violence (IPV) is explored through multiple perspectives- those of women themselves, policy makers, and formal and informal service providers. The specific objectives of this study are:
Objective 1: To examine the role of Ugandan government policy and government representatives in shaping the experience of women with IPV and HIV, through archival research and in-depth interviews with government representatives at the local, district, and Parliament level to address the following questions:

a. What are the written policies of the Ugandan government which address issues surrounding women affected by IPV and HIV and how are these related to the global discourse on the same subject?

b. What are the perceived effects of this legislation on women’s experiences of IPV and HIV, focusing on the construction of gender roles and potential responses to violence?

c. How do these perspectives differ by level of representation and between Kampala and Mbarara?

Objective 2: To examine the role of medical, legal, and social service providers in shaping the experience of women with HIV and IPV. In-depth interviews with medical, legal, and social service providers regarding their understanding of broader policies and goals and practices in service implementation were done to address the following questions:

a. What are the services available for HIV positive women being affected by IPV and how do those relate to national policy and global discourse?
b. What are service providers’ perspectives of women’s experiences of HIV and IPV, in terms of prioritization in service delivery and potential responses available for women?

c. How do service delivery, availability, and utilization differ between Kampala and Mbarara?

Objective 3: To understand women’s experiences of living with both IPV and HIV. HIV positive women were surveyed about their health, relationships, and experiences of violence. Those who also reported intimate partner violence were interviewed again, focusing on illness narratives and in-depth interviews to learn about priorities in illness management, cultural values about sex, marriage, and gender roles, and perspectives on available resources and policy to address the following questions:

a. What are factors associated with the presence or absence of violence among HIV infected women?

b. What services and policies do women view as influential in the experience of IPV and HIV, in determining their responses to violence and its effects on accessing ARV treatment?

c. How do the prevalence of IPV and perspectives on gender roles differ between Kampala and Mbarara among HIV positive women?

This research uses the concept of intimate partner violence (IPV) as a theoretical construct; this phrase is inclusive of multiple types of violence and various types of marital and partnership arrangements. In everyday Ugandan
discourse, the phrase domestic violence is most commonly used- and so as a locally salient and understood concept, ‘domestic violence’ is used in presentation of these data. A more comprehensive explanation of terminology is explored in Chapter 2.

A multi-sited design was used in this research for two primary reasons. Firstly, data collected during pilot work in 2006 indicated a perceived difference in the prevalence of violence and access to resources between rural and urban Uganda. The two sites have different ethnic groups and rural residents suggested that urban areas were more prone to intimate partner violence due to rapid social change and conflicts in gender roles, while urban residents thought that rural tribes, especially in western Uganda, culturally were more prone to violence as part of the maintenance of traditional gender roles. The two sites selected also have vastly different access to resources, particularly social services which address intimate partner violence. Secondly, multi-sited ethnography is one manifestation of global-minded anthropology, allowing for the assessment of both the role of location in experience and differential exposures to international discourses (see Chapter 2).

1.3 Significance

This research contributes to anthropological theory in two ways. Firstly, a layered approach of studying stakeholders and policy in conjunction with local experience furthers the theorization of globalization, building connections between the local and the global and potentially reconceptualizing hierarchical models of power and influence (Ferguson 2006). This is complementary to, but
qualitatively different in scope from, traditional political economic and critical approaches within medical anthropology because of the integration of levels of interrogation (Lee and Zwi 2003; Schoepf 2001). The voices of multiple stakeholders illustrate the way in which global processes are experienced and interpreted across levels. In this way, an anthropological approach enhances the contextualization of experience and women’s vulnerability. Experiences of vulnerability for women in Uganda are both place-based and constructed as a result of broader sociocultural and political economic forces. A multi-sited approach within Uganda serves this same purpose, making findings more generalizable than a single location-specific study (Marcus 1998). The use of cross-culturally validated instrumentation to measure the acceptability of violence, the prevalence of IPV among HIV positive women, and their decision-making power in relationships likewise makes the findings comparable to other settings in which the surveys have been utilized (Dunkle et al. 2004; WHO 2005), therefore adding to this body of knowledge.

Secondly, an examination of the intersection of HIV and IPV in later stages of living with HIV broadens the current interdisciplinary literature on the subject, which focuses primarily on violence as a risk for HIV acquisition or the threat of violence as a barrier to testing and disclosure (Jewkes et al. 2006). In an era of gains in access to treatment and lengthened life expectancies for those living with HIV, understanding long-term illness experience and potential barriers to treatment for women is particularly salient (ibid.). Beyond the theoretical realm, the proposed research has potential implications in service provision and
screening for women receiving antiretroviral treatment. Women affected by IPV similarly stand to benefit from this work, as it is uniquely positioned to bridge levels of both policy and service implementation.

1.4 Chapter Overview

In this chapter, I have laid out the framework in which this study of women’s experiences of HIV and intimate partner violence was carried out. Chapter 2 contextualizes the research within anthropology, through the theoretical orientation of globalization, the literatures on HIV and intimate partner violence, and the overlap of these subjects as it has been studied thus far. The next chapter puts these topics into perspective in Uganda, as well as within the history of social science research in the region. Field methods, sampling, data collection and analysis are described in Chapter 4, along with a description of the two fieldsites. Chapters 5 and 6 describe the policy maker and service provider samples and their perspectives on women’s experiences and options. In Chapter 7, I introduce the large sample of women from the clinical interviews, their characteristics, their experiences of violence, and statistical results of the survey. Chapter 8 focuses on women’s narratives and the follow up phases of ethnographic interviewing with women on relationship stories, illness experiences, and help seeking behavior. In the discussion in Chapter 9, I tie the women’s stories to broader discussions of women’s vulnerabilities in contemporary anthropology and the global discourses on HIV and intimate
partner violence. Chapter 10 summarizes and concludes, with suggestions for the application of the research findings and potential ways forward.
CHAPTER 2: BACKGROUND/ LITERATURE REVIEW

2.1 Introduction

This research is informed by the theoretical literature on the anthropology of globalization and health. In recent years this body of literature has grown tremendously, encompassing many facets of health and the many forms of globalization. Outlined below are the concepts pertinent to this study, which also draws from and contributes to the literature on the anthropology of HIV and intimate partner violence. Each of these literatures has a history within the discipline as emerging research subjects and this chapter describes that evolution to the current body of literature. Finally, I examine the intersection of these two subjects as it has been approached by the social sciences, as well as public health and related disciplines.

Globalization can be a vague and catch-all term, describing an array of contemporary social processes. However, as it is explored below, globalization has direct consequences for individual health and the experience of health. HIV in particular is a global disease, fueled through the movement of individuals and has been dealt with on a global scale through prevention, treatment, and aid. Domestic violence is frequently the result of entrenched cultural ideologies, but the responses to domestic violence have been fueled through global women’s and human rights discourses. In Uganda, the intersection of these two vulnerabilities for women are experienced on an individual level, but in the context of broader social processes and the global movement of ideas, treatment, and policies.
2.2 Defining Globalization

The body of anthropological work examining the relationship between globalization and health has grown rapidly in recent years. The link between global policy and discourse and local illness experience remains contested, however, and has proven difficult to clearly identify. Broadly defined, the process of globalization refers to the intensification of interconnectivity (Beck 2000; Inda and Rosaldo 2002; Scholte 2005). In the realm of health, the utilization of globalization as a theory marks a paradigmatic shift away from development and post-war international health strategies (Banta 2001; Gardner and Lewis 1996; Keane 1998). Notions of globalization and crossing boundaries pose a potentially significant challenge to anthropologists to refrain from reifying and prioritizing national boundaries in their analysis, and to instead examine reconfigurations of power and their spheres of influence as experienced in daily living. Ferguson’s writings on Africa highlight previous ideas of assumed verticality of power—where the state is above other influential entities, such as the domestic sphere, or that of civil society (2006). Anthropological work giving weight to multiple levels of influence has the potential of reconfiguring/respatializing power dynamics as they are experienced on a local level. Monolithic methodologies that concentrate on only local people, whether through interviews or surveys, potentially overlook the relationship of power to experience. Experience in a global era is subject to a host of potential influences, and also individuals have the potential to impact their surroundings.
The proliferation of non-state modes of governance and non-national identities in places like Uganda are testament to the changing nature of nation states in the era of globalization. As Ferguson (2006) writes, “civil society” has come to be an important part of current African political life. These voluntary associations, including various nongovernmental organizations (NGOs) and faith-based organizations, have increased in both number and power over the past twenty years. Hence, these are an important consideration in women’s experiences.

Globalization theory in medical anthropology does not, as of yet, constitute a unified body of theory. Theoretically, considerations of globalization are similar to political economic and critical approaches of the past twenty years, yet represent a qualitative shift. Much of this is manifest in analysis, particularly considerations of the state. By conceptualizing the world as a set of flows (Appadurai 1996), global assemblages (Ong and Collier 2006), or zones of friction (Tsing 2004), anthropologists’ work reflects the messy reality of life in a global context.

Medical anthropologists working across various settings have adopted methods to complement the local-level expertise of traditional ethnography to incorporate broader social influences in the construction and experience of health (Friedman 2005; Marcus 1998; Stoller 1997). Gutierrez and Kendall highlight the relevant role of ethnography despite far-reaching international connections in even the most remote locations, “paradoxically, globalization spreads linkages widely over the globe but contributes to the dynamics of local concentration”
Methodological innovations have contributed to the rethinking and reconfiguration of past notions of power structures (Ferguson 2006), policy implications (Janes 2004; Justice 1986, 1999), and service impacts (Pfeiffer 2003) in the era of globalization. Multi-sited ethnography is one manifestation of global-minded anthropology, allowing for the assessment of both the role of location in experience and differential exposures to international discourses (Gupta and Ferguson 2002; Marcus 1998). The present study utilizes a multi-layered approach in interviewing stakeholders at the policy level, service provision level, and individuals suffering from HIV and IPV. Similar to Justice’s work on lay midwifery in Nepal (1986; 1999), the use of multiple stakeholders contributes to a holistic analysis of policy implementation and the points of potential impediments to successful service delivery.

Other contemporary anthropological scholarship in Africa makes an effort to bring Africa into the ongoing dialogue about globalization more broadly. Due to ongoing poor living conditions in Africa, countries there are not often used in illustrating the effects of globalization (Ferguson 2006). Likewise, the focus on the relationship of indigenous subsistence systems to world economy, trade and migrant labor done through Marxist and non-Marxist perspectives in the rest of anthropology has been less of a theme in Africa than other places (Scholte 2005; Rodney 1975). Ferguson uses the concept of “Africa” as a deliberately homogenized whole to show how Western scholars have constructed the continent as a vast Other (2006). With the grounding of years of fieldwork, he shows that the agency and cultural particularities in Africa are overshadowed by
“global” discourses of culture as universalizing, rather than pluralizing. The wealth of natural resources in Africa indicate it has an important role to play in global economic development, despite the fact that the benefits are not usually seen locally. Ferguson writes that the “flows” of capital in the global economy are more appropriately thought of as “skips” and “hops” in the African context, where different analytical tools are needed.

The sheer number of volumes written on the subject of globalization in recent years is testament to its contested nature and potentially far-reaching implications. The term globalization pervades academic and popular discourse, though its meaning is not always clear. Globalization in anthropology is not a new concept; the discipline has studied many forms of interconnection over its history. The roots of the current theoretical construction of globalization lie in post-World War II development and modernization theories. Over time, these theories have been questioned and have given way to dependency theories and critiques of development. Parallel to this transition is the shift from international health (rooted in a development paradigm) to global health (based on notions of globalization). Within medical anthropology in particular, the shift to globalization has been adopted by different theorists and may constitute its own theory, as it is being currently constructed. I will first outline five conceptualizations of globalization as a process, as well as their ramifications for health, followed by development and modernization theories as precursors to globalization, and finally summarize the uses of globalization theory within medical anthropology today, as it relates to IPV and HIV in Uganda.
2.3 Theorizing globalization and HIV

As many globalization theorists have written, globalization is a sometimes-elusive category and a slippery essence (Appadurai 1996; Scholte 2005). The discourse of globalization is far-reaching, even without a consensus in definition. In its broadest sense, globalization refers to the intensification of relationships and interconnections across the world in the contemporary era (Scholte 2005:60). However, the implications of this reach far beyond simple communication or economics. As Scholte writes, the following domains all manifest the consequences of globalization: communication, travel, production, markets, money, finance, organizations, military, ecology, law, and consciousness. While health is not written of as one of these domains, the others combine in a globalized construction of health and healthcare.

As a term, globalization was originally written of in the 1940s as an ambiguous concept of interconnection, but re-emerged in 1972 (credit is given to Modelski for coining the term in its current usage) to describe the growing impact of multinational corporations on economic relations within and among countries (Collins 2003). The nature of these connections are often seen as qualitatively different from the past, hence the new terminology. According to Giddens (1990), the major difference beginning in the late twentieth century has been the intensification of connectivity. People and goods now move at an unprecedented pace, making social relations global in nature, rather than localized or based on
Lee (2003) writes of the three dimensions of globalization as being spatial, temporal, and cognitive.

As Nguyen (2006, 2009) and others have written, globalization has had a profound impact on both the spread and experience of HIV/AIDS. This is true for those afflicted, as well as policy makers and funders. Unprecedented movement of people has led to both infection and access to resources in dealing with HIV/AIDS. Experience is susceptible to local nuances of resources and cultural beliefs and global policies of NGOs and multinational donors. Nguyen suggests that the competing interests of stakeholders across levels in the HIV/AIDS epidemic have created a new type of therapeutic citizen, one that is simultaneously aware of global discourses and attune to local survival.

In a review of four texts on globalization, Morton (2004) notes that one of the most common flaws in attempting to theorize globalization is the failure to differentiate process from state. Globalization as a process (what Morton calls explanans) is used to explain contemporary phenomena and is given agency and theoretical substance. This is in contrast to simply describing globalization as a state (explandum), which then makes globalization itself the outcome of other social processes- the explained, not the explainer. In light of Morton’s distinction, other texts on globalization fall into the two categories, with those describing a process more substantive in the construction of a “globalization theory” (Tsing 2000). Scholte (2005) gives an overview of five conceptualizations of the process of globalization, including internationalization, liberalization, universalization, westernization/ modernization, and respatialization. Each of these contributes to
the theorizing of globalization, building from the assumption of globalization as a process. Taken together, the five domains constitute a comprehensive way of examining health, though separately each has both strengths and weaknesses.

Internationalization refers to the increasing of connections and interdependence between nations, through trade and otherwise (ibid.). Other scholars (i.e., Appadurai 1996; Beck 2000) have noted that not only have relations between nation states changed in the process of globalization, but the nature of nation states themselves has changed. Clark writes that the state is itself both shaped by and formative of the process of globalization; “globalization shapes the state and, is at the same time, what states make of it” (Clark 1999: 18). Appadurai even goes so far as to suggest that the nation state is on its “last legs.” The proliferation of non-state modes of governance and non-national identities is testament to this fact. As Ferguson (2006) writes, “civil society” has come to be an important part of current African political life. These voluntary associations, including various nongovernmental organizations (NGOs) and faith-based organizations, have increased in both number and power over the past twenty years.

In terms of health, organizations such as the World Health Organization (WHO), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and numerous NGOs have come to dominate healthcare delivery systems throughout the developing world- particularly in Africa. Often internationally funded interventions work within national frameworks, though many open clinics and healthcare facilities operating independent of national infrastructure to target
specific diseases or deliver relief aid. As criticized by some anthropologists (Clark 1997; Gardner and Lewis 1996; Pfeiffer 2003), these organizations can fragment local health-related efforts and undermine national progress. Nonetheless, health organizations begun in the development era have multiplied with time and continue to spread today, providing services internationally.

Globalization conceptualized as internationalization runs the risk of prioritizing and reifying national boundaries. In daily life, however, power is not exerted vertically through a nation state, but is built in reciprocal relationships. Ferguson’s writing on Africa highlight the idea of assumed verticality of power—where the state is above other influential entities, such as the domestic sphere, or that of civil society (2006). In daily life, however, power structures may not constitute a hierarchy of influence, with each playing a different role in decision-making. This is apparent in the respatialization dimension of globalization, seen below. Important to note in this discussion of the state is that nations have not necessarily lost their power in everyday governance, rather to understand globalization is to look beyond bounded notions of governance and territoriality (Clark 1997). Other organizations operating above and below the level of the nation state (in a vertical model of power) can both enhance national power and undermine it. The state should not be eclipsed in theorizing globalization, but should be taken as one form of power structure among many (ibid.). In the case of health, this can mean looking outside of national health trends and delivery systems to both grassroots and international healthcare policies.
The second conceptualization of globalization written of by Scholte is liberalization, or the opening of markets through decreasing regulations. This is closest to the original economic meaning of globalization, when the term was introduced in the 1970s. Policies of the World Bank (WB), International Monetary Fund (IMF) and World Trade Organization (WTO) designed largely by economists advocate this dimension of globalization, with the assumption that free market economics will eventually lead to generalized socio-political progress. One major critique of this facet of globalization by anthropologists and other theorists is its narrow scope (Scholte 2005). By concentrating on the global economy, impacts on individuals can become obscured. Others argue that economic interventions such as structural adjustment policies are holdovers from outdated modernization theories and have been proven ineffective (Escobar 1995).

Ramifications of economic liberalization on the widespread availability of pharmaceuticals have been significant. The international TRIPS (Trade Related Aspects of Intellectual Property Rights) agreement has placed restrictions on the ownership and manufacture of pharmaceuticals, inhibiting the manufacturing of generic life-saving drugs in the developing world (notable recent exceptions include ARV generics being made in India, Brazil, and South Africa) (Badawi 2004; Biehl 2007). Like other policies related to trade, TRIPS is criticized for favoring those already in ownership of resources. Its five conditions for overriding a license require government petition, and exceptions have thus far not been widely granted. So-called liberalization policies are widely critiqued for their
uneven impacts and favoritism, particularly in regards to health (Collins 2003). Uganda receives most of its antiretroviral treatment through multinational donors and has achieved, to date, 53% coverage of those in need (UNAIDS 2010).

Thirdly, universalization is the idea of global flows of people and goods across boundaries- making previously inaccessible opportunities available. Scholte warns against the dangers of universalization becoming a homogenizing discourse. While automobiles and McDonald’s spread to the corners of the globe, they do not mean the same thing in each place. Local interpretations of goods and ideas can lead to radically different meanings and uses. In fact, despite material similarities increasing, a heterogenization may occur simultaneously as local cultures assimilate new ideas or, as has been the case in some Central American locations, backlash against globalization and the global distribution of goods (Harris 2003). To illustrate this point, Appadurai writes of migration and media, specifically among South Indians (1996). While people of Indian descent move across the globe, they rely on media to create an identity linked to a specific place. He suggests that the ubiquity of diasphoric spheres and multiple identities for traditionally place-based groups demonstrates the encompassing nature of globalization. Accompanying migration is the media portrayal of a selectively constructed identity, as well as goods and products from migrants’ home region.

Ong (2003) extends the idea of transnational identity and migration to healthcare for Cambodian migrants living in California. Accompanying people to their new location are not just family members and food, but also traditional
beliefs about health and healthcare. The friction created by migrants entering American healthcare systems is an important aspect of universalization. In Uganda, the long history of biomedical influence and presence eclipses some of the potential conflicting interfaces with patient beliefs, as it has largely been integrated into indigenous healthcare beliefs. Patients in the clinics are still likely to seek nonbiomedical care for illnesses, but in the case of HIV, it is widely recognized as a biomedically treatable disease.

Next, westernization or modernization can illustrate globalization by tracing the flow of ideas from western nations to others. Technology is a prime example of westernization, though as with universalization, these objects are reinterpreted within a local context. One limitation of this conceptualization is the marginal role that bi-directional flows play in analysis. There is an implicit assumption in westernization models that money and western ideas trump the reciprocal movement across space from poorer nations to wealthier ones. However, as the example of international aid and relief shows, media portrayal of victims plays a crucial role in the impetus for public support. Like the above illustration of migrants in western healthcare settings, the reverse is an example of westernization. Biomedicine is exported to nations and implemented, sometimes without regard to existing beliefs (Baer et al. 1997). The creation of a biomedical hegemony is often a strong case against the process of globalization, as driven by western policies. As Inhorn (2003) has studied, the technology of in vitro fertilization across contexts has very different meanings, particularly for infertile women in the Middle East. The human rights and feminist discourses
denouncing domestic violence are crucial to the current Ugandan context and motivate the current changing policy and care environments (as will be illustrated in Chapters 5 and 8).

Finally, important to anthropological analysis, is the concept of globalization as respatialization. Parallel to discussions of the state, respatialization is the reconfiguration of space as a result of the intensification of interconnectivity. Harvey (1989) refers to this as the “time-space compression”, which entails the shortening of time and shrinking of space. Whereas news from remote areas was previously constrained by the time taken to relay this information, it is now possible to be almost instantaneously aware of events occurring throughout the globe (Inda and Rosaldo 2002). This phenomenon is a result of what Giddens (1990) calls the “time-space grid” being overlaid on the planet, wherein new modes of movement and communication are imposed upon all societies through technology, whether or not the society chooses. Ferguson (2006) and others have critiqued this view by noting that marginalized regions, particularly in Africa, remain outside the material realm of global flows. From this arises a “global” social life, stretched across space. Overlapping somewhat with the five conceptualizations of globalization outlined by Scholte, but within the realm of respatialization, are Appaduari’s notions of scapes and the dimensions of globalization. He writes of five types of flows that occur in the contemporary world: ethnoscapes, mediascapes, technoscapes, financescapes, and ideoscapes (1996). Scapes are a conscious move away from place-based
theories of globalization, focusing on similar concepts as Scholte, but with reference to their movement.

The implications of respatialization in disease transmission include significantly more rapid transmission of previously isolated pathogens. With people crossing spatial boundaries at an unprecedented rate, so too, pathogens travel. The rapid spread of HIV, is a case in point. The virus’ rapid spread is attributed to the wide-scale movement and contact of people across boundaries (Lee and Zwi 2003). Following the creation of roads across sub-Saharan Africa, HIV has followed migration routes and concentrated in urban hubs of migration and connections. The disease is contextualized within a global political economy, both in its spread and in responses (ibid.). The “rural” fieldsite in this research, Mbarara, is where the road from Mombasa on the Indian Ocean splits to either the Democratic Republic of Congo or Rwanda. The placement of this town and the rapid growth of the transport industry made it and several other towns along the same highway early hotspots in the Ugandan epidemic.

Roots of globalization theory

A distinct turning point between development-era thought and globalization was the formation of dependency and underdevelopment theories and critiques of development failures by theorists in the 1960s and 1970s (Gardner and Lewis 1996). Development policies were viewed as exploitative and perpetuating the “lower” status of poor nations both economically and socially. Economists also understood that the financial well-being of wealthy nations was a function of the maintenance of poverty in other places. Lal (1985)
used concrete economic data to prove that inequalities were in fact widening, not
decreasing as hoped. Some theorists analyzed this on a global level, separating
economic theory from the social ramifications of development. As Rodney writes,
“development cannot be seen purely as an economic affair, but rather as an
overall social process which is dependent upon the outcome of man’s efforts to
deal with his natural environment” (1975:6). Based on these facts, dependency
theory is a direct critique of modernization theory, and encourages capacity-
building in poorer nations, rather than strict economic development. At this time,
developing nations called for new international economic order (NIECO),
including changes in trade and debt cancellation (Epstein and Guest 2005).

However, the shift away from development theories did not signal an
abrupt end to development; as Migdal writes, notions from modernization
“continue to sway, even today, interpretations of how change occurs”
(2001:196). Theoretical notions of progress and linear development through
economic means were questioned by the implementers of programs and
academics, though economic institutions continued endorsing policies of trade
liberalization, deregulation, and privatization. This is manifest most notably in
structural adjustment programs (SAPs), where a loan is given by the IMF to a
government based on criteria of development or conditionalities. SAPs have had
mixed results in different nations and are the subject of widespread criticism. The
implications for health are often cited as negative, due to the dismantling of
healthcare systems in the redistribution of government funds to meet the
conditions of the loan (Cornia 2001; Epstein and Guest 2005; Ferguson 2006; Gardner and Lewis 1996; Lee 2003).

Development projects have continued to be implemented following criticisms of development and dependency theories, even into what Escobar (1995) refers to as the “post-development” era. Escobar condemns anthropologists working in development for failing to incorporate change in anthropological discourse into their work. Their work in development, even if the term “development” is carefully avoided, is perpetuating the system against which they are trying to work. He advocates a relativist stance in applied work, as is used in the rest of anthropology. An anthropologist can be of assistance in health programs, as long as she or he remains skeptical of the system and utilizes anthropological tenets of relativism. Likewise, others have advocated “studying up” within health bureaucracies to dismantle assumptions of hegemonic control (e.g. Foster 1982).

Escobar’s writing exemplifies a shift in development and dependency discourse into that of globalization. The reification of boundaries is questioned and assumptions upended. Like the postmodern transition in academia, globalization discourse is a theoretical break from the past, though undoubtedly influenced by its predecessors. Development may continue as a practice, though the assumptions and goals are questioned in light of contemporary thinking (i.e. Burkey 1996; Chambers 1993). Health, as a goal of development, is subject to similar criticism in policies and development. The realms of globalization, seen above, represent new territories in theorizing health in the modern “global” era of
Globalization and health

In studies of health, globalization is utilized conceptually by theorists who identify themselves under the rubric of critical medical anthropology or political economy, among others. The political economy of health and political economy of medical anthropology have both taken on what Morsy calls the “dependency” or “world systems” approach (1996). As seen above, these two concepts were integral to the creation of contemporary globalization theory and the transition away from development. However, in her description of global methods within political economic medical anthropology, Morsy’s argument stops there. She highlights studies done by van Der Geest and others who contextualize their local subjects within a global context. Much of this is done within the confines of the nation state, thereby reifying the power of the nation state and maintaining a place-based sense of culture. Lee and Zwi (2003) extend the traditional political economic approach in their study of AIDS. They use the “global political economy” to situate both experiences of and responses to the pandemic. Incorporating concepts from international relations and political economy, their approach is comprehensive and moves beyond what they call the “economic determinism” of earlier political economy of health research. In this sense, they approach the theoretical breadth of other anthropological scholarship on globalization.

Health is often seen as a personal, bodily experience. When understood on that level, it is difficult to see connections between health and the abstracted
processes of globalization. However, for some time, critical medical anthropology (CMA) has taken a perspective of emphasizing the social nature of health (Baer, et al. 1997). With reference to Wallerstein’s World Systems theory (1979), they purport that an anthropology of health “must be conducted with the recognition that disease and its treatment occur within the context of the capitalist world system” (Baer, et al. 1997:26). CMA writing is largely critical of power structures and systems in the area of health, highlighting the dependency and vulnerability of groups. As seen with the criticisms of dependency theory, working within the framework of a “world system” is not a radical departure from global partitioning. CMA then, represents the beginning of a global-minded theoretical approach, though an incomplete transition into that of globalization.

Globalization theory in contemporary medical anthropology is not, as of yet, a unified body. As explored above, the distinction between globalization as a process and as a state is one major divide within the construction of theory. The five realms of globalization outlined by Scholte and echoed by Appadurai represent significant gains in theorizing globalization, as distinct from previous theories. The present research incorporates concepts of globalization as respatialization and internationalization in the context of liberalization to examine the intersection of two globally increasing problems- HIV and intimate partner violence- in a locally particular, globally influenced space of the treatment situation in Uganda. In other words, how IPV and HIV overlap and interact in a globally influenced, locally dependent context.
As seen in the above conceptualizations of globalization, HIV is known to be a global disease and global processes influence its transmission, prevention, and treatment (Pope et al. 2009). Transmission is spread through rapid interconnectivity, in particular, transport routes through sub-Saharan Africa rapidly spread the early epidemic. Prevention is funded by international and multinational donors. As seen in Chapter 3, US funding of HIV prevention programs is partly derived from early successes in Uganda and has since in turn shaped the current prevention strategies there.

Antiretroviral treatment for HIV has changed the face of the epidemic. Where available, it is life-saving. In 1996, drug trials found success in suppressing viral load with HAART- highly active antiretroviral therapy, or multi-drug combinations (Jones 2009). Initial drug therapies were prohibitively expensive for those in need in the developing world. Through international advocacy drug companies have since lowered prices to a manageable, though still expensive price (Mugyenyi 2008). In 2000, UNAIDS, WHO and other global health groups were able to negotiate with pharmaceutical companies to reduce prices (Kaiser Family Foundation 2009). More recently, several developing countries have been able to negotiate the TRIPS agreement and manufacture generic drugs. These include India, Brazil and South Africa (Biehl 2007). Uganda has built manufacturing facilities, but most of the drugs in country are still from foreign manufacturers. The World Health Organization in 2003 announced their “3 by 5” initiative- with the aim of enrolling 3 million people on treatment by the year 2005 (WHO 2003). This initiative has been a major impetus for treatment
rollout in recent years, though the original target was not met. Treatment rollout has been successful, but slower than anticipated due to infrastructure and funding constraints. As Pope and colleagues write, the issue is not a new one, nor is it unique to HIV: “the traditional issue of lack of access to health care in the poorest countries will continue to effect lack of access to HIV medications as well” (2009:2).

As many others have shown, globalization processes are all encompassing and inextricable from the history of the HIV epidemic (Pope et al. 2009). Women are biologically and socially more vulnerable to HIV infection. Their marginality has been documented across settings, but persists nonetheless (Go et al. 2003; Gupta and Weiss 2009; Kelly et al. 2003). They are burdened more heavily from infection as well, due to their roles as caregivers and limited economic power in places like Uganda.

2.4 Domestic violence research

Gender-based violence, called by various names, has been a focus of public health and social science research since the feminist movement in the 1970s in the United States. Domestic violence (DV) was a catch-all phrase used by many disciplines until recently. Generally domestic violence has referred to physical violence between a cohabiting couple, with men perpetrating violence against women. It has more recently been abandoned in favor of both more inclusive and more specific terms (Kilpatrick 2004; Saltzman 2004). Violence against women (VAW) has been used to describe physical violence, sexual
violence, and threats of physical or sexual violence, without reference to the context. Suggestions that the phrase be broadened to include nonviolent behaviors has led to the term “violence and abuse against women” (VAAW), which encompasses controlling behavior, verbal violence, and stalking. Intimate partner violence (IPV) is similarly encompassing, without specification of gender-acknowledging that men can also experience all forms of violence in a relationship. However, IPV excludes broader concerns of violence against women unless it occurs in the context of an intimate relationship. The goal of such definitions is to broaden the scope of potential incidents to be included in reporting and estimates of incidence.

Anthropologists acknowledge that both “domestic” and “violence” are culturally constructed categories (Adelman 2004). Hence, they are difficult, if not impossible, to define universally. As per this research, IPV is the most relevant category. In light of the following differentiations of violence, I choose to use the term “domestic violence” in lieu of other names because that is still the most frequent label in the literature and to emphasize the domestic dimension, separating it from other settings of violence against women. The category of domestic violence is also one recognized throughout the world, in part because of recent activist moves to bring the subject to public attention (Keck and Sikkink 1998). Similarly, Ugandans recognize the term as both a part of a growing rights-based discourse in women’s empowerment and a long-standing locally salient category. The WHO standardized instrument utilized in the present research focuses on violence within marriage, whether formal or through cohabitation. So,
in the context of this research, the terms domestic violence and intimate partner violence are both used to refer to the concept of intimate partner violence.

Research on violence defines the term variably, based on the motivations for the study and the disciplinary perspective. As will be seen below with anthropological work on the subject, this has much to do with identification of violence as problematic and the local particularities of contextualizing violence. For example, a legal perspective would concentrate on the criminal definitions of violence in gathering data. This is a perpetrator-centered view, sometimes contradictory to that of the perspective of the victim, and is dependent on the presence of legal sanctions against domestic violence. As Kilpatrick (2004) asserts in a review of United States-based research, these definitions do not always overlap. Criminal justice views and reports of violence against women concentrate on murder, sexual offenses, assault, and stalking. Consequent research and data from the Bureau of Justice Statistics reflect only convictions according to legal definitions of those crimes, irrespective of circumstances. A public health approach more closely mirrors the definition given by the WHO (given below). In contrast to a criminal justice approach, public health focuses on relationships and contexts of violence. This is particularly apparent in the case of gender-based violence or violence occurring in relationships. The working definition of violence utilized by the WHO, drafted by a working group in 1996, is

the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has the high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (WHO 2002:5).
The World Report on Violence and Health (WHO 2002) further expands this definition to create a typology of violence. The report defines violent domains as including self-inflicted, interpersonal, and collective actions. The nature of violence in each of these realms can be physical, sexual, psychological and deprivation. Interpersonal violence can occur within a family- among children, partners, or elders- or in the community between acquaintances or strangers. Each categorization of violence is significant by itself, though many are interdependent. For example, a household with violence occurring between partners is more likely to have child abuse than a household with a nonviolent relationship between partners (Krug et al. 2002). Domestic violence, as I examine it in the literature fits into the category of physical, sexual, and psychological interpersonal violence within the family and between partners (see Figure 1), though it clearly overlaps with violence of other natures within the same setting.

**Figure 1: WHO typology of violence**

(Who 2002:7)
Community violence is a broad domain of actions, which implicitly incorporates acts of violence “not narrowly defined as domestic or political” (Brandt et al. 2005:329). The focus of research on community violence is often that of risk or exposure, not victimization and perpetration as in domestic violence. Some instances of community violence overlap with domestic violence, in the lack of differentiation between domestic and public space. Also, the involvement or interference of neighbors or relatives in what was originally a domestic dispute blurs the boundaries (Shostak 1983).

The anthropology of domestic violence

Anthropologists have, in general, shied away from the task of defining violence, and instead focused on experiences, abstract definitions, or explanations. This is one means of avoiding imposition of an outside definition, but the approach is not generally applicable to cross-situational comparisons or large-scale data collection. Some anthropologists’ work on violence is encompassing to a degree that violence may not even be identified as such by the people being studied. For example, Farmer’s work on structural violence in Haiti links macro-level forces to health inequalities and poverty (2003). He defines structural violence as such because of the physical and material consequences, which he compares to other acts of political or personal violence. This is situated in a larger discussion of human suffering and the lack of agency in poverty-ridden settings; suffering from poverty is without a perpetrator, making it incomparable to more overt acts of violence against victims. Farmer is critical of other anthropological work on violence, despite widespread emphasis on
human rights. He calls their attention to localized suffering neglectful and the result of a “diverted gaze” (ibid:266). As will be seen below, there has been a tension in ethnographic work between describing and explaining domestic violence, both closely linked to defining and identifying violence (Renzetti 1994).

Other forms of violence studied by anthropologists include references to domestic violence, though not as the primary focus. These include family violence and child abuse (Korbin 2003), gender violence in the context of conflict (Giles and Hyndman 2004), sexual violence (Wood et al. 2007), and psychological effects of violence on individuals and groups (Das et al. 2000). Domestic violence also falls into the realm of studies on gender roles (Rosaldo 1974), familial roles (Weisner et al. 1997), and social change (Harvey and Gow 1994).

Prior to the 1970s and 1980s, ethnographic accounts of domestic violence appeared as random anecdotal descriptions. These descriptions document that domestic violence was present among groups being studied by anthropologists, but was not at the forefront of research. Some has been described in missionary writing, attesting to the historical record of violence (Burbank 1994). Early work on familial/ gender roles, marriage patterns, and village structure includes suggestions that women were subjugated in a number of ways from lower status (eg. Bohannan 1960). Upon examining the role of women in “primitive society,” Evans-Pritchard suggests that women in nonindustrial societies are unilaterally oppressed in marriage and decision making, compared to European women. He also claims that women do not resent this status, as they know it is unlikely to
change. On women’s subjugation, he posits that there are “deep biological and psychological factors, as well as sociological factors involved, and that the relation between sexes can only be modified by social changes, and not radically altered by them” (1955:54-55). Evans-Pritchard does not relate evidence of domestic violence, but it is implicit in his broad statements concerning men’s victimization of women both inside and outside the home. Other anecdotes appear scattered in ethnographic literature across time and space, though more often than not in regions of the Pacific and Central America, for reasons explored more below (Bohannan 1960; Counts et al. 1999; Harvey and Gow 1994).

In the United States, the feminist movement and awareness of domestic violence directly related to the subject’s inclusion in research. Despite the stigmatization of violence and general perception among the US population that it was not “their” problem, some of the first literature specifically on domestic violence was written in the United States. The first significant ethnographic account of domestic violence in the US was a then-shocking revelation of high rates of abuse in general, as well as violence perpetrated by women against men (Straus et al. 1981). This brought the issue close to home, making it a concern for researchers in the US, furthering feminist agendas for inclusion of violence against women in studies. The idea that women were just as violent as men, however, was troublesome for the feminist agenda of raising awareness. Women were no longer being portrayed as passive victims of male-perpetrated violence (Saunders 1988). In their study of over 2,000 families, Straus et al. found women nearly as likely as men to commit violence against their spouse in what they term
‘mutual combat.’ Women’s violence, however, has been found to be primarily in response to men’s, as a means of self-defense. Additionally it is often less likely to result in injury (Straus et al. 1981).

Research on domestic violence in the US has continued to stay a few steps ahead of global investigations. This research has grown to include studies of vulnerable groups of women and others afflicted by violence, who are not traditionally considered in the definition of domestic violence. For example, recent work on same-sex couples shows that they often experience violence at the same rate as heterosexual couples. Stigma and shame keep these figures from being reported or discussed widely (Loue 2001; Kahuna 2005). Likewise, violence among immigrants to the US is underreported. This is due to their decreased likelihood to utilize formal support mechanisms because of illegal status, mistrust of officials, lack of information about resources, and other cultural or familial barriers (Abraham 2000).

Globally, the movement for women’s rights and attention to violence against women was slower to follow suit. The main normative legal code on women’s rights, the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW), drafted in the 1970s and adopted in 1979, does not mention violence against women. By 1994 the UN Conference in Cairo and 1995 in Beijing, however, violence against women was a primary issue, inclusive of domestic violence, rape, female genital mutilation, trafficking of young girls, and crimes during war. Between these years, a significant international network brought issues of violence against women to the forefront, owing in large part to
US-based feminist ideas of human rights as women’s rights (Keck and Sikkink 1998). Women’s groups, particularly in Latin America, brought this international agenda back to their homes and pushed for social change (McClaurin 1996). Within anthropology, Adelman suggests that a focus on domestic violence was not emergent in the literature until work had been completed cross-culturally on sexual asymmetry and male dominance (2004). This is also contextualized in the growing international discourse on women’s rights as human rights and the feminist agenda.

*Domestic violence as a research priority*

There has been a reticence within anthropology to penetrate violence within the domestic sphere. This is in part because of the inaccessibility (perceived or actual) to the ethnographer to observe or record behaviors occurring outside the public domain (Counts et al. 1999). Domestic violence is in the private sphere and in many cultures is a source of shame and not a part of public discourse on gender or familial relationships. Contradictorily, however, some anthropologists have suggested that in non-industrial societies, domestic violence becomes a communal concern due to lack of privacy in housing conditions (Erchak 1984; Mitchell 1999; Shostak 1983). The gender of the ethnographer and the informants is also important in accessibility. Female victims would potentially be more reluctant to divulge information to a male ethnographer, who in turn may not recognize the role of domestic violence in a given location using male informants.
Another reason for the dearth of literature on the subject is the reluctance of some anthropologists to portray their subjects in a negative light (Brown 1999; Erchak 1984; Harris 1994; Zorn 1999). Likewise, revealing high rates of violence in a community is stigmatizing to individuals and potentially harmful to female informants. There is also the issue of cross-cultural definitions and acceptability. Studying domestic violence is a challenge to the tenet of cross-cultural relativity held in high regard by anthropologists (Ember and Ember 1993; Gibbs 1984; Korbin 2003). This slippery slope is difficult to traverse. On the one hand, to unilaterally condemn domestic violence can obscure local variations and interpretations. On the other, too heavy an emphasis on local context runs the risk of condoning violence. Early literature on the subject has tended to fall on the side of situating violence, without condemning the behavior. Later feminist and rights-based anthropology takes a harder stance in denouncing violence and its perpetrators (Fineman and Mykitiuk 1994; Green 1999).

Previously a footnote to a cultural portrait, domestic violence began to be the focus of study in its own right following the call to incorporate domestic violence into the anthropological research agenda. In recent years, two volumes addressing gender and violence in relationships in anthropology have appeared (Counts, et al. 1999; Harvey and Gow 1994). Across the world, ethnographers have found the same thing: gender inequity is entrenched in social structures, male violence against women is commonplace, regardless of other violence within the culture, and men themselves are often not blamed as individuals, they too are victims of the social system and manipulated by alcohol. In order to avoid
potential pitfalls, anthropological research has often focused on the most severe forms of physical violence occurring between spouses that are considered unacceptable cross-culturally or exceptional societies with an apparent lack of domestic violence (Brown 1999; Mitchell 1999; Nash 1999).

The Whiting School at Harvard developed codes from the Human Relations Area Files (HRAF) for wife beating across societies. The first published studies to use these codes found a slight correlation between wife beating and narcissism, general female oppression, and high rates of divorce in societies (Slater and Slater 1965; Lester 1980). Levinson (1981) also uses a subsample of the HRAF to test the hypothesis that corporal punishment for children was linked to domestic violence. He found some support for this relationship, but not as high as predicted. In a study of 186 societies, Whiting and Whiting (1975) examined the characteristics of what they call “aloofness and intimacy” between husbands and wives. They found strained marital relationships (which potentially includes violence) to be associated with the degree of isolation among a married couple. In yet another correlational study, the only factor consistently linked to domestic violence was the practice of widow inheritance (Broude and Greene 1983). However, as Brown responds to this study, “this single finding could be the result of chance and suggests that wife beating in many societies may have little to do with the nonsexual relationship between husbands and wives” (1999:7).

As some authors are quick to note, the absence of data on domestic violence in ethnography does not necessarily equate to a violence-free society (Brown 1999; Gibbs 1984). Factors within a society linked to violence explored in
subsequent studies have hypothesized, but not proven, the role of: wife isolation/familial proximity, female support networks (sanctuary), gender integration in daily life, legal and social sanctions against violence, and gender roles more broadly (Campbell 1985; Counts et al. 1999; Levinson 1988; Mushanga 1977-1978; Websdale 1998). Likewise, social change in the form of migration is hypothesized to lead to a breakdown in families and result in increasing violence (Gelles and Cornell 1983).

Following this era of nascent study of domestic violence, through previously collected data, Erchak (1984) wrote an explicit call for anthropologists to be more inclusive of issues of spouse abuse in their research. He notes that at the time, research on child abuse was growing more acceptable in the literature, but despite growing importance in US discourse more broadly, research on spouse abuse had not followed suit. For this he suggests a number of reasons, several of which are included above. He also suggests, based on fieldwork among the Kpelle in Liberia, that “the most significant reason for the lack of data from small-scale preindustrial communities, however, might very well be the most obvious: that very little violence exists among family members in such communities” (1984:331). This assertion does not hold up in the research done since, but his observation that social change, urbanization, and the use of alcohol increase the prevalence of violence has been shown to hold true.

Campbell’s work marks a transition toward recognition of the importance of the ethnographer in accessing and describing domestic violence, rather than focusing on correlates of violent behavior. She reviews studies done by female
ethnographers working with female informants (1985). Campbell chose fifteen variables to assess and relate to what she termed “a continuum of wifebeating,” including: the general acceptance of violence in a society, the physical punishment of children, low social status of women, low female autonomy, no matrilocality, cultural sanctions allowing violence, female virtue as an issue of honor, females viewed as male property, male sexual jealousy, machismo, absent/distant fathers, females associated with nature, other forms of violence against women, forced marriage, and high industrial development. These all represent hypotheses of Campbell’s contemporary female ethnographers and each held true for certain societies, except that of industrial development and the physical punishment of children, which she declared to be “essentially unrelated” to wifebeating.

While individual risk factors do not consistently hold true across cultures, cumulative stress within a household and the presence of multiple factors can begin to predict the likelihood of violence within a household. Straus and colleagues (1981) found in the US, using a checklist of factors, that the more points a couple had on this list, the more likely they were to have a violent relationship. In this case, it was not narrowed down to any single factor, but the accumulation of vulnerabilities and stress. This gives some credence to the apparent contradictions in literature that finds factors such as divorce, urbanization, patrilocality, or the absence of legal sanctions to be highly related to domestic violence in some settings, but not others.
One comprehensive anthropological volume on domestic violence (Counts et al. 1999) differentiates wife battering as an extreme form of wife beating, considered unacceptable cross-culturally. This emphasis on extreme cases eschews the difficulties of potentially problematizing violence for subjects who do not necessarily find the behavior problematic and the victims in this instance clearly identify themselves as having been victimized. A few studies in this volume concentrated on anomalies in the incidence of wife beating—societies in which little or no violence is reported. Among Wape men in New Guinea, Mitchell found an ethos of both pacificity and nonconfrontation (1999). He attributes this to societal beliefs in ancestors who monitor and oversee all behavior, which generally occurs outdoors. In this society, duties of work and space are also shared between men and women, making for regular interaction and little antagonism between genders; women are able to choose husbands and divorce is infrequent. Also in New Guinea, Nash writes of the Nagovisi people and their infrequent use of physical violence in domestic arguments (1999). She suggests that disagreement is not uncommon, but the resources available to women through the practice of matrilocality prevent arguments from becoming physical. When alcohol is involved, men sometimes fight among themselves, but rape and other violence against women is nearly inconceivable. In both the Wape and Nagovisi, however, suicide is common among unhappy wives. Neither author gives a full explanation of this apparent contradiction, but suggest it may be related to the shame of a strained marriage in a society of expected satisfied relationships.
Other ethnographic accounts in this volume focus on societies with high reported incidences of violence. The factors associated with this include idealized gender expectations that are not easily met (Counts 1999; McKee 1999; Lateef 1999), sedentism and familial estrangement (Carucci 1999; Draper 1999), overall cultural norms of acceptable violence (Lambek 1999; McDowell 1999), corporal punishment for children (Scaglion 1999), low status of women (Miller 1999) and nearly all of the authors include the influence of alcohol. The explanations for domestic violence (in Harvey and Gow 1994) mirror the contextualized explanations seen above, with normative social violence, alcohol use, and asymmetrical gender roles most commonly implicated as the causes (eg. Harris 1994; Harvey 1994; Toren 1994; Moore 1994; Wade 1994). These authors also focus on deviance and write that violence is “by definition unacceptable, out of control, beyond reason. Furthermore it is transgressive” (ibid: 6).

Mentioned above, much of the recent work on domestic violence concentrates on the contextualization of violent acts and the ethnographic particularities of male-female relationships in a given location. Given the localized nature of these studies, the explanations for behavior constitute emerging models of behavior, rather than theories-- including ecological, feminist, and globalization/ social change explanations for the occurrence, severity, and changes in acts of domestic violence. Other explanations include evolutionary and psychological origins for violent behavior.

An ecological model of understanding domestic violence places the couple in a series of increasingly broad contexts, with each environment contributing
factors to the increasing potential for a violent relationship between partners. Firstly there are individual factors (including history or psychological disposition), then those of the relationship, the community, and the broader society (WHO 2002). In general, ecological approaches focus on the broader causes of violence, rather than individual predispositions. Many early studies on violence that use this model find societal-level predictors cross-culturally, as seen above. Likewise, work on family roles and household relationships follow this model. They stress the importance of context in both marital disagreements and the possibility that these will result in violent behaviors.

One dimension of an ecological approach contributed by anthropologists, is the importance of formal legal sanctions and judicial systems in the construction of and resistance to domestic violence. In a study of rural Kentucky, Websdale found that the policing structures in place were inhibiting enforcement of domestic violence laws and contributing to ‘patriarchal ideology’ in the region (1998). The predominantly male police force were derogatory toward abused women, turned a blind eye to some men’s behavior, and themselves were abusive to their wives. He argues that the legal structure has the potential to give legitimacy and ultimately protection to women, though the social norms of rural Appalachia constricted the enactment of written laws. Among First Nations (or who the authors call Aboriginal) people in Canada, another study found legal systems to be prohibitive in the resistance to violence (McGillivray and Comaskey 1999). They contextualize this group within the historical political practices of the Canadian government to show how the legal system has led to
restructuring of gender relations and ultimately an increase in violence. The creation of the reserve system disrupted traditional family households and support networks for women, as well as increased the availability of alcohol and other drugs.

A feminist approach to domestic violence is less-context based than the above ecological examples. Rather, theirs is a rights-based moral argument that the widespread oppression of women in all spheres of life is what causes domestic violence. Within anthropology, the feminist perspective has called for greater inclusion of women’s voices in research and investigation of important topics relevant to women, beyond their reproductive and familial roles (Lamphere et al. 1997; McClaurin 2001; Moore 1994). More recently, feminist literature on domestic violence has been based in the concept of universal human rights, overlapping somewhat with the above legal perspective. Zorn (1999) warns that extreme relativism on issues of violence against women can obscure human rights violations or the potential for changes in women’s status, “relativism should not blind us to the fact that all cultures are subject to change and that legal change can facilitate changes in custom that are favorable to women” (Lyons 1999:x). Feminist anthropologists working in domestic violence emphasize the importance of socially responsible research and warn of the dangers of relativism in potentially condoning violence.

In pondering the position of the feminist anthropologist, Davis (2006) writes that to academically engage with subjects such as domestic violence without also socially and politically engaging is unjustifiable. She, as well as
others, finds the idea that anthropologists can or should stay out of the creation of discourse in the communities where they work outdated and incorrect. Writing of her work with battered women, Davis outlines a pedagogical, research, and practical dimension for involvement towards social change. She worked using methods of participatory research and an iterative process between her ideas and those of the community, ultimately sharing results with women themselves, women’s organizations, and policy makers.

Similar to an ecological perspective, domestic violence can also be examined through the lens of social change and globalization. This rests heavily on the assumption that increasing migration, urbanization, and isolation of families leads to increasing rates of domestic violence. The literature on this is clear in some instances, and uncertain in others. Anecdotally, however, the argument is widespread and largely assumed. Many of the above studies list “social change” as a factor in the increase or perpetuation of domestic violence without specifying which dimension of change is related to violence. Often times this is an implicit reference to alcohol, urban housing conditions, labor migration, or the clash of “traditional” and “modern” gender roles (Green 1999). The process of globalization does not occur at the same pace or to the same extent everywhere. So violence contributed to “globalization” as a cause could both be because of increasing connectivity and because of an increasing sense of isolation as some are not included in the process of social change. Additionally, it is not the processes of urbanization or globalization themselves that cause changes in social fabric-- it is in the consequent changes in resources, networks,
and social norms that people’s vulnerability to or propensity for violence can change.

Among Aboriginal women in Australia, Burbank found a breakdown of familial roles in the context of settlement and social change. Previously socially sanctioned ritualized violence was disappearing from its original context and often resulted in male frustration and aggression. Combined with alcohol use, this led to a drastic increase in injurious assault against wives (Burbank 1994, 1999). Similar patterns were found in a previously isolated community in Northern Australia. McKnight parallels increasing contact with outsiders to a change in the meaning and frequency of alcohol use (2002). This, he argues, has broken down social fabric in the realm of marriages, politics, child-rearing, overall gender relationships, employment, housing, and education. The role of social change in alcohol consumption and consequent familial violence is a trend seen across the developing world (Busby 1999).

In the last several decades, domestic violence has also been taken up as an issue in public health and as an area for intervention. This literature is often not addressed by anthropologists, but as will be seen in the next section takes the form of either describing the physical or mental health effects of violence or targeting interventions for women (Harvey and Gow 1994; Krug et al. 2002; Loue 2001; Sokoloff and Pratt 2005).
2.5 Intersection of HIV and domestic violence

Violence and health, particularly HIV, do not always have a direct relationship. Violence is part of a complex constellation of predisposing factors of poor health outcomes, as well as an outcome of poor health status. The complex intersection of violent acts and health consequences is exacerbated by other social factors such as poverty, gender, alcohol consumption, relationship status, and political stability, to name a few (Krug et al. 2002, WHO 2002, 2004). There is a complex causal pathway between violence and health, with a sometimes bi-directional or synergistic nature. Research on domestic violence often focuses on the risks for violence; studies on other health issues frequently list violence as one of many potential risk factors.

Cumulative exposure to violence in the community is said to increase the risk of children developing a host of problems. Age of exposure is key to a child’s development. Factors associated with this risk in childhood include socioeconomic status, prior victimization history, substance abuse, having a disability, and community size (e.g., Brandt et al. 2005). Outcomes from violent exposure include psychological problems such as emotional developmental delays, strained relationships, depression, and post-traumatic stress disorder. The stress of being in a violent community over time not only increases the propensity for a child to later commit violent acts, but also their potential for becoming a direct victim. As an adult then, a person experiencing violence may not have trauma from simply one act.
Mental health consequences of violence can include depression, anxiety, insomnia, social dysfunction, post-traumatic stress disorder, borderline personality disorder, dissociative disorder, somatization, and self-harm behaviors (Campbell 2002; Stewart and Robinson 1998).

The psychological consequences of violence vary with the type, duration and severity of violence, social support availability, and the individual’s own ability to cope. The threat of violence or fear of living within a violent situation, more than the acts of violence themselves, are linked with mental health problems. Long-term chronic depression is one of the most common problems (Campbell 2002; Stewart and Robinson 1998). This is accompanied by isolation and withdrawal; when the victim is a mother, the effects of her mental health radiate throughout the household. More severe symptoms may require hospitalization, though this is often difficult when the victim is married. Similar to the challenges faced by women’s shelters, mental health providers must prioritize the safety of their patients when domestic violence is implicated as the cause of psychological problems. One study of psychiatric inpatients revealed that nearly 20% reported a history of abuse (Brown and Anderson 1991). Kemp et al. (1991, cited in Stewart and Robinson 1998) found that more than 80% of battered women in shelters met the criteria for post-traumatic stress disorder.

The relationship between violence and health is clearer in the case of sexually transmitted infections and coerced or forced sex. According to one World Health Organization regional office, the Pan American Health Organization,
The links between HIV/AIDS and gender based violence are becoming increasingly apparent based on findings of various studies conducted primarily in the United States and Sub-Saharan Africa. Findings show an increased risk of HIV/AIDS among women victims of gender based violence and also show that being HIV positive is a risk factor for violence against women. This relationship has grave consequences for global health and human development, especially with regards to adult women, adolescents, and girls, who are most affected by sexual violence and are consequently more susceptible to HIV/AIDS. (PAHO/WHO 2005:1)

Physiologically, the trauma of coerced sex makes transmission of HIV and other STIs more likely than during consensual sex. Likewise, data from the US indicate men who commit acts of violence against their partners are less likely to use a condom with any partner (Campbell 2002), and more likely to engage in sex with a commercial sex worker or someone outside the relationship. A pattern of risk-taking behavior is often associated with contexts of domestic abuse. Vulnerable women in these situations may have a "low sexual relationship power" (Fonck et al. 2005). To suggest using a condom is to risk further violence, despite the heightened risk (or perception of risk) of contracting HIV.

Statements from the WHO, UNAIDS, and the Global Fund, among other international agencies recently have highlighted the relationship between gender-based violence, in its many forms, and HIV- whether risk for contraction or as a barrier to disclosure (Klein and Wallner 2004; Krug et al. 2002; WHO 2004a). A WHO multi-country study of violence against women in ten countries, involved over 24,000 women from 15 sites, and findings indicate that between 15-71% of women have experienced intimate partner violence during their lifetimes, with the higher incidence occurring in provincial areas (WHO 2005). These data show a wide range of variation, but also report on specific behavior rather than treating
the absence or presence of something like physical violence as a binary variable. Much of the research from various disciplinary perspectives on gender-based violence struggles with terminology and variable definitions for violence against women perpetrated by intimate partners, particularly cross-culturally (Kilpatrick 2004; Saltzman 2004). As is true for the WHO study, research which incorporates local definitions of acceptable violence overcomes some of the limitations of local variability.

Other health problems related to violence are of a more complex etiology. Based on data from women’s shelters, battered women have significantly higher than average reports of gastrointestinal symptoms, eating disorders, hypertension, colds, and influenza (Campbell 2002:1332). Campbell speculates that this is due to “the shame and stress reported with forced sex manifesting as especially high levels of stress and depression known to depress the immune system” (ibid.). Being immuno-compromised could then lead to many types of infectious diseases. The consequences of violence, in this instance, are not direct. Violent contexts, rather, are the stressors in a complex model of health. A household experiencing violence may react as a unit- with the children developing health problems although the wife may be the one being abused.

The relationship between alcohol use and sexual or domestic violence has been documented across a number of settings (Campbell 2002; Koenig et al. 2003, 2004). One study found more than half of women who had experienced partner violence did so after their partner had consumed alcohol (Koenig et al. 2003); women whose partners often consumed alcohol were at a five times
greater chance of experiencing violence than those whose partners did not. The risk-taking mentality of those who consume alcohol, combined with the disinhibiting properties, create an atmosphere of potential violence.

As seen with women affected by IPV in other settings, violence can act as a barrier to accessing treatment due to shame, stigma, or fear (Bauer et al. 2000a, 200b). For women already enrolled in treatment, IPV could likewise inhibit successful completion of treatment, adding to or exacerbating other barriers already faced by women and undermining social support, though this has not been examined specifically (Koenig and Moore 2000; Krug et al. 2002; McGrath et al. 2006).

The intersection of IPV with HIV infection highlights a case of synergistic vulnerability for women. Each separately contributes to hardship in daily life, especially in the experience of health and illness. When combined, women are particularly disadvantaged. Current literature on the subject focuses on the potential risk for HIV due to coercive sex or on the threat of violence as a barrier to HIV disclosure in early stages of infection (Dunkle et al. 2004; Jewkes et al. 2006; Karamagi et al. 2006; Koenig et al. 2004; Krug et al. 2002). This dissertation research instead contextualizes experiences of violence within the new context of living with HIV as a chronic disease.

In East Africa, including Uganda, both intimate partner violence and HIV are unfortunately frequently a part of daily life. The next chapter describes the Ugandan setting and related social science research that has been done in the region.
CHAPTER 3: THE UGANDAN CONTEXT

3.1 Introduction

Uganda is located in East Africa, in the Great Lakes region and shares borders with Kenya, Tanzania, Rwanda, the Democratic Republic of Congo and Sudan. The country has a total population of approximately 32 million people and continues to have one of the highest fertility rates in the world, with an average of 6.8 children per woman and the second highest birth rate in the world (CIA 2010, UDHS 2006). The average life expectancy at birth has risen in recent years and is 53 years (slightly higher for women). Uganda is predominantly rural, with only an estimated 13-20% of the population living in urban areas and 80% dependent on subsistence agriculture. An estimated 35% of the population lives below the poverty line (ibid.).

According to the 2002 and 2004 censuses, males and females have similar educational expectancy of 11 and 10 years, respectively. This is in large part attributed to the national program of Universal Primary Education and will likely increase with the recent introduction of Universal Secondary Education. However, there remains a large discrepancy between literacy rates for males (77%) and females (58%) (UDHS 2006).

The current situation in Uganda is one focused on development. The markers are not as poor as some other African countries, but the country has been marred by its history of HIV/AIDS. This section gives an overview of social research done in Uganda in the colonial context, up to the contemporary era. The themes show shifting priorities and an increasing movement towards applied and
development-focused research. The final sections show the current HIV context in Uganda, and a brief description of the two fieldsites of Kampala and Mbarara where the research was carried out.

3.2 Contextualizing research in Uganda

Uganda has been defined by borders only since colonization. But as this section shows, through the lens of colonial history and research priorities, there has been considerable foreign involvement within the country, for rule, development, and research since that time. The current Ugandan context is inextricable from its past and current relationship and dependency on foreign aid.

The settlement of Uganda by colonial powers began in the mid to late nineteenth century. Uganda’s history of settlement and method of indirect rule, as was conducted in other parts of British East Africa, gave researchers access to the Ugandan people, funded by the colonial administration and other funding agencies. Indirect rule meant that the British relied heavily on local people for day to day governance and management of the colony, and hence anthropological knowledge was valued for information about pre-existing systems of governance and to minimize disruption and conflict during settlement (Doornbos 1982; Fallers 1956; Furley 1982; Young 1977). This was then directly linked to the need for anthropological knowledge by colonial administrators. They requested studies of political systems, legal systems, language, and other “tribal customs” that could aid the colonial endeavor (Killingray 2000). The dominant British influence mapped early research priorities in Uganda, as presented below. More recently
there has been a diversification of research interests and local researchers in the social sciences, though they are still frequently supported by international funding and in line with global research priorities.

The portion of Eastern Africa in the Great Lakes region which came to be known as Uganda was introduced to the Western World following contact with explorers and missionaries in the mid to late 1800s (Beachey 1996). At the time of Western contact the Buganda tribe was numerically and politically dominant in the central region of the country on Lake Victoria. Hence, the Baganda were given much colonial power and became the focus of much scholarly study (Doornbos 1982; Fallers 1960; Furley 1982). As one early scholar noted, the Buganda were one group of many, but their centralized political organization and geographical location gave them enormous influence under crown rule. Buganda was considered most important for maintaining tribal stability and smoothly transitioning to outside governance (Cunningham 1905:145).

The Baganda people of the region of Buganda are a Bantu-speaking people and the largest tribe in Uganda. The region of Uganda was claimed as an official British Protectorate on 19 June 1894; King Mwanga, the Buganda Kabaka (king) at the time maintained power and was aligned with British royalty (Uzoigwe 1982; Young 1977). Roscoe and Cunningham, writing at this time, suggested that precolonial tribal rulers were brutal and Baganda people suffered from hardship and even human sacrifice. This, they conclude, made colonial rule a welcome change and a means of curbing the violent past (Cunningham 1905; Roscoe 1911).
Despite the hands-off approach of indirect rule, the British colonial administration had ambitious goals for development in Uganda. In exchange for the exportation of cash crops grown in the region, such as cotton and coffee, the British Government spent large amounts of money building up infrastructure. This included subsidizing farming cooperatives, building railroads (for connection with Kenya and a major sea route), introducing western style education, and creating healthcare facilities (British Information Services 1962). Unlike other African colonies, Uganda does not have large amounts of mineral resources, and hence Britain’s interest was mainly in agricultural production and services for farmers. During this era, social science research began to be concerned with issues of development and the practical application of knowledge, as has continued as a primary issue in East African research since (Brokenshaw and Little 1988).

In a retrospective analysis of colonial administrative documents regarding health, Kuhanen (2005) writes of the surprisingly early and progressive measures taken by the colonial government. Initially, the outbreak of sleeping sickness in central Uganda was the central and nearly sole focus of the British in terms of health. In 1908, the British administration quarantined and subsequently evacuated all of the Ssese Islands on Lake Victoria to control it. As early as 1920, Uganda was one of the few colonial locations with policies prioritizing women and children. The following decade saw the introduction of large scale disease prevention programs and the proliferation of biomedical clinics throughout the country. However, as in other domains, the privilege given to the Buganda was potentially to the detriment and negligence of other regions. This
disparity remains today, with the bulk of infrastructure and development resources concentrated in the central region and war-affected north of the country.

One of the most prolific writers of the early colonial era in Uganda was John Roscoe, a British missionary and member of the Church Missionary Society, a group prevalent throughout colonial Africa (Cunningham 1905; Roscoe 1966[1911]; 1966[1915]; 1921; 1923). Though originally trained as a missionary, Roscoe developed a keen interest in ethnographic methods and anthropology (Ray 1991). Roscoe’s work, despite its narrow scope of formal customs, has endured as authoritative accounts of early Buganda. Roscoe championed the perspective that indirect rule as practiced through the Buganda was ideal and should be used as a model for other colonial enterprises (Roscoe 1911; Musisi 2002). This led to extensive documentation of native customs and laws, with the aim of protecting the Buganda from “extinction.”

Following this early period, the number of writers in Uganda increased significantly. In large part, this was due to the sponsorship of anthropological work through the British government and the establishment of the East African Institute for Social Research (EAISR) in 1950. EAISR was led by Richards, Fallers, and then Southall- each of whom wrote extensively on village structure, Buganda royalty, and land ownership respectively. EAISR, like the Rhodes Livingston Institute of the same era, had a liberal multi-disciplinary agenda, emphasizing studies of culture contact, labor migration, urbanization, and these institutes “served as magnets for the postwar generation of anthropologists.”
Both were influential in the training of anthropologists and hubs for research.

Fallers, a former director of EAISR wrote of the institute’s mission to understand the Buganda and other tribes in light of the colonial context. She encouraged studies of social change and political systems, as seen with the work of Radcliffe-Brown and Evans-Pritchard during the same era (1964). Fallers, like Richards, was explicitly critical in her writing of the general trend in anthropology to avoid contemporary, relevant issues in Africa during the decades before independence (1964). They cite the churches, education, and economic reform as irrevocably transforming social landscapes, while some researchers wrote about outdated customs and African personalities. In accordance with an international movement towards development and social obligation for the developing world, EAISR advocated applied anthropological research alongside theory building and historical documentation.

While EAISR was connected institutionally to Cambridge, much of the work was done for the benefit of indirect rule and those in administrative positions often worked simultaneously for the institute and colonial government. Richards was seen to have an exceptionally close relationship with the governor Sir Andrew Cohen in Uganda; British colonial administrators often times relied on economists or rural development experts in lieu of anthropologists (Kuper 1996: 110). Uganda was also exceptional in that the colonial government sponsored a journal specifically for scholarly research, encouraging both theoretical and applied work in Uganda. The Uganda Journal was founded in 1934 and ran for
several decades, providing a venue for small-scale work to be published and a means of sharing information among scholars (Killingray 2000).

Women and families in Uganda

Similar to research being done by the Whitings, Kilbrides, LeVine, Weisner, and others in British East Africa over decades (e.g., Whiting and Whiting 1975; Kilbride 1979; Kilbride and Kilbride 1990; Levine et al. 1994; LeVine 1981; Weisner et al. 1997), Uganda was the site of much anthropological research about families. Initially, the emphasis was on family structure, shifting towards an interest in household economics, social change, and more recently, the breakdown of familial ties. Women likewise have featured prominently in Ugandan ethnography. This is in part because of the significant role which women have played in Uganda’s informal sector through household influence or women’s organizations (Obbo 1990; Tripp 2000; Wallman 1996).

Richards (1966) argued, in contrast to the general anthropological assumption, that the new system of land use under the British was beneficial to Buganda families and strengthened household ties, particularly in village settings. Her study of a village near Kampala suggested that pre-colonial informal land use caused migration among populations and fragmentation of extended family relationships. Newer villages were more settled and families with large compounds cared for elders and extended family networks. Other work done at the time begins from the perspective that past families were more cohesive and the advent of wage labor and migration was disruptive. Richards relied on oral history rather than longitudinal research, and her participants suggested that
families may not have been cohesive in recent memory. Similar to work on tribes and colonialism, however, it is difficult to assess social change without the benefit of written history (Southall 1970; Wallerstein 1961).

Like earlier writings, later colonial ethnography included information on the role of women—again in the context of households, families, and marriage practices. Much of the colonial ethnography of the Buganda became synonymous with urban ethnography, as most of this work was done in Kampala and the colonial administrative seat of Entebbe (Obbo 1980). Hence, women that were included were often “town women” and deviant. Without a sufficient frame of reference for rural Buganda women, these town women were painted as simply the opposite of what an ideal woman would be. They were loose, immoral, not reliant on men, wage earners, and morally suspect in general (Kilbride 1979).

Musisi (2002) used missionary and colonial records to recover some representations of Baganda women in the early 1900s. This was in direct response to colonial debates on the medical particularities of Buganda women’s pelvises. The Church Missionary Society recorded events through hospitals, maternity training schools, and published their information widely, particularly on women and children’s perceptions of health and illness. According to these records, Buganda women had uncontrollable sexual urges, and consequent peculiar gynecological problems. Their tribal customs led to problems not seen among Western women and they were a source of curiosity.

Musisi writes that missionaries and historians noted the high status of women among the Buganda, in comparison to other African tribes in general.
The historical record seems to corroborate this assertion; the status of women was seen as key for the perpetuation of the Buganda and the Buganda model of indirect rule (Musisi 2002; Tripp 2000; Kyomuhendo and McIntosh 2006; Beachey 1996). If women lost status, the kingdom would disintegrate, according to colonial records. Thus a tension seems to exist between the actual role of Buganda women and their secondary role as represented by texts.

Important to note, however, in the reconstruction of colonial texts is the actual role of women in colonial times (as understood from oral tradition and historical documents). Often they were relegated to behind closed doors and excluded from political processes, despite wielding power over the domestic sphere (Hanson 2002). Hence, there is likely validity in both accounts of Buganda women; they may have had significant informal power, though still marginalized from formal economic and political activity.

West African feminism has taken a decidedly more radical tone than feminist scholarship in East Africa. African feminism from an East African perspective focuses on the empowerment of women within the domestic sphere. Women are respected for their contributions to families and fulfillment of social obligations (LeVine et al. 1994; Obbo 1990; Tripp 2000; Kyomuhendo and McIntosh 2006; Kisekka 1972). Ugandan women’s organizations have been around for over a century, despite periods of having to go underground, such as when they were banned during Amin’s rule in the 1970s. Though many are not formally recognized within the political structure, women have been networking and building status for themselves within local communities for years. The
anthropological writing about these women since independence has begun to focus on women’s agency and accomplishments, without defining roles in relationship to men. As mentioned above, Ugandan women have not always enjoyed a large degree of formal autonomy, though they have had a comparatively higher status than other women in sub-Saharan Africa. Particularly since the advent of HIV/AIDS, very many studies have focused on women’s relationships, status, and power in Uganda and across the region (ex. Schoepf 1992, 1997, 2001; Tripp 2000; Kyomuhendo and McIntosh 2006; Obbo 1990).

Since early anthropological research, the family—“each composed of a man with his wife or wives and their young children” (Radcliffe-Brown and Srinivas 1958:142)—was considered the most basic unit of social structure, and universally so. The family was considered not only the atomic unit of social structure; it was also the reproductive center, for both socialization and procreation. Families are often considered microcosms of larger social forces, and changes in family dynamics are reflective of change more broadly (Weisner et al. 1997). Much was written on families in East Africa during the transition from colonies to independent nations, though specific discussion of political movements does not always factor into this work. Often there is an implicit assumption that colonization had deep-seated effects on individuals and societies, so a study of social change within a family is truly a study of colonialism more broadly, as experienced on a small scale (ibid). Weisner suggests that these changes have created a crisis for African families, where social support networks of extended kin relations have broken down and people
are generally more vulnerable. As will be seen below with Richards’ work in Uganda, however, this was not always the case. Richards argued for the strengthening of familial relations through the process of settlement and growth of familial compounds (1966).

Kilbride and Kilbride (1990) wrote of families in both Kenya and Uganda, with special attention to changes in child-rearing across time, as their fieldwork straddled the Amin years and was carried out over decades. They use the concept of “delocalization” to show how the construction of normative values and behaviors is no longer produced within a family system, and now includes influences from a host of other sources. They conclude that this has been to the detriment of families and breakdown of moral values; as seen with the increasing number of single parent households, pregnancies outside of marriage, and wage migration forcing families to separate. Their theoretical framework is similar to later developments in studies of globalization, particularly the notion of globalization as deterritorialization (Bradley and Weisner 1997; Scholte 2005).

The Kilbrides argue that the drastic economic changes in East Africa have led to female powerlessness and widening gender gaps (1990). Women in earlier times had access to land through families and regardless of whether they were married or not could cultivate and support themselves. Unmarried women who become pregnant in the age of wage labor and separated families are in more dire circumstances than before, without a social network for support. Likewise, women who are the victims of violence or being oppressed lack resources if they are not near extended kin. Their analysis seems to be predicated on the
assumption of close-knit families in the past, though other writers have shown that migration and social isolation are not new phenomena (Richards 1966).

Regardless of how families functioned in the past, however, ethnographic work featuring women in the postcolonial era paints a similarly challenging situation (LeVine et al. 1994; Tripp 2000). Women featured more prominently in anthropological discourse at this time, with the advent of much of feminist anthropology. African feminism was late to follow suit, though attention to women as subjects in writing increased. As seen with postcolonial studies of women in Uganda, women began to feature more prominently in research as individual, agentive beings, rather than in relationship to male figures (e.g., LeVine 1981; Obbo 1980).

Contemporary Uganda

Contemporary anthropological work in Uganda is diverse in the topics it covers and is both theoretical and applied. Related to above patterns, issues of state-building, nationalism, politics, and independence dominated the early postcolonial period (Mamdani 1983). Since then, there has been a strong emphasis on applied anthropology in relation to gender (Obbo 1980, 1990; Tripp 2000; Tibatemwa-Ekirikubinza 1999), development (Bernt Hansen and Twaddle 1991), and more recently the HIV epidemic (Wallman 1996). Since the 1950s, the major research hub in Uganda continues to be Makerere University. The aforementioned East African Institute for Social Research (EAISR) continues on today as the Makerere Institute of Social Research. Anthropological and social
science research today then, is carried out by both international scholars as well as local researchers, trained locally as well as internationally.

In the decade preceding independence, Uganda saw a growth of nationalist movements in a variety of forms (Turyahikayo-Rugyema 1982; Mamdani 1983; Tripp 2000). Turyahikayo-Rugyema describes one facet of this as a conflict between traditional and modern nationalisms. Across ethnic boundaries, groups aligned to overthrow British colonization. Simultaneously, individual groups struggled to maintain autonomy in the face of a homogenizing nationalism, with the hope of gaining power and maintaining identity in a newly formed government (1982). In response to some historians’ depictions of African nationalism as solely a response to colonialism, he suggests that group identity, though not called nationalism, existed in the precolonial era. During the subsequent decades, it may have been dormant, but was never erased. Hence, movements during the transition toward independence were resurgences of already fomented alliances (Gukiina 1972; Kizza 1999).

Kizza, writing decades later, demonstrates the importance of indigenous institutions (beyond those of the Buganda kingship) in nation-building (1999). Like Turyahikayo-Rugyema, she notes that these organizations were maintained throughout the colonial era, despite being eclipsed in writing. Though these organizations never reached the point of violence, as seen in the Mau Mau movement in Kenya at this time, Ugandan groups advocated for independence and African leadership (Kizza 1999:75). Unfortunately, elites with exposure to concepts of nationalism and educated by the British were in control of many
resources as well; they were the ones to maintain power after independence, leaving many people dissatisfied with an incomplete transition.

Uganda’s independence from Britain in 1962 was a largely uncertain period, as other colonies in the same region also gained independence. In a document from the colonial administration, immediately preceding independence, there is an obvious hopeful anticipatory tone. Britain pledged to help Uganda monetarily and with the structure of the Commonwealth. British administrators oversaw the writing of a new constitution, the swearing in of Prime Minister Milton Obote, and the process of “Africanisation” of government positions (each of whom had to be interviewed by British officials before being approved for office). Even Kabaka Yekka, the political party in support of the Buganda kingship was to have a formalized position within the new government (Doornbos 1982; Furley 1982).

According to Mamdani (1983), however, the transition to independence was merely a new label for imperialist domination, in accordance with some of the dependency and underdevelopment theories of the era. He suggests that the introduction of the World Bank to Uganda in the same year as independence marked a new presence and maintenance of foreign influence, despite the illusion of an autonomous government. The development across sectors begun by the British was continued through nongovernmental organizations and continued to be withheld from the grasp of the people most affected. Mamdani illustrates this point by listing the largest companies in operation in Uganda before and after Independence, as well as their foreign supporters. The same
companies remained prominent over the course of a decade, and were still linked to British investors and other European governments (1983).

Since colonialism was conducted through indirect rule, traditional kingdoms remained important throughout. Tribal allegiance superseded national allegiance prior to independence. Traditional kingdoms maintained power in the immediate postcolonial period, but were then abolished as forms of governance in 1967. Prime Minister Milton Obote, with the assistance of Idi Amin, overthrew King Mutesa of the Buganda and the earliest government established with the help of the British (Ray 1991). As Young (1977) writes, this was an effective "decapitation" of the power of kingships in the region and followed the pattern of other countries in sub-Saharan Africa, including Ethiopia, Rwanda, Burundi, and Swaziland. The Buganda kingdom, after 500 years had lost its stronghold in the region. At the time of Young’s writing, the Kabaka had not yet been reinstated as a figurehead, which would occur following the years of Idi Amin.

Following independence and several violent transitions of power, the notorious dictator Idi Amin took power by a coup in 1971. In addition to his terrorization of Ugandans and brutal regime, the time period until 1979 when he was deposed also caused a break in scholarship of the region (Tripp 2000).

The country still shows scars of fighting from the 1970s, though research done at the time largely tacitly ignores the implications of Amin’s rule on their work and the region as a whole (Mamdani 1983). Colonial critiques were ripe in the back of field workers’ minds, perhaps one reason writing was so often apolitical in a time of unprecedented political and economic changes (Asad

More recent work on politics in the social sciences resembles that of Ferguson and attempts to bring Uganda into the larger dialogue of globalization. Like Mamdani’s critique of neocolonial development, Chachage (2005) suggests that globalization is merely a new label for colonialism. He claims that globalization is inherently a moral process which erodes national identity through introduction of new customs in the form of money or material goods and reliance on outsiders for governance, support, and direction.

In the past several decades, Uganda has again enjoyed a relatively stable political economic situation. The current president, Yoweri Museveni, has been in power since a coup in 1986; his administration, known as the National Resistance Movement (NRM) is a political organization, rather than a political party; political parties were outlawed when the group came into power. Though there is ongoing unrest in the northern part of the country and in neighboring regions, Museveni’s Movement government and no party system has been held up as an example for East Africa.

The current government system is highly decentralized, and has become even more so in recent years. Representatives, known as local councilors (LCs), are elected at varying levels of representation, from the district down to the village level. They have official power in their capacities and can mediate, enforce penalties, and even operate local courts. More recently, all local
councilors and representatives have been designated as public officials and receive remuneration for their work, whereas many positions were formerly on a volunteer basis.

Many of the concerns from earlier eras are still pertinent in terms of land tenure, nation building, and ethnic/national identity formation. Current social science scholarship in the region covers a breadth of topics and is being carried out by both local and foreign scholars (ex. Davis 2000; Parikh 2009; Rwabukwali 1997; Thornton 2008; Tripp 2000; Whyte 1997).

3.3 HIV in Uganda

In Uganda, HIV is still widespread and shows some regional and gender differences. According to the most recent UNAIDS data, there are approximately 940,000 people living with HIV in the country and a prevalence rate of 5.4% among adults, though the Ministry of Health reports 6.4% prevalence among adults (UNAIDS 2010). The central region, including Kampala, has the highest prevalence rate of 8.5% and southwestern Uganda where Mbarara is located has a prevalence of 5.9% (ibid.). In all regions of the country women have a higher prevalence of HIV than men. Urban residents have a higher risk of HIV infection than rural residents, particularly among women (ibid:18). The Ministry of Health also reports slightly higher infection rates among men and women who are employed and those in higher wealth quintiles. Recent evidence suggests that despite early successes, the current rates of infection have plateaued, or are potentially increasing (Wawer et al. 2005).
Antiretroviral treatment has become available in Uganda only in recent years, and the service delivery environment is still being researched (McGrath et al. 2006, 2009a, 2009b). According to recent estimates, 53% of those in need of antiretroviral therapy are currently receiving it (UNAIDS 2010). Treatment was available in Kampala in the early 2000s on a paid basis, or through research. The two clinics in this study and others now offer free treatment to thousands of men and women.

Because of early prevention efforts and ongoing campaigns to raise awareness, HIV is now entrenched into daily discourse in Uganda. Billboards plaster urban areas and trading centers in rural areas encouraging faithfulness, promoting testing and treatment, or targeting specific groups, such as those engaged in cross-generational sex. The most recent Demographic and Health Survey in Uganda (2006) showed widespread knowledge of HIV transmission and prevention. For prevention, 89% of women and 95% of men report that they know limiting sex to one uninfected partner with no other partners can reduce their chance of getting HIV. Knowledge of condoms as prevention is not as high, but still widespread among men (84%) and women (70%).

NGOs have also played a large role in addressing HIV/AIDS treatment and prevention in Uganda. TASO, the AIDS Support Organization, was created in 1987 by a group of infected persons to bring counseling into communities. The AIDS Information Center was created in 1990 and established the first anonymous testing and counseling facility in Africa (Pisani 2002). They have since created dozens of Voluntary Counseling and Testing Centers (VCT) and
assisted organizations to create more throughout the country (ibid). These organizations have arisen out of a local interest and perceived need to supplement the national healthcare system.

International involvement in HIV in Uganda began concertedly in the late 1980s and early 1990s, and focused on building diagnostic and testing facilities and prevention through education. The Ministry of Health is largely dependent on donor funding and its key areas continue to be driven by donors’ priorities. More recently, the United States and England have both played major roles as donors (Ibembe 2009). In developing its PEPFAR strategy, US policy makers have highlighted Uganda’s prevention model, subsequently emphasizing abstinence programs as a core element in programs receiving PEPFAR funding (Sussman 2006, cited in Ibembe 2009). The narrow focus of large amounts of funding dealing with HIV have been criticized as neglectful to other diseases and comprehensive infrastructure building in a country with continued rates of poverty and death from other infectious diseases (Ibembe 2009).

Social science research on HIV in Uganda

Uganda, the site of the first identified AIDS cases in Africa, was one of the hardest hit countries early in the epidemic and has consequently been the site of extensive research (also in part because of government support). In 1993, Uganda had one of the highest infection rates in the world. Ten years later the country reduced infection rates from 30% in some areas to 6.5% as a national average (Uganda AIDS Commission Secretariat 2003). This has largely been
attributed to government initiatives and national prevention programs (ibid.). The government’s acclaimed prevention method is the ABC Program, which stands for Abstinence, Be faithful, or use a Condom (Pillsbury 2003). In 1986, the Ministry of Health began a structured multi-sectored response, involving the Ministries of Defense, Internal Affairs, Education, Agriculture, Planning, Economics, and Gender and Labor (Ibembe 2009).

Uganda’s reported success has taken on a “paradigmatic quality” among the international community (Farmer 2003:7). President Bush even cited Uganda as a model of success in his global AIDS campaign (Riehl 2003). The actual reasons for Uganda’s declining infection rate, especially in consideration of the outcome, are the source of ongoing debate. Anthropologists have been particularly engaged in this debate. The ABC model has been widely used in both HIV prevention strategies and as an appeal for funding. There is sharp debate as to the contribution of ABC to the decline in Uganda’s HIV prevalence rate (Farmer 2003; Feldman 2003; Green 2003; Pillsbury 2003). Notable, the critiques do not discount the reliance on national programs and initiatives. They question the effectiveness of specific prevention methods and the reasons for the decline in infection rates in the population as a whole.

There are several alternative explanations for Uganda’s declining infection rate, other than the national prevention strategies. Wawer and colleagues (2005) examine the role of death or mortality rates as contribution to declining prevalence. Early in the epidemic, mortality rates were potentially high enough to significantly alter the epidemiological profile of HIV in the country, indicating a
more significant decline in infection than would be true if the number of deaths is consistent (ibid.). Similarly, others have speculated that Uganda’s high fertility rate contributes to the appearance of a decline. The country has one of the highest fertility rates in the world (6.8 children per woman) and the rapid population growth may have been a factor the declining HIV prevalence, by increasing the denominator in determining the prevalence rate (Ibembe 2009).

Traditional sexual and marital practices in Uganda have also been examined for their role in the declining infection rate (Caldwell and Caldwell 1993; Obbo 1980). In general, marital practices are endogamous in Uganda; Ugandans are likely to select their sexual partners from a nearby region and tribe. Historically, Ugandans have owned and inherited land and are generally less mobile than other regions of sub-Saharan Africa, despite some rural urban migration (Gutkind 1963; Southall and Gutkind 1957).

Recently, Thornton (2008) published a compelling social epidemiological explanation for the decline of HIV in Uganda using a grounding of these social and historical trends in the country. He compares national prevention initiatives between Uganda and South Africa, two countries that have followed similar trends with A, B, and C though admittedly at different paces. However, the epidemics in the two places have followed drastically different patterns, and the infection rate in South Africa remains high. Thornton’s argument relates the spread of HIV to the configuration of sexual networks in the two countries. In South Africa, the populations are significantly more migratory and have less history of land ownership due to the colonial and apartheid history. In Uganda,
many people are linked to land and the epidemic followed individuals across migratory routes.

In both places, fears of infection and prevention campaigns have changed the behavior of some high risk individuals and many of those infected with HIV have died. These individuals then, are no longer a part of the sexual network. In South Africa to remove a few key individuals from the sexual network does not significantly change the configuration of the mixed sexual network. In Uganda, to remove a few high risk individuals from the sexual networks removes connections between otherwise largely endogamous groups. Hence, the removal of a few individuals through death or early prevention efforts re-insulated sexual networks in the country thereby reducing incidence. Thornton’s work highlights the importance of deeply contextualized research. Without the grounding of historical data and detailed information about marital and sexual practices, his argument would be untenable.

One of the earlier collections of social science essays during the time of highest prevalence and mortality from HIV is edited by Sandra Wallman and focuses on women’s lives in Kampala and strategies for coping (1996). She utilizes case studies of urban women to highlight more broadly the daily effects of the virus and social disruption. Wallman did not originally intend to study HIV, but given the time at which she was writing, it was inevitable. She set out to examine women’s daily lives and household decision making regarding health. She found that the main criteria in deciding to seek treatment were whether or not an illness’ symptoms were deemed “serious enough.” Severity was determined through a
complex model of symptom monitoring, daily life interference, and in the case of children, age. Many women in Wallman’s study were suffering from sexually transmitted diseases and other opportunistic infections indicative of HIV infection. Women frequently put their children’s illnesses, particularly diarrheal diseases, before their own health.

Other anthropologists have focused on families, gender, economics, migration, poverty, and social change in relationship to HIV—representing a large body of the social science research being conducted in Uganda and sub-Saharan Africa currently through multiple theoretical frameworks (e.g., Davis 2000; Green 1999; McGrath et al. 1993; Rwabukwali 1997).

3.4 Domestic violence in East Africa

One study done by Fonck et al. (2005) in Kenya examined the lifetime occurrence of sexual violence among women attending an STI clinic for HIV testing. More than a quarter of the 520 women in the study had experienced sexual violence in their lifetimes, and more than 5% had been raped. Most violence was from the women’s current partners. In their review of the literature, Fonck and colleagues note that these numbers are not unusual; similar or higher rates of domestic violence have been found in population-based studies from Zimbabwe, Uganda, Rwanda, and South Africa. In the other studies as well, there was a high correlation between HIV seropositivity and lifetime history of physical partner violence. Physical violence, when in an intimate relationship, often includes sexual violence.
The women in the Kenyan study all felt at some risk for contracting HIV, hence their attendance at the STI clinic for treatment or HIV testing. The women were not yet aware of their HIV test results at the time of the interview, therefore controlling for the reporting of violence based on disclosure of test results. Other studies have found an association between having a physically abusive partner and a lower frequency of condom use among women (Pulerwitz et al. 2002). Contradictorily, the women who had ever used condoms in Fonck et al.’s study had also experience high levels of physical violence. In accordance with many other findings, the higher the education level of the women, the less likely they were to be in an abusive relationship (Fonck et al. 2005; Koenig et al. 2003). This suggests that education protects women from entering abusive relationships in the first place, rather than simply giving them the means to get out of an unhealthy relationship.

In two Ugandan studies in a rural district, Koenig et al. (2003, 2004) found a strong association between women’s perception of their male partner’s risk for HIV and the women’s risk for domestic violence. One potential explanation is that women who perceive their partner to be at risk may be more reluctant to engage in sex with him (2003). The women’s resistance could be met with violence in response. Nearly one third of women reported incidents of physical partner violence and resulting injuries in the year prior to the research (2004). Koenig and colleagues situate this in the cultural context of gender norms in the area. Most participants in their study (70% of men and 90% of women) responded that beating one’s wife was justifiable in certain circumstances. Women believed
beatings to be justified if a wife refuses sex with her husband, or if a woman used contraception without disclosing that to her partner. This is in accordance with the above findings of the relationship between perception of partner risk and risk for violence. Surprisingly, these attitudes were more prevalent in younger men and women. Typically, status differences in gender are associated with older populations and so-called traditional roles. Koenig and colleagues were unable to explain this phenomenon, other than the pervasiveness of “traditional” gender role ideologies within the community, and perhaps childhood exposure to violence.

In Uganda, reported prevalence of DV/IPV is variable, but studies indicate that up to one third of women living in a rural southwestern district have experienced intimate partner violence in their most recent relationship (Koenig et al. 2003, 2004). Women in another rural district, in the eastern region of the country reported 54% lifetime prevalence of intimate partner violence (Karamagi et al. 2006). In Kampala, half of surveyed women attending antenatal care at the primary referral hospital reported IPV in their lifetime (Kaye 2006). According to the most recent demographic health survey, physical violence is higher among women in rural areas than those in urban areas (61% compared with 54%) (UDHS 2006).

Intimate partner violence, in general, is associated with overall poor health, encompassing physical, mental and reproductive health concerns (Krug et al. 2002; WHO 2005). Reasons for the proliferation of violence against women in developing countries, particularly in East Africa are both conflicting and varied.
In the Ugandan context, pervasive gender inequalities in marriage, the workplace, social interactions, and governance are implicated in the perpetuation of violence against women (Hattori and Dodoo 2007; Obbo 1990; McGrath et al. 1993).

3.5 Fieldsite one: Urban Kampala

Kampala is the capital of Uganda and located in the south central region of the country near Lake Victoria. It is the largest city in the country and located in the center of the traditional Buganda kingdom of the Baganda people, although today, due to migration, the city itself is comprised of many ethnic groups. In recent years, Kampala has undergone significant economic development, in large part due to the country’s role as host to the 2007 Commonwealth Heads of Government Meeting (CHOGM). Development indicators for Kampala and the surrounding region are higher than the rest of the country due to the focus on infrastructure and development in the capital (UDHS 2006).

Interviews were conducted at the Joint Clinical Research Center (JCRC), which is located in a suburb of Kampala. The JCRC is among the largest distributors of antiretroviral treatment in Sub-Saharan Africa since treatment became available in the region. As of 2009, 5164 adults received ARVs through JCRC clinics (2,951 women, 2,213 men).
3.6 Fieldsite 2: Peri-urban Mbarara

Mbarara is located in the southwestern region of Uganda and is the capital of a district of the same name. Mbarara town is where the roads to Democratic Republic of Congo or Rwanda meet and as such, is a busy transportation hub. All goods transported via roadway from Kampala or from Mombasa on the coast pass through this town, which has grown from a truck stop to a town, with many small hotels and bars lining the center of town. The surrounding region is rural and one of the most fertile in the country, producing staple crops for the entire country. The main ethnic group is the Banyankole, the second largest in Uganda. There is also a significant population of migratory cattle-rearing Bahima people on the border with nearby Tanzania.

Development indicators in Mbarara are lower than those in the central region, but higher than other parts of the country (UDHS 2006). Many of the political leaders in Uganda, including President Museveni, are from southwestern Uganda. Due to this, the district often receives larger amounts of funding for development and infrastructure than other rural regions. Also due to the fertility of the soil and high crop yield, there is less poverty in Mbarara than in other rural regions of the country.

Twenty years ago, the Mbarara University of Science and Technology opened on the edge of town and has brought growth and development to the area. Mbarara Hospital, the site of the clinic-based interviews in this study, is affiliated with the Mbarara University of Science and Technology, and has only in recent years begun to distribute ARVs to their primarily rural patient population.
Their lab facilities opened in 2006 and now serve more than 4500 adults (60% women) receiving antiretroviral treatment.

3.7 Summary

Uganda has been the site of extensive and rich research over the years. Foreign involvement has played a major role in shaping the country through its colonial history and in years of development since independence in 1962. Currently, the country is stable under President Museveni, but relies heavily on foreign aid. Domestic violence and HIV are common problems for women in Uganda, and in the region as a whole. Both issues affect health and productivity in the country and the way in which they are being addressed by the national government is described in Chapter 5. These facts together make Uganda an ideal site to investigate the issues of DV and HIV through a lens of globalization. The rich historical and ethnographic data available also serve to contextualize contemporary issues.
CHAPTER 4: METHODS

4.1 Overview

This research utilized mixed methods in four phases of research, each repeated in two research sites over the course of 12 months. Data collection consisted of semi-structured interviews, close-ended surveys, open ended ethnographic interviews, and observation. A stratified random sample was used for the quantitative component and a purposive sample was used for the rest of the interviews. The overall objective of the study was to holistically examine women’s experiences of HIV treatment and intimate partner violence. The three specific objectives of the study were to:

1. Examine the role of Ugandan government policy and government representatives in shaping the experience of women with IPV and HIV, through archival research and in-depth interviews with government representatives at the local, district, and Parliament level.

2. Examine the role of medical, legal, and social service providers in shaping the experience of women with HIV and IPV. This involves in-depth interviews with medical, legal, and social service providers regarding their understanding of broader policies and goals and practices in service implementation and observations of service delivery environments.
3. Understand women’s experiences of living with both IPV and HIV. This involves surveying HIV positive women, and subsequently following up with those who are also affected by IPV, focusing on illness narratives and in-depth interviews on priorities in illness management, cultural values about sex, marriage, and gender roles, and perspectives on available resources and policy.

This research was conducted in English and the local languages for each fieldsite- Luganda and Runyankole, depending on the participant’s choice. Two social science university graduates, Ms. Kisakye Sheila Irene and Ms. Namanya Judith, assisted throughout the data collection, acting as translators when English was not the language of choice for interviews.

The study design was cross-sectional and observational with multiple groups of interviewees, and repeated in the two fieldsites- the central urban capital Kampala and peri-urban Mbarara in the southwest of the country, using both qualitative and quantitative methods. The sampling and data collection procedures for each phase of research are described below, as well as data analysis for the project as a whole, limitations and ethical considerations for the study.

4.2 Sampling procedures

Three types of interviews were conducted in each of the two sites for this research. The first were semi-structured interviews with policy makers and
service providers. Second, a random sample of women on antiretroviral
treatment attending the two clinics was interviewed using a standardized
instrument. And third, a subset of women at each site was selected for follow-up
in depth ethnographic interviews. Observations at clinics and with NGOs were
also done throughout the research. Daily fieldnotes were kept throughout the
study period.

Policy makers were selected purposively to represent a range of
perspectives in terms of both position and location. The Ugandan government
system is highly decentralized with local councilors representing constituencies
as small as a village or a zone in a more urban area. The policy-related
interviews encompassed those representing the smallest political unit to those
participating in drafting of legislation up to a district level Parliamentary
representative. The selection criteria for this group included: a formal relationship
to policy development or implementation, over the age of 18, and consent to be interviewed.

Service providers were also selected purposively. Selection was intended
to encompass the range of places where women seek help for either issues of
domestic violence or HIV infection. Therefore, service provision was broadly
defined to include formal social service provisions through clinics, the police, or
nongovernmental organizations with legal or psychosocial support and informal
service provision through religious institutions, cultural leaders, and local leaders. The eligibility criteria for service providers were: over the age of 18, currently
primary employment or full time volunteer in a service-related position, and willing and able to consent to be interviewed.

Table 1: Policy and service-related interviews by site and gender (n=42)

<table>
<thead>
<tr>
<th>Site</th>
<th>Type of participant</th>
<th>male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kampala</strong></td>
<td>NGO/ activists</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>(n=23)</td>
<td>Medical providers</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Government/police</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td><strong>Mbarara</strong></td>
<td>Informal social services</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>(n=19)</td>
<td>Medical providers</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Government/police</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Policy and service-related interviews overlapped in content and roles of the interviewees (see Table 1 for type of interview by site and gender).

Government representatives charged with policy implementation also viewed themselves as resources for women and service providers as well viewed themselves as policy advocates for women’s rights. A total of 42 interviews and observations were done between the two fieldsites that related to policies or services affecting vulnerable women.

A total of 200 women were recruited from Joint Clinical Research Center (JCRC) in Kampala and Mbarara University of Science and Technology ISS (Immune Suppression Syndrome) Clinic. Women eligible for the clinic-based interviews were over the age of 18 and currently enrolled in antiretroviral treatment.

Initially, study procedures for the clinic surveys of women sought to recruit a random sample through interviewing every fourth eligible and consenting
woman until five interviews were completed per day (the maximum agreed with the research assistant in each site). However, the long duration of some interviews inhibited the selection of women so frequently during busy clinic days. Additionally, early interviews revealed observable differences in the characteristics of women attending the clinic by the time of day. Women attending the clinic in the early morning often were more likely to be employed, while those later in the day were less likely to be employed and stayed at the clinic for long periods of socializing during the early afternoon, following their midday meal. In the morning, women who live closer to the clinic were more likely to attend, with those from a further distance attending in the early afternoon, after traveling across the district or sometimes further.

Therefore, a modified sampling procedure was developed that was stratified by time of day. This was the most practical means of addressing the issues of a long interview time with the variability in women across time of day. Women were selected every 90 minutes throughout the day until a maximum of five interviews were done or the patients were finished for the day. Morning interviews were the most difficult in terms of recruitment due to the above mentioned tendency of women attending the clinic in the morning to be employed and have less free time.

Following completion of the clinic-based interviews, 20 women were purposively selected in each site for further interviewing. The total of 40 women out of 200 was chosen to represent 20% of the entire sample. These women were selected from among those who had disclosed any history of physical,
sexual, or psychological violence. Women were chosen based on their cooperativeness and to represent varied experiences—encompassing those with variable age, level of education, current marital status, severity of violence, recentness of the violence, and number of children.

4.3 Data gathering procedures

Policy makers were interviewed in a semi-structured format and audio recorded when permission was granted. Participants were introduced to the research in general and brought through the process of verbal informed consent. The topics covered in the policy-related interviews varied by the individual’s relationship to policy development. Interviews lasted between 20 and 90 minutes, often dependent more on the convenience of the participant than the completion of the interview. All interviews were done in the location of the participant’s choosing, and all but one were done in their place of employment. Domains covered in the interviews included current and pending legislation affecting women in Uganda, the process of transforming activism into legislation, the role of individuals and institutions, and the perceived experience and options for women affected by IPV and HIV. These interviews were all conducted in English.

Service providers were interviewed also in a semi-structured format and audio recorded when permission was granted. Participants were introduced to the research and verbal informed consent was obtained. The topics covered in these interviews varied by the type of formal or informal service with which participants were involved. The domains included the individual’s role in assisting
or advising women, the organization’s roles and resources, other available resources, the perceived experiences of women seeking help, and suggestions for improvement in service provision. These interviews were conducted in the language of choice by the participant, though mostly in English. Interviews lasted between 20 and 90 minutes and all were conducted in the participant’s location of choice- all chose their place of employment and a confidential location was selected for the interview.

Three sets of observations were conducted with service-related organizations, in addition to daily observation of the clinic setting during clinic-based interviews. These were done informally (though with formal invitation) with a legal clinic for people with HIV, the Kampala Central Police Station’s Child and Family Protection Unit (CFPU), and outreach with a women’s advocacy organization. Additionally, both the legal clinic and CFPU allowed me to review their closed files to familiarize myself with their typical caseload. File reviews in both places were conducted with no identifying information gathered.

At the two clinic sites, the study was first introduced to the entire clinic staff through presentations at the weekly staff meeting regarding recruitment procedures and general study overview. Staff in each of the two sites were asked individually to assist in recruitment as well, by identifying eligible women and referring them to the study. These were those working in reception or the pharmacy- the first and last points of contact during a clinic visit. Women were escorted by the research assistant to a private area in the clinic. In both sites, this was a semi-permanent tent on plastic chairs, behind privacy screens. The
study was explained to women and written informed consent was obtained if possible. If the participant was unable to write, they marked an X and the consent form was signed by an additional witness.

The WHO survey on violence and women’s health was administered to each woman (see Appendix A). This survey is extensive and has been validated for use in developing countries, across urban and rural regions. This instrument measures women’s views on the acceptability of levels of violence and attitudes towards gender roles within a relationship, avoiding external definitions struggled with in much research on domestic or intimate partner violence (Kilpatrick 2004; Saltzman 2004). Women are also asked about lifetime history of physical and sexual violence in intimate relationships. Additionally, demographic data on women’s education, work history, household composition, and service utilization were collected to compare characteristics of women disclosing experiences of violence with those who do not.

At the end of the clinic-based interview, women disclosing a history of intimate partner violence were identified and asked permission for possible further follow up. Women either gave their phone numbers or other instructions for follow up contact if they consented. Women were contacted two or more times before the follow up interview by phone before scheduling the interview. Women were asked if the interview could be done in their home or if not, in a location of their choice. Many women chose to return to the clinic because they were not comfortable speaking candidly in their home environments for a number of reasons. Interviews were conducted in women’s homes, their relative’s or
neighbors’ homes, at the clinics, in cafes, shops, or outdoors. Verbal consent was obtained for these women for the interview and audio recording. These interviews were open ended and most were guided to cover the domains of relationship histories, illness histories, family history, work experiences, help seeking experiences, sources of strength and advice for other women.

4.4 Data Analysis procedures

Throughout the course of research, daily fieldnotes were maintained. These were grouped and paired with data collected in each phase, to supplement the more formal notes taken during and after interviews. Since the data collected was a mixture of both qualitative and quantitative, analysis includes content analysis for themes and basic descriptive and univariate statistics- described below for each group of interviews.

Interviews with policy makers/ implementers and service providers were translated if necessary, transcribed if recorded, and compiled. They were coded for themes of legislation, help seeking, HIV, resources, and challenges and then compared between types of service providers (formal, informal, medical, legal, government) and between Kampala and Mbarara. Responses were also compared with those of women collected during the ethnographic follow up interviews. Due to the small sample size of policy and service interviews (n=42), analysis is limited to descriptive comparisons.

Quantitative data from the clinic-based interviews were entered into SPSS. Descriptive statistics were run for the entire sample and by site.
Associations between variables were assessed using chi square tests or linear by linear tests for directionality. For demographic variables, chi square tests were used to compare all characteristics between Kampala and Mbarara to assess statistically significant differences between the two samples.

For the types of violence, gender perceptions, and health assessments, scales were created to test against 34 of the collected variables for significant associations across the entire sample and between sites. Four types of violent behaviors were assessed in the standardized instrument: controlling behaviors, verbal violence, physical violence, and sexual violence. Each behavior was assessed through a series of close-ended questions about specific behaviors and experiences. During analysis, several questions in the original instrument were excluded (see Chapter 7 for a detailed description of invalid/ excluded questions).

For each type of behavior a scale was created to tally the responses. The WHO study which the instrument is drawn from has only, to date, released preliminary results. For this current study, scales were created to further organize and present the data, grouped by types of questions. Each scale had a different number of points, depending on the number of questions used to assess behaviors: 6 in controlling behavior, 4 in verbal violence, 6 in physical violence, 2 in sexual violence. A “total violence” scale was then developed to incorporate all four of these other assessments. The scale was weighted to reflect the importance of physical and sexual violence, giving each positive response 2 points for these behaviors and one point for verbal violence and controlling
behavior. The final scale is from 0 to 26 points. The scores for the scales are reported in Chapter 7. The ranking of low, medium, or high for each scale was determined from the distribution of scores, rather than a priori or by equal divisions. The distribution of scores was clustered in three groups and the cutoff was made between these. A score of 0-5 indicates little or no violence, a score of 6-14 indicates some reported violence and 15-26 is moderate to severe reported violence.

A health scale was created from a series of 15 questions about specific health issues reported in the past month. These ranged from headaches and stomach pains to depression and fatigue. Each of these health issues were given equal weight and the final scale reflects a tally of individual health problems rather than a weighted measurement. The scale was broken into poor (12-15), fair (5-11), and very good (0-4) health from the clustered distribution of responses.

Three sets of questions in the standardized instrument assess women’s perceptions of gender equality and decision making abilities. The first is a series of six vignettes on women’s opinions of what a wife should or should not be able to do, and women responded with agreement, disagreement, or don't know. The second set of six questions asks women whether or not they think it is acceptable for a man to hit his wife under different circumstances. The third set of four questions in this section asks if women think that a married woman can refuse sex with her partner under different circumstances. From these three sets of questions, a scale of women’s perceptions of gender equality was created with a
possible score of 0 to 16 points. As with the health scale, all responses were given equal weight, and the final score is a tally of all responses that indicate low beliefs in gender equality (as determined by the WHO instrument). The scale was divided into very little belief in gender equality (11-16), moderate beliefs (6-10), and strong beliefs in gender equality (0-5). As will be discussed further in Chapter 7, some of the questions used to assess women’s decision making ability and beliefs in gender equality are interpreted differently in Uganda than they may be in other settings. When taken as a whole, rather than individual questions, the scale acts as a gauge of women’s perceptions of equality in relationships and ability of women to make independent decisions.

Narrative data from in depth interviews with HIV positive women reporting a history of intimate partner violence were transcribed and translated to English if necessary. Recordings were spot checked with other native speakers to ensure reliability of translation. Following transcription, data were coded into 25 themes, under six general categories. These themes were examined through the process of content analysis.

The 25 coded themes from the narrative data were created both a priori and following data collection (see Table 2). The six main categories include relationships, HIV/health, family, support, economics, and other concerns. All categories except for economics and family were anticipated in advance, due to the planned interview probes. Economic concerns emerged throughout data collection and were added as their own category. Families, likewise, proved to be an important domain in interviews, as many women initially felt more comfortable
talking about their parents’ relationships before delving into their own. Transcripts were hand coded into each of the 25 variables and compiled.

**Table 2: Codes for narrative data**

<table>
<thead>
<tr>
<th>Category</th>
<th>Specific codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Dating</td>
</tr>
<tr>
<td></td>
<td>Violence/conflict</td>
</tr>
<tr>
<td></td>
<td>Marriage practices</td>
</tr>
<tr>
<td></td>
<td>Male gender roles</td>
</tr>
<tr>
<td></td>
<td>Female gender roles</td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
</tr>
<tr>
<td>HIV/ health</td>
<td>General health concerns</td>
</tr>
<tr>
<td></td>
<td>Testing</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td></td>
<td>Disclosure</td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
</tr>
<tr>
<td></td>
<td>Group support</td>
</tr>
<tr>
<td></td>
<td>Sickness</td>
</tr>
<tr>
<td>Family</td>
<td>Childhood/education</td>
</tr>
<tr>
<td></td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td>Children</td>
</tr>
<tr>
<td>Support</td>
<td>Sources of strength</td>
</tr>
<tr>
<td></td>
<td>Religion</td>
</tr>
<tr>
<td></td>
<td>Help seeking</td>
</tr>
<tr>
<td></td>
<td>Advice for other women</td>
</tr>
<tr>
<td>Economics</td>
<td>Partner’s work/money</td>
</tr>
<tr>
<td></td>
<td>Money difficulties</td>
</tr>
<tr>
<td></td>
<td>Employment</td>
</tr>
<tr>
<td>Other</td>
<td>Worries</td>
</tr>
<tr>
<td></td>
<td>Future concerns</td>
</tr>
</tbody>
</table>

### 4.5 Scope and Limitations

The proposed research is subject to some potential limitations, due to sampling and methodology. The first two phases of research use purposive sampling to access limited populations of government representatives and service providers, potentially leading to a non-representative sample. However, due to the target population, this remains the most effective means of accessing them. Additionally, the focus on women already undergoing ARV treatment could
be non-representative of women experiencing HIV and IPV, or even of HIV infected women in Uganda, due to uneven treatment distribution throughout the region. The focus on women on treatment, however, expands research on the relationship between HIV and IPV to this population. Similar to all research on intimate partner violence, there is a potential for under-reporting or low disclosure of experiences of violence through the use of surveys. Nonetheless, the reliance on ethnographic methods which utilize local constructions of meaning and cross-culturally validated instruments minimize potential barriers against disclosure.

Initially, the study design included follow up interviews with all of the policy and service providers, but for logistical reasons, those interviews could not be conducted.

4.6 Ethical Considerations

As both HIV and domestic violence are potentially sensitive topics of discussion for women and providers alike, careful attention has been given to the protection of human subjects. Prior to commencement, the study was reviewed and approved by IRBs at Case Western Reserve University, the Joint Clinical Research Center in Kampala, and the Mbarara University of Science and Technology, in addition to the Ugandan National Council on Science and Technology which provides national level clearance. Women in the clinic setting gave written or verbal informed consent and were assured of confidentiality during the interviews and anonymity in analysis and presentation of the research; service providers and government representatives were interviewed in their
official capacities and in the private location of their choice. Throughout the course of the research, data was stored in a locked location.

Special attention was given to individuals who disclose a current abusive relationship or history of violence. These women were referred to services for counseling, advice, and support in the area, both at the clinic and through other organizations. All women who completed surveys were given an informational sheet with contacts for support-related and women's organizations, regardless of their personal history of violence.

Women were given small stipends of 5,000/= Ugandan shillings (approximately $2.50) for their interviews. In the clinic setting, this is an accepted and expected practice for researchers. Written informed consent was waived for the home-based interviews to minimize intrusion or suspicion of family members or neighbors.
CHAPTER 5: POLICY ENVIRONMENT

5.1 Overview

The first objective in this research was to examine the role of Ugandan government policy and government representatives in shaping the experience of women with IPV and HIV through archival research and in-depth interviews with government representatives at the local, district, and Parliament level. Unexpectedly, interviews which examined policy turned out not to strictly be with those in an elected political position. Rather, the interviews encompassed those working in advocacy organizations and otherwise concerned with policy development. There was some overlap with participants working in a more traditional service delivery position. This chapter examines policy from the angle of those who write and develop legislation, advocate for women’s issues in Parliament, and are elected or appointed to implement policy. Policy related interviews include members of government agencies that develop and advocate for policy in Parliament, eight elected representatives- ranging from a member of Parliament to LC1s (local councilors, the lowest level of elected official in the country) on a village level, district health officials, women’s advocates working in the nongovernmental realm, and formal and informal service providers. Current written and pending legislation in Uganda is also discussed.

Policy interviews were done in a semi-structured format and audio recorded when permission was granted. The topics covered in the policy-related interviews varied by the individual’s relationship to policy development. Interviews lasted between 20 and 90 minutes, often dependent more on the
convenience of the participant than the completion of the interview. All interviews were done in the location of the participant’s choosing, and all but one were done in their place of employment. Domains covered in the interviews included current and pending legislation affecting women in Uganda, the process of transforming activism into legislation, the role of individuals and institutions, and the perceived experience and options for women affected by IPV and HIV.

Interviews for policy makers/ implementers and service providers were translated if necessary, transcribed if recorded, and compiled. They were coded for themes of legislation, help seeking, HIV, resources, and challenges and then compared between types of service providers (medical, legal, or social), level of representation or relationship to policy and between Kampala and Mbarara. Responses were also compared with those of women collected during in-depth follow up interviews. Due to the small sample size of policy and service interviews, analysis is limited to descriptive comparisons.

Below is an overview of the current and pending legislation in Uganda as relevant to women’s experiences of responding to issues of domestic violence and HIV and the ideal role of the government in responding to women’s needs as described by all participants.

5.2 Current and pending policy in Uganda

Uganda’s fourth constitution since independence was ratified in 1995 (Leiter 2005). This version contains specific provisions for equality among sexes, races, social and economic classes, and disabled persons. It provides that
“women shall be accorded full and equal dignity with men” (ibid: xxx; LAW-U 2007). Individuals have the written right to non-discriminatory legal access; however, the fear of stigma and retribution may prevent many women from utilizing legal or judicial services in seeking help for domestic violence. Article 33 in the constitution provides that “the State shall protect women and their rights, taking into account their unique status and natural maternal functions in society,” and “women shall have the right to equal treatment with men and that right shall include equal opportunities in political economic and social activities” (LAW-U 2007). Article 27 contains the clause that “no person shall be subjected to interference with the privacy of that person’s home, correspondence, communication or other property.” Police often refer to the privacy of a household as a reason for nonintervention in matters of domestic disputes. Finally, Article 31 is the only one in the Constitution which refers to marriage practices and rights and says “men and women of the age of eighteen years and above have the right to marry and found a family and are entitled to equal rights in marriage, during marriage and at its dissolution.” As will be seen below, these provisions are open to interpretation and may not translate into equality for women or protection from violence within a home. Only in recent years were women granted equal ownership in property inheritance, despite the above clause for equality.

Recent moves to decentralize the government and make representatives accessible to their constituents has resulted in local council members elected and appointed for regions as small as villages, on up through the district level.
The country is divided and represented at the level of District Councils, Municipal Councils, Town Councils, and Parish Councils. Local councilors, known as LCs, act to mediate conflicts within their jurisdiction—particularly social and familial issues. LCs range from an LC1 at the village level to an LC5, at the municipal level. All levels of courts must defer to higher rulings when in conflict and the Constitution is the final set of rules.

During the period of data collection, domestic violence was not illegal in Uganda. Only when violence is severe enough to constitute criminal assault, can it be prosecuted under the Penal Code. According to the police and some providers, this type of prosecution is rare. They believe this is because that severity of violence itself is relatively rare. Violence within households is recognized as being very common throughout the country. However, severe violence does not occur with great frequency. When it does and women are forced to go for medical care or the police is when they are counseled or given or the means to prosecute their violent partner. For reasons that are explored further below, to separate the family or put the man in prison is both a source of shame to the entire family and an economically unsound decision, due to economic dependence. So the police and other policy makers recognize that whereas many women may not know their rights, those who do still may choose not to prosecute an abusive partner under the current system. In cases that do progress to court and imprisonment, women will often bail men out because of the long delay before trial, the gap in household income and the decision to save face as a family unit. As described by one police officer,
Ok, there is law to protect the women. When you are assaulted, you come and we handle you. We take that part of criminally he has committed an offense. There is an offense there. So the act, the act he has done or what he has used, it is criminal. Yeah, and when you are taken to court, you are charged criminally. Yeah, because there is an offense to answer. There is a case to answer. Yeah. So women, if they are assaulted, if they steal their things, when they come to police of course, that person will be dealt with accordingly. Not until sometimes, these women when they come, they come when they are bitter. But when they reach here sometimes they say that, ‘ahh, I’ve decided to pardon my husband. I’ve decided to pardon my fellow woman.’ So from there, we also come in and support them to go and stay with harmony.

(police, female, Mbarara)

This officer was unaware of the pending legislation, but was clearly dissatisfied with the current procedures and criminalization. She spoke at length about the delays in court processing times and women’s reluctance to respond because of the systematic constraints. A local councilor in Kampala remarked on the subject, also from the angle of responding to women within the constraints of the current system. He says that women bail men out because they earn money for the household and this usually stalls the legal process.

I used to tell them that assaulting somebody is a criminal offense that could be taken to police straight but these women at times were skeptical. The moment you tell them we go to police, they say “if we go to police, they will arrest him! And if they arrest him, I will not be earning the bread for the children!” Some of them are in rentable premises. They say “if my husband is taken to prison, who will pay the rent? I will be thrown out by the landlord! Who will pay the school fees? I will not be able to meet the needs of life for me and my children.” So they end up actually going the other round and withdrawing the case and saying no, I don’t prefer a criminal case opened against him. Things end up there like that without going any further. (LC, male, Kampala)

This local council member was dissatisfied with the current course of action. He has been serving his home region for the past 7 years, moving up within the ranks of leadership. He, along with a group of other stakeholders in the
community, through a collaborative effort with a rights-based NGO, drafted bylaws to make domestic violence illegal in their particular division of the capital city. In the decentralized Ugandan government system, local leadership has the power to draft and create new legislation applicable to their particular area, provided it does not conflict with any higher laws. The members of this particular community found violence to be common, without solution, and with the assistance of the NGO, something to be acted upon. The stakeholders who contributed to this bylaw were not unrealistic about being able to stem domestic violence completely. Rather, they hoped it would be an example to other communities and the national government. As one LC who co-authored the bylaw commented, “If they don’t see it [domestic violence legislation] as a priority we thought why not have it as a bylaw to be effective so that it can act as a sample in a given locality so even Parliament can appreciate [the example]” (LC, male, Kampala).

The bylaw was passed by the division, but not enacted during the time of fieldwork. The newspapers reported that the division was ready to enact the law when the Domestic Violence Bill was passed. In the bylaw, domestic violence is defined broadly, using the WHO definition. Community members are obligated to report “any person or persons that he has reasonable cause to believe to have committed, to be committing, or to be likely to commit an act that in his or her view, amounts to Domestic Violence.” The responses to reported violence can include: reconciliation, declaration, compensation, restitution, costs, apology, and attachment and sale. In this way, victims receive compensation that they would
not be entitled to in a criminal court prosecution. The division level has the ability to enforce a maximum fine of 2 currency points (each currency point is approximately $5USD) or 6 months imprisonment. Their emphasis is primarily on local mediation and reconciliation, once people are compelled to report, with a goal of reducing processing times and making a faster response than through the current system.

Marital rape is currently not illegal, nor are there sociocultural sanctions against it. Marital relations are considered a “bedroom issue” and not appropriate for discussion in the public sphere. Women reported high rates of sexual violence within the home, but this was rarely a topic broached by those concerned with policy. There is a growing discussion of marital rape in the realm of activist NGOs and rights-based discourse. These women’s groups have been advocating for the inclusion of marital rape in the pending legislation, though with an understanding of the difficulties in identifying and reporting of such a crime.

The Domestic Violence Bill was passed in November 2009, shortly after the completion of data collection. The status of the bill before Parliament was a major source of discussion and contention among both policy and service oriented providers at the time of data collection. All groups expressed a cautious hope that the bill would be passed soon, with many refraining from drawing comparisons with the decades-long battle to pass the Domestic Relations Bill. According to one district official, the Domestic Violence Bill is more likely to pass because of its focus on human rights;

This one [the Domestic Violence Bill] is actually addressing issues concerning mostly about human rights, about human dignity, so
that someone can be free of domestic violence in a given area throughout the whole country. So this one is most likely to go through faster than the Domestic Relations Bill. I hope. (LC, male, Kampala)

The new legislation’s largest change from the current process focuses on utilizing the heavily decentralized government. Domestic violence is reclassified as a civil violation, rather than criminal—except in severe cases. The two primary implications for women from this change are 1) the processing of cases in local council courts, which are close to home and convenient (LCs are where women often go for help once the decision is made to report outside the home) and 2) for civil offenses, the complainant can receive monetary remuneration. Very few of those in a position of policy implementation knew about the [then] draft Domestic Violence Bill. They were aware that currently violence is dealt with as a criminal assault, but not that there were moves to change this.

The process from passage of a bill to its implementation is a long one. The Uganda Law Reform Commission is required to translate the bill into local languages and begin dissemination among the constituencies across the country, with collaboration from NGOs and stakeholders who helped to draft the bill initially. The Police Act, which dictates the police responses to violations also needs to be amended before the police can comply. The process of awareness raising and implementation is estimated to be several years, dependent on the funding for these activities.

For more than 40 years, the Domestic Relations Bill has been before the Ugandan Parliament in varied forms. It has been one of the nation’s most contentious pieces of legislation. In its various manifestations, the bill has been
written to legislate issues of legally recognized marriages, polygamy, and
divorce. A representative from a women’s legal group said about the issue that
there are no current laws addressing marriage and the bill is not a priority.

> Currently we don’t have a domestic relations bill or a law
> addressing that [marriage]. There are sort of different laws and
> most of them unfortunately are not very favorable to women and at
> the moment- since the 1960s- they’ve been trying to pass this
domestic relations law. It has never been passed because for some
> reason, it becomes a circus and men come up in arms and it is
dropped and then the government goes and it’s not a priority
> anymore. And then another one resurrects it. (NGO, female,
> Kampala)

The 2006 version of the bill attempted to outlaw polygamy and was
protested by, according to a legal officer “conservative Muslims and other
traditionalists”- not the general population, and the bill was quickly defeated
(NGO, female, Kampala). The 2009 version of the bill called the Marriage and
Divorce Act (though still generally referred to as the Domestic Relations Bill)
made special provisions for Muslims, in the Muslim Personal Clauses Bill. This
section of the Bill allowed polygamy for Muslim men to have up to four wives, in
accordance with their traditions, provided the women consented. Quadic courts
were also proposed to deal with Muslim-related conflicts within homes and
families. The name alone was off-putting to some potential supporters. As
explained by a women’s activist and NGO worker, the mention of divorce ends
the conversation and brings to mind the split up of families and negative Western
influences. She disagrees with this uninformed view;

> Because the bill is saying marriage and divorce bill, people
> unfortunately before they even read the bill, they are saying the bill
> is coming to tear up families. I heard some of them discussing in
> the media, saying here in Uganda marriage is forever, divorce is a
western thing. And I was shocked! Because as we were growing up, even before people started talking about these rights, I was seeing people divorcing. People begin relationships even if they are not married, they end. I don’t think that’s a western thing. I don’t like to say mean words, but that’s how bad it gets. (NGO, female, Kampala)

The rest of the 2009 bill recognized those wed through traditional marriages with the same rights as those married in a courthouse or religiously, but cohabitation was contentious and removed from the bill. The bill is currently stalled in Parliament, with its proponents pessimistic about the progression beyond its current form. One women’s activist in Kampala commented that the current Ugandan government “does not have the political will” to pass the legislation. She remarked that during the time that the DR Bill was up for passage and repeatedly stalled, the Parliament passed a constitutional amendment to term limits (allowing the current president to stay in power) in “record time”- an illustration of what she called a double standard and de-prioritization of women’s issues in policy making. She thinks the current women’s movement in Uganda “feels very deflated.” Speaking also to structural constraints in passing legislation, another representative of a women’s advocacy group noted that while Uganda’s constitutional requirement to have women as 30% of representatives across all levels may seem progressive, this is still the minority and a barrier. Men may see the bill as limiting current freedom in marriage and feel threatened by it. She said of the Domestic Relations Bill, “it is tricky. It may take time- reason being it really suppresses the men and when you look at Uganda Parliament, over 70% of the Parliamentarians are men and then 30% are women so it really becomes- to me, I really feel it is going to be a very
tricky bill to be passed now” (NGO, female, Kampala). Another activist, the same one who was ‘shocked’ by the uninformed opposition to the bill is angrier about the delay in the bill’s passage and the lack of focus on issues related to marriage and protection for women. She says,

“It’s a very long battle because of the hypocrisy surrounding all this, people are getting charged over the non-issues in the bill and leaving out the very nice provisions within the bills. Because if the bill is defining how marriage should be and how people should live as intimate partners, the rights of each, as in making the decision of marriage, the right to decide when to leave and the right to ownership of property. I think those are very important things. Unfortunately they are not focusing on those things. They are focusing on rumors. They just look at the title of bill and say this is too bad! (NGO, female, Kampala)

The current policy regarding marriage gives favor to men and makes no provisions for most traditional marriages and all informal cohabitation; this activist’s views highlight the frustration in gaining rights and protection for women and families.

Currently there is no protection from discrimination for those living with HIV/AIDS. The pending, but now stagnant legislation regarding HIV/AIDS in Uganda has also been controversial, particularly internationally. The text of the HIV/AIDS Bill from the Uganda Law Reform Commission (the governmental body charged with researching and drafting potential legislation) in 2009 provided rights for those living with HIV/AIDS and protection from discrimination. The controversial portion criminalized intentional transmission of HIV in vague language and has been criticized by international human rights groups. A primary concern of the bill’s opponents is the potential for the criminalization to disproportionately affect women, by the interpretation of mother to child
transmission of HIV as a form of intentional transmission. The policy advocacy officer at the Uganda Women’s Network, Andrew Bahemuka writes in a newspaper editorial, “it reinforces the stereotype that people living with HIV are immoral and dangerous criminals, rather than, like everyone else, people endowed with responsibility, dignity and human rights” (New Visions, 15 April 2009). One representative of a women’s advocacy organization expressed similar concern about the violation of rights in the potential legislation, but felt strongly that it was being backed currently by members of Parliament and provided international attention did not detract from the current momentum, the bill would be passed in the next few years. Several women working in legal and advocacy organizations mentioned that they were fearful of the bill being passed as a “private members bill”—which is brought forth through individual Members of Parliament and not subject to the same scrutiny as that which passes through the Law Reform Commission. Providers in the HIV clinics were more mixed on the issue. They all condemned the criminalization of transmission, but also generally approved of the provisions allowing healthcare providers to inform someone’s partner of their HIV status, particularly in situations where the man tests alone and they fear he will not tell his partner[s].

5.3 Views on government

The policy environment is changing in Uganda. Representatives and providers both frequently commented on the deceptive nature of written policy in the country. On paper, Uganda looks like a strong rights-based culture, with
progressive and fair laws. In reality, they see the laws as being ineffective at best and the government is appreciated for its efforts and criticized for the incomplete enactment of policy. Across all of the interviews, participants in the research expressed mixed views on the current political environment in Uganda and the role that they believe the government should be taking in responding to women’s needs arising from situations of HIV infection and domestic violence. Healthcare for HIV is viewed as given directly by the government. Local councilors are frequently viewed as the accessible arms of the government and should be capable of enacting change. Given these two factors, the “government” is not necessarily discussed as a disembodied entity, rather the sense of proximity to government allows for open dialogue and critique. A tension remains, however, in the close relationship of government to constituents and the constituents’ perceptions of slow and corrupt change that is out of reach.

One religious leader, who emphatically praised the government and its support for his mission, also commented more generally about the corruption and lack of transparency across levels of representation. He says,

*And another problem we have, I think we have the law in Uganda. But we still have a problem with corruption, that one I cannot hide. I am Ugandan, I love my country, I love my government, I support this government, but we have a problem with corruption.* (religious leader, male, Mbarara)

Corruption inhibits the passage and enforcement of laws and he believes it pervades all levels of governance.

Of the eight government representatives interviewed, only two were reluctant to discuss what they thought could be improved in the governmental
response to women’s issues. One opened up after the audio recorder was turned off, explaining that “social” issues are simply not a priority. He feels that roads and measurable indicators of development are the priority because of their appeal to international funders. In the realm of health, this includes distribution of medicines, but not necessarily other means of helping those on treatment or capacity building in clinics and social services.

The current AIDS treatment policy, though funded internationally, is domestically viewed as the work of the government. Women attending clinics thought of their free medications as directly from the Ugandan government, bringing them proximately closer to women’s daily lives. In this closer relationship, expectations were increased. Early reductions in HIV infection were talked about frequently and praised, though also criticized for the narrow scope of prevention campaigns. Government roles and responsibilities in decentralized Uganda are a part of everyday discourse. Individuals feel simultaneously empowered in their representation and ability to speak freely about the government and constrained by corruption, bureaucracy, and a disembodied sense of government. The following section gives an overview of all participants’ views on the government in Uganda- in terms of achievements, shortcomings, and the desired role it ought to play.

Internationally lauded as a pioneer in HIV prevention, the Ugandan government is criticized from within. All of the policy makers, implementers, and service providers recognized the initial efforts made by the government to curb the epidemic. Currently though, they are ambivalent about the government’s
efforts and mixed on how resources should be allocated. With the HIV rate currently steadied but increasing in some areas, there is work to be done. In both clinic sites for this study, antiretroviral drugs are being provided free of charge to thousands of HIV positive men and women. UNAIDS currently estimates 53% coverage of ARVs for those who are in need (UNAIDS 2010). The drugs are manufactured abroad and paid for by bilateral aid programs, multinational health development organizations and the Ugandan Ministry of Health. Patients in the clinic are aware that much of the funding comes from abroad, but the government is held accountable for procurement and distribution of the drugs.

One nurse, working in HIV care for nearly two decades commented that the situation in Uganda was commendable, particularly in contrast to other country’s efforts. She said, “the government decided to help HIV people, and in some countries there are leaders who shunned the HIV positive” (nurse, female, Kampala). A representative of a women’s legal organization felt the same way about the government’s response to HIV/AIDS, though she was openly critical of many of their other policies relating to women. She commented, “So for certain thematic areas like HIV/AIDS, I think Uganda has done very well…I think it was an area of interest, political powers were also interested in that area. So it is an area where the government really worked very hard” (provider, female, Kampala). Though acknowledging the initial successes, one HIV counselor expressed his disappointment with progression in the country. He says,

Of course it was one of the first countries to act immediately when HIV was identified and all of the efforts were done. But now things have changed. Things are completely different. That’s not the
experience. If we are still following the same, by now it [HIV] would be too minimal in Uganda. (counselor, male, Kampala)

A Christian minister who frequently counsels HIV positive members of his congregation was resigned about the situation. From his personal experience of losing many friends and family members to HIV, he viewed the government as failing and unable to address the epidemic on any level. “All of my agemates were erased. So this disease, the government intervened later. Our governments are also weak, they are weak” (religious leader, male, Mbarara). He went on to explain that his helplessness in influencing broader change deepened his mission to respond locally through his church. A young HIV counselor in Kampala was equally as bleak about the efficiency of the government’s response to AIDS. He spoke at length of his frustration in turning patients away and the growing urgency of the need to develop sound policies in HIV care. The policies exist on paper, but in reality, the government is not accountable for efficient distribution of ARVs and money is not being used efficiently. He says,

Because look, ok, it [policy] is saying that access to ARVs, there is a policy of that, of availing ARVs to everyone who needs them. But where are they? So on paper they sound very superb but in reality, nothing. The government is not doing much to ensure drugs reach the people who need them, even if your drugs are out. They just expire in the stores. And two, I don’t see even a budget to facilitate that. Because like if we depend on donor funding, the budget should be clear and say this percentage is going to this service. But he doesn’t even want to put in budget when the donors will give us. You can’t depend on such. And two, if the policies work, like if we had problems with funding that comes to deal with HIV, people have been abusing this money- look at what has been done. So the policies are like this cobweb policies, they apply to some few and others they just run through the cobweb. Nothing is done to them. I think we need better policies. (counselor, male, Kampala)
Women on ARVs were first and foremost grateful for the lifesaving treatment. They praised the government’s role in providing ARVs, but were still open about additional programs that ought to be in place for helping women. Both clinics in the study receive government funding. One woman in Mbarara traveled for hours to go to the clinic, rather than an outpost closer to her home. She explained the reason for this simply, “it’s because it is a government hospital. So everything is there. That is why I choose to go there” (age 45, Kampala). She believes that the smaller clinics and those privately funded are more susceptible to drug shortages and the only way to ensure ongoing quality healthcare is in a large government-funded facility.

Treatment is not the entire picture though. Women also need transport money to get to the clinic, proper nutrition to guarantee effectiveness of treatment, and care for other members of their households and families. One woman described her early experience on treatment as being difficult and something that could have been helped by the government through food supplements. She says,

_The first two weeks the medicine was so bad, it was so bad on me and if the government now can give the women at least some food that they can eat the HIV positive women at least by the time you take that medicine if you have something in your stomach that medicine wouldn’t affect you so badly but they don’t have what to eat and the government is not really providing any food so you should provide food that is paramount._ (age 28, Kampala)

Many other women on ARVs echoed the sentiment above, mainly citing lack of employment and the cost of school fees for children as the main barriers to adherence. In their view, if the government is taking responsibility for providing
medication, it also ought to provide comprehensive services for people living with HIV or the programs will not be effective. A narrow approach to serving people with HIV is, according to many, not only ineffective, but also unethical. Women desire to be productive members of society with their regained health and call upon the Ugandan government to assist with employment, school fees, and food.

*If only they [the government] could get money and educate our kids.* (age 32, Kampala)

*What I’m saying, the government should really consider HIV positive mothers because most of us even when we are sick. The reason why we get up to try to do anything absolutely is because of our children because your child doesn't have what to eat, doesn’t have clothes, cannot go to school and now like for me I have one child who’s HIV positive.* (age 28, Kampala)

*Most of the women who have HIV and are widows don’t have jobs. Others have children and school fees. But their children can’t study. So the problem is big in women because at least if they would get organizations that would help, so that women can go and work and be there and their children. The government would have helped but the government help gets lost on the way. It’s not easy as the help is coming it gets lost.* (age 33, Kampala)

As one LC1 summed up the situation, efforts are being made in all sectors and improvements are gradual, but insufficient. “*HIV is still a big problem. The government is trying. Programs are teaching people. Groups and organizations are doing a lot to educate. It goes on and on*” (LC, male, Mbarara). The government and other groups are working on issues surrounding HIV, without much progress in recent years.

On the issue of domestic violence, participants were more uncertain as to what the role of the government should be. In contrast to HIV, domestic violence is still seen as a “private” issue to be dealt with in the home or at a very local
level. As will be shown later, women often turn to local government representatives for help, but in their capacity as counselors, not representatives. Several of the policy makers and implementers noted above, spoke of the need for legislation and lobbying towards the [now passed] Domestic Violence Bill. Though beyond the level of policy, at the interface with women themselves, both women and providers were more ambivalent regarding the government’s responsibility. Legislation ought to be in place, awareness raised, but when domestic violence occurs, they are uncertain if the “government” should intervene.

With this issue of IPV, the idea of government again becomes a bit fuzzy. One is uncertain if the government being referred to is actual state-driven infrastructure and policy, or simply a call for help from those in a position to do so. As one woman commented,

*I say that women who are abused by their husbands should seek protection from the government, because when you seek help from government protection, they can stop him and he can get scared. But instead of staying home, and being beaten all the time, they should seek help from the government.* (age 36, Mbarara)

Her comments indicate that women should seek assistance, rather than enduring violence, but the specific mechanism through which “government” help can be obtained is unclear and could refer to law enforcement, NGOs, LCs, or services which do not currently exist.

Social service providers were more explicit in the government’s role towards vulnerable women. They spoke of the Ugandan state’s management of social services as being heavily influenced by donors and poorly managed within
the country. One activist believes that the impetus for changes in policy and improvement of services is from within as part of a growing human rights discourse, but is insufficiently connected to broader global concerns. As she says,

*I think its [a growing human rights discourse] more first from internally from realizing the problem and now its making them [policy makers] connect to the global issues, because globally it was already recognized but here because they were like, those are foreign things they had not yet started thinking about it in a more positive way but the level of awareness that has been created now is making these people connect to those global issues and now they are feeling more obliged to act as the government.* (provider, female, Kampala)

Another activist, working for a women’s legal group differed in her opinion- in that the changes in policy are externally motivated, though she agrees that the government is obligated to enact services and to date has not done so sufficiently. She commented,

*...yes they [the Ugandan government] adopted them [social services] because it was influenced by the international community, but at the end of the day, the people who are supposed to benefit from these programs don’t benefit because partly because the government has failed in its duty, partly because there’s also a lot of corruption within the government system itself and sometimes partly because maybe they never thought seriously about what they were taking on before they did. So there’s a lot of things which come into the country.* (provider, female, Kampala)

5.4 Summary

The new legislation addressing domestic violence represents a way forward in the global community, though as expressed by all participants, it is to date insufficient. International human rights discourses and grassroots activism are driving the pending legislation. Poverty is still a major concern in the
treatment of HIV. Despite the internationalization of AIDS treatment and heavy reliance on donor funding, the Ugandan government is perceived to be the key player in provision of treatment and care for men and women living with HIV. Strategically, service providers in formal and informal positions work around the inefficient government in their practices by increasing donor funding, individually contributing to causes, while simultaneously lobbying for a stronger government and more effective policies. As one representative of a women’s legal advocacy group said about her organization’s activities, “this should have been really the job of the government but they are not doing it” (provider, female, Kampala). Current legislation is not viewed as sufficient to increase women’s options for responding to violence or assistance in dealing with HIV infection. Representatives interviewed were generally consistent in their views of the government’s progress and limitations, regardless of their level of representation or location. The next chapter shows the strategic provision of services for women through governmental, nongovernmental, and nontraditional realms.
CHAPTER 6: SERVICE PROVISION

“So NGOs, as much as we are trying to fight it [domestic violence], it is impossible to erase it from our society, I assure you.” (legal officer, female, Kampala)

6.1 Overview

The relationship between national policies and women’s experiences is seen in the provision of services for women affected by HIV and IPV. This chapter explores the availability of resources within Uganda from the perspective of service providers, in both formal and informal roles. This relates to the second research objective to examine the role of medical, legal, and social service providers in shaping the experience of women with HIV and IPV through in-depth interviews and observations with medical, legal, and social service providers regarding their understanding of broader policies and goals and practices in service implementation and perceptions of women’s vulnerabilities and help-seeking behavior.

Service providers also were selected purposively; as described in Chapter 4, the interviews had significant overlap with those concerned with policy. These interviews aimed to encompass the range of places where women seek help for either issues of domestic violence or HIV infection. Therefore, service provision was broadly defined to include formal social service provisions through clinics, the police, or nongovernmental organizations with legal or psychosocial support and informal service provision through religious institutions, cultural leaders, and local leaders. The eligibility criteria for service providers were: over the age of 18,
current primary employment in a service-related position, and willing and able to consent to be interviewed.

Service providers were interviewed in a semi-structured format and audio recorded when permission was granted. Participants were introduced to the research and verbal informed consent was obtained. The topics covered in these interviews varied by the type of formal or informal service with which participants were involved. The domains included the individual's role in assisting or advising women, the organization's roles and resources, other available resources, the perceived experiences of women seeking help, and suggestions for improvement in service provision. These interviews were conducted in the language of choice by the participant, though mostly in English. Interviews lasted between 20 and 90 minutes and all were conducted in the participant's location of choice- all chose their place of employment and a confidential location was selected for the interview.

This chapter gives an overview of medical services, formal and informal social services, providers' attitudes towards assisting vulnerable women, and constraints and suggestions from service providers.

6.2 Medical providers

Between the two HIV clinic sites where women were recruited for research, a total of eight providers were interviewed- including counselors, nurses, pharmacists and a physician. The two clinics are among the largest providers of antiretroviral treatment in sub-Saharan Africa, with the Mbarara clinic
attached to the university there and operating as one of many satellites of the Kampala clinic. Both clinics distribute free antiretrovirals (ARVs) to men and women, once they clinically manifest a low CD4\(^1\) count and undergo mandatory counseling. The issues presented by medical providers were similar in both sites; in both Kampala and Mbarara they spoke of the difficulties of a heavy workload and expressed similar concerns for their patients’ economic constraints. In both places, the issue of blaming women for their troubles tinged conversations, particularly with male providers.

Currently in Uganda, funding cuts and drug stockouts are becoming a reality, after the initial optimism and rapid treatment roll out (UNAIDS 2010). However, during the course of this research, only the Ministry of Health was experiencing drug shortages and the clinics, both funded by multiple international sources, were able to supplement the shortages through other means and the interruptions went unnoticed by the patients.

**Clinic settings**

Both clinics open five days per week and offer comprehensive services for men, women, and children with HIV. ARVs are free, as are tests to determine CD4 counts. Prophylactic Septrin, viral load tests, other lab tests, and treatment for opportunistic infections are generally only available for a fee. Many men and women have had these services covered for varying lengths of time, as well as comprehensive care for their households as a part of larger research studies.

---

\(^1\) CD4 refers to T-lymphocytes bearing a CD4+ receptor. CD4 tests measure the level of these disease-fighting white blood cells in the blood. A low CD4 count is indicative of a compromised immune system and is used to determine when a person with HIV should begin antiretroviral treatment.
The clinic in Kampala is in a grassy, gated compound, guarded by military personnel, due to the clinic’s association with the Ministry of Defense. The buildings are spread across a neatly manicured campus, and many patients visit the clinic socially and sit outside on days other than appointment days if they live in the area. The waiting area becomes crowded by late morning through the mid afternoon, with clients lined up on benches throughout the main building and the adjacent tent. The clinic in Mbarara has a high-ceilinged entry without open sides and a reception and waiting area in the middle. The main building for the clinic opened in 2006 and has two stories and new lab facilities. The clinic itself only began distributing ARVs for free in 2004 and has grown rapidly beyond capacity since that time. Patients are now screened to attend the clinic and sent to other regional facilities when possible. Early in the morning, clients crowd the reception area- as they are given appointment days rather than times and are seen on a first come, first serve basis. By late morning every available space is filled with people sitting, the hallways are lined with benches on either side and become nearly impassable.

Views on patients

Staff at both clinics are stretched thin with large patient loads and limited resources. Though they may recognize that the clinic is a good setting to address social issues such as domestic violence, since the women are already seeking care, other concerns remain central. All of the providers interviewed spoke of women as having separate challenges from men for accessing and maintaining antiretroviral treatment. The main challenges that women face, according to
medical providers, are due to dependency on their partners and part of a larger context of poverty. Clinicians feel helpless to respond to these structural injustices and instead typically only discuss clinical concerns.

One nurse described women as having more difficulty in keeping appointments, for various reasons. He complained that though the reasons may be legitimate, they disrupt the order of the clinic and make his job more difficult.

Some of the patients who are on treatment, they fail to turn up on the days when... we give them. And they give many reasons. I have no transport, my what, I had this sick baby, I was sick, my wife or my husband, you know, was A, B, C, D, sick, you know, such that generally definitely they give genuine reasons, but we try to encourage them to respect their appointment dates. (nurse, male, Mbarara)

The same nurse continued on this thread, suggesting that while men may make more money in a household, the issue of women’s dependency was becoming not only moot, but also laughable.

Men are usually the bread earners of the family and if the husband is not cooperative to give the money to the wife for treatment, or for you know, whatever, then that could affect the adherence. But these days you claim that we are equal and what. I think sooner or later that excuse will vanish [laughs].

His view is not an uncommon one; he is just the most vocal, perhaps because of his age and gender. Other providers hinted at the idea that women were to blame for their own burdens, but none said it so explicitly. His blame of women for violence and other troubles continued throughout our conversation. This nurse suggested that immorality and serial monogamy among women made them more vulnerable. Women who have children with more than one partner are common, but socially stigmatized for their behavior. As he says,
We cannot always keep on blaming men. Women are also pains. They don't disclose. And another thing… the challenge which I see, most women who are vulnerable, who are coming from in the villages, they are married to more than one husband. Mmm. They can tell you that ‘I first married to one husband of mine and we got like 2 kids and another one, we got one, we separated.’

Others providers are more sympathetic towards women’s issues, recognizing that HIV treatment and illness management exacerbates women’s dependency on men for money- for transport or proper nutrition to mitigate side effects. On countless occasions, I witnessed clinic staff members reaching into their own pockets to assist needy clients, despite the official admonishment of this behavior by both clinics. As one physician described,

*We had instances, within a period of 2 or 3 months, I may give transport to about 4 patients, my own money…so they sell a goat or they borrow money, and after you see them, they tell you don’t even have money to go back. So if you have some money, you give it to them. And I’m sure all the clinicians here, we’ve done that a number of times.*(physician, male, Mbarara)

Economic concerns were by and large recognized as the most significant inhibiting factor towards women’s success on ARVs. Economic difficulties typically first impact adherence through a lack of money for transport, and as seen above, clinicians often go beyond their prescribed duties to assist those who are the worst off. The other ramification of poverty for those on ARVs is insufficient nutrition. Side effects of treatment are exacerbated without proper nutrition. Most providers also recognize that poverty is gendered and most difficult for their female clients. Women are much less likely than men to be employed (particularly in rural areas) and hence dependent on men for money to feed the family, send the children to school, and travel to the clinic for their
appointments. Women who are in partnerships therefore must be able to tell their partner why the money is needed, and those who are widows become dependent on others for all income. One counselor spoke of this as the most significant problem facing women with HIV,

*In case of women, the major problem is lack of enough money to look after their families. And even to the extent of failing to get money for transport. And most of the females are widows. And jobless.* (counselor, female, Mbarara)

Women struggle to get employment for basic needs and transport to the clinic.

**Counseling**

Clinic staff promote disclosure unilaterally as a means of improving treatment adherence. In Mbarara, all of those enrolling into treatment must bring a “treatment supporter” to initial counseling sessions before they are allowed to begin treatment. This is ideally a spouse, family member, or close friend to whom the patient has disclosed and can rely on to remind them to take the pills as prescribed and encourage a healthy lifestyle. Despite the emphasis on disclosure, counselors in particular are realistic about the dangers that this can pose to women. They know for many women disclosure can lead to blame, arguments, violence, or even separation and a lack of support. However, some counselors continue the strategy despite the potential dangers, particularly in Mbarara where women must find a treatment supporter. As one counselor there commented, women are always vulnerable, but they have to focus on disclosure nonetheless:

*Ladies you know they are always vulnerable. Whenever they disclose to their husbands, their husbands, at times they are harsh, they beat them, they chase them away, they throw away their*
A female counselor spoke at length on the issue and shared her personal hesitation in encouraging disclosure in all situations. She felt her role was more of a guide than that of a teacher or authority figure, expressed by the other counselors interviewed. She says,

*For us counselors, we don’t advise. We simply discuss the options. We talk about the advantages of disclosure. We first discuss the importance of disclosure. Then it is up to the client to decide whether to disclose or not.* (counselor, female, Mbarara)

Nonetheless, the counseling sessions in both clinics are done with the aid of checklists and issues outside the immediate purview of treatment concerns rarely enter into the conversation. Counselors know that they can potentially impact their clients' lives to a great extent, but due to the inability to have ongoing intensive sessions are limited to advising and suggesting courses of action.

*Medical provider workload*

Systematic constraints within the medical system limit providers' interactions with needy women and the resources they have to respond to issues outside of an immediate medical purview. The sheer volume of patients in each clinic is well beyond the ideal capacity of caregivers. One nurse in Kampala, in her late fifties, commented that nurses have always been busy, but in recent years it has become unmanageable. She views nurses to be “natural counselors” and enjoys visits where she can check up on the client's personal life. She and every other clinician lamented their inability to engage beyond the medical, describing extreme situations where up to 250 patients are seen by one clinician
in a single day, or a more typical load that can still include up to 70 or 80 patients (the described ideal is 20-30 per day for a comprehensive visit). One physician described his typical clinical encounter as rushed, but in large part possible because of the success of ARVs in restoring health.

By the time they come to the clinician, they have been triaged, all this has been done, so you ask them, are you on ARVs, they say yes, which ones you are taking, by looking at their form, they are able to tell, so you stick with what medications they are using, ask them if they are taking septrin, they say yes and you assess how adherent they are. Any complaints, none. So if somebody has no complaints, you look at their eyes, mouth, no problem, their skin is fine. You spend very few minutes and you are done with most of these patients. So the clinic picture of patients that we see has changed from those who are very sick to those are very well has helped us to see many patients in a day, within a short time.

(physician, male, Mbarara)

He and other providers move quickly through clinic visits because patients are healthy and they are lined up outside waiting. As another nurse summed up her feelings of her hands being tied- the lack of staffing limits a clinical encounter to the bare necessities, not what she ideally wants to do. She says, “if they are too many sometimes, you just do what you’re supposed to do, not what you want to do, like maybe talk to a client for another 10 minutes. You cannot do this because the line outside is so long and people have to go away to work” (nurse, female, Kampala). Patients are lined up, and she cannot discuss more in depth issues.

Service provision for HIV in Uganda has grown rapidly in recent years and thousands of men and women have access to life saving drugs that were inaccessible until only a few years ago. The clinics are filled to capacity and clinicians stretched to their limit. The social dimensions of HIV, including
gendered vulnerabilities and exacerbated economic dependency are recognized by clinicians. However, their own constraints and exhaustion can lead to laying blame upon some women or, more commonly, focusing on the immediate clinical aspects of the illness to promote adherence and clinical success.

6.3 Formal social service provision for intimate partner violence

There is currently only one formal shelter for women in Uganda. This opened only in late 2008, and is located in the eastern region of the country. Neither Kampala nor Mbarara have any currently operating shelters for women seeking refuge from violence. One shelter was being run previously by an NGO, but shut down around 2006 due to insufficient funds and corruption. Women seeking help for violence from an intimate partner have few formal options. Many take the path of running to family members or neighbors if they need refuge. For mediation they may approach a local councilor, and these cases usually do not enter local courts. The police and several NGOs are the primary formal options, though each of these have their own limitations as well. In Kampala, there are a plethora of nongovernmental organizations and many are dedicated to causes of vulnerable women or children. Unfortunately many are advocacy-based organizations and do not provide direct service or have limited activities due to insufficient and intermittent funding. In Mbarara, the primary legal organization providing services and representation for women closed recently due to lack of funds and there are currently no service organizations there. As will be seen in the next section, many of the options for women in western Uganda and rural
areas are informal, through community and religious leaders. Below is an overview of available services for women, and the views of representatives from the police and several organizations.

Kampala formal service providers

The Central Police Station (CPS) is in the center of Kampala and houses the Child and Family Protection Unit (CFPU). According to one officer there, there are only places for children to stay temporarily at the Central Police Station. She showed the small dark rooms that were currently empty, just behind the police offices. Sometimes if women have a small child and there are no other children there, they can stay overnight. Women seeking shelter are sent away and advised not to return home and try to go to relatives. Many sleep in the park or some even sleep on benches in the CPS waiting area. Two police officials were interviewed in Kampala, and as will be seen below, expressed similar concerns to those in Mbarara, focusing on a lack of resources and legal sanctions. They focus on mediation and referrals in cases of family conflict, which they cite as very frequent throughout the country.

The Kampala CFPU is in a single room, with long benches where children and family wait to give their handwritten statements on blank paper. An officer is assigned to the case, and if they have money for transport or enough money for airtime and the offender has a phone they will call and make home visits. More often than not, a person is summoned to the police station and a written agreement is dictated by the officer and signed by both parties.
A review of twenty randomly sampled closed cases at the Kampala CFPU from 2008 showed frequent domestic violence complaints. However, in none of the cases was this the primary complaint or reason for going to the police. The files were dominated by complaints of a lack of male financial support for the household or children's school fees. Also common were cases of inheritance disputes, where a woman was widowed and denied her legal property by the husband's family because of informal marriage arrangements, multiple partners, or other family disputes. Particularly in the cases of familial economic neglect, violence was written into statements as a side note. The police deal with the entire case, but due to the legal limitations of being unable to respond to domestic violence unless it is criminal assault, written agreements focused on money and property. Typically the solution is to have the man bring part of his paycheck directly to an LC or the police, where the woman later comes and signs that she has received the money. In other cases, one or two sessions of mediation are offered at the police station and then they are left alone.

One counseling organization in Kampala has existed for 15 years, but in different forms. A group of mental health psychiatrists recognized the need for counseling for “survivors of abuse.” They began a small group which offered psychosocial counseling and couples mediation in the city, and eventually opened a small shelter for women as well- which closed several years ago due to a lack of funding. At other points in time, when funding has been available, the group expands to incorporate preventive activities and capacity building through training of healthcare workers, local councilors, police and magistrates to
sensitively respond to physical and sexual violence. They have seven district offices throughout the country, which offer small-scale counseling to women in the area. When funds are short for counselors, the organization takes on volunteers and also practices “advocacy, research and documentation” through contract work for the government or other organizations. The program manager says that HIV is rampant among women who come for assistance, but the organization must refer out for testing when a woman is raped and she frequently does not return, and they are unable to follow up. He says that women have few options and many are stuck at home, because they refuse to leave their children behind. Women who are not working cannot afford to take the children. If they are working, they can only have custody with the man’s consent. He says,

To those who leave the home, many of them go back to their relatives. Then there are those who are in business …earning a salary-- those who are working, you know they just quit the home. And then rent their own units and then many of them have ended up going with their children because they have fear that the men cannot really take care of the children. (NGO, male, Kampala)

The organization operates on a system of referrals from healthcare providers and social service organizations. The clients who arrive for counseling are usually extreme cases, particularly refugees and those who have suffered extreme ongoing violence. Women in the area who are affected by physical or sexual violence are welcome to come for a session or two of counseling, but are not the priority group. Since the shelter closed, the only direct assistance available from the organization is psychosocial counseling when counselors are available. However, the friendly receptionist and volunteers give advice and refer women to other sources of legal support.
There are two primary legal support organizations available to women in Uganda. Both have headquarters in Kampala and offices throughout the country. They are staffed by a core group of employed lawyers and clerks, but heavily depend on volunteers doing pro bono work. One group had an office in Mbarara which closed recently and the region is currently without a legal organization.

Four interviews and one set of observations were conducted with these two groups, which are generally packed to capacity, with lines of waiting women. One organization operated a legal clinic two times per week specifically for those with issues related to HIV/AIDS. The other legal clinic recently closed and now the former HIV/AIDS center serves as the central legal clinic for the area. Women arrive early to the large, open, low-ceilinged building and either make an appointment or register their follow up with a receptionist. Three legal officers have small offices off of the main waiting area, where they call clients one by one from the rows of benches. A review of 200 randomly sampled closed case files from this clinic show a myriad of cases. However, exactly as was the case with the police, domestic violence was frequently recorded in the cases, but not usually the primary complaint. The majority of cases involve child support, familial maintenance, property issues and other economic concerns. As one activist commented about the lack of help seeking directly related to domestic violence, “But if some of those women had some of the money, they would not be able to endure those things. Because they endure those things for the basic need which is survival” (NGO, female, Kampala).
One of the legal organizations is only mandated to serve “indigent” persons, as defined by law. So they first do a needs assessment for individuals and then take their statements. The primary course of action is mediation, particularly when there are couples involved. Legally, not all of the conflicts have a solution, but the legal officers have formal training in counseling and use that as a first resort. The main cases that go to court are severe criminal offenses and property disputes. The largest population is women, particularly those with informal marriage unions, looking for rights to child custody or maintenance.

The legal officers know that women frequently face violence, but they have a heavy case load and generally only address the primary complaint. They each handle sometimes 30 or more cases per month, and focus on non-court resolutions (approximately 2/3 of cases are handled in this manner). The legal officers at both organizations said that the primary reason they think women do not come forward is cultural. To seek help for a home issue brings shame to the entire family, a loss of respect from relatives and community members, and may result in divorce. As one said,

_A lady, you walk from NGO to NGO reporting your husband, you’ll not be respected. You’ll not be respected. Who’ll marry you at the end of the day if you are a young lady running up and down? So it’s still you lose respect among your in laws. At the end of the day you’ll end up filing for divorce._ (NGO, female, Kampala)

Divorce is a last resort and those cases are few compared to economic concerns. Another legal officer said that part of this is due to women’s “dependency spirit” of having to rely on men. Women are taught from birth to be subservient and when a man does not provide, they lack the industriousness and
skills to generate their own income. In general, women stay out of formal organizations and go to families or local resources, particularly parents-in-law. The same legal officer said that women’s typical response to violence is to “just relax, keep quiet, maybe tell your mother-in-law then as I told you, usually our first court usually in our cultures in Africa in Uganda if you have parents-in-law, go there.” Women keep familial issues within the family because of cultural expectations and a lack of other options.

One organization in Kampala has had sustained funding through bilateral, international, and individual sources for the past decade and focuses on prevention of violence and empowerment of women. Their approach is comprehensive and has become well known. The organization works with police, religious leaders, healthcare workers, the media, and local councilors to sensitize them to a rights-based discourse on women’s equality. They do community outreaches with each of these groups and “train trainers” from all over the country to spread the discussion-based curriculum. Likewise, within individual communities, they train community workers to hold discussions and inform men and women of nonviolent means of conflict resolution and potential resolutions through town hall meetings, movie screenings, football games, and other community activities. This organization was also a primary author in the aforementioned community bylaws in one region of Kampala. Their mission is to address all forms of violence at the root cause of gender imbalance. However, the workers there are sometimes frustrated by their inability to respond directly to ongoing violence. In a series of observations and outreaches with this group, I
saw a welcoming response from communities and an excitement to engage in dialogue. Men and women expressed frustration with violence in their communities and brainstormed ways to respond as a community, given the lack of formal support available. The executive director and strong women’s rights advocate, described women as dependent, which feeds into a cycle of poverty, conflict, and sometimes HIV/AIDS.

When she goes to the other side [her husband’s home] to be married, unfortunately, the men don’t usually provide 100%. Or even when they provide, they provide little, with still the assumption that this belongs to me. In fact not assumption, the belief that this is mine, she can only get a little piece and it is me to make all the decision on how to spend my money. And the men often times put a lot of conditions on how they provide. For example, like if you still want me to provide, you don’t have to work. You don’t have to associate with whoever you want to. You should have as many children as I want. And then when it comes to the issue of how to have sex, now that is most critical moment. Because I provide, you live in my house, there is no way you can use a condom. And then if you ask, if he still thinks you are in his favor, when it comes to things like access to treatment, of course that needs money. Medical care. If he still wants to take care of you, if he’s not violent to you and he still thinks you are important to him, then he will be able to give you money for transport to access medical services as well as to pay for the treatment itself. Most times, when all the other violence is happening, he is not going to provide all these things. And now that of course increases the women’s vulnerability to progression to AIDS state. (NGO, female, Kampala)

The formal social services for women in Uganda exist predominantly in Kampala and some upcountry locations, though not in Mbarara. Services encompass legal advice, counseling, and police action in severe cases. Other organizations address women’s issues through activism and research. The organizations themselves are constrained by limited funding and reliance on donors and volunteers. They believe that while their case load is high, many
women do not seek help formally due to culturally ascribed stigma and economic dependency issues.

*Mbarara formal service provision*

In Mbarara, there are few avenues for women to seek formal assistance. Two interviews were done with officials from the police and Probation office. There is one national organization in town that does advocacy for women’s rights, but a representative said the organization has little to do with direct service and no one was available for an interview. The group which runs the legal clinic in Kampala recently closed their Mbarara offices due to a lack of funds.

The situation at the district police in Mbarara is much the same as in Kampala. The small room where the CFPU office is housed there is also cramped with overfilled file cabinets and covered in posters from NGOs to promote the elimination of child beating, child labor, and domestic violence. They list similar cases, as to those seen in Kampala of estate disputes, marital infidelity, child abuse, and household issues such as “drunkardness.” For cases that do not qualify for court, they counsel families, create written agreements, or refer to the district Probation Officer. As one officer says she feels limited in her capacity, and forwards as many cases as possible where counseling does not work. “*But most of the cases since they happen in the families, I counsel. Where I fail, I forward. For further management. Meaning that if the case has been reported, I have counseled and really these people they cannot be advised any*
further” (police, female, Mbarara). When asked about how she learned counseling skills, she says that she learned through life experience primarily.

I think through experience. So far I’m also a married lady. I’ve spent like 10 years in marriage and with four children and I’m officially married. Yeah. So and I’m 38 years. So maybe for that and I’ve been tending some seminars, workshops, with those people in the villages. So through the experience and yeah. And I’ve been also working with other officers who also do the same work.

This officer was unaware of either of the draft Domestic Violence and Domestic Relations Bills pending at the time.

The probation offices in Mbarara are some distance outside of town on a hilltop with other district offices. They are charged with overseeing child welfare for the district and, as a result, frequently deal with general familial conflicts and cases of household violence. The officer there, however, expressed the same limitations as the police and tries to refer out as many cases as possible. If a woman comes to him without having first gone to the LCs or police, he will try to send her there. He said that the majority of cases there are brought forward by women when men are neglecting the household and legally he has the ability to enforce child and household support. He says a few situations are cause by women being inattentive to household duties, but largely due to men’s infidelity. He says,

A man is an adventurous animal. Yeah. And he is an adventurous animal. He moves around and sneaks somewhere there and then the woman will discover that he is having another concubine somewhere. And when she hears of that and she talks about it and what, that’s the beginning of the quarrel. (probation officer, male, Mbarara)
Like the others, he tries to create a written agreement and encourages the couple to stay together if possible. The cases are more than he feels he can handle, even with a formal master’s degree in counseling and a decade of experience in civil service.

6.4 Informal service providers

As mentioned above, the Ugandan government system is highly decentralized—down to the level of village representation. A board of local leaders is elected at the local level and serves as the liaison between local people and higher levels of representation and is given some power within their own right. The lowest level of representation within the system is that of an LC1. Local council courts, made up of five local council leaders, operate on the level of town, division, or subcounty. These courts have the jurisdiction to hear cases related to marriage, divorce, debts, contracts, assault, damage to property, and trespassing. They can order reconciliation, declaration, compensation, restitution, costs, apology, or fines—so long as they are not in conflict with a higher level of court. In reality though, when the majority of women turn to LCs for help, the matter is kept outside of court or formal agreement. So while local courts are potentially a venue for local legal action against domestic violence, in this study they were found to be largely irrelevant and unused by women seeking services. Instead LCs act as informal mediators of conflict within communities.

Eight local council members were interviewed in both Kampala and Mbarara regarding their roles as resources for women seeking help. Although
they do some formal mediation and written agreements, most act informally within their capacities to provide counseling for women. The position of LCs as known community members is both potentially advantageous and damaging to the couple in mediation. Many women spoke of their attempts to seek help from an LC, only to be cast aside because the LC is a friend of her husband. Their closeness to the family can also be advantageous in deescalating conflict and making the couple feel comfortable.

*Local councilors, Kampala*

One woman LC in Kampala has been in her position for 10 years and, as she calls it, “marching” for women’s rights for the past 20. On the side of a busy road, she sits in her hardware store everyday and listens to the radio, to learn from different programs. On this day she is wearing a tie-dye dress, with a Guinness apron on top, and periodically fishes through the pocket on her belly for her keys or spare change. She is a tall, strong woman and is more than happy to sit and chat with us. Given her experience in activism, this LC speaks in broad terms about women in general, though her office is very near to the HIV clinic in Kampala and deals with many of the women from the clinic directly.

She believes that women’s rights are growing rapidly in Uganda, especially in Kampala. She says in the zone where she is responsible for handling local women’s issues, domestic violence is rare and men fear women’s equality, but are gradually embracing it and the situation is improving. She believes that the police have a special unit specifically for domestic violence and all forms of violence in a relationship, including physical, emotional, verbal, and
sexual, are illegal in Uganda currently- just not enforced. As seen above, this is not the case. Women are dealt with through the Child and Family Protection Unit, and domestic violence is not illegal unless it constitutes criminal assault. Although she deals with most women’s cases through mediation, she has found that when police help is sought, they are generally responsive.

The main barrier to improvement is not poverty but “ignorance” according to this woman LC in Kampala. The main goal of activism is then to spread “enlightenment” about rights among both men and women. This is increasing because of media campaigns, radio programs, television shows, and community sensitization projects throughout the country. The persistence of domestic violence in rural areas is due to poverty and the cultural imbalances of men and women. She refers to some women who tolerate domestic violence as “ignorant” and “backward” and products of a system which does not prioritize female education. Like some of the medical providers, she blames women for domestic violence.

This woman’s husband is also an LC for the same area; he is the vice chairman of the local council. He aspires to move up in the local government in the upcoming elections. He said very few women come to him with issues of domestic violence, and the serious cases he refers to his wife to be dealt with. At times, the two of them together counsel couples. When asked about how he learned this role and became a counselor, he replied that,

They [women in the community] come with domestic violence, from their husbands. We [he and his wife] call them to sit together and we advise them to start a new life in marriage. It usually works. We
have experience- we have been married for more than 20 years!
(LC1, male, Kampala)

In general however, he viewed himself as merely a stepping stone to refer
couples with problems to other people or the police if it is severe. And issues
brought to him stem from an “African” culture, rather than local particularities,
making the situation similar throughout the country and region. Other social
issues in the community he views as significant include school absenteeism,
defilement, poverty, and HIV. Despite his proximity to the largest ARV distribution
center, he thought HIV was still rampant and problematic—in large part because
of a lack of fear. He says,

*People fear HIV during the day, but not at night. Like you meet
someone and you move with the condom, just in case she resists. If
she doesn’t resist you can go without. Women are not fearing HIV
and don’t use condoms. When they feel they are safe they don’t
use. If you see these women on the street, if you are going to use a
condom it is 10,000 [approx. $5USD] if you are not going to use a
condom, it is 20,000. That is how it is. The main cause is poverty.
She is scared that he will go away and she will lose her chance.*

He is acknowledging the role of poverty in HIV infection and unequal sexual
relationships, particularly transactional sex. But, since men continue to take
advantage of women, he is uncertain of the way forward.

Another LC related HIV and sickness in the home to poverty and stress,
and frequently violence as a consequence. This local council member is now an
LC5 and a primary author of the domestic violence division bylaws mentioned in
the last chapter. As an LC1 for a decade previously, he remembers frequent
instances of domestic violence, primarily perpetrated by men and occurring in
poor homes.
There is the highest level of domestic violence is found in most poverty stricken homes. The sick. You can find that the husband is the provider, the breadwinner, and he is the one down first, for example with AIDS. So the sustenance of the family becomes a very big problem and in the process this provider if he fails to achieve what he could do, he can change to become hostile. And when he becomes hostile, the effect is assault, is this, is the battering of the family, disappearing, doing this and that. (LC5, male, Kampala)

His proposed solution is both structural and immediate- the bylaws allow penalization without custodial sentences and he advocates with local organizations to promote mediation and conflict resolution at the local level, allowing men and women to seek help near their homes.

Local councilor, Mbarara

In Mbarara, one of the LC1s spoke frankly about his ability to deal with issues of counseling or conflict resolution. He feels inadequately trained and refers women who come to him to whatever services are available, though as noted above, there is a lack of formal social services in Mbarara and the surrounding region. He says of the situation,

So we find it difficult here in our offices. It’s a challenge because dealing with such issues when you are not trained, because we are local leaders, we just jump into things the way we see them. It’s a big challenge, but we try to comfort them, we direct them where to go. (LC1, male, Mbarara)

LCs can offer mediation and basic conflict resolution, but more often than not, refer women elsewhere for help.

Religious leaders, Mbarara

Ugandans are typically very religious. Beginning in the 1800s, missionaries had a very strong presence in the country and continue to do so...
today. The population is estimated to be 80% Catholic or Protestant, 10% Muslim, and 10% other religions- mainly born-again Christian (UDHS 2006). Religious praise and ideology are seamlessly woven into daily discourse, regardless of religious affiliation. Religious leaders therefore, have a significant role in moral guidance among their followers. Women seeking advice, counseling, refuge or spiritual guidance frequently turn to their religious leaders, rather than formal service providers early in the help seeking process. In Mbarara, where there are few formal social service organizations to assist women, I interviewed representatives of the four largest religious institutions in the region: Muslim, Anglican, Catholic, and Pentecostal.

The region’s main mosque is located within Mbarara town and is filled to capacity at prayer times daily. Behind the enormous mosque sits an administrator and two primary imams. The one available to share his experience was difficult to contact, due to his busy schedule. He is a middle aged man, and has been at the same mosque for 15 years now. Throughout the interview he was called away to deal with conflict resolution issues- including the two very angry young men who were sent to him in the midst of a heated argument over payment for some manual labor. The imam was calm and dealt with each issue in its time. He said that his schedule is always as busy as the day we visited. Both men and women come to him equally if they are having problems with money or work or with their children or in the home. He has gone to training for counseling in Kampala and attends workshops several times per year to learn conflict management skills and mediation. The men and women who come are
encouraged to do so as a couple and their most common issues include
difficulties with polygamy, infertility, infidelity, and physical, sexual, and verbal
violence. He says that the practice of polygamy can be stressful for certain
couples, but when done respectfully can create a healthy family unit with extra
support. The imam offers multiple sessions of counseling and makes
recommendations, including separation. He explains that divorce is not
problematic for Muslims. So while he is available and encouraging to couples to
resolve problems, there are sometimes issues that are too large and he confers
with the elder sheik and recommends they separate.

The Anglican Church has two large churches within the town of Mbarara
and dozens of other small ones scattered through the district. The two in town
are busy and filled to capacity during services on the weekends. At the main
church, one of the reverends shared his experiences in the past year in serving
his congregants. He views himself as a counselor and encourages parishioners
to come to him with any sorts of troubles they may have to develop a spiritually
sound solution. True to his claim, during the course of the 45 minute interview,
three parish members arrived seeking guidance for money problems, school
problems, and a home issue. The other primary concern that people come with is
spiritual possession and the reverend says he does an average of a few
exorcisms per month and continues ongoing prayer with the people after. Other
than making himself available at the church for counseling and advice, he and
the other reverends practice what he refers to as “pastoral” visiting.
As he sums up his advice for couples having troubles, “our mission is unity.” He does not advise divorce or separation of families, even in extreme cases. The pastor views conflict in a home as being perpetuated by men and exacerbated by poverty. He says, “You find a husband being drunkard and he cannot give school fees to the children and you find out there is such a problem. I think what we do, we, at times we try to tell the woman to be calm.” In terms of dealing with HIV, he says that stigma is still quite strong and inhibits men and women from disclosing to him or other church members their status. The ultimate goal of their advising is to pray for people and give them hope to change their situation.

At the center of the Catholic diocese in Mbarara is an enormous Cathedral on a hilltop and about a dozen surrounding buildings, housing a school, a tailoring apprenticeship workshop, housing, and a center for counseling. The counseling center is responsible for community outreach throughout the region and also trains and awards degrees to new counselors. A pair of the outreach counselors shared their experiences in the community, particularly in regards to familial issues. They do community based seminars and sensitization projects, followed up by visits to community-identified needy families. Home visits include mediation sessions with trained counselors and teaching of conflict management to the families. The Catholic Diocese program of counseling is the only one of its kind in the region that has been sustained.

The counselors themselves are quietly confident and articulate. They are proud of their positions within the community and take the position quite
seriously. Their speech is not peppered with the blame, judgment, or exhaustion
that frequently worked its way into conversations with other providers. They cited
the causes for domestic violence within the community to be rooted in poor
communication and gender imbalances within families. Like the pastor, they cite
alcohol as a major cause of fighting and conflict. One counselor says,

When there is drunkardness, there is definitely violence. Because
when the husband comes drunkard, he comes shouting of course
and they start off fighting, beating, then the children are also
violated. There is a lot of violence. (counselor, male, Mbarara)

The other adds that cultural priorities in educating men furthers the gender
imbalance in relationships. There is often a conflict between traditional and
“modern values” which they try to mitigate through community meetings of
people with similar issues. She says that sometimes this is also exacerbated
through the use of drugs or alcohol.

You might find one of the partners, either the husband or the wife
has gone to school and the other one does not have the same
education. So the other one believes that the cultural values should
override the modern values you learn from school. And equality is
not easily attained. And they don’t fight because one is abusing
drugs or alcohol, but because they don’t agree because of what is
in the home. (counselor, female, Mbarara)

The counselors work in a team doing outreach in the community. They first
consult with LCs and have community-identified issues as the center of initial
meetings. They bring men and women into small groups separated by sex and
administer psychosocial evaluations. The group meets over three sessions
talking about community and individual issues and people make commitments to
change behaviors, including drinking, quarreling, or poor communication. The
counselors then follow up with individuals and families for as long as is necessary to implement the action plans.

One of the many growing born-again Christian churches in western Uganda is housed in a huge, sprawling one-story barn at the edge of town, down a dusty road. The inside of the building is filled with plastic chairs, fake flowers, and towering sound equipment. Behind the building are a few administrative offices that always seem busy with young men and women coming and going or sitting under the tree playing music and singing. The pastor of this specific church sits in an air-conditioned office behind the church with huge leather sofas. He is in an over-sized suit and instructs his young wife to sit quietly in the corner, also dressed nicely in a lavender suit. The pastor speaks in sermons, rather than responding to questions. He gives a long story of coming from his humble orphaned beginnings and the mentorship of an Italian priest.

He has a church-sponsored program to assist orphans and widows in home-building. As pastor for the past ten years, with formal training in counseling, he says that congregants are encouraged to come to him for social problems. However, this is as a last resort so they do not separate and a job that he feels should ideally be fulfilled by other providers.

*I want to tell you the truth, we as church leaders, we are overburdened by the work that should have been done by somebody else. Like if there is FIDA [association of women lawyers], if there is a unit at police, they should have been the people to handle the cases. But these poor ladies, after failing there, they come here.* (religious leader, male, Mbarara)

Predominantly, he views conflicts between men and women as resulting from the conflict between tradition and modernity. He says that he tries to preach
during services that men should know their wives are equal, but women should also not embrace “western culture” too much. The families that come to him for counseling he teaches the same and tries to solve conflicts through mediation. He says there are not the resources for home visits or follow up sessions, but he does the best he can with the time he has free.

_Cultural advisor Mbarara_

In many Ugandan cultures, education about gender roles and marriage is done for women by their paternal aunt before their wedding. The aunt serves as a negotiator for the couple early in the relationship and continues to deliver advice about being a wife to women throughout marriage and adulthood. In Banyankole culture (the majority tribe in Mbarara region), an aunt is known as a _shwenkazi_ (_senga_ for the Baganda people in the central region). In recent years, due to the scourge of AIDS and increased mobility, some women have taken the role of a professional shwenkazi to give advice. In Mbarara, there is a professional shwenkazi who works for the local language daily newspaper. She writes a column advising men and women on marital issues, when they do not have someone else to ask. The current shwenkazi has been doing her job for four years and says her workload is so high that she now has a team of writers to assist her efforts. They attempt to answer every question that is sent in, whether by email, letter, or in the newspaper’s column. She speaks frankly on issues of sex and other issues that couples may have, which are often culturally taboo to speak of in public. Her column is widely read and serves as one outlet for women seeking help anonymously, who do not want to bring shame upon their families.
The vast majority of her questions are from women, but they respond to those from men and children as well. She regularly attends workshops and conferences sponsored by women’s groups to keep informed about counseling, rights, and options for women.

The professional shwenkazi described the most common issues she sees and her typical solutions, which she tries to keep in line with traditional culture while still informing women of their rights. The usual issues are lack of economic support, infidelity, alcoholism and consequent money issues or quarreling, unemployment, sickness—particularly with HIV serodiscordancy, stepchildren, remarriage, polygamy, and “bed issues.” Her most common solution is for families to make time to sit together and plan. She encourages communication surrounding all issues and gradual, measurable changes—as in the case with alcohol. She refers people to government schools for children to decrease the economic burden. In the case of “bed issues” she frankly tells women to try new positions, lubricants, and romantic outings to decrease men’s infidelity. Likewise, she advises them to be around the home and take part in cooking so a man is not tempted to cheat with the housegirl. However, if things get too bad, women are told to go stay with relatives and work on issues with their partners from outside the home:

Of course, when a man neglects you, you go to your family friends or your relatives, they can look after you. Because if the man says no, I don’t want you…For them the husbands say I no longer want you, nothing you can do. Because when you persist, he can even kill you. So you advise them to look to the relatives, the relatives have to look after them. (cultural advisor, female, Mbarara)
She says some women come directly to her office at the newspaper with partners after reading her columns to get further advice. She is respected in her position because of the cultural significance and the anonymity of those seeking advice.

6.5 Summary

There is acknowledgement among all of the providers that violence happens to all women in Ugandan society. As one legal officer said, “it is everywhere really, I can assure you.” Several providers also mentioned the issue of class. Women who are educated or wealthy are viewed to be just as likely to experience violence from their partners, but face greater pressure to save face and not draw attention to themselves by reporting their partners. So while these women are the most likely to have the knowledge of available resources or live in an area where help is available, they are also unlikely to utilize the services.

The reasons for violence are variable, but there is an apparent “othering” of women who are affected by violence from the service providers. A handful shared very personal stories of how they got into their line of work—particularly of their parents’ relationships, but now they are separated in space and ideological difference from the women they work with. Most of the explanations for violence, other than poverty and stress within a home, blame culture. Culture in this sense is used as a derogatory term and is pitted against “modernity” or education as the alternative. Culture is an outdated set of beliefs that inhibits individuals from progress, and particularly the empowerment of women. As one
physician commented, “here in Uganda there is still that kind of culture, whereby the man is the one who gets resources” (physician, male, Mbarara).

Women are typically alone when they seek help. LCs and other service providers are then in a difficult situation of giving women advice and counsel on how to deal with their partners without also speaking to the partners. Because of this, women are frequently instructed to defer to their partners and appease them, rather than solving the conflict as a couple. One LC spoke of what he found to be a frequent problem of the husband’s infidelity with the maid or “house girl:"

*We tell them to take care of their husbands. They are supposed to cook for them. Not the house girl. They are supposed to lay the bed, not the house girl. They are not supposed to let the house girl enter their bedroom anyhow. They are not supposed to, say when they are going to the villages for a visit, a woman goes alone and leave the husband in the house, that even gives a chance to the husband or the house girl to, you know.* (LC, male, Mbarara)

While he gives the woman advice to avoid situations which “tempt” the man, she is blamed for the situation and her lack of attention to culturally prescribed gender roles.

The woman LC interviewed in Kampala who believes that domestic violence is decreasing also cited culture as a stumbling block to further improvement. In Buganda culture, aunties or *sengas* are responsible for premarital education of women. In their lessons, sengas often teach women to be subservient and to deal with household conflicts within the home, lest they bring shame to the entire household.
The LC above and four of the other providers interviewed referred to the case of Specioza Kazibwe, who was once a Vice President of Uganda. She publicly came forward and said that her husband was beating her. She was shamed in public and before Parliament, and thought to have brought great embarrassment to her household before eventually separating from and divorcing her partner. This case they use to illustrate the cultural intolerance for disclosing familial matters in public, in particular for a woman to come forward as a victim. Violence, while not publicly tolerated, is a matter to be dealt with behind closed doors. As one LC spoke of women who had experienced violence,

*Some of them, they will keep quiet and not tell. It stays between them. Because that is women’s culture. If a husband beats you, keep it at home. Some think if he beats me, he loves me. Then they keep quiet.*

The rhetoric of “if he beats me, he loves me” is pervasive, when it comes to domestic violence. Clinic staff and service providers alike mentioned this phrase as being a belief, particularly among tribes in western Uganda and those less educated. It removes the impetus to intervene in domestic violence, when the women herself does not problematize it. Even a popular song sung by a Ugandan male in the early 2000s used this phrase. However, as seen in the next two chapters, women themselves never made reference to this cultural belief in their own narratives. There is ongoing tension between the human rights promoted by some women’s advocates and social media campaigns throughout the country and traditional cultural gender roles. Women are expected to be subservient to fulfill their duties, but told to act independently and potentially bring shame to the family by seeking help if there is conflict.
Service provision for HIV positive women seeking assistance for IPV in Uganda is limited at best. Men and women working within that realm are constrained across a number of levels—including systematic considerations of a lack of resources, training, personnel, and funding, as well as in cultural dimensions of blaming victims and upholding unequal power structures. Even with the best of intentions, service providers in the current policy environment are limited as to their potential impact. Those working to help vulnerable women often donate their own time and money, though prosecution for domestic violence is rare and difficult. Women face barriers of shame and stigma to access services initially and service providers struggle with limited resources to assist those who do come forward. Outside of Kampala, other than the police who are used in extreme cases, only informal assistance is available through local leaders and religious leaders. Medical and social resources are separate. So while a woman may be seeking treatment for HIV, her other concerns require an extra effort to seek out services if they are available and navigate the shame and blame associated with disclosure of “household matters.” Policies described in Chapter 5 are largely independent of the services available in the country. They primarily come into play when a woman seeks legal redress and is unable to do so because of a lack of protection for informal marriage unions.
CHAPTER 7: SURVEY DATA

7.1 Introduction

The intersection of intimate partner violence and HIV infection is a sensitive and personal subject to discuss with women. Each individually is difficult and when compounded, create a stigmatized and dual vulnerability. To address the third research objective of understanding women’s experiences of HIV and IPV, women attending clinics in Kampala and Mbarara were interviewed using an extensive standardized survey about their health and relationships (see Appendix A). Women were interviewed in the clinics on the day of their appointments. Research projects are common at the two clinic sites and in general, women were comfortable discussing their health in that setting.

This chapter reports the results of the close-ended clinic surveys done with women living with HIV- modified from a standardized WHO instrument. Chapter 8 reports ethnographic results from 40 women chosen from this larger sample for follow up based on their experiences of violence. As described in Chapter 4, a total of 200 women were recruited for this portion of research, using a stratified sampling strategy. Women eligible for the clinic-based interviews were over the age of 18, currently enrolled in antiretroviral treatment, and able to give written or verbal informed consent.

The 200 surveys were done to achieve part of the third research objective-to understand women’s experiences of living with both IPV and HIV, including identification of factors associated with the presence or absence of violence among HIV infected women and assessment of the differences between
Kampala and Mbarara. Below are the demographic characteristics of the sample, marriage patterns and perceptions of gender equality, violence prevalence and factors associated with different types of violence, economic assessments and practices of the women’s household, and responses to violence.

### 7.2 Sample Characteristics

Table 3 shows the average characteristics of women in the sample, by site and in total. The average age and religious affiliation of the women are generally representative of both the general population in Uganda and other large randomly selected samples in the two clinics (McGrath et al. 2009a, 2009b; UDHS 2006). Women on average are 38 years old (range 18-65).

#### Table 3: Demographic Characteristics of Clinic Sample

<table>
<thead>
<tr>
<th></th>
<th>Whole Sample N=200</th>
<th>Kampala N=100</th>
<th>Mbarara N=100</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (range)</td>
<td>37.93 (18-65)</td>
<td>39.83 (23-59)</td>
<td>36.02 (18-65)</td>
</tr>
<tr>
<td>Total pregnancies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (range)</td>
<td>4.30 (0-12)</td>
<td>4.54 (0-12)</td>
<td>4.06 (0-12)</td>
</tr>
<tr>
<td>Living children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (range)</td>
<td>2.97 (0-10)</td>
<td>3.27 (0-10)</td>
<td>2.67 (0-8)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>67 (33)</td>
<td>34 (34)</td>
<td>33 (33)</td>
</tr>
<tr>
<td>Protestant</td>
<td>77 (38.5)</td>
<td>30 (30)</td>
<td>49 (49)</td>
</tr>
<tr>
<td>Muslim</td>
<td>18 (9.0)</td>
<td>8 (8)</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Born again/ other</td>
<td>31 (15.5)</td>
<td>22 (22)</td>
<td>4 (4.0)</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(years completed)</td>
<td>6.80 (0-16)</td>
<td>8.09 (0-16)</td>
<td>5.53 (0-16)</td>
</tr>
<tr>
<td>Mean (range)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>33 (16.8)</td>
<td>6 (6.1)</td>
<td>27 (27.3)</td>
</tr>
<tr>
<td>Primary</td>
<td>89 (45.2)</td>
<td>44 (44.9)</td>
<td>45 (45.5)</td>
</tr>
<tr>
<td>Secondary</td>
<td>64 (32.5)</td>
<td>39 (39.8)</td>
<td>25 (25.3)</td>
</tr>
<tr>
<td>University/ Tertiary</td>
<td>11 (5.6)</td>
<td>9 (9.2)</td>
<td>2 (2.0)</td>
</tr>
</tbody>
</table>

Chi square: *p<.05, **p<.001
This group has an average of 4.3 pregnancies (range of 0 to 12) and 2.97 living children, much lower than the national average of nearly 7 children per women (UDHS 2006). The discrepancy between this group and the national population is most likely due to HIV status. All of the women are known to be positive, and many said they chose to stop having children after testing. Also due to HIV status, a large proportion of the women are widowed and are no longer sexually active.

In terms of religious affiliation, the sample was divided into Protestant (38.5%), Catholic (33.0%), Muslim (9.0%), and born again Christian or other (31%). Nationally, the population is estimated to be 80% Catholic or Protestant, 10% Muslim, and 10% other religions- mainly born-again Christian (UDHS 2006). As will be seen in Chapter 8, these religious affiliations are important for women as a source of identity and group belonging. The high percentage of born again Christians among this group can probably be attributed to the number of women who choose to be 'saved' or 'born again' following a positive HIV test. The number of women in Kampala who are born again is significantly higher than those in Mbarara, potentially due to the greater number of evangelical churches in the area.

On average, the women have completed 6.8 years of school, with a range of 0 to 16 years. Women were asked which level of schooling they reached in their studies, ranging from none at all (16.8%), completed up to seven years of primary school (45.2%), completed up to six years of secondary school (32.5%), or university level or tertiary training, including professional degrees (5.6%).
Kampala, women have completed significantly more years of school (8.1) than women in Mbarara (5.5). This difference is consistent with the population as a whole, potentially due to greater educational opportunities in Kampala than in rural areas, and the greater need for girls to contribute to household and agricultural labor in rural areas (UDHS 2006).

Women’s health

All of the women in the sample are HIV positive and currently enrolled at one of the two clinics for antiretroviral therapy (see Table 4). On average, the women have known their HIV status for nearly 6 years. There is a wide range in variation among women- between those who have only known their status for one month to those who have known themselves to be positive for two decades. Of the few women who have been positive for 20 years, some are uncertain of the exact dates, though others say they are among the first in the country to enroll in antiretroviral treatment when it became available. Women in Kampala have been on ARVs significantly longer (3.9 years, p<.001) than women in Mbarara (3.1 years), potentially due to the earlier roll out of treatment in the capital.
<table>
<thead>
<tr>
<th>Table 4: Women's health</th>
<th>Overall (n=200)</th>
<th>Kampala (n=100)</th>
<th>Mbarara (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length of Time with HIV</strong></td>
<td>Mean (range)</td>
<td>5.97 (.08-21)</td>
<td>6.11 (.25-20.0)</td>
</tr>
<tr>
<td><strong>Length of time on ARVs</strong></td>
<td>Mean (range)</td>
<td>3.53 (.08-12)</td>
<td>3.92 (.25-12.0)</td>
</tr>
<tr>
<td><strong>Health Assessment</strong></td>
<td>n(%)</td>
<td>n(%)</td>
<td>n(%)</td>
</tr>
<tr>
<td>Excellent</td>
<td>76 (38.0)</td>
<td>13 (13)</td>
<td>63 (63)</td>
</tr>
<tr>
<td>Good</td>
<td>93 (46.5)</td>
<td>67 (67)</td>
<td>26 (26)</td>
</tr>
<tr>
<td>Fair</td>
<td>29 (14.5)</td>
<td>19 (19)</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Poor</td>
<td>2 (1.0)</td>
<td>1 (1)</td>
<td>1 (1)</td>
</tr>
<tr>
<td><strong>Health Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Good (0-4)</td>
<td>124 (62.0)</td>
<td>63 (63)</td>
<td>61 (61)</td>
</tr>
<tr>
<td>Fair (5-11)</td>
<td>66 (33.0)</td>
<td>32 (32)</td>
<td>34 (35)</td>
</tr>
<tr>
<td>Poor (12-15)</td>
<td>10 (5.0)</td>
<td>5 (5)</td>
<td>5 (5)</td>
</tr>
</tbody>
</table>

Chi square, **p<.001

Currently, this group report themselves to be mostly healthy. When asked, “In general, would you describe your overall health as excellent, good, fair, poor, or very poor?” more than three quarters of the women (84.5%, n= 169) reported themselves to be in excellent or good health. 14.5% (n=29) said that their health is fair, and only two women (1%) said they were in poor health. No women described themselves to generally be in very poor health.

Using a longer checklist to assess current health status, women were asked 15 yes or no questions ranging from whether they experienced headaches or trouble sleeping, to sadness or exhaustion in the past four weeks. From these 15 questions a scale was developed (see Chapter 4 for detailed description of scale development). A low score (0-4) indicates good health or few health problems in the past four weeks, a medium score (5-11) indicates some health problems and fair health in the past four weeks, and a high score (12-15) indicates poor health and many problems in the past four weeks. Using this
scale, the results were similar to the individual health assessment: 62.4\% (n=124) were in good health, 33.0\% (n=66) scored in the middle range, and 5\% (n=10) reported significant health problems in recent weeks (see Table 4).

7.3 Marriage Practices and Gender Norms

To assess marital status women were asked about their current or most recent union. Due to serial monogamy and multiple lifetime partners, those who are widowed may be underreported if they had a partner after their partner died. Currently only 30.3\% (n=60) of the women are married. Women who are single (never married) or separated or divorced make up another 34\% of the sample (n=68) and the largest group are widowed (35.4\%, n=70, see Table 5). On average, women were married or lived with a partner 1.3 times, with the range being from zero to three. Of the whole sample, 18.5\% report that their first sexual encounter was forced, compared to the finding in the most recent Demographic and Health Survey that 25\% of women reported their first encounter as forced. (UDHS 2006).
Table 5: Marriage Practices

<table>
<thead>
<tr>
<th></th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=198)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently married</td>
<td>60 (30.3)</td>
<td>22 (22)</td>
<td>38 (38)</td>
</tr>
<tr>
<td>Not married</td>
<td>68 (34.3)</td>
<td>31 (31)</td>
<td>30 (30)</td>
</tr>
<tr>
<td>Widowed</td>
<td>70 (35.4)</td>
<td>38 (38)</td>
<td>32 (32)</td>
</tr>
<tr>
<td>Number of times</td>
<td>Mean (range)</td>
<td>1.30 (0-3)</td>
<td>1.38 (0-3)</td>
</tr>
<tr>
<td>married or lived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with partner</td>
<td>(n=198)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Practices*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=178)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monogamous</td>
<td>97 (50.3)</td>
<td>31 (31)</td>
<td>50 (52.1)</td>
</tr>
<tr>
<td>Polygamous</td>
<td>81 (42.0)</td>
<td>55 (55)</td>
<td>42 (43.8)</td>
</tr>
<tr>
<td>Age at first sex</td>
<td>Mean (range)</td>
<td>17.25 (3-29)</td>
<td>16.90 (12-25)</td>
</tr>
<tr>
<td>(n=195)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced</td>
<td>37 (18.5)</td>
<td>20 (20)</td>
<td>17 (17)</td>
</tr>
<tr>
<td>Convinced</td>
<td>57 (28.5)</td>
<td>24 (24)</td>
<td>33 (33)</td>
</tr>
<tr>
<td>Wanted</td>
<td>101 (51.8)</td>
<td>51 (51)</td>
<td>50 (50)</td>
</tr>
</tbody>
</table>

Chi square: *p<.05, **p<.001

Women were asked if their husbands had other “wives”- to which 42% (n=81) responded yes. Many other women qualified their negative response by saying that their husbands had other girlfriends outside the home. These women whose partners had girlfriends were common, but not represented in the proportion of the sample reported as being in current or recently polygamous unions.

This group of women became sexually active at an age comparable to the national population. Of women ages 15-49 in Uganda, the median age of first sex for women ages 15-49 is 16.6 years (UDHS 2006). Among this group, it is 17.25 years- slightly, though not significantly higher in Mbarara than in Kampala.

Partner Characteristics

On average, women’s partners have completed an average of 9.1 years of education, compared to women’s 6.8 years. Other studies have found that in predicting violence, the absolute value of the difference between partners’
education is more telling than the number of years completed (Babcock et al. 1993). Among this sample, 50.3% (n=89) had from zero to three years difference in education between partners, 28.8% (n=51) have between four and six years difference between partners, and 20.9% (n=37) have a difference of seven or more years (see Table 6). The difference between partners education is significantly larger in Mbarara than in Kampala (p<.05).

### Table 6: Partner Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner education**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=179)</td>
<td>Mean (range)</td>
<td>9.07 (0-18)</td>
<td>10.44 (0-18)</td>
</tr>
<tr>
<td>None</td>
<td>19 (10.8)</td>
<td>3 (3.6)</td>
<td>16 (16.8)</td>
</tr>
<tr>
<td>Primary</td>
<td>47 (26.3)</td>
<td>18 (21.4)</td>
<td>29 (30.5)</td>
</tr>
<tr>
<td>Secondary</td>
<td>87 (48.6)</td>
<td>40 (47.6)</td>
<td>47 (49.5)</td>
</tr>
<tr>
<td>University/ Tertiary</td>
<td>26 (14.5)</td>
<td>23 (27.4)</td>
<td>3 (3.2)</td>
</tr>
<tr>
<td>Educational difference*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=177)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3 years</td>
<td>89 (50.3)</td>
<td>45 (54.2)</td>
<td>44 (46.8)</td>
</tr>
<tr>
<td>4-6 years</td>
<td>51 (28.8)</td>
<td>28 (33.7)</td>
<td>23 (24.5)</td>
</tr>
<tr>
<td>7+ years</td>
<td>37 (20.9)</td>
<td>10 (12.0)</td>
<td>27 (28.7)</td>
</tr>
<tr>
<td>Partner Alcohol*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=194)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyday</td>
<td>69 (35.6)</td>
<td>37 (38.1)</td>
<td>32 (33.0)</td>
</tr>
<tr>
<td>1-2 per week</td>
<td>16 (8.2)</td>
<td>9 (9.3)</td>
<td>7 (7.2)</td>
</tr>
<tr>
<td>1-3/month</td>
<td>20 (10.3)</td>
<td>4 (4.1)</td>
<td>16 (16.5)</td>
</tr>
<tr>
<td>Occasional</td>
<td>10 (5.2)</td>
<td>9 (9.3)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td>Never</td>
<td>73 (37.6)</td>
<td>34 (35.1)</td>
<td>39 (40.2)</td>
</tr>
<tr>
<td>DK</td>
<td>6 (3.1)</td>
<td>4 (4.1)</td>
<td>2 (2.1)</td>
</tr>
<tr>
<td>Partner drunk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=191)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most Days</td>
<td>50 (27.5)</td>
<td>30 (34.5)</td>
<td>20 (21.1)</td>
</tr>
<tr>
<td>Weekly</td>
<td>9 (4.9)</td>
<td>7 (8.0)</td>
<td>2 (2.1)</td>
</tr>
<tr>
<td>Once a month</td>
<td>14 (7.7)</td>
<td>5 (5.7)</td>
<td>9 (9.1)</td>
</tr>
<tr>
<td>Less than monthly</td>
<td>9 (4.9)</td>
<td>6 (6.9)</td>
<td>3 (3.2)</td>
</tr>
<tr>
<td>Never</td>
<td>100 (54.9)</td>
<td>39 (44.8)</td>
<td>61 (64.2)</td>
</tr>
<tr>
<td>Most recent partner positive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=196)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>118 (60.2)</td>
<td>61 (61)</td>
<td>57 (57)</td>
</tr>
<tr>
<td>No</td>
<td>11 (5.6)</td>
<td>8 (8)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Not sure</td>
<td>67 (34.2)</td>
<td>28 (28)</td>
<td>39 (39)</td>
</tr>
</tbody>
</table>

Chi square: *p<.05, **p<.001

Women report that their partners frequently take alcohol and are frequently drunk. Of the whole group, 35.6% (n=69) say that their current or most recent partner drinks alcohol every day and 27.5% (n=50) say their partners drink
to the point of being drunk most days in a week. A large group of women, 37.6% (n=73) report that their partners never drink alcohol and 54.9% (n=100) say their partners never drink to the point of being drunk.

The large group of non-drinkers in a country with one of the highest per capita alcohol consumption rates in the world is potentially due to HIV or religious affiliation (WHO 2004b). When they begin on ARVs, men and women are advised to stop drinking all together. Likewise, some religions, particularly Muslims and born again Christian groups, prohibit drinking. Therefore, many of the partners who currently do not drink alcohol may have done so in the past before becoming saved or beginning on ARVs; the instrument does not measure this.

Women were asked if their most recent marital partner had HIV. More than half of the women (60.2%, n=118) of the women responded a definitive yes, 5.6% (n=11) said no, and 34.2% (n=67) responded that they were unsure. Of the women who said they were unsure, many are currently widowed. Oftentimes, they were suspicious that the man was positive, but he never tested or revealed the results to her. Also included in the uncertain group are women who are separated or divorced and not in contact with their most recent partner. Still others are married, but have not discussed their own status with their partner or they have and he has refused to test.

**Perceptions of gender equality**

In addition to the experiences of different types of violence, the instrument used also assessed women’s perceptions of gender equality and decision
making abilities. This assessment has three parts: vignettes of individual freedom, the acceptability of violence, and the belief in a right to refuse sex.

From these three components, a total scale of perceptions of gender equality was created (see Chapter 4 for detailed description of scale development).

Table 7: Gender vignette responses

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Overall n (%)</th>
<th>Kampala n (%)</th>
<th>Mbarara n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A good wife obeys her husband even if she disagrees</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=197)</td>
<td>Agree 158 (80.2)</td>
<td>Disagree 37 (18.8)</td>
<td>Don’t know 2 (1.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>72 (74.2)</td>
<td>13 (13.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 (24.7)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>86 (86.0)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td><strong>Family problems should only be discussed with people in the family</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=197)</td>
<td>Agree 179 (90.9)</td>
<td>Disagree 18 (9.1)</td>
<td>Don’t know 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>81 (83.5)</td>
<td>2 (2.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16 (16.5)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98 (98)</td>
<td>0</td>
</tr>
<tr>
<td><strong>It is important for a man to show his wife/partner who is the boss</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=195)</td>
<td>Agree 131 (67.2)</td>
<td>Disagree 63 (32.3)</td>
<td>Don’t know 1 (.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>71 (74.0)</td>
<td>39 (39.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 (24.0)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60 (60.6)</td>
<td>0</td>
</tr>
<tr>
<td><strong>A woman should be able to choose her own friends even if her husband disapproves</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=197)</td>
<td>Agree 102 (51.8)</td>
<td>Disagree 95 (48.2)</td>
<td>Don’t know 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50 (51.5)</td>
<td>48 (48.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>47 (48.5)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52 (52.0)</td>
<td>0</td>
</tr>
<tr>
<td><strong>It is a wife’s obligation to have sex with her husband even if she doesn’t feel like it</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=197)</td>
<td>Agree 76 (38.6)</td>
<td>Disagree 120 (60.9)</td>
<td>Don’t know 1 (.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26 (26.8)</td>
<td>50 (50.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>70 (72.2)</td>
<td>50 (50)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 (1.0)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50 (50.0)</td>
<td>0</td>
</tr>
<tr>
<td><strong>If a man mistreats his wife, others outside of the family should intervene</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=197)</td>
<td>Agree 160 (81.2)</td>
<td>Disagree 32 (16.2)</td>
<td>Don’t know 5 (2.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>89 (91.8)</td>
<td>25 (25.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 (7.2)</td>
<td>4 (4.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>71 (71.0)</td>
<td>0</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001

In the vignettes, women were read six statements with which they could respond agree, disagree, or don’t know. The specific questions are reported in Table 7. For four of the six questions, the women in Mbarara responded significantly different than those in Kampala, each time in a manner consistent with perceptions of less gender equality. The questions revealed mixed
responses, with three of the six questions having positive or gender-equal
responses by the majority of women in the entire sample and three of the six
questions having majority responses on the side of gender inequality.

Some of the questions in the Ugandan context may not have the same
interpretation as in other places the instrument has been used. The scale is
limited by its non-culturally specific design, but can act as a proxy for women's
perceptions of their power or equality within a relationship or expectations of an
ideal relationship. For example, the statement “a good wife obeys her husband
even if she disagrees” had 80% agreement among the whole sample. This is
consistent with traditional marital values taught to women in Uganda by their aunt
before marrying. Importantly, when women were presented with specific
scenarios they reported the belief of obeying one's husband to be situationally
dependent. Their strong agreement with obeying one's husband could, therefore,
represent perceptions of the ideal for a relationship, but is interpreted and
negotiated differently across contexts.
Table 8: Acceptability of physical violence

<table>
<thead>
<tr>
<th>In your opinion, does a man have a good reason to hit his wife if:</th>
<th>Overall n (%)</th>
<th>Kampala n (%)</th>
<th>Mbarara n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>She does not complete her household work to his satisfaction (n=197)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19 (9.6)</td>
<td>13 (13.4)</td>
<td>6 (6.0)</td>
</tr>
<tr>
<td>No</td>
<td>178 (90.4)</td>
<td>84 (86.6)</td>
<td>94 (94.0)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>She disobedys him (n=194)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>63 (32.5)</td>
<td>22 (23.4)</td>
<td>41 (41.0)</td>
</tr>
<tr>
<td>No</td>
<td>130 (67.0)</td>
<td>71 (75.5)</td>
<td>59 (59.0)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (.5)</td>
<td>1 (.1)</td>
<td>0</td>
</tr>
<tr>
<td>She refuses to have sexual relations with him (n=197)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30 (15.2)</td>
<td>12 (12.4)</td>
<td>18 (18.0)</td>
</tr>
<tr>
<td>No</td>
<td>164 (83.2)</td>
<td>84 (86.6)</td>
<td>80 (80.0)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3 (1.5)</td>
<td>1 (1.0)</td>
<td>1 (2.0)</td>
</tr>
<tr>
<td>She asks him if he has other girlfriends (n=197)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11 (5.6)</td>
<td>5 (5.0)</td>
<td>6 (6.0)</td>
</tr>
<tr>
<td>No</td>
<td>185 (93.9)</td>
<td>91.0 (93.8)</td>
<td>94 (94.0)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (.5)</td>
<td>1 (1.0)</td>
<td></td>
</tr>
<tr>
<td>He suspects that she is unfaithful (n=197)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28 (14.2)</td>
<td>5 (5.2)</td>
<td>23 (23.0)</td>
</tr>
<tr>
<td>No</td>
<td>166 (84.3)</td>
<td>92 (94.8)</td>
<td>74 (74.0)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3 (1.5)</td>
<td>0</td>
<td>3 (3.0)</td>
</tr>
<tr>
<td>He finds out that she has been unfaithful (n=196)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>113 (57.7)</td>
<td>40 (41.2)</td>
<td>73 (73.7)</td>
</tr>
<tr>
<td>No</td>
<td>82 (41.8)</td>
<td>57 (58.8)</td>
<td>25 (25.3)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1 (.5)</td>
<td>0</td>
<td>1 (1.0)</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001

The acceptability of violence was assessed through questions about different reasons why a man would hit his wife, including a woman not completing housework, disobeying, refusal of sex, asking if he has girlfriends, his suspicion of her infidelity and discovered infidelity (see Table 8). There is only one reason that is agreed by the majority of women (57.7%) to justify a man’s hitting his wife- “if she is caught being unfaithful.” One third of women (32.5%) agreed that a man was justified in beating his wife for disobeying him. Similar to the gender vignettes above, the notion of obedience is not necessarily negative in the Ugandan context. Violence is generally viewed negatively, but is justifiable in certain circumstances, such as infidelity.
Table 9: Views on women’s ability to refuse sex

<table>
<thead>
<tr>
<th>In your opinion can a married woman refuse to have sex with her partner if:</th>
<th>Overall n (%)</th>
<th>Kampala n (%)</th>
<th>Mbarara n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>She doesn’t want to <em>(n=197)</em></td>
<td>Yes 119 (60.4)</td>
<td>71 (73.2)</td>
<td>48 (48.0)</td>
</tr>
<tr>
<td></td>
<td>No 75 (38.1)</td>
<td>24 (24.7)</td>
<td>51 (51.0)</td>
</tr>
<tr>
<td></td>
<td>Don’t know 3 (1.5)</td>
<td>2 (2.1)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td>He is drunk <em>(n=197)</em></td>
<td>Yes 148 (75.1)</td>
<td>83 (85.6)</td>
<td>65 (65.0)</td>
</tr>
<tr>
<td></td>
<td>No 42 (21.3)</td>
<td>12 (12.4)</td>
<td>30 (30.0)</td>
</tr>
<tr>
<td></td>
<td>Don’t know 7 (3.6)</td>
<td>2 (2.1)</td>
<td>5 (5.0)</td>
</tr>
<tr>
<td>She is sick <em>(n=197)</em></td>
<td>Yes 185 (93.9)</td>
<td>92 (94.8)</td>
<td>93 (93.0)</td>
</tr>
<tr>
<td></td>
<td>No 12 (6.1)</td>
<td>5 (5.2)</td>
<td>7 (7.0)</td>
</tr>
<tr>
<td></td>
<td>Don’t know 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He mistreats her <em>(n=197)</em></td>
<td>Yes 154 (78.2)</td>
<td>88 (90.7)</td>
<td>66 (66.0)</td>
</tr>
<tr>
<td></td>
<td>No 42 (21.3)</td>
<td>9 (9.3)</td>
<td>33 (33.0)</td>
</tr>
<tr>
<td></td>
<td>Don’t know 1 (.5)</td>
<td></td>
<td>1 (1.0)</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001

The third component of the gender equality scale is women’s views on whether or not a woman can refuse to have sex with her partner under several circumstances (see Table 9). More than half of the overall sample (60.4%) believe that a woman can refuse sex with her partner if she does not want to have sex- this is significantly higher in Kampala than Mbarara (p<.05). A higher proportion of women responded that a woman can refuse sex if the man is drunk (75.1%), if the woman is sick (93.9%), or if the man is mistreating her (78.2%). The overwhelming response of women’s ability to refuse sex if she is sick is interesting among a group of HIV positive women. Women were not asked if “sick” included HIV infection. Most women report themselves to be currently healthy and may not include themselves in this category unless they are symptomatic.
Table 10: Overall perceptions of gender equality

<table>
<thead>
<tr>
<th></th>
<th>Overall n (%)</th>
<th>Kampala n (%)</th>
<th>Mbarara n (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Equality (0-5)</td>
<td>57 (28.5)</td>
<td>39 (39)</td>
<td>18 (18)</td>
<td>**.000</td>
</tr>
<tr>
<td>Medium (6-10)</td>
<td>112 (56.0)</td>
<td>54 (54)</td>
<td>58 (58)</td>
<td></td>
</tr>
<tr>
<td>Little Equality (11-15)</td>
<td>31 (15.5)</td>
<td>7 (7)</td>
<td>24 (24)</td>
<td></td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001

The three above components combined create a gender equality scale, which ranges from 0 to 16 points (see Table 10). The scores were divided from the distribution and reflect a range of beliefs in gender equality and women’s decision making capacities (see Chapter 4 for scale creation). A score of between zero and five points indicates a strong belief in equality between the sexes and a woman’s ability to make independent decisions, a medium score is between 6 and 10 points, and a high score of 11 to 16 indicates little belief in gender equality or highly dependent decision making. The instrument was developed for use around the world, so not all questions are specific to the Ugandan setting. The scale is a proxy for women’s perceptions of equality and ability to make decisions in relationships. Overall, the score was normally distributed with the majority of women (56%) having a medium score; 28.5% of women scored low- indicating a strong belief in gender equality or power of women within a relationship. In the whole sample, 15.5% scored high, indicating low perceptions of gender equality and women’s power within relationships.

This scale differed significantly (p<.000) between Kampala and Mbarara (see Table 10). The finding that women in Mbarara scored significantly higher on the gender equality scale is consistent with the findings in the WHO study that women in more rural areas generally tend to view physical violence as justifiable-
due to traditional gender norms, differences in education, and different access to resources and information. This highlights differential impacts of globalization, wherein social media campaigns and the promotion of rights-based discourses happen first in urban centers. Women in more rural regions, such as Mbarara and the surrounding districts may have less exposure to these messages. Differences between the two areas, often explained through differences in normative cultural gender roles, may in fact be due to disparities in resources and information.

7.4 Economic Considerations

Economic data are notoriously difficult to obtain, particularly for women in developing countries. Oftentimes, women do not earn money or are part of the informal economy and may have a difficult time assessing total income. The WHO instrument has a series of questions about ownership, and allows women to indicate if they own the items themselves, own with other people, or do not own (see Table 11). Also part of the economic assessment are a series of questions about household practices and the level of control women have over money related decision-making (see Table 12). Economic concerns and being able to provide for a family emerged as a key theme in women’s follow up interviews and as the primary impetus for formally seeking help.
Table 11: Economic practices

<table>
<thead>
<tr>
<th></th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Earns money</strong> (n=198)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>149 (75.3)</td>
<td>61 (61.6)</td>
<td>88 (88.9)</td>
</tr>
<tr>
<td>No</td>
<td>49 (24.7)</td>
<td>38 (38.4)</td>
<td>11 (11.1)</td>
</tr>
<tr>
<td><strong>Partner Employed</strong> (n=195)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>184 (94.4)</td>
<td>92 (93.9)</td>
<td>92 (94.8)</td>
</tr>
<tr>
<td>Looking for work</td>
<td>7 (3.6)</td>
<td>3 (3.1)</td>
<td>4 (4.1)</td>
</tr>
<tr>
<td>Retired</td>
<td>4 (2.1)</td>
<td>3 (3.1)</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td><strong>Who earns more</strong> (n=85)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than husband</td>
<td>21 (24.4)</td>
<td>6 (31.6)</td>
<td>15 (22.7)</td>
</tr>
<tr>
<td>Less than husband</td>
<td>58 (67.4)</td>
<td>12 (63.2)</td>
<td>46 (69.7)</td>
</tr>
<tr>
<td>About the same</td>
<td>6 (7.0)</td>
<td>1 (5.3)</td>
<td>5 (7.6)</td>
</tr>
<tr>
<td><strong>Ever refused job</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>because of partner (n=125)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 (32.0)</td>
<td>8 (22.2)</td>
<td>32 (36.0)</td>
</tr>
<tr>
<td></td>
<td>85 (68.0)</td>
<td>28 (77.8)</td>
<td>57 (64.0)</td>
</tr>
<tr>
<td><strong>Husband ever took</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>savings (n=120)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>63 (56.8)</td>
<td>14 (58.4)</td>
<td>49 (57.0)</td>
</tr>
<tr>
<td>1 or 2 times</td>
<td>6 (5.4)</td>
<td>0</td>
<td>6 (7.0)</td>
</tr>
<tr>
<td>Several times</td>
<td>8 (7.2)</td>
<td>5 (20.8)</td>
<td>3 (3.5)</td>
</tr>
<tr>
<td>Many/ all</td>
<td>6 (5.4)</td>
<td>0</td>
<td>6 (7.0)</td>
</tr>
<tr>
<td>N/A</td>
<td>27 (24.3)</td>
<td>5 (20.8)</td>
<td>22 (25.6)</td>
</tr>
<tr>
<td><strong>Husband refused</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to give money* (n=158)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>94 (56.6)</td>
<td>52 (70.3)</td>
<td>42 (50.0)</td>
</tr>
<tr>
<td>Once or twice</td>
<td>12 (7.2)</td>
<td>5 (6.8)</td>
<td>7 (8.3)</td>
</tr>
<tr>
<td>Several times</td>
<td>29 (17.5)</td>
<td>14 (18.9)</td>
<td>15 (17.9)</td>
</tr>
<tr>
<td>Many times/ always</td>
<td>23 (13.9)</td>
<td>3 (4.1)</td>
<td>20 (23.8)</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001

Three quarters of the women in the whole sample report earning an income. This is significantly higher in Mbarara than Kampala, though is likely due to differences in the probes used by research assistants in the two sites rather than true differences in employment (p<.05). In both sites, women who do not have formal employment were likely to report themselves as unemployed despite earning money for informal activities. Those in Mbarara were more frequently probed for these income generating activities than those in Kampala. Women in Mbarara were more likely to report themselves as working in the informal sector, selling home grown produce or making small crafts for income generating activities than those in Kampala who were more likely to only report formal
employment. Across the two sites, over 90% of men were reported as working or earning a steady income for the household.

When asked if they or their partner earned more money than themselves, 31.4% of the women responded that they earned more or the same as their partner, and 67.4% said they earn less. Nearly one third (32.0%) report that they have ever refused a job opportunity because of their partner. Women in Mbarara (36.0%) were more likely to have reported that they have ever refused a job because of their partner than women in Kampala (22.2%). Of the whole sample, 18.0% of women report that their partner has taken their savings against their will. Women in Mbarara (50.0%) were also more likely to report that their partner had ever refused to give them money than in Kampala (29.8%).

Table 12: Economic assessment of assets

<table>
<thead>
<tr>
<th></th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Own land</strong> (n=198)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own self</td>
<td>52 (26.1)</td>
<td>19 (9.2)</td>
<td>33 (33.0)</td>
</tr>
<tr>
<td>Own with others</td>
<td>44 (22.1)</td>
<td>14 (7.1)</td>
<td>30 (30.0)</td>
</tr>
<tr>
<td>Do not own</td>
<td>102 (51.3)</td>
<td>66 (33.7)</td>
<td>37 (37.0)</td>
</tr>
<tr>
<td><strong>Own house</strong> (n=199)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own self</td>
<td>52 (26.1)</td>
<td>24 (12.1)</td>
<td>28 (28.0)</td>
</tr>
<tr>
<td>Own with others</td>
<td>50 (25.1)</td>
<td>24 (12.1)</td>
<td>26 (26.0)</td>
</tr>
<tr>
<td>Do not own</td>
<td>97 (48.7)</td>
<td>51 (25.8)</td>
<td>46 (46.0)</td>
</tr>
<tr>
<td><strong>Own business</strong> * (n=199)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own self</td>
<td>59 (29.6)</td>
<td>35 (17.7)</td>
<td>24 (24.0)</td>
</tr>
<tr>
<td>Own with others</td>
<td>13 (6.5)</td>
<td>3 (1.5)</td>
<td>10 (10.0)</td>
</tr>
<tr>
<td>Do not own</td>
<td>127 (63.8)</td>
<td>61 (30.8)</td>
<td>88 (88.0)</td>
</tr>
<tr>
<td><strong>Own large animals</strong> * (n=199)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own self</td>
<td>14 (7.0)</td>
<td>12 (6.0)</td>
<td>2 (2.0)</td>
</tr>
<tr>
<td>Own with others</td>
<td>17 (8.5)</td>
<td>7 (3.5)</td>
<td>10 (10.0)</td>
</tr>
<tr>
<td>Do not own</td>
<td>168 (84.4)</td>
<td>80 (40.5)</td>
<td>88 (88.0)</td>
</tr>
<tr>
<td><strong>Own small animals</strong> (n=199)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own self</td>
<td>60 (30.2)</td>
<td>27 (13.6)</td>
<td>33 (33.0)</td>
</tr>
<tr>
<td>Own with others</td>
<td>24 (12.1)</td>
<td>10 (5.1)</td>
<td>14 (14.0)</td>
</tr>
<tr>
<td>Do not own</td>
<td>115 (57.8)</td>
<td>62 (31.3)</td>
<td>53 (53.0)</td>
</tr>
<tr>
<td><strong>Own produce/ crops</strong> * (n=198)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own self</td>
<td>63 (31.8)</td>
<td>27 (13.7)</td>
<td>36 (36.4)</td>
</tr>
<tr>
<td>Own with others</td>
<td>34 (17.2)</td>
<td>7 (3.5)</td>
<td>27 (27.3)</td>
</tr>
<tr>
<td>Do not own</td>
<td>101 (51.0)</td>
<td>65 (33.3)</td>
<td>36 (36.4)</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001
Approximately half of the women in the entire sample report that they own land, either by themselves or with others (see Table 12). In Kampala, women are significantly less likely to own land either alone or with others. In the capital, parts of the city are crowded and many families rent houses, or some women rely on friends or relatives to have a place to stay. Women in Mbarara are more likely to own produce or crops, either by themselves or with a partner (63.7%) than those in Kampala (34.4%)—a logical extension of the ownership of property, and indicative of the dominance of small scale cultivation for survival in rural and western Uganda. Women in Kampala were more likely to report owning a business (35.4%) alone than those in Mbarara (24.0%). The types of businesses that women reported owning are those more frequently done in urban areas because of the opportunities and local demand, such as cooking and selling street foods, tailoring clothes, or running a small shop out of one’s home or neighborhood. A large majority of women (84.4%) in the whole sample report that they do not own large animals, such as cows. While cattle are very common in western Uganda, they are kept as bridewealth and often owned by men rather than by a family as a whole. Small animals, such as chickens or goats are much more common among this group, with approximately 30% of women in both sites reporting that they own small livestock themselves.

7.5 Violence: Prevalence and Associated Factors

The WHO standardized instrument of women’s health and violence assesses four types of violent or abusive behaviors: controlling behaviors, verbal,
physical, and sexual violence through a series of 19 questions on specific behavior. These were all asked for the current or most recent partner. As described in Chapter 4, these four assessments were weighted and combined into a total violence scale. Subsequently, 34 variables were selected and analyzed using chi square tests for associations with the four types of behaviors and overall violence scale.

Controlling behavior and verbal violence

As seen in Chapter 2, controlling behavior and verbal violence can also have devastating effects on women. The WHO study using the same instrument found between 20% and 75% of women in the ten countries reported verbal violence and between 21% and 90% report controlling behavior from an intimate partner. They are careful to note that verbal violence and controlling behaviors are widely variable across cultures, and in their study as well as this one, the assessment used is a starting point. In the original assessment, there was an additional question of whether the partner “insists on knowing where you are at all times?” In the current analysis, this question was removed. The Ugandan women in this study generally interpreted this question positively- an indicator that their partner was interested in their behavior.

<table>
<thead>
<tr>
<th></th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Controlling behavior (n=200)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>119 (59.5)</td>
<td>64 (64.0)</td>
<td>55 (55.0)</td>
</tr>
<tr>
<td>High</td>
<td>81 (40.5)</td>
<td>36 (36.0)</td>
<td>45 (45.0)</td>
</tr>
<tr>
<td><strong>Verbal Violence (n=200)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>146 (73.0)</td>
<td>75 (75.0)</td>
<td>71 (71.0)</td>
</tr>
<tr>
<td>High</td>
<td>54 (27.0)</td>
<td>25 (25.0)</td>
<td>29 (29.0)</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001
Acts of verbal violence and controlling behavior were measured for women through a series of thirteen questions. For controlling behavior, women were asked if it is generally true that their current or most recent partner:

- Tries to keep you from seeing your friends?
- Tries to restrict contact with your family of birth?
- Ignores you or treats you indifferently?
- Gets angry if you speak with another man?
- Is often suspicious that you are unfaithful?
- Expects you to ask his permission before seeking healthcare for yourself?

These six questions were tallied into a scale of controlling behavior (see Chapter 4). A score of 0 to 3 indicates little or no controlling behavior from the most recent partner, while a score of 4 to 6 indicates moderate to high levels of emotional violence and controlling behavior (see Table 13).

Verbal violence was likewise broken into a scale of little to none or moderate to severe. Questions to measure verbal violence included the specific acts of:

- being insulted or made to feel bad about oneself;
- being humiliated or belittled in front of others;
- being intimated or scared on purpose (for example, but a partner yelling and smashing things);
- being threatened with harm (directly or indirectly in the form of a threat to hurt someone the woman cared about).

From these behaviors, a verbal violence scale was developed from 0-4. A low score (0-1) indicates less verbal violence from a partner and high is more (2-4). There are no significant differences between Kampala and Mbarara for levels of controlling behavior or verbal violence from partners. Overall, once the question of wanting to know where she was at all times was excluded, the majority of women reported low incidences of controlling behavior (59.5%). Likewise, nearly
three quarters of the women (73.0%) reported low scores of verbal violence from partners.

*Physical and sexual violence*

Physical and sexual violence was similarly assessed through a series of questions on specific behaviors. Table 14 below gives the full results by type of behavior. The only difference between sites regarding physical behavior is women who have been threatened with a weapon. Women in Mbarara are more likely to report this behavior (24.5%) than those in Kampala (10.3%). Probing and fieldnotes reveal that women who report this type of behavior most frequently describe incidents with their partners involving a panga (machete), which is commonly used for compound maintenance and farming-related tasks. Given that more women in Mbarara are living in farming households, it follows that there is easier accessibility to this weapon than in Kampala where it may not be so commonly used.

**Table 14: Physical and sexual violence**

<table>
<thead>
<tr>
<th></th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Violence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slapped</td>
<td>77 (39.3)</td>
<td>40 (40.8)</td>
<td>37 (37.8)</td>
</tr>
<tr>
<td>Pushed</td>
<td>48 (24.5)</td>
<td>24 (24.5)</td>
<td>24 (24.5)</td>
</tr>
<tr>
<td>Punched</td>
<td>49 (25.0)</td>
<td>24 (24.5)</td>
<td>25 (25.5)</td>
</tr>
<tr>
<td>Kicked</td>
<td>27 (13.9)</td>
<td>11 (11.5)</td>
<td>16 (16.3)</td>
</tr>
<tr>
<td>Choked/burned</td>
<td>12 (6.2)</td>
<td>9 (9.3)</td>
<td>3 (3.1)</td>
</tr>
<tr>
<td><em>Threatened w/ weapon</em></td>
<td>34 (17.4)</td>
<td>10 (10.3)</td>
<td>24 (24.5)</td>
</tr>
<tr>
<td><strong>Sexual Violence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced Sex</td>
<td>83 (42.3)</td>
<td>41 (41.8)</td>
<td>42 (42.9)</td>
</tr>
<tr>
<td><em>Sex when scared</em></td>
<td>74 (37.8)</td>
<td>28 (28.6)</td>
<td>46 (46.9)</td>
</tr>
<tr>
<td><strong>Total Violence scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Little or no violence (0-5)</td>
<td>114 (57.0)</td>
<td>59 (59.0)</td>
<td>55 (55.0)</td>
</tr>
<tr>
<td>Moderate violence (6-14)</td>
<td>50 (25.0)</td>
<td>27 (27.0)</td>
<td>23 (23.0)</td>
</tr>
<tr>
<td>Severe violence (15-26)</td>
<td>36 (18.0)</td>
<td>14 (14.0)</td>
<td>22 (22.0)</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001
The most frequent form of physical violence reported by women is slapping or having something thrown at them (39.3%). Other more severe behaviors were less frequently reported in both sites. Women were also asked if they had been pushed or shoved (24.5%), punched with a fist or hit with an object (25.0%), kicked, dragged or beaten (13.9%), choked or burnt on purpose (6.2%), or threatened with a weapon (17.4%) by any partner. These numbers are high, but not surprising given other findings in Uganda (Koenig et al. 2003, 2004; Kaye 2006) and nearby countries (WHO 2004a), which show a similar range among women in general and women with HIV in particular.

Sexual violence was assessed through three questions. One question of whether a partner had ever forced a woman to do something sexual that she found degrading or humiliating was omitted from analysis due to large numbers of missing data. Both research assistants later both admitted that they felt the question to be inappropriate, particularly in regards to their roles as young unmarried women speaking to their elders. The other questions were asked with more consistency, but often elicited responses of uncomfortable laughter or admonishment for the directness. Despite these difficulties, the two questions used to assess a history of sexual violence revealed very high numbers of women having experienced forced sex from a partner (42.3%) or having had sexual intercourse when they did not want to because they were afraid of what their partner might do (37.8%). Sex when afraid was significantly higher in Mbarara than in Uganda, potentially due to the above-seen trends in women’s views on gender equality in that site. Women who report low beliefs in gender
equality and women’s decision-making abilities potentially may also feel less able
to refuse unwanted sex from a husband.

**Total violence scale**

The four types of abusive behaviors assessed were combined into a
weighted total violence scale and divided into three categories (see Table 14).
Overall, the majority of women in the entire sample report little or no history of
violence from intimate partners (57%), one quarter report moderate experiences
of violence, and 18% of women report severe violence from intimate partners.
Although there are more women in Mbarara (22%) than in Kampala (14%) who
report severe violence, the difference is not statistically significant.

**Factors associated with violence**

A total of 34 variables were tested for association with all four types of
violence and the overall violence scale using a chi square test (see Table 15).
Appendix B has the complete list of results from these analyses. Those variables
found to be associated with overall violence include having other wives, partner’s
drinking frequency, partner’s drunkenness frequency, a history of either the
woman or partner’s parents physically fighting, home ownership, refusing a job
because of one’s partner, partner taking the woman’s savings, and partner’s
refusal to give the woman money. Ownership of large or small animals and
produce or crops are all associated with physical violence.
Table 15: Factors associated with types of violence and overall violence

<table>
<thead>
<tr>
<th>Associated variables</th>
<th>Physical violence</th>
<th>Sexual violence</th>
<th>Verbal violence</th>
<th>Controlling behavior</th>
<th>Overall violence score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Other Wives†</td>
<td>• Other Wives†</td>
<td>• Overall Health Score</td>
<td>• Other Wives†</td>
<td>• Other Wives†</td>
</tr>
<tr>
<td></td>
<td>• Partner Drunk</td>
<td>• Husband’s parents hit</td>
<td>• Partner Drunk**</td>
<td>• Partner Drunk**</td>
<td>• Partner Drunk**</td>
</tr>
<tr>
<td></td>
<td>• Husband education</td>
<td>• Own large animals</td>
<td>• Education difference</td>
<td>• Partner Drinking**</td>
<td>• Partner Drinking**</td>
</tr>
<tr>
<td></td>
<td>• Own house</td>
<td>• Own small animals</td>
<td>• Parents hit**</td>
<td>• Partner Drunk**</td>
<td>• Partner Drunk**</td>
</tr>
<tr>
<td></td>
<td>• Own large animals</td>
<td>• Ever refused job because of partner†</td>
<td>• Husband’s parents hit**</td>
<td>• Parents hit**</td>
<td>• Parents hit**</td>
</tr>
<tr>
<td></td>
<td>• Own small animals</td>
<td>• Husband refused to give money**†</td>
<td>• Own land</td>
<td>• Husband’s parents hit**</td>
<td>• Husband’s parents hit**</td>
</tr>
<tr>
<td></td>
<td>• Own produce/ crops</td>
<td>• Own house**</td>
<td>• Own large animals</td>
<td>• Own house**</td>
<td>• Own house**</td>
</tr>
<tr>
<td></td>
<td>• Ever refused job because of partner**†</td>
<td>• Own small animals</td>
<td>• Own small animals</td>
<td>• Own small animals</td>
<td>• Own small animals</td>
</tr>
<tr>
<td></td>
<td>• Husband take savings</td>
<td>• Ever refused job because of partner†</td>
<td>• Ever refused job because of partner†</td>
<td>• Ever refused job because of partner†</td>
<td>• Ever refused job because of partner†</td>
</tr>
<tr>
<td></td>
<td>• Husband refused to give money**†</td>
<td>• Husband refused to give money**†</td>
<td>• Husband refused to give money**†</td>
<td>• Husband refused to give money**†</td>
<td>• Husband refused to give money**†</td>
</tr>
</tbody>
</table>

(† indicates significant association with all types of violence assessed. Chi Square, p<.05, **p<.001)
Health-related indicators of length of time with HIV and length of time on ARVs are associated only with verbal violence. Partner’s HIV status was not associated with any form of violence, despite some authors’ suggestion of serodiscordancy as a risk factor for violence (van der Straten et al. 1998). Partner’s education was found to be associated with physical violence, but not other forms. In contrast to literature on the subject, the difference in educational levels between a woman and her partner is only associated with sexual and verbal violence, not physical violence or controlling behavior.

These data reveal the significant association of several economic factors with violence. Women’s employment status, their partner’s employment and differences in income between the two are not significantly associated with violence in this group. However, behaviors that indicate conflict regarding money, such as taking a woman’s savings or forbidding her to work are consistently associated with violence of all types measured. Taken in a household context, these associations make sense. When a woman and her partner are in disagreement over money issues there is more likely to be violence within the home.

Living with a husband’s family or patrilocality can often indicate that a woman has less access to her kin-based social network. Other studies have found patrilocality and social isolation to be linked to an increased likelihood of violence (Counts et al. 1999; Strauss et al. 1981). In these findings it approaches significance.
Also consistently important is the role of alcohol. As ethnographic interviews reveal, the role of alcohol is complex in its relationship to violence. Alcohol consumption within a household can either precede or result from violence. What these data show is that both the frequency of alcohol consumption and excessive alcohol consumption are associated with a history of violence within a household.

7.6 Effects of and responses to violence

Following questions regarding experiences of violence, women were asked about the effects of and their responses to violence. The instrument is designed such that those women who do not report violence do not answer these questions. Many women report having been forced to have sex with a partner or having been slapped, however, they would not consider themselves as having been the “victims” (a word not used during the interview) of violence. In certain contexts, experiences of some acts of violence, such as being slapped, was not necessarily viewed as unacceptable and thus, questions regarding a response to violence would be inappropriate. All women who reported violence were asked if they had experienced injuries. If women reported violence but no injuries they skipped questions about effects of and responses to violence. Violence which causes injury is considered inappropriate or unacceptable violence. Fewer women then completed the questions regarding responses to violence than reported violence in the overall sample and some completed only a portion of this section.
Of the 78 women asked whether they have ever been injured as a result of violence, 46.2% responded yes (see Table 16). The types of injuries range from scratches and bruises to concussions and fractures. Of women who reported injuries, 77.8% said that they were injured badly enough to seek healthcare at least once for their injuries. Of those who sought healthcare for violence-related injuries, 92.6% (25/27) report that they disclosed to a healthcare worker the real cause of their injury (100% in Kampala). While the number of women in this sample who report having been injured is not large, the proportion of those who seek care and disclose to healthcare workers is noteworthy.

In response to a partner’s violence, some women may engage in mutual combat (Strauss et al. 1981) and others may instigate physical violence at times when they are not being mistreated. In this study, 59.6% of women responded that they had fought back when they were being mistreated. Only 8.6%, however,
said that they ever physically mistreated their partner when he was not mistreating her.

Table 17: Responses to violence

<table>
<thead>
<tr>
<th>Question (n valid)</th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affected Mental Health (n=58)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>16 (27.6)</td>
<td>6 (22.2)</td>
<td>10 (32.3)</td>
</tr>
<tr>
<td>A little</td>
<td>17 (29.3)</td>
<td>9 (33.3)</td>
<td>8 (25.8)</td>
</tr>
<tr>
<td>A lot</td>
<td>25 (43.1)</td>
<td>12 (44.4)</td>
<td>13 (41.9)</td>
</tr>
<tr>
<td><strong>Told anyone? (n=60)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>55 (91.7)</td>
<td>28 (96.6)</td>
<td>27 (87.1)</td>
</tr>
<tr>
<td>No</td>
<td>5 (8.3)</td>
<td>1 (3.4)</td>
<td>4 (12.9)</td>
</tr>
<tr>
<td><strong>Ever leave? (n=59)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>45 (76.3)</td>
<td>21 (72.4)</td>
<td>24 (80.0)</td>
</tr>
<tr>
<td>No</td>
<td>14 (23.7)</td>
<td>8 (27.6)</td>
<td>6 (20.0)</td>
</tr>
<tr>
<td><strong>Where did you go the last time you left? (n=43)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Her relatives</td>
<td>30 (69.8)</td>
<td>16 (84.2)</td>
<td>14 (58.3)</td>
</tr>
<tr>
<td>His relatives</td>
<td>3 (7.0)</td>
<td>1 (5.3)</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td>Her friends/neighbors</td>
<td>5 (11.6)</td>
<td>2 (10.5)</td>
<td>3 (12.5)</td>
</tr>
<tr>
<td>Hotel/ lodgings</td>
<td>2 (4.7)</td>
<td>0 (0.0)</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td>Street</td>
<td>2 (4.7)</td>
<td>0 (0.0)</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td>Church</td>
<td>1 (2.3)</td>
<td>0 (0.0)</td>
<td>1 (4.2)</td>
</tr>
</tbody>
</table>

Women report significant impacts from violence, include work interruptions, physical injuries and mental health effects (see Table 17). Of those who experience violence and were asked whether their partner’s violence had affected their mental health 43.1% of women said that it had affected it “a lot.”

As seen in interviews with service providers, domestic violence is a stigmatized issue that can bring shame to the family. Many women are reluctant to discuss the issue. But, of those who experienced violence, 91.7% report that they had ever told anyone about the violence. Fieldnotes show that most of these women spoke to neighbors, relatives, and their partner’s relatives before going elsewhere.

Women who report ever leaving their partners, even just for one night (76.3%) mostly went to their relatives (69.8%), their partner’s relatives (7.0%) or
neighbors (11.6%). Few could afford any other lodging, and the lack of shelters in the country do not make that an option. The reliance on women’s own kin is closely related to the trend of correlation with patrilocality and violence. Women who are near to their relatives have a place to go when there are difficulties in their home.

Table 18: Formal help seeking in response to violence

<table>
<thead>
<tr>
<th>Did you ever go to any of the following for help: (n valid)</th>
<th>Overall n(%)</th>
<th>Kampala n(%)</th>
<th>Mbarara n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police (n=60)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13 (21.7)</td>
<td>6 (20.0)</td>
<td>7 (23.3)</td>
</tr>
<tr>
<td>No</td>
<td>47 (78.3)</td>
<td>4 (80.0)</td>
<td>23 (76.7)</td>
</tr>
<tr>
<td>Hospital (n=58)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28 (48.3)</td>
<td>14 (48.3)</td>
<td>14 (48.3)</td>
</tr>
<tr>
<td>No</td>
<td>30 (51.7)</td>
<td>15 (51.7)</td>
<td>15 (51.7)</td>
</tr>
<tr>
<td>Court (n=59)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3 (5.1)</td>
<td>1 (3.4)</td>
<td>2 (6.7)</td>
</tr>
<tr>
<td>No</td>
<td>56 (94.9)</td>
<td>28 (96.6)</td>
<td>28 (93.3)</td>
</tr>
<tr>
<td>Local leader (n=59)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19 (32.2)</td>
<td>8 (27.6)</td>
<td>11 (36.7)</td>
</tr>
<tr>
<td>No</td>
<td>40 (67.8)</td>
<td>21 (72.4)</td>
<td>19 (63.3)</td>
</tr>
<tr>
<td>Women’s organizations (n=59)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (11.9)</td>
<td>4 (13.8)</td>
<td>3 (10.0)</td>
</tr>
<tr>
<td>No</td>
<td>52 (88.1)</td>
<td>14 (86.2)</td>
<td>27 (90.0)</td>
</tr>
<tr>
<td>Religious leader (n=57)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15 (26.3)</td>
<td>4 (13.8)</td>
<td>11 (39.3)</td>
</tr>
<tr>
<td>No</td>
<td>42 (73.7)</td>
<td>25 (86.2)</td>
<td>17 (60.7)</td>
</tr>
</tbody>
</table>

Women were asked about formal sources they may have gone to for help (see Table 18), including the police (21.7%), the hospital (48.3%), a court of law (5.1%), local leader (32.2%), women’s organizations (11.9%), or a religious leader (26.3%). These findings corroborate what was found with service providers. Police, courts, and formal women’s organizations are not highly utilized for issues of domestic violence, except in extreme circumstances and when they are available and accessible. Women are more likely to seek help from their LC or a religious leader who is known to them.
7.7 Summary

The results of the quantitative portion of this research are generally consistent with literature on women in Uganda and other results from the WHO survey. The 200 women interviewed in clinics reported generally good overall health. In the next chapter, women elaborate on the treatment context, showing that health is not a primary concern because treatment is generally effective. Instead, in depth interviews show economic concerns regarding being able to access treatment and support a family are of utmost importance.

A large portion of the sample (43%) report moderate to severe experiences of violence from an intimate partner. While many women leave their partners because of this, few report formal help seeking and frequently return to their partners. Several factors were found to be consistently associated with women’s reports of violence. Economic conflicts, multiple marriage partners, and men’s alcohol use are significantly associated with all types of violence assessed. These key findings are elaborated in the next chapter. Women struggle with informal marriage unions and polygamous arrangements because of the instability and lack of rights if they separate or are widowed. They also frequently worry about providing for their families and this is the primary impetus for help seeking, rather than relationship conflicts. Alcohol fuels conflict as its purchase detracts from household income and is related to high frequency of infidelity or quarreling.
8.1 Ethnographic sample

Following completion of the clinic-based interviews, 20 women were purposively selected in each site for further interviewing. The total of 40 women out of 200 was chosen to represent 20% of the entire sample as well as 50% of those women who disclosed a history of violence. These women were selected from among those who had disclosed any history of physical, sexual, or psychological violence. Women were chosen based on their cooperativeness and to represent varied experiences- encompassing those with variable age, level of education, current marital status, severity of violence, recentness of the violence, and number of children.

At the conclusion of the clinic-based interview, women disclosing a history of intimate partner violence with a score of moderate to severe in the overall violence scale were identified and asked permission for possible further follow up. Women either gave their phone numbers or other instructions for follow up contact if they consented. Women were contacted two or more times before the follow up interview by phone before scheduling the interview. Women were asked if the interview could be done in their home or if not, in a location of their choice. Many women chose to return to the clinic because they were not comfortable speaking candidly in their home environments for a number of reasons. Interviews were conducted in women’s homes, their relative’s or neighbors’ homes, at the clinics, in cafes, shops, or outdoors. Verbal consent
was obtained for these women for the interview and audio recording. These interviews were open ended and most were guided to cover the domains of relationship histories, illness histories, family history, work experiences, help seeking experiences, sources of strength and advice for other women.

Following transcription, data were coded into 25 themes under six general categories: relationships, HIV/ health, family, support, economics, and other concerns. These themes were examined through the process of content analysis. This chapter examines the key themes of marriage and violence, illness experience, and help seeking. All of these 40 women are HIV positive, on treatment and report current or past experiences of violence.

On average, this group is 36.8 years old; roughly one third are currently married, one third are not married and one third are widowed. One quarter of these women are currently polygamous or were polygamous in their most recent union. They have been HIV positive for an average of 2 years and on treatment for 1.1 years. The mean number of pregnancies is 4.25, with 2.95 living children. See Appendix C for a more detailed quantitative description of the ethnographic sample.

This chapter explores four primary domains covered in the ethnographic follow up interviews with women- marriage, violence, living with HIV, and resources and responses. Women drove the direction of the open-ended interviews. Marriage or partnerships with men dominated the conversation- in terms of experiences, violence, ideals, hopes, and disappointments. HIV was a secondary concern for the women, after the management of the household and
survival. Help seeking was woven throughout the narratives as a concern, whether acted upon or not. The conclusion of this chapter gives four case studies to show the complexity and interconnectedness of these themes.

8.2 Marriage

A key theme in the discussions with women was type of marriage. Women consistently expressed feeling trapped, no matter their marriage circumstances. All cohabiting unions with men were described as “marriages” and the men “husbands” regardless of how the union began. In formal unions, women feel they cannot leave because of the exchange of bridewealth. Traditionally, men give cows or other gifts to the woman's family and a traditional “introduction” is done to formalize and solidify a union between two families, rather than two individuals. To break this union brings shame to the family. If they choose to leave, the man is legally obligated to provide for the children and sometimes the woman can, through a lengthy court process, gain custody of the children—although this significantly reduces her chances of remarriage. In informal unions women feel trapped because if they leave they will have no rights to their children. The current laws do not allow a woman to have custody outside of marriage if the man says he wants the children (if the man does not pursue custody, the woman is free to raise the children on her own). The practice of polygamy, both informally and formally, was another source of stress to women. As seen with the larger sample, polygamous unions are very common in Uganda.
Below highlights women’s discussion of marriage on the topics of ideal unions, choices in marriage, types of marriage, and separation and divorce.

**Ideal Union**

An ideal marriage is not necessarily a romantic one. The ideal is a man who provides, does not argue, and does not have other women. He helps to fulfill the goal of having children, though if a woman is unable to produce children, the man may leave her or bring another partner, whereas she cannot leave if a man is impotent. This is both socially unacceptable and not currently legal grounds for divorce.

One woman married young, but was initially pleased with the union. As she explained, “I got married at 17 years of age. His mother was from our home. His sisters and aunties went to same church. He came to our home. It was a good marriage, it was peaceful and he did not drink much because he feared his father a lot” (age 39, Mbarara). His lack of drinking, staying home, and providing for the household were fulfillment of this man’s marital duty. For this, he was seen as a good man. Other character traits or relationship compatibility, particularly among younger women, were rarely part of the discussion. A man is good if he fulfills his obligations.

Most women described an ideal union by describing the example of their parents. In situations where the father provided and the mother was able to be present and care for the children, women felt the home to be happy. Often women describe some disagreement, but the ability to resolve disagreements without divorce still constituted a happy marriage. Those women whose mothers
and fathers separated always mentioned this in their upbringing as significant and disappointing. Polygamy is approached ambiguously. It is an inevitable and quite often expected situation, but not part of an ideal marriage. One woman commented, “If a man has so many wives, then he is not a good man” (age 40, Mbarara). Below are some experiences of women in marriages with multiple wives.

Some women spoke more about desires to communicate with their partners and be in love, but those concerns were secondary to survival and success in the union. Another dimension of an ideal union is a formal marriage. Women wanted to be formally recognized in a union to secure their rights to maintenance and property and for the status within the family. This could be done through a religious or a traditional ceremony, rather than staying together without a marker. As described below, the practices of formal and informal unions both have benefits and drawbacks to women’s status, but in general, a formal marriage is preferable.

Marriage Choice

Early marriage is common among this group of women; and the median age in Uganda at first marriage is 17.8 years (UDHS 2006). Due to informal unions and “boyfriends” (non-cohabiting partners), the survey did not measure age at first marriage, but women had sexual intercourse first at an average of 16.5 years, and most report their first union to be immediately or shortly after. The decision to get married is often out of obligation. Some women become pregnant and are then expected to go live with this man at his home and become
his wife. Others are told by their parents that it is time, often when there is not enough money to continue education. The husband is chosen by parents or relatives and little say is given to women in the matter, though they do meet the man before the wedding. And yet others independently choose marriage as a survival strategy to have a stable lifestyle. Some, of course, choose marriage out of love, though that was infrequent among this group of women- potentially due to describing an “unsuccessful” marriage in hindsight and the bias of all having been in physically violent partnerships.

One woman explained quite frankly that her family was poor and she had to leave school. She described the period of leaving school and the family’s struggle as “the difficult times.” During this time, she worked as a maid and scraped by on the small income. Through that work, while at a market one day, she met her husband and married him to survive- “my first husband, I met during the difficult times. And because the situation was hard, I said to myself, now that I have found a man, I will get married. Since I was working hard and the situation was really hard, I decided to get married” (age 36, Mbarara). This man was a heavy drinker and physically abusive. He brought home another woman to the household and she stayed for financial support and their children. The man died suddenly in an accident. Her second marriage was also a result of circumstance and survival- the first husband’s family convinced his brother to marry the woman. They stayed together until his family chased her and the children away- accusing them of witchcraft. She has since stayed on her own and although
economic concerns are still pressing, she has since found out that she is HIV positive and is choosing to stay single.

Another participant’s family insisted that she marry to maintain the family’s reputation. She met a man while in school and because the family was suspicious that they were sexually active, they sent her to the man’s home. She reflected later that she was too young for marriage and unprepared for the union she later left.

*My husband, how we met, he had completed S4 [fourth year of secondary school] and volunteered to teach at a school. So he was like a teacher for me in class. Like when we would be going home and I am holding books for him, so people and other children would talk and say that I was with so and so and as a parent my father would think that that I was with this man and he was “kukwana” [in a boy/girl relationship with] me. And my dad found out about him. And as a parent he thought we were in some kind of girlfriend/boyfriend relationship and then he told me to go and he marries me. At that time things of marriage I did not know and it actually seemed like the boy was forced upon me when I was not ready. And I would think why are they forcing me when I am not ready to get married? And I think this was what was in the middle of our unhappiness with him.* (age 37, Mbarara)

While getting married young and because of family was generally viewed negatively, some women spoke of early marriage as a happy time and a comfortable one, when men provided for them and they had the space to mature. One describes her first partner, who her family insisted she marry at age 16, as a good man who took care of her despite her not yet knowing how to be a wife.

The man had other women and was not always home, but she was content with the situation. “*He made sure that I never lacked of anything. He married me as a child and I did not know much. I really did not know much. When he came I was always there to welcome him and when he went, he went. He would come and*
go” (age 39, Mbarara). She was provided for, and the man’s other behaviors were not a concern.

**Types of Marriage**

The type of marriage is a major factor in a woman’s perceived ability to leave of her own accord. In a formal marriage, which involves the exchange of bridewealth, a religious ceremony, or both, women feel obligated to fulfill their role. Were they to leave, the family would be ashamed and they would have to return bridewealth to the man- which is not always possible. One woman who was married formally never left her abusive husband and was later widowed. Her narrative details ongoing violence and many difficult times. But as she said, she could not even think of leaving, “Since we wedded, I couldn’t [leave him]. Because I knew I was his wife. I was married. So I couldn’t think of going” (age 32, Mbarara). On the other hand, in a formal marriage, men are obligated to provide for women and their children and women are more likely to seek help (given that they know their rights). One woman describes her attempts to leave a man and go back to her family’s home, where they were not able to take her in. She went to the police and demanded that the man provide for her, which turned into a long court battle. Eventually this failed and she went to her family’s home. The formal marriage is what she views as most important in being able to access formal support.

*When he chased me, to chase me, the family said that the household was not prepared for me when I came to live with them. The lucky thing for me is that I was wedded to him. So in all that “kavuyo” [chaos], I was married to him. I had gotten married and so I went to police, we had court cases and it was all so prolonged and everything just got messed up and died there like that. He got*
another wife, brought her to the house and then chaos. The story became quite too long. He was asked to build me a house, went to jail for a while because of this and so many other things but all to no avail. Building for me did not even happen, at the end of it all we ended up where we had started and we went home. He just continued to make me suffer. He said that this wife I do not want her any more, that his family had rejected me. Actually the last time we were in court he said that he did not want me as a wife any more because his family had rejected me so I had to go. It was then I just found my way home and went back. (age 37, Mbarara)

In another case, the woman’s status as a legal wife successfully gave her access to property that would have otherwise been denied her in the separation. She says, "they said that since I had gone home I was not going to get the land, so I had to use the government authorities to try and get a share of the land. The fact that I was a legal wife, the government decided to give me a share of what belonged to my husband" (age 31, Kampala). Legally, she was allowed to access her inheritance because of the formal marriage.

In informal unions, many women believe they cannot seek help for problems through formal means. Many are obliged to stay on for the sake of children. However, the other side of a cohabiting couple without the obligation of marriage is the fluidity of the union and some women’s independence in the situation. One woman is happy with her situation, in which the father of her children provides for them, but does not always stay with her and she can do as she pleases- freed from the expectations of a “wife”. She describes her relationship with the man,

*He was a boyfriend, I never got married to him. This one’s [pointing to her nearby child] father. He has his work that he does and he travels and stays there. He is never here. He goes and does his job and does his own things and I do my own. It is not like I was married to him. Since I was not married to him, it was just like that.*
I was more like his partner and not necessarily his wife. So he had his work that he was doing. But when he comes, he comes by and sees his child and then he leaves. (age 34, Mbarara)

The informal arrangement gave her and her child some support, but she is not bound to one man. She can work and do as she pleases and the man does the same.

Polygamy as a cultural practice is both common and generally socially acceptable, but adds to the stress of women within a household, both emotionally and financially. None of the women spoke of their co-wives in positive terms. Polygamy is either problematic to the degree of ending a union, or simply a fact of life that must be endured. One NGO director in Kampala suggested that the practice of marriage itself perpetuates the double standard in acceptable behavior for men and women. Men, she says, are given more freedom and less accountability once they are married while women become tethered to a partner and household responsibility.

It’s like the unmarried men are monogamous. And more faithful to their partners. When the men here in Uganda get married, they become the most adulterous. They keep sleeping around because he’s married. He lies that he’s Christian. Marries a woman in church. But has very many he is having unprotected sex with, because he has a string of children. And very many girlfriends. And people look at that as ok.

Married men may therefore have more partners than those who are unmarried, and their behavior is culturally tolerated.

Polygamy is legally sanctioned for Muslim men- they may have up to four wives. Customary marriage also does not limit the number of wives. A church or formal wedding is the ideal for women to gain security and recognition in
marriage. Therefore, the practice of polygamy done culturally or religiously limits women’s formal power within a union. As a result, they may be inhibited from seeking help when there is a problem or denied inheritance if the man dies.

As is seen in the case studies below, polygamy is sometimes imposed upon women after their decision to marry a man. The man maintains households in separate areas and after the women are committed or because of financial need, he may consolidate the household and bring the women to the same place. One woman married a man, knowing he had been divorced. However, after several years of marriage she found out the number of other wives he has had, including two others concurrently.

*I found out that I was wife number six. He had had other women before me…. In getting married to him, I knew that he had separated with other women, but I did not know how many. It is his mother that told me. It was after a while… when I was already established in his home. After getting used to my new home and everyone, I was able to find out.* (age 39, Mbarara)

This woman’s mother-in-law told her that she was the sixth woman in the man’s sting of marriages and separation. She independently chose to marry the man, but was deceived into sharing her life with other women as well.

The women in this sample were not positive about polygamy. There is some literature to suggest the practice’s acceptability in parts of Africa, due to the decreased workload for women and the sharing of burdens (Kilbride 1994). However, these women emphasized the emotional difficulty in having a husband with multiple partners. Men’s infidelity outside of the union was the most shameful, but even other women who came to stay were viewed negatively.
Divorce and separation

The decision to leave a marriage is a difficult one. A major factor is the type of union, and also important are children, reputation, and other options available. Several women left partners, only to return for economic support or for their children or both. One woman remarked that child-rearing is more expensive than it used to be. She ran away from her husband multiple times, always to return for the children. She says,

*Today, you have children, but they need so much and find that you are not easily managing them…. Raising children today is harder than it was for my parents…. When people in a relationship work together it cannot be a problem, but if they both work and each one makes their own money and spend it without consideration of the other, then problems arise. If the money does not benefit the whole family then it is bad. If there is not collaboration in a marriage, then the roles are problematic.* (age 39, Mbarara)

Others were unapologetic about leaving when the man did not fulfill his prescribed duties. One woman commented, “*I do not regret [leaving my husband] because I am better off now than when I was with a man*” (age 55, Mbarara). She is happier to support herself without the added burden of a partner who does not fulfill his obligations. Another woman married her husband because of his “hardworking spirit” and ability to provide through his job as a trader in the market. However, with time, he began to leave more frequently and had affairs. The neglect at home combined with the affairs fed her decision to leave the union.

*In the beginning he was a business man, never staying home but he would work and not bring money home and that was the beginning of the break up of the marriage- because the money never was used in our home and it never led to any significant changes and this led to problems and extra marital affairs on his*
part. This was the beginning of our problems and consequently separation. In the beginning he was a hard working man and I appreciated him for that. He was a good business man and then he got me and after two months he left and he would be gone for extended periods of time. I did not know much about his character or even what he was like. What drew me to him was his hardworking spirit. (age 39, Kampala)

The man’s hard work did not manifest as material benefits for the family or home. His absences were not as problematic as the lack of support, but combined with infidelity, led to the breakup of the marriage.

Another, tormented by leaving her children, justified at length the decision to leave her marriage. Her husband did not allow her to work outside the home, nor did he give her spending money and she felt her basic needs were not being met.

*Why did I leave? I felt abandoned. I was always by myself and his mother. I was fed up and I just could not stand it any more. I felt like I was young and did not need to suffer anymore. I decided that I should go home and would get married again some time.* (age 39, Mbarara)

After spending enough time alone in the home, the woman moved back to her parents’ home and eventually remarried because she was still young.

As this illustrates, marriage itself is culturally viewed as binding, but in practice can be more fluid and many women have multiple “marriage” partners in the course of their lives (though frequently because of being left or “chased” from the union- not of their own accord). Women are reluctant to leave because of dependence on the man’s income and support, particularly for their children. But when this contract is broken, women feel devalued in the marriage. Many remain
“patient” in trying to appease the man or because of a lack of other options. One woman commented on her status as a woman and guilt in leaving the marriage,

*The man doesn’t “okwesigaliza” [rely /bank] on the fact that he is a man. Most of the time the woman, you cannot talk and you just be patient. Especially for the children. You cannot leave the children behind. So you are patient for the children so that I don’t leave them like I suffered.* (age 40, Mbarara)

She was dependent on her partner in a way that he was not dependent on her. Her main concern is the welfare of the children, above the relationship with her partner.

When a man is providing for the home, the women feel that they cannot leave. Even in the face of ongoing physical, sexual, or verbal violence women will stay with a partner who provides. A 44 year old woman in Kampala was shocked when I asked her if she ever thought of leaving her marriage during the times when her husband was drinking heavily and beating her regularly. She responded strongly, “There’s no way I can tell him to go because sometimes he gives me help. He gives me money for school fees for the children, so if I go or tell him to go, who will help me? Even for the house, he gives me money to pay the rent. So why should I tell him to go away?” (age 44, Kampala). In her mind, the good of the family and provisions for the children overrode any concerns she had about her own safety or happiness. The man may not have been ideal, but he was at least bringing home money for her and the children, something she knew she would have been unable to do on her own.

Culturally, when women leave their partners, they are expected to go back to their birth families- regardless of whether they choose to leave or are forced to
leave. These women, however, all have HIV and face another set of difficulties. They need to maintain their treatment and cash flow to attend the clinic. Many have not told their families about their status. As seen in Chapter 6, formal options for women are few—particularly in Mbarara. Women choose patience out of necessity when a marriage is not working, because they do not have the income to provide for themselves, their children, or maintain healthcare. Those who are abandoned or forced to leave their partners face barriers in supporting a family and maintaining their health.

8.3 Violence in marriage

Reported frequency of intimate partner violence among women in Uganda is widely variable due to methodological and reporting constraints. Nonetheless, the range is exceptionally high, with 40-70% of women reporting physical or sexual violence from an intimate partner in their lifetimes (Koenig et al. 2003 2004, UDHS 2006). In the sample of 200 women, 43% reported moderate to severe experiences of physical, sexual, verbal violence or controlling behavior. All of the 40 women followed experienced physical violence from an intimate partner at some point throughout their lives. As seen above, many women are currently widowed and so do not face ongoing violence. The discussion of violence with women focused on experiences of physical violence, particularly responses and coping. Responses and help seeking are explored more in depth in section 8.5. Below are women’s reports of experiences and causes of conflict in relationships.
The two main causes of violence within the home cited by women are infidelity and alcohol (or often a combination of the two). All of these women are HIV positive, but their status is mentioned as another stress, not a cause of violence itself (illness management of HIV for women is discussed in the next section). A man’s violent behavior is attributed either to his innate personality, often unrevealed until later in marriage, or an effect of peer influence and alcohol.

One woman in Kampala is in an unhappy and currently abusive relationship. She said that she and her husband have had problems for years. His infidelity and lack of support in the home are what she says causes quarrels on a regular basis. She is educated, but he does not allow her to work. After their child fell sick and they decided to go together to test for HIV, they made a deal. The man said that if he tested negative, he would divorce her and they would both move on. However, if they both tested positive, they would stay together and work on improving the marriage. If she happened to be positive and him negative, he did not make any provisions. Both tests came back positive and they are still together. She is certain that she was infected by her husband and sadly, the relationship has not improved.

As seen above, infidelity and polygamy are common problems that women encounter. Many women spoke of their partners as “womanizers” (malaya in Runyankole and Luganda, meaning most closely “philanderer” or “someone who is unfaithful/ loose”). This habit of men was sometimes hidden early in the marriage and got worse with time. Some say it is a result of men earning more money. When the man earns more money, socializing and drinking are part of
this new lifestyle and affordable in a way previously unknown. Women blame men’s peer groups for encouraging unfaithfulness or some say it is a character flaw in their partners themselves. As one said,

\[ I \textit{think what caused him to change is the peer group. Some of his friends would tell him that a wife should not have power over you. Some of his friends would tell him that if my wife answers back, I beat her. I think because of all this, he behaved the way he did.} \]

(age 36, Mbarara)

Regardless, while women encourage men to earn money for the family, particularly when they are prohibited from working, this also comes with the fear that the man may begin spending less time at home or potentially find other partners.

Summed up quite simply, one woman attributed all of the conflict in her marriage to her husband’s character: “\textit{he was just a womanizer}” (39 Mbarara). He was frequently away from the home and would not tolerate questions. When he returned, he would accuse her of infidelity and their fights erupted into violence or he forced her to have sex. Another spoke of this in terms of the man’s “habits” – other women and alcohol. “\textit{He had bad habits. He was a womanizer and he used to beat me. He would get drunk a lot and fought a lot. And he quarreled a lot. He had too many other women}” (age 32, Kampala). She blamed the man for his actions, but felt his actions were the result of learned behavior and not an innate character flaw. In Kampala, one woman said that her husband’s infidelity was due to his increasing income. As soon as he could afford to court more women, he did. She says that, “\textit{everything changes when a man gets more money; he adds on loving women}” (age 44, Kampala).
Alcohol and conflict

In Mbarara, a widowed, middle aged woman recounted the role of alcohol in her marriage. Her husband began the relationship peacefully but with time his drinking became more problematic and he was more violent.

_He always drank alcohol but when we were newly married he was secretive about it but when the relationship progressed he just did what ever he pleased. Fighting. When he came home drunk I would tell him why does he not stop drinking. And when I complained, it led to beatings and spending nights outside. So for the sake of peace, I just decided to keep quiet._ (age 36, Mbarara)

They quarreled often after he drank and to keep peace in the home she eventually stopped confronting him about it.

Alcohol contributes to violence and conflict in two ways. The first and most direct is that when a person is drunk their inhibitions are decreased and what may have been a verbal argument at another time can turn violent. The other more indirect contribution is the economic consequences of excessive alcohol consumption. When a family is surviving on a single income to support themselves, their children, and pay health expenditures, money diverted to purchasing alcohol is a source of conflict. Women complained that when men started drinking, they began bringing home less money for household expenses. The arguing over money, therefore, is often more directly related to the violent conflicts, and arguments themselves may, in fact, be instigated by women’s frustration. A young woman in Mbarara admitted her frustration in the situation, “he is drinking and not having good responsibility for money. This makes me angry and we start arguing” (age 21, Mbarara). Another said her husband had a short temper when drinking and became unpredictable. She did not know what
would set him off when alcohol was the catalyst, "When he came and would find like a cup has dropped, or even the child is crying. Basically anything would annoy him when he was drunk. Anything would make him quarrel, he quarreled about this and that and everything" (age 41, Mbarara). The man’s drinking made him unreasonable and unpredictable.

Other Reasons for Violence

Few women reported ever fighting back. Only one told of attacking her husband while he was not fighting with her. In that case, she had had enough and attacked him in his sleep. She went to jail and they divorced when she left, but she does not regret her behavior. She feared the man would have killed her if things had continued the way they were. The majority of women report not fighting back, even when the man was violent. They would leave the home or bear it. Only a few said that they fought back to defend themselves or when provoked. For example, "We would just quarrel. When he would beat me or quarrel for nothing, I would also quarrel" (age 30, Kampala). One summed up her resignation to stay in the situation by saying, “going away is a waste of my time. I think that all men are the same” (age 24, Mbarara). She would have left if there was hope of something better elsewhere, but she had lost that hope with years of enduring a violent partner.

In one instance, a woman suggested that her husband’s single violent episode was the result of witchcraft from her co-wives. She was a first wife and happy in the marriage until the man insisted on bringing home two other women. The man rarely drank and provided for all members of the home. One day during
an argument, he snapped and beat the woman severely. He chased her with a
panga (machete) and she left for her relatives’ home. The man came to visit
frequently, but she stayed in a separate household until he died several years
later. In this instance, she could not explain the one-time incident that so
dracastically changed her marriage in any other way, except for the interference of
jealous co-wives. “I think that they [the co-wives] might have give him some
traditional herbs because the way he was acting was a way I had never seen him
act towards me” (age 31, Mbarara).

Regardless of their explanation or response, none of the women treated
violence as normal or tolerable behavior. Those who chose not to leave did so
out of obligation to their reputation, children, and families, or because of
dependence and a lack of other options. Unlike the providers in Chapter 6, the
women interviewed did not suggest that violence was a sign of love or
necessarily intrinsic to “culture.”

8.4 Living with HIV

All forty women interviewed are currently HIV positive and taking life-
saving antiretroviral drugs. These women are part of a new era of HIV, in which
treatment is available and HIV can be lived with as a lifelong chronic illness, as
long as there is consistent adherence to and availability of antiretroviral
medication. As mentioned above, HIV is not the priority for the majority of women
interviewed. When asked about their worries, most cite concerns about money,
children, and work. All of the women are currently on treatment; although many
had early side effects, they have since regained health and are managing their illness. Some still fear dying and leaving behind their children, but it is secondary to the daily struggles of poverty. Below are women’s illness experiences through the phases of testing, disclosure, and treatment.

Testing and fear

In this group of women, many tested through routine testing, whether in the hospital for another problem or going for antenatal care. Most said they suspected they had HIV by the time they tested—often because of ongoing unexplained illness, suspicion because of their partner’s infidelity, or children’s sickness. Not unsurprisingly, the typical first response was shock and denial. As seen below, treatment has changed the way these women approach living with HIV, but at the initial time of testing many feared for their lives, having lived through the recent years when HIV was inevitably a death sentence, particularly in rural Uganda.

One woman who is now healthy and bears no physical markers of her illness, told me of the time when she tested. She was at the hospital for another illness and the doctors advised her to test. She had been suspicious of having HIV for some time, but was too frightened to test. When she finally received her results, she was certain that it was a death sentence. She resigned herself to this inevitability, “By that time I knew I was dying anyway, so I just did not care. I was not scared because I knew I was dying anyway, so they were just going to confirm what killed me” (age 37, Mbarara). The counselors talked to the woman
over time and eventually she agreed to begin treatment, which has changed her life quite drastically.

HIV counselors, in this situation and others, are crucial to mediating the women’s response to testing and encouraging disclosure and treatment seeking. One woman tested alone and was in shock. She had not told her partner, and was certain that she would be thrown out of the home. She said the counselor spoke to her at length and even disclosed to the husband for her. She was convinced to stay in the marriage, and the man and co-wives who also tested positive are currently on treatment too.

I was pained, I cried, they counseled me and comforted me for over three hours. They continued to counsel me. Then they told the man…I was in a lot of pain about testing positive. I came and tried to pack up my things and leave but the other women comforted me and told me to stay and so I stayed patient up to date. (age 32, Mbarara)

Testing is also a potential point of conflict with partners. If women tested through antenatal care or other clinic visits, they often do so alone. Those who choose to test may try to go with a partner. But those who test first are faced with the difficult task of disclosure and asking the man to test as well. Several women reported men who simply refused to test, ever. One told of her late husband’s stubborn refusal to test or seek treatment despite being deathly ill.

I think he did not seek medical care because he said that he was not going to waste resources by selling his land and property to seek medical care because he never wanted to waste it, he really never sought treatment. I think if he had sought care, he would still be here. The entire time I was with him he did not take medicine. He must have died of the virus. (age 31, Mbarara)
He never sought treatment and she is convinced that he died from HIV. She is on treatment and currently experiencing no side effects.

Another recounted a similar experience of her husband’s blatant refusal to test and denial of the illness. She was certain that he was positive as well- and most likely the source of her own infection, but in his denial he blamed her for infidelity and refused to test. She tells of her disclosure to him, “I tell him ‘I found myself sick. Will you accept to go for an HIV test?’ and he refused and he said for him, he was not sick” (age 31, Kampala). Several women who tested alone reported that once they disclosed to their partners, they discovered the men to have known already. Two women said their partners were already on treatment, but had not disclosed to them. One woman’s husband, however, was immediately remorseful. When they went to test together and both tested positive, she recounts that “he was crying to me saying forgive me because I know I’m the one who has infected you” (age 47, Kampala). The man had four other wives, all of whom he infected with HIV before he died a few years later. The woman said testing was the hardest part, because he was so apologetic afterwards and their lives improved through treatment and his attentiveness.

Since the availability of treatment, testing is less feared than in the past. Women are more open to knowing their status once they suspect infection because death is no longer a certainty. In Mbarara, a woman was widowed and the neighbors and her mother-in-law suggested that she may be infected. She went to test after the funeral, and immediately started treatment. “What made me go [test for HIV] was when the man got sick, people told me that don’t you see
that he is suffering from HIV? So when we had buried and I came back from his home, his mother told me to go and test. And then I went and tested" (age 30, Mbarara). Her mother-in-law’s advice to test was not stigmatizing, but encouraging and truthful about her husband’s cause of death.

Disclosure and Stigma

Disclosure of HIV status is strongly encouraged by counselors (see Chapter 6) and other healthcare professionals as beneficial to treatment course, social network support, and overall coping. In reality, disclosure is a complex decision, variable by individual, context, need, and illness course. Most of the women have disclosed their status to others, outside of the healthcare setting. However, the choice of whom to disclose to varies greatly and even those who have told a few people may fear repercussions of disclosing more widely. Three of the women have told their status publicly and try to use themselves as examples for others seeking treatment.

In the Mbarara clinic, all clients are required to bring a treatment supporter to begin enrollment on ARVs. There are multiple counselor visits leading up to treatment initiation and individuals there are forced to disclose their status to someone close to them (preferably a family member or nearby neighbor). Several women complained that they were not ready to tell their partners for fear of violence or being abandoned, but were required to by the counselors. One woman in Mbarara feared to worry her mother, despite the urging and waited until she had regained her health to disclose. She says,

The people here kept telling us that we should try and disclose to some people. At least tell a few people in our lives. We were
continuously taught to share about our illness. I was really worried about my mother. I was concerned that telling her would be too much for her to take. (age 31, Mbarara)

The primary fears in disclosing status that were reported were fear of gossip and social ostracism. One woman refused to disclose outside of her immediate family because she had heard cases of others losing their jobs for it. “When you have HIV you really suffer a lot,” she described, “because even if you have a job the chances of you being fired are very high people will be pointing at you. All the time you are the topic on people’s table, that you have HIV. They’ll be pointing at you; they’ll fire you from the job. People who have HIV are facing it really hard” (age 45, Kampala). She thinks that if others in the workplace found out, her HIV status would always be a source of worry, gossip and discrimination. Another also feared gossip in the workplace, that it would not help her health. She thought gossip and backbiting would decrease the gains she has made from treatment and did not feel the need to share. Her re-found health makes it possible to avoid the gossip. “You know such things when someone talks about you a lot, it makes your situation-- your life goes on decreasing. I don’t need someone to say that you are sick. Such things make people not to tell others” (age 31, Kampala).

Women who did eventually disclose reported that their fears were unfounded and responses from their social network were primarily positive and supportive. In Kampala, one woman was scared to tell anyone, but a neighbor found out anyway. She says that this has improved her health and happiness, to have someone so supportive despite her fears; “Ok, there was a woman who
knew about it but she hasn’t mistreated me. She comforts me. She tells me to take care- that I’m not the first person to get sick. So she gives me back my energy” (age 31, Kampala). The same woman, however, explained that she feels that she cannot tell others to test themselves. There is still a strong stigma surrounding the disease, such that a woman who has lost a partner to AIDS may still remain in denial and respond quite negatively to the suggestion to test.

Very few women can easily talk about their sickness, so women, like women in the village, even if she has just lost a husband, for her she thinks that she has stayed alive. You can even tell her that go and test yourself to know your status and she’s not able to do it. And she wants to go ahead in her life and she can even hate you.

At both clinics, some men and women who are on treatment assist the clinics as volunteers and are known as “expert clients.” These individuals have disclosed publicly and encourage others to do the same. Three of the women in the ethnographic sample fall into this category and speak freely to anyone they meet about being HIV positive. Two women work doing outreach through the clinics to encourage people to test and know their status or to enroll in treatment when they are positive. All three report initial fear and said that some people gossip. But they are now healthy and challenge stigmatizing stereotypes by being so vocal, saying that they are not isolated or discriminated against in such a way as to interrupt their lives. One woman posts her status literally through signs; “in fact I’m so free that when you come to my home, the first thing that will greet you on my door are posters on HIV” (age 47, Kampala). Following her positive test, she became an LC of her village and says that disclosure has made her strong enough to both regain her own health and help others to do the same.
Nonetheless some women did in fact have the consequences they feared when others found out their status. In Kampala, one woman was diagnosed after her husband died. She resolved that for her children, she would try to maintain her health and work hard. “When I discovered I had HIV/AIDS I made myself strong I decided to be as strong as possible and I decided that after that I would be strong for my children try to get away and trying to make myself survive” (age 32, Kampala). Because of her strength and resolve, she chose to tell her status widely to get support and resources from people she knew. Unfortunately for her, not everyone responded well. Her husband’s family was the worst and took her inheritance: “My in-laws really mistreated me. They took away the property from me.” Without the land she was supposed to inherit, she has suffered a lot and struggles to provide for herself and children.

In Kampala, a woman who had suffered from ongoing physical and sexual violence from her husband feared to tell him. She had sores on her faces and was trying to think of a way to make an excuse: “So I asked my friend, ‘so if I’ve got herpes zoster what am I going to tell the husband?’ ‘So we say that, we lie to him that you got a caterpillar on your face!’” (age 47, Kampala). The man believed the lie about the sores being from a caterpillar bite, which bought her some time before she eventually did tell him and he tested positive as well.

Being asymptomatic takes away the need for disclosure until one faces challenges in getting support or resources to maintain treatment. One woman said, “I’ve not told any of my friends. With time, I may because like when I will be sick, I will have to reveal it to them” (age 38, Kampala). She believes that
disclosure is only necessary for the material consequences, not because it is good for her otherwise. She will not tell her friends until she has to. Appearing healthy has changed many of these women’s lives. One was widowed and people were gossiping about her initially but now she says, “because of the way I look, some people think that my husband didn’t even die of AIDS” (age 47, Kampala). They no longer believe that she is infected nor that her husband died from AIDS.

Treatment

The women in this study have been on antiretroviral treatment for an average of 3.5 years. When asked about their experiences on treatment, overwhelmingly the responses were positive and emphasized the drastic changes to health and productivity. When probed further, a few shared some of the early side effects and others spoke of some difficulties with their partners in staying on treatment. The greatest concern, by far, is not the direct effects of the treatment but the context of relying on a constant supply of money to be able to access the medicine or to maintain a healthy diet. Many said worrying too much about having HIV was not good for their health and tried to focus on positive living.

After falling very sick repeatedly, a woman in Mbarara found her status to be positive and immediately began taking antiretroviral treatment. The difference was rapid and drastic:

Since being on medicines I became so well. Chest was clear, the stomach pains were gone and I had no illness at all. I have been completely well. Apart from recently when I had financial issues, I have been well, and even the slight feelings of ill health are due to
doing work that I should not be doing. I even gained a lot of weight! I do not have a problem as long as I do get sick. I don’t fear to swallow them [the pills] and I am ok with it. The only concern is the fear that I may fail to get money to come get the medicine. (age 39, Mbarara)

Her concerns are typical of the whole group; the positive is emphasized and concerns are not directly related to the medicine itself. Only a few said they had headaches and insomnia early on the treatment. One says that the drugs have affected her memory; “the difficulty I got is that it [the treatment] disturbed my brains. I forget a lot” (age 47, Kampala). However, she does not want to tell her doctor for fear of being taken off of treatment all together.

Taking the pills after several years is routine and not given much thought by many women. Several times during the course of an interview, women would stop what they were saying mid-sentence, pull bottles of large pills and a water bottle out of their purses and take their medication at the precise designated time before finishing what they had been saying. One summed up her routine nonchalantly, “When the time comes I just take them, it is part of my everyday things to do” (age 42, Mbarara). Taking treatment is embedded in the normalcy of daily activities.

Most of the women were very invested in their own healthcare and status, knowing detailed information about dosing, types of medications, and their CD4 count—sometimes despite being unable to read and write. The local translation of CD4 cells is “soldiers.” Women told me their exact number of ‘soldiers’ at the beginning of the illness, compared to now, to illustrate the drastic changes. Many have undetectable viral loads and plan to keep it that way. A 36 year old woman
in Mbarara, while talking about her children, paused to take her medicine, and resumed to tell me:

I have not had any problems with medication. Actually to start medication, I had only six soldiers, but now I have 664 soldiers. I have never been sick since I started the medicine. Once in a while there is some fear. This is often due to seeing so many other people that have it pass away due to HIV. But even though there is some fear, there is a little comfort in knowing that the medications make us healthy and the fact that when we started taking them we knew we were taking them for life. So whether scared or not you just have to take it.

Her “soldiers” have increased dramatically and she has faith in the efficacy of treatment, but she still has some lingering fear from living with an incurable disease. Her concerns are typical of this group. The women are not naively unconcerned about their HIV status, but rather have incorporated it into a daily routine and the initial sense of fear is no longer the most important thing in their lives. Most follow their doctors’ orders carefully and make great sacrifices to arrive at the clinic on their designated appointment dates.

Only two women reported interference or problems with their husband in regards to treatment. Neither woman had sought help for other issues in the marriage, but did so once their health was involved. One said her husband was throwing away her medication, saying that since they were both positive, they should die together (he tested, but had refused treatment). The other said the husband took her medication, presumably for himself because he would not go to the clinic. Both reported the matter to the LC in their area, one in Kampala, another outside of Mbarara, and the LCs’ response was enough to resolve the issue. Neither man began on medication, but they left their wives alone. One
says of the situation now that she has gotten help: “For me, I normally take [the medicine]. When I am supposed to come here, I have to come. Whether it is what or what, I come. He doesn’t even stop me. He doesn’t interfere” (age 38, Kampala). The man no longer stands in the way of her healthcare seeking.

Others when talking about medication had very little to say. They try not to worry, and focus on health instead of sickness. Or as one woman summed up her lack of interest in discussing medication or sickness, “I am not on those things of sickness, I am thinking about life. I don’t tie myself on such things at all” (age 47, Kampala). Another, echoing the worries of things that go along with treatment rather than treatment itself, describes her experience: “for me to be on medicine, it has been ok. Other than issues like poverty, medicine is really not an issue” (age 37, Mbarara). Now that she is healthy, she worries about providing for her family more than about medical side effects.

Poverty and money consistently remain concerns- in deciding to stay in a relationship, in adhering to medication, and in caring for children. One side effect of medication is an increased appetite, and women are also instructed at the clinics on proper nutrition to minimize negative complications from the sometimes difficult drug regimens. This increased appetite and need for food are great sources of stress, though stress is also something to be avoided, as advised by the counselors. As one woman describes her outlook,

> When you over-worry, sickness seems to persist. You don’t work yet you have to eat. The doctors tell you- you have to eat. Me, if I have I got money or a source of income that would be the least of my worries but now the whole problem is money. And I don’t spend my time thinking about the diseases--I spend my time thinking
about money. I’ve been counseled- things changed. (age 47, Kampala)

In general HIV treatment has been successful among this group. They are not without worry regarding transport and nutrition but being HIV positive and adhering to a sometimes difficult course of drugs is not at the forefront of women’s concern.

8.5 Resources and help seeking

All of the women in this group have faced a dual vulnerability of being HIV positive and facing violence in their relationships along with other struggles of poverty and familial issues. For some of the women, their infection and experiences of violence did not necessarily coincide and, in fact, many are currently widowed. At some points, each of these 40 women has faced compounding vulnerabilities and issues. To deal with either issue, they have adopted a number of strategies. All of the women have sought and received healthcare, as explored above. For the violence or other health and economic concerns, many rely on informal groups and religious membership. Some seek help in strategic ways, through NGOs and social service organizations, or in emergency situations through the police and LCs.

Sources of strength

Women reported different means of getting through difficult situations. Some belong to women’s groups, either for others who have HIV or microfinance savings groups. Still others rely strongly on their religion to give them strength. Many, alternatively, looked internally and described self-motivation techniques.
they have used, particularly by comparing themselves to others who are worse off. Below are a few examples of ways in which women sought to remain strong, outside of the traditional realm of help-seeking behavior through formal organizations. This luxury of not-worrying is only possible because of successful HIV treatment. While women worry about poverty and typical concerns, they are also able to live with HIV as a chronic disease—something unprecedented until a few years ago in Uganda.

The support of other women was a recurring theme. Women felt they gained strength when they saw the situation of others. In terms of HIV, this was life-affirming. They were among many other people, who also looked healthy and were able to survive. Some hang around the clinic even when they don’t have appointments to be in an environment where they feel they are not being stigmatized or judged and disclosure is a non-issue because everyone else there is also positive. One woman who was a regular at JCRC said that she goes there for the company of other women. “What makes me stronger on those issues of sickness because I see that when I am there at JCRC and I see my friends when they are sick it makes me stronger … because I’m not the only one who’s sick” (age 32, Kampala). Women see others with similar problems and, although the problems are not even necessarily discussed, the camaraderie and friendship between them eases the burden.

A smiling, older woman in Kampala said that the way she has gotten through everything in her life is with the help of friends. She sells chapati on the
side of the road to earn an income, but mostly she says that the social aspects of
her job are even more important than the money. She feels that,

*When you are with your friends when you make friends with people it really puts back strength in your spirit you don’t over think you don’t become depressed you instead become happy. Me, actually ever since they checked me for HIV, I discovered that I was sick I have never spent time there and cry, cry, what. No, its about spending time with people making myself busy.* (age 50, Kampala)

Friends strengthen her spirit; work keeps her busy; these stop her from dwelling
on her sickness.

Similarly other women emphasized that their preferable course of action is
to take no action at all. To deal with problems, they instead focus on work or
family. Over and over, women echoed that a negative mindset was not
constructive and was also damaging to their health. While many do worry about
financial matters and their children, they try not to focus on it. As told by one
woman in Kampala, her business and not her health are the focus of her energy
on a daily basis.

*How do I stay strong? It is one thing, I work and I work hard and I don't spend time there saying, 'now you see me, I have HIV- then me I have problems then from here.' No, no, no. I put that behind me and now I have to also reach something on myself- I have to get food I have to survive, you know. And if I have to survive it is that I must do. So I started up my businesses. My mind works a lot.* (age 45, Kampala)

Religion and religious faith are particularly important among this group of
women. All report some membership in a church or mosque, whether they are
able to attend services regularly or not. Several women reported being saved
following their HIV diagnosis- a process through which they affirm or reaffirm
their Christian faith, frequently in evangelical churches. Most become more
involved in church practices following a conversion. In general, religious leaders and other church members encouraged women not to leave their husbands and to fulfill their roles as wives dutifully. They did not encourage formal help seeking or separation and focused on internal strengthening or prayers to resolve problems.

In dealing with fear or stigma associated with HIV disclosure, some women said they instead turned to God. One said she had told friends who later gossiped about her, and she regretted the disclosure after being saved; believing it not to be necessary if one relies on God for support instead. As she describes,

> God is not like friends, now like all that information that I told friends if I had known from the start and I told them to God, no one would be knowing it by now. But now friends look at you and they think that so and so is sick, he shows off and yet he is sick, such stuff. But when you tell it to your God he strengthens you within. (age 31, Kampala)

A personal relationship with God gives her strength and she no longer wishes to tell other people of her HIV status.

In Mbarara, one woman said that whenever she feels bad or is having problems, she goes to church. That is where she has made many friends and has told them about her troubles at home. In response, the people at church "would say you keep things mum, because this is your man. You have to accept all of the things that come" (age 32, Mbarara). They urged her to fulfill her prescribed duties and bear the problems, rather than leave. From them she said that she gained strength and decided not to bring shame upon the family by going to the police or LC with their problems.
Both HIV clinics have active women’s groups. These groups offer emotional support, although they cannot offer financial or material support to the members. The women who were a part of these groups were quite positive about the experience of sharing their burdens and encouraging others to get tested or on treatment. At the Kampala clinic, the women’s group has more than thirty regular members. They meet in town once or twice per week to do crafts together, talk and plan outreach activities- including dancing and singing. A woman who attends weekly said that the group initially was for emotional support for the members but as they all have gotten stronger they have expanded their activities and are now quite excited about the opportunities they have to do outreach and influence others;

So we begun singing because we realize that people listen a lot to music and a message can pass through a song when you sing it. When people hear our songs wherever we are going, they come out because they like the songs. They get energy and there are so many people now through our group and our music that are brought to the clinic to be tested. (age 33, Kampala)

The other type of group that women regularly attend is for microfinance loans. Some are structured through formal organizations, but others are formed by women on the grassroots level who work together and pool money- allowing a different member a loan each month. As one woman describes the genesis of a group she helped to begin in Mbarara, it was for mutual support as much as for the economic benefits. The women harvested crops together and sold the surplus to make loans to group members.

The women had helped me and I had harvested millet and had a lot in the granary but that is the time that I was chased away from my home and was not even able to enjoy the fruits of my labor… How
the group came into being? Well we found that we were all alike. One the husband had abandoned her and was married in the shops, the other one the husband has also left her had got another wife in Kampala and left her so we found that we all had the same problems and decided to help each other in our cultivation. We realized that we all had the same problems and so we decided to help each other out and dig for each other. So every season we would devote our time to each other. (age 37, Mbarara)

She felt that this group was quite successful and would have continued to participate had circumstances been different and her husband had not made her leave their home. Sometimes women are reluctant to join this type of group or the ones at the clinic because of issues of disclosure. They are not comfortable speaking about either their HIV status or the situation within their homes. One woman said that she relies on other women for support when there are problems with her husband but avoids disclosing her health status to them.

No, I’ve not gone to those groups, but for me when I have a problem, like he is mistreating, I talk to my friends, but not regarding AIDS, not regarding the sickness. They advise me to remain strong and they have also gone the same experience. This happens, you are not alone in this situation, there are all of us, we are like that as well. (age 38, Kampala)

In her mind, being HIV positive is more stigmatizing and she fears the gossip, but is comfortable in telling them about issues with her partner because they have that in common.

*Formal help seeking*

In the traditional sense of formal help-seeking, few women went to formal organizations outside of the HIV clinic they attended. A handful went to the police or LCs when they were being severely mistreated by their partners, and a few even went to the available women’s organizations. In Mbarara, these options are
limited (as seen in Chapter 6), but even where available women did not generally feel that seeking help would significantly change their life circumstances. In general, only in an emergency situation would a woman seek assistance outside of her immediate social network. Women were more willing to seek assistance for their children and a handful of women went to national and international NGOs to get sponsorship for children’s school fees or assistance for their children who also had HIV. Group membership is viewed more favorably, with many women regularly attending women's groups for those who are HIV positive or for microfinance and savings.

As explored in Chapters 5 and 6, the police and legal system in Uganda have many constraints to dealing with HIV. There is not the legislation to back up action nor are there resources to allow officers to offer women a shelter or follow up in homes. Women are aware of these limitations and are reluctant to seek help there. One woman in Kampala was abandoned by her husband. He left her in a hut that was falling down, with no money and no other assistance. Desperate, she went to the police.

I sought help from the police. They told him that because we were legally wedded, he had to build me a house somewhere and take care of me. He said that he did not have anywhere to put me and that I should go to my home. So confused, I just went home. (age 37, Mbarara)

They told the man to provide for her, but did not enforce this. She eventually gave up and went to live with her parents instead. Previously she had tried going to them when the man was drinking and abusive. Just as in the case of telling the man to build her a house, she felt they were ineffective and unsupportive;
They [the police] call people, witnesses and the man. You go in and tell you to tell them about your troubles, they encourage that people get together again most of the time. They never encourage you to separate. For my husband I almost gave up because he never changes even when they put him in jail. For me I never see his money even after all that. I just rest in the lord.

Due to the lack of response or change, she resigned herself to the problematic marriage until the man stopped providing. Only then, because she had no alternative, did the woman leave and go back to her parents’ homestead.

Another woman in Kampala said of her refusal to seek help from the local councilors, “LC1, LC2, LC3- these are very difficult people. They need to be taught and enlightened. Most of them are ignorant and then they are people if they are taught can be the ones to help people” (age 45, Kampala). She felt strongly that they were not sufficiently trained to deal with women’s issues, though they could be a good resource if properly equipped.

Not all experiences with authorities have been negative for women. Some have gotten effective results, as seen in the cases above where two women reported their partners to LCs for interfering with their treatment seeking. Another woman in Kampala went to the police and eventually to court at the time her child was falling sick to seek maintenance from a man who had abandoned her. The hearings were successful and her husband complied with the court-ordered payments. Looking back, she attributes her son’s health to her course of action, “even me with this peace I have it’s because I took him to the courts of law” (age 39, Kampala). Largely though, women are reluctant to seek help, not wanting to imprison the sole breadwinner in the home or to bring shame upon the family for disclosing personal problems publicly.
The few women who went to NGOs for help did so primarily for the sake of their children. Several international NGOs in Kampala have the funds to sponsor children on treatment and for their school fees. The women who were able to get help there are grateful and tell other women to do the same. A few went to legal organizations to seek maintenance—again, typically when there was not enough money for children’s education or food in the home. A woman who had ongoing troubles with her first husband said that even when things were very bad, she did not seek help; “No, I have never reported. I just kept quiet.” When asked how she was able to manage, she said,

> At first I was patient, but I got fed up and chased him away. My help came from an agency…the organization took care of my children’s school till primary 6. There were some whites who helped but when they went back, even the help stopped there. (age 40, Mbarara)

The threshold at which she was willing to look to others for support was only for her children’s education, not her own safety.

Only one woman reported having gone to a legal organization in Kampala for help with domestic violence. Her husband was drinking a lot and beating her. They responded by counseling the couple, since the violence was not severe enough to send the man to jail. She said that he improved for a little while over the few months during which they had ongoing contact with the counselors. However, the pattern of drinking and violence did not change long term and she resolved to simply bear the problem and stay with the man, not seeking help again after her experience.

While women were overwhelmingly positive about the role of counselors in the course of testing for HIV and enrolling in treatment, they were ambivalent to
use them as a resource for other issues. A woman in Kampala who struggled with severe depression as a result of her separation decided to talk to the counselor at the clinic about her suicidal thoughts. She said that the counselor responded by cutting her short and saying,

‘Our jobs don’t concern that, our jobs concern you people who are just going to be tested those results are positive when you start bringing things that are too in depth, we don’t deal with such issues.’ That’s what the counselors are telling people just come and we talk to you about it you find yourself negative what will you do if you find yourself- it is not about in depth conversation. (age 32, Kampala)

The counselor did not have time for personal problems, only those related to treatment. Another woman said that she found the counselors to be more supportive and she had no trouble speaking to them freely about issues unrelated to treatment, though she did not think that the counseling impacted her relationship. She says, “they help when you are here. But when you go back home, things are not the same” (age 38, Kampala). The counseling did not translate into actual changes in her household.

Formal help seeking, therefore, is not a typical course of action for women. In extreme circumstances or when their children are suffering women are most likely to seek help. They instead usually rely on the strength of their peers or a religious faith to get through difficult times. This is sometimes due to having had or heard of negative experiences with authorities and NGOs, or simply the belief that the situation will not change if they do seek help.

8.6 Case Studies
Below are four case studies from the in depth interviews with women; two from each fieldsite. Each of these case studies shows one woman’s in depth experience and how the above themes of marriage, illness experience, and help seeking intersect in different ways. Two of the women were selected for having exceptional stories, and two for their similarity to the rest of the sample. A is highly educated and represents an exceptional case of a woman seeking help formally for her children. Although B has faced high levels of violence, her story of feeling trapped in a polygamous union is sadly quite common. C is unmarried and has no children, so her story is unique in a place where both marriage and motherhood are expected and valued for women. D’s story is of a woman who has faced some struggles in her marriage, but like many others, she has chosen to endure for the sake of maintaining her family. All of these women are HIV positive and at one point in their lives (two currently), have been in a physically abusive relationship.

*Case Study A: Attempted polygamy and divorce (Kampala)*

When we met, A was living outside of the city with her two daughters and running a hair salon. She is a large woman with a constant smile, and she looks even younger than her 34 years. Despite losing a parent at a young age, A is highly educated and dreamt of becoming a physician when she was young. Her English is flawless and she knows this could have helped her in achieving her career goals. However, during secondary school A got pregnant by a young man and had to stop school. She married the young man informally and they stayed
together peacefully, though one of the two children they had together died. And after a few years, the man died as well.

Uncomfortable on her own with a child, she sought and found another man and became pregnant again. He married her in a traditional ceremony thirteen years ago. He is a bus driver with a stable income. They had a child together and the relationship started smoothly until her elder child from the first man went for school and began falling sick. The daughter tested positive for HIV, so A and her husband went to test as well. The man was HIV negative and A tested positive, and then quarreling began in the home. Up to now, she has not told anyone except her positive daughter her status, though she says her mother suspects. She described this period in a detached way, as something not relevant to her current state of mind. She attributes his change in her relationship not to the discordancy but to witchcraft.

_Someone can be given herbs to turn their head around. So you find someone who was good turns out to be very bad. Someone who was understanding and you can sit at the table and discuss your family matters, you find you are no longer discussing with him. So that is the kind of man he is now._

This second man converted to Islam and came home one day, demanding that A convert as well. She found out that he had converted in secret and only decided to tell her after their tests were discordant. This conversion, which he did not explain to her, she believes to be a ploy to get more wives—just as his father and brother have done. Since birth A has been a devout Christian, so she asked the man to explain the religious aspects that might help her to convert, he refused and so she refused to convert. “So when he told me I am now a Muslim and I
want you to be a Muslim, I said no….Because he didn’t even explain to me the
good things.” He brought another woman into their home and A was so unhappy
that they began fighting and had several violent incidents, where the man kicked
and dragged her when she complained about the other woman and A fought
back. She sought healthcare for the injuries after one big fight, but did not tell
anyone else. She stayed with her family for a week after the fight, but came back
to try to make the union work. Her husband was adamant about having another
wife and took A’s savings from her salon to help with the costs. The man
eventually took the woman and their youngest daughter to another district,
ending the union.

Today A is busy with her salon business, which she says does not allow
time to take a break, lest she lose regular customers to someone else in the
area. She says that she does not plan to remarry as right now she has enough to
provide for herself and daughters. She might consider a boyfriend- a sexual
partner who would not live with her, but she is concerned about passing on HIV.

The younger daughter who usually stays with the father recently ran away
from him and came all the way back to the city to be with her mother, because of
physical violence from her stepmother. A is involved in a lengthy court battle to
have full custody of the daughter. She has sought legal advice from a few NGOs
and has an attorney from Legal Aid to assist her.

She appears strong and healthy, but A says that she often feels weak in
the mornings after taking medicine and can’t leave home until she has something
substantial to eat for breakfast- a luxury she cannot always afford. She loses
sleep worrying over the younger daughter and money concerns, but knows that she is better off than many other women at the clinic.

A was able to separate with her abusive husband and refuse a polygamous relationship probably in large part due to her education and ability to provide for herself. Although she is currently struggling to have custody of her youngest daughter, she works regularly and has custody of her elder daughter. She is a woman who, because of circumstances, can choose to live on her own and does not wish to live dependently. She and her partner were discordant, and this led to the breakup of the marriage. She was reluctant to seek help for herself while married, but has gone to NGOs and legal organizations to seek help for her one daughter with HIV and to gain custody of the younger daughter.

Case Study B: A surprise(d) third wife (Mbarara)

B is married to a soldier and invited me to speak with her in her home within the barracks while her husband was out for the day. She is a small nervous woman of indeterminable age, though she believes that she may be in her early 30s. The barracks, just a few kilometers outside of Mbarara town, are heavily guarded and made up of rows of concrete houses with shared toilet and bathing facilities and newer mud huts built by families once the concrete rows were over-filled. As B describes the situation, “the soldiers are few, the wives are many.” Doors are kept open when people are at home, and soldiers have the right to come in at any time, for any reason.
Our interview was interrupted multiple times by angry soldiers arriving in the room and looking around, claiming to be “searching” for something unknown. We settled into the dark living room, with newspaper covering the walls, and B tearfully spoke of her marriages and experience with co-wives- a story she says she has not fully shared before. Her first husband she met when she was young, “we come from the same village. He comes from near my home, and that is how we met. But he was city raised. When he came looking for a wife, people referred him to my father’s house.”

She was unhappy in the union (not formalized through a ceremony), because of the man’s behavior. She says that he drank alcohol frequently, was physically abusive, and had affairs; “he had bad habits. He was a womanizer and he used to beat me. He would get drunk a lot and fought a lot. And he quarreled a lot. He had too many other women.” So B left him with the children and moved back to her parents’ home. Her only regret in leaving is that she is unable to see her children, though she recognized this before she left the man and still chose to do so. She returned to him after six months and they stayed together for two years. After which, despite leaving her children, she ended the union permanently.

*When his behavior was too much for me, I told the people at home, and they told me to leave the children and go home. And I could not handle anymore, I went back home. They told me to leave the children. The man, I was fed up of him, so I let him go, he did not try to stop me. I first went and stayed for six months then I went back, then I went back and spent two years but I was not able to stand it anymore and I left.*
B struggled with money for a few years on her own and staying with her parents and chose to join the army at a base several hundred miles from her home to work steadily. Ten years ago there she met her current husband, also in the army and several decades older than she. B was deeply unhappy with her struggles at the time and was resigned to being dependent on a man to earn enough money for survival. As she describes, “I married him because I just had too many problems.” They were not happy, but stayed together at the army base for several years before moving to their current post, at which time B stopped working.

Shortly before they moved, she learned that he had two other wives, in other areas that he was supporting and had children with. She was suspicious initially, but he reassured her and, after three years, the discovery came as a shock. “I actually asked him how an old man like him did not have other wives. A man of 62, how can you not have a wife? And he said that he did not have other wives. He just said that he had never married. I got to find out three years into the marriage that he had other wives.” She was pregnant at the time and felt she could not leave him. After they moved to the current barracks, the man brought another wife to live next door and the third to stay nearby. Because of the man’s mobility throughout the country, his wives are all from different regions and none speak the same language. They are ordered to cook together and stay in the same space but cannot communicate.

She went on at length about the man’s maintenance of other wives being unacceptable and she feels cheated out of the union. The other women interact
very little, as observed when one who interrupted the interview multiple times to fetch beans from the house. They are clearly not on friendly terms, despite their daily interactions and close proximity. They communicate through the children, their husband, or through basic pointing and hand gestures. The husband returned while we were speaking and he aggressively demanded explanation. He is lean and muscular and appears much younger than B thinks he may be.

Once the man left the area, she whispered for the rest of our conversation. She told of days when she was falling sick and convinced her husband to test for HIV with her nearly three years ago. After the test, she learned that he had known himself to be positive already and was on treatment. He agreed to test with her, pretending that his status was unknown. She doesn’t know if the other wives have tested, but she suspects they are positive as well. Her four year old son, thankfully, is negative.

B pities her other wives and is unhappy with the man. He drinks frequently, is often violent, and the household feels very unstable. She has been injured so badly that he has knocked her unconscious and she has scars from beatings. The man switches off between which wife he stays with, demands sex, and sometimes on pay day disappears for several days and returns with no money. She reports the man to the offices which oversee the barracks and he is periodically imprisoned, but during that time she does not receive any financial support for herself and young son to survive. Mostly the reporting goes without response and she stays in the home only for the sake of her child. She knows that if she tries to leave, she would lose rights to the child, because the union is
informal. “There are these offices where you report but after a while you get tired. They do nothing, nothing being done. If it wasn’t for my child I would have left. But he refused to give me my child so I stayed for my child.” She has gone to the man’s family, counselors at the clinic, and friends for help, with no result- since she will not leave. Much the way she felt when she got married, B is resigned to staying with the man until her son turns 18 and they can leave. She listens to church preachers on the radio and generally keeps to herself, knowing that help is ineffective, others in the barracks do not care how the man treats her, and she will not leave another child behind. Even her garden plot outside is removed from the others.

I think everyone keeps their troubles to themselves. My husband sometimes will beat me in public. Everyone knows that when a fellow soldier is beating his wife you do not interrupt or try to help. Some times he will go out to work and come back and go to the other wives. Some times he comes back and he has been gone the whole day and you ask him for money and he beats you. When you try to say something he can beat you.

And so B, now in her early 30s, steadfastly keeps her troubles to herself, waiting for her son to turn 18. She says that although it is hard to raise the money for transport and she often has to walk, she looks forward to days at the clinic and interacting with people outside of the barracks.

B, unlike A, cannot leave her polygamous marriage. She was tricked into the union, believing that despite her partner’s age, she was an only wife. Now that she has her son and the man will not give her custody, she has resolved to stay in the violent and largely unhappy marriage. She has left the children of her first union behind and cannot bear to do the same again. She has reported her
husband for severe instances of violence but bails him out because he cannot provide for the family when he is in jail. She finds strength in her faith and stays strong for her son.

Case Study C: The single brewer (Kampala)

C is a tall angular woman, born in Northern Uganda and believes that she is nearly 40 years old, but is not sure. She describes her childhood as a happy one, until her father and twin brother both died. She had to stop school in her fourth year to help her mother at home. She got pregnant from a man she loved, but miscarried and the man died shortly after in the conflict in the North. She migrated south to Kampala to find work ten years ago. Her auntie brews and sells local millet beer (malwa), so C came and joined the business. She says it is a difficult business, especially dealing with the men, but has gotten easier with time. Her late brother’s two children were sent to live with her in the city, but she struggled to work and provide for them so they were sent back to relatives in the north.

While working at the bar, she met her one and only husband. He was unemployed and spent much of his time hanging around and charming her. She smiles fondly at the memory of this happy period, though they were poor, recounting how she looked quite “smart” in those days.

They began staying together and trying to build a life. He found a job as a security guard and began earning money. She managed to run her own bar with the income. The money, she says, changed the man for the worse. He began
seeing other women and staying out late. When she questioned him, he frequently responded with violence. She sought help from the LC1 and her neighbors who would come and talk to the man when they were fighting. Unfortunately, they were not effective in changing his behavior and she gave up. The quarreling continued and he eventually left her. She says that he still stays nearby in Kampala, but does not acknowledge her if she greets him or tries to call his phone.

After they separated, she began falling sick off and on with malaria until a friend suggested she get tested for HIV. She tested positive and quickly started treatment, and someone took over her bar in the meantime. She has only told a few friends about her status, for fear of discrimination. She’s not sure if her husband was positive and he is unresponsive when she tries to contact him and talk about it. She is frightened of worrying her mother with the news, but hopes to tell her one day. She says the treatment has helped her to stay strong and return to her work brewing. She says, “And this work anyway I have [gotten] used to. I can manage and right now I’m getting treatment and I feel like I am strong. I can manage to do that work.”

C is still working at a bar now, but no longer with her aunt who returned to the north. She lives with a friend in a tiny rented room. The room has mud walls and a dirt floor, with little ventilation, no water or electricity, and one single bed. We sit on the floor to talk on mats borrowed from a neighbor. She is worried about money and sleeps poorly, in part because the friend she stays with is often drunk and asks her to leave when she wants to have someone over. C is
unhappy about being dependent, since she used to have her own home and be
able to provide; “I used to be in my house, me alone, but right now I’ve gone
back to zero to staying with somebody. Who is now tired of me. I used to think at
night, I don’t sleep.” She refers to her previous life as if it were another person
and feels as if she is starting from scratch after being diagnosed with HIV: “So
the life which I had last time, it was not mine.”

She dreams of earning enough money to start her own business selling
clothes. She says that she would move back to her home village in the north and
travel around with her business, visiting friends and working. She does not have
any children of her own, but one day hopes it will be possible and she will provide
for her mother and brother’s children as well.

Currently C’s main concern is money. She knows the importance of taking
her drugs on time every day and does so, whether or not she has the money to
have food at the same time. She says, “sometimes I can take [the medication]
without taking tea. I take it because I am keeping time. I want to take my time is
around 9. I take my medicine. My tablets. But again it means when you have
eaten something. That is the problem.” She continues on about her worries,

Right now I feel like eating but if I don’t have money, I’m very weak,
and I’m thinking very far. My mind is very far. Sometimes there-
sometimes I used to come and sit down like this and I start to cry. If
I failed to get money and I want to buy something to eat.

C is nearly in tears with this last admission of her worry and desperation over
money.

Abandoned by her partner and childless, C works in a bar to brew beer in
Kampala. She struggles to make ends meet for herself, and for the children of
her deceased brother in northern Uganda. She lives with a friend who is not always welcoming. Her money troubles translate into feeling weak when she has to take HIV medication because she cannot always afford food to eat with it. C is socially marginalized by her HIV status, her childlessness, occupation in a bar, and poverty. Because she was not formally married to her only serious partner, the man has no obligation to give C support.

Case Study D: Patience in marriage (Mbarara)

D is a broad shouldered, strong 40 year old woman with a strikingly beautiful face and big smile. She lives on a dirt road, over an hour’s drive away from the clinic she attends in Mbarara. We sit in her cool, clean concrete house on the hot afternoon and she speaks clearly and confidently of her experiences. She is married and has a teenage son who was outside chopping firewood during the interview. D says that while growing up, she saw her parents fight though they remained together and she thought them generally contented. D left school in her sixth year of primary because she did not excel and did not care to continue. She worked at home until she married at 17 through a traditional ceremony. The man’s mother arranged the union and she was satisfied with the choice. She describes her husband simply. He is a good man who provides, but with time he started drinking and having other women. She says, “he takes care of the home, but he does drink a little, and sometimes this leads to quarrels between us.” She describes the shift, “the changes were because of him having many other women. That killed the trust in the relationship.”
The couple’s first two children died, and D was devastated. She went and stayed with her parents for a week and once she returned, she decided to ‘get saved’ in the Christian church. As she describes this turning point, “I got saved and I gave all my problems I gave them to the lord. And I settled and whatever came, I considered it a trial and with stood each as it came and God sometimes you see God see you through.” This resolve and patience permeates D’s discussion of everything. In total, she has had nine pregnancies including four miscarriages.

D’s decision to test was not based on sickness or suspicion. Rather, five years ago an NGO in the area came door to door testing the entire district and paid particular attention to women who wanted to have children. So D, pregnant at the time, tested and found herself positive. She was shocked and uncertain of what would come next. She says, “when I was diagnosed it induced a lot of thoughts, thoughts about life and how it was going to end. And when I came back I told him.” Her husband eventually agreed to test as well and is also positive. She thought their illness would improve the relationship, but it did not. The main change came after the man began falling sick and lost energy, “after a while he was weak and did not have energy to beat me.” D gave birth to the baby she was pregnant with when she tested but he died shortly after his first birthday and the couple decided to stop having children and began using condoms.

The resolve D gained after being saved has kept her strong. She says that sometimes she gets worried, but prays a lot and thinks of others who are not as well of. “By seeing and comparing what other women were going through, I
realized that my situation was not as bad. Like you see someone that does not even have a house to live in then you remain calm.” And she says in the village, there has been some stigma, but she tries not to let herself be bothered by the gossip. After neighbors suspected that she was positive she says that “no one has treated me badly but sometimes there is a lot of gossip among women. But in your heart you stay free because you know in your heart that you are well.” She has not told anyone except for her husband and siblings about her status, but feels that she will not have to because she is strong and appears healthy from the ARVs.

After being saved and falling sick, D has dedicated much of her time to women’s groups, where she both finds strength and tries to pass it on to other people. She does not consider leaving her marriage since she feels obligated to the man and overall he is not as bad as some other men. She tells women to be patient with their partners and avoid conflict by treating their husbands well and maintaining the union. She also encourages financial independence for all women, especially those who are widowed or struggling. “Women should join women’s groups so that they can get resources from one another. So that if you sell like 5 matooke [green bananas], you can get money. The woman should be planning and seeing how to get money.” D’s husband has been without steady work for over a year, though he travels around the region looking for work on farms as it is available. D herself runs a banana plantation on the land that they own and sells the bananas and other produce at the market to support the family. They use the income together to provide for the five children and both of their
medical expenses; with her unwavering faith, D is certain that her health will remain good and her family provided for.

D is married and, despite quarrels with her husband, has no intention of ever leaving him or their five children. She is a strictly traditional woman concerned with fulfilling her duties. The formal union has been good for her despite her husband’s infidelity; he is obligated to provide for her and the children. She has been saved and her Christian faith helps her to stay strong and she feels she is healthy.

8.7 Summary

The above case studies highlight the complex interrelationship of relationships, violence, HIV infection, and decisions to seek help. All of these women have faced violence but their circumstances and responses are varied. All of them likewise are enrolled in HIV treatment and are adherent to their medications.

From the case studies, only B ever sought help for instances of violence; A has gone to organizations for her children, but C and D have chosen not to seek help. As with the rest of the women, formal help seeking is uncommon. Whereas all of the women in this study access medical services, few seek assistance for dealing with relationship conflicts. Instead, many turn to family or stay with their partner in the face of violence. Only when there are difficulties providing for children or having enough money for the household do women tend to seek help.
As seen with the full ethnographic sample, the marriage arrangements range from formal to informal and monogamous to polygamous with or without unfaithfulness. Formal marriage, legally recognized through a traditional or religious ceremony, is ideal from the women’s perspective and secures rights for women. A and D were formally married in monogamous unions. They both benefit from the security of it. Despite A’s separation from her partner, she is able to leverage the legal recognition of her marriage in court to fight for custody of her youngest daughter. D’s formal union ensures that her husband will continue to provide for her and the family.

What remains consistent is these women’s physical health. All appear healthy and are taking their medication regularly. As a result, HIV currently is a concern only in a monetary sense of getting money to attend the clinic or to maintain proper nutrition. It is just one concern among many in their daily lives and they are able to live with HIV as a chronic disease. The next chapter contextualizes women’s experiences in the global context of HIV and violence, showing how these experiences are locally particular in Uganda, but part of broader processes of expanding HIV treatment and social discourses on human rights.
CHAPTER 9: DISCUSSION

9.1 Summary findings

This research draws from and contributes to several bodies of medical anthropological literature, namely that on HIV, globalization, and domestic violence. The study results are briefly summarized below followed by discussion of their placement and contributions to these bodies of literature.

The policy environment in Uganda is changing. Pending and current legislation establishes potentialities in responding to and ultimately preventing some of women's disproportionate vulnerabilities surrounding HIV infection and management and domestic violence. The Domestic Relations, Domestic Violence, and HIV/AIDS Bill expand current options for women through the creation of marriage rights, the shift of domestic violence into the realm of non-criminal jurisdiction, and rights of non-discrimination for those living with HIV/AIDS. During the course of this research there was no national legislation on these issues, although some small-scale efforts have begun to address them. The government is viewed as a proximate entity responsible for direct needs of citizens. Women and providers recognize the mediating levels of funding, policy, and implementation, but hold the government accountable. Despite early successes of curbing HIV prevalence in the country, the government is criticized for current lack of response to those already infected.

Service providers expressed frustration with the systematic constraints of their positions, whether in healthcare, social service provision, or informal positions of serving women. They experience difficulties in addressing issues of
poverty and domestic violence, despite how frequently these occur among their clients. Medical and social service resources are kept separate, and women seeking help need to use multiple sources to address their needs. In Mbarara, there is little in the way of formal social service provision and women must rely on family members, religious leaders, and others in the community. In Kampala, there are more NGOs and resources, although all of these are still constrained by a lack of consistent funding. Providers sometimes also are at odds with women in their perceptions of violence as culturally acceptable or caused by women.

The quantitative surveys done with HIV positive women found some differences between the two sites in the incidence of specific types of violence, though there were few overall differences. Women in Mbarara faced significantly more sexual violence and severe physical violence, such as being threatened with a weapon. Despite differences in resources between the two sites, women in both places often chose informal means of responding to violence instead of formal help seeking. Approximately one third of the women are married, one third currently single, and one third widowed. Many are in polygamous unions and approximately half report moderate to severe violence from a current or previous partner. Alcohol use and economic discrepancies are the factors most associated with experiences of violence.

Women’s narrative accounts of relationships and HIV reveal their daily struggles, which are frequently not related to HIV or domestic violence. Instead, they center around concerns for children and family and basic needs. Economic concerns are foremost. HIV is not a “worry” in the sense of health, but rather as...
an economic stressor. Women are able to live with the disease privately if they choose, a luxury not previously available before treatment. They appear healthy and do not need to disclose their HIV status unless they choose to do so. Women tend to seek help when their children need help or when there is not enough money for the household. Despite all being enrolled in medical services, women’s help seeking behavior for relationship conflicts occurs primarily on a local level to relatives, neighbors, or local leaders; only when conflicts are very severe do women go to formal legal or social organizations. Women feel more secure in a union and have more legal rights if it is formalized through a traditional or religious ceremony. These women, therefore, would support government policies that impact the social dimensions of living with HIV or economic difficulties associated with conflict in marriage.

IPV and HIV treatment intersect as synergistic vulnerabilities for women. This study did not assess causality between the two, but rather how women live with and respond to both. In Uganda, women have few formal means of dealing with IPV, and even where services are available, they may choose not to seek help or disrupt their relationships. Most of the social service organizations in the country are centralized in Kampala, and those individuals outside of the region who want to seek assistance or counseling must do so informally, through family or religious leaders. Providers themselves are also limited in their ability to assist women because of a lack of resources and the limited legal sanctions available. All of the women are already living with HIV and enrolled in treatment. They worry about sustaining an income to be able to continue to access services or
support their families. Those who face or have experienced violence are faced
with another set of challenges. IPV frequently occurs in conjunction with
economic difficulties within a home. Women only have legal rights for
maintenance in formal marriages, but many are in informal or polygamous
partnerships.

9.2 In global context

The theories of globalization laid out in Chapter 2 give a framework to
piece together the four types of data collected- from policy, resource and service
providers, HIV positive women, and women who have also experienced violence.
This study serves to comprehensively illustrate one local example of women’s
vulnerabilities in Uganda, that are influenced by larger global processes.

Particularly significant is Ferguson’s (2006) conceptualization of spheres
of influence rather than hierarchical divisions. In daily life, he argues, the political
sphere is not ranked above the domestic sphere. Instead, power is felt through
the interaction of civil service, global processes, household dynamics, and
governmental policies. As data from the policy chapter show, the government is
viewed as a proximate entity in Uganda. Local councilors, particularly LC1s who
serve at the village level, are seen to be directly related to issues of national
policy and capable of enacting change. These relationship configurations are in
line with globalization as a form of respatialization.

Given this close relationship between citizens and the government,
Nguyen’s “therapeutic citizen” is a reality in Uganda (2006, 2009). Therapeutic
citizens are created in a setting where individuals seeking healthcare participate in both the local healthcare delivery and in global processes making that care possible. They are attuned to non-local influences of health and healthcare. Women in this study may focus on survival and not worrying about their HIV status, but are simultaneously attuned to the other influences affecting their health. Their experiences of treatment are not limited to the clinical encounter when they refer to the government or other organizations as playing a role in their treatment experience. Treatment rollout and women’s access to services is locally and globally dependent. Both of the clinics in this study receive funds from multinational, bilateral, governmental, and private sources. The disbursement of the drugs and treatment falls on the presence of trained and compensated healthcare workers. In Uganda, there are trained personnel, but the burdens of patient load and dependable compensation limit their effectiveness.

These limitations highlight the uneven impacts of globalization in the developing world (Collins 2003). Treatment may be available to many more men and women in Uganda than in the past, but coverage still only reaches approximately half of those in need (UNAIDS 2010). HIV treatment rollout is an example of accelerated globalization through economic liberalization and development, or what Nguyen (2009) refers to as “therapeutic globalization.” As he argues, oftentimes, antiretroviral treatment rollout occurs in the absence of other development.

For many, antiretroviral programs will be one of the few—or maybe the only—interaction they have with the kind of modern institutions those who live in industrialized countries take for granted. In effect, the growing numbers who take part in antiretroviral programs—and
the discourses and forms of discipline they embody—do so in an environment where they are otherwise largely disconnected from the cardinal features of global modernity. (2009:548)

These women’s access to treatment may be their only point of contact with modernized institutions, particularly in rural areas. If they are participating in therapeutic citizenship because of the global processes that allowed treatment availability, they are still sometimes living in regions without basic provisions such as safe drinking water or electricity. They are trapped in a paradoxical, partially globalized existence, as are many others in the developing world.

Providers, policy makers, and women viewed the Ugandan government as capable of impacting their daily lives, and indeed responsible for responding to concerns of individual citizens. In reality the government’s role is mediated by the creation of policy, dependency on external donors, and the cooperation of providers and policy implementers. The three key pieces of legislation that, if passed and implemented, could influence women’s rights include the Domestic Violence Bill, the Domestic Relations Bill, and the HIV/AIDS Bill. The Domestic Violence Bill has now been passed as a result of strong advocacy from national and international women’s rights groups. If this bill is implemented effectively, it could potentially drastically change women’s responses to domestic violence. Women would be able to seek compensation for damages, without imprisoning their partner and facing stigma and economic hardship. The long-contentious Domestic Relations Bill could likewise significantly alter women’s lives by granting rights to cohabiting couples. Women in this study were consistently
concerned about securing rights through formal unions and this legislation could grant those rights to cases of informal unions.

The HIV/AIDS Bill has not been passed due to international opposition to portions of it which criminalize intentional transmission. Had the bill not gained media attention around the world, it may have been passed in its original form. It is currently being revised, and if passed could give those living with HIV security from discrimination in the workplace.

9.3 HIV as a chronic disease

Since the discovery of multi-drug combinations to effectively treat HIV/AIDS in 1996, the experience of living with HIV has changed drastically. A disease that was previously a death sentence can now be lived with as a chronic illness given consistent access and adherence to ARVs. Initially, this treatment was incredibly expensive and unavailable in the developing world. Through policies of economic liberalization, trade agreements, and global advocacy of groups and individuals, treatment is becoming more widely available in places where it is needed the most. In Uganda, where treatment was not available or accessible until a few years ago, it is now available to 53% of those who are in need. The women in this study who are all currently on ARVs, therefore are part of the new era of HIV/AIDS that has come about rapidly in the last few years.

In the early 1990s, HIV was rampant in Uganda. This is the time when Wallman wrote of women's struggles to manage health for their children and themselves and scrape together a daily living in Kampala (1996). One of the key
findings in her work was the threshold of a disease being “serious enough” to seek treatment, either for women or their children. This judgment is still made frequently today by those who cannot afford healthcare. But the advent of routine HIV testing in antenatal clinics and during all other hospital visits minimizes women’s need to make as many decisions regarding initial healthcare seeking for suspected HIV infection. Additionally, antiretroviral treatment for many is free. Similarly, in the earlier years of treatment rollout, women reported significant delays between the times at which they suspected they had HIV, when they tested for it before eventually seeking treatment (McGrath et al. 2006; Rundall et al. 2005). These delays were due to several factors including denial, fear, lack of symptoms, and lack of information about treatment. Now, a woman may test during antenatal or routine screening before ever showing symptoms and be referred for free treatment immediately.

Wallman found HIV to be a “private disease.” This was from shame, stigma, embarrassment and fear. Women’s experiences in the present research show that some negative attitudes towards those living with HIV still exist. However, women who did choose to disclose found a surprising level of support and acceptance. The availability of treatment shifts disclosure to a decision rather than a necessity- in part because people do not need as much assistance with serious illness costs and mostly because of the lack of outward symptoms. HIV is still indeed a private disease, but not in a way that would cause one to hide in their home (see next section for description of strategies for living with HIV). In Mbarara, disclosure is required to a treatment supporter before initiation
of treatment. While this disclosure is mandatory, patients choose their own treatment supporter. They can select a trusted individual in their social network, rather than face suspicion and stigmatization especially if they had been symptomatic.

Economic concerns are still foremost in women’s survival, but now in a different light. Since the time of Wallman’s book, universal primary education has been introduced in Uganda, relieving a portion of the burden in providing for children’s school fees and treatment has become widespread for those in need. Women instead worry about transportation to the clinic and the cost of food to meet their greater nutritional demands on treatment.

Very recently, Uganda has been in the press for drug shortages, as a result of the global economic depression and shifting aid priorities (NY Times 10 May 2010). During the course of this study, shortages were only occurring from drugs supplied by the Ministry of Health. These were managed smoothly because of the other available funds. Patients do not know who supplies their drugs, although in the pharmacy they are differentiated. Enough money from other sources covered the few stockouts and patients did not notice an interruption in treatment. Several healthcare workers, however, were concerned about long term funding projections.

9.4 Living with HIV

A key finding in the ethnographic interviews with women is the notion of “not-worrying”- especially in regards to HIV status. The women in this study are
all on antiretroviral treatment and appear healthy, which, as noted above, is only recently possible. Few have side effects from the medication and therefore do not need to disclose their status. Women report getting through daily struggles by focusing on health, rather than illness. Their worries center around typical issues related to poverty—mainly those associated with money for their children’s survival and education—not HIV.

This condition of “not worrying” in the face of HIV is a relatively new phenomenon in Uganda and in the context of HIV in the developing world. It is a byproduct of the rollout of treatment as promoted by the WHO and funded through PEPFAR, Global Fund, and other international and multinational donors. The medication itself saves individuals’ lives in terms of health. Once that health has returned, however, men and women can return to their lives as socially productive citizens, rather than those marked by illness.

What I am referring to as “not worrying” is not a psychological assessment of coping, but a daily strategy for survival. Women suggest that by putting thoughts of illness aside, they could remain healthy. Other authors have examined this daily survival of men and women in other settings. Zraly (2008) uses the political economy of emotion to contextualize the suffering of genocide rape survivors in Rwanda. She found the concept of “bearing” to be how women moved on with their daily lives and survived. This bearing in large part had to do with living alongside traumatic memories and sometimes children that were products of the sexual violence as a part of the process of resilience.
The term bearing implies carrying or somehow shouldering a load. However, the Ugandan women in this study did not express their concerns as burdens or as always being present. Their non-worrying rather, sets aside HIV status or relationship concerns for the daily struggles of working and maintaining a household. This is closer to Zraly’s concept of “bearing living” which involves active engagement with the world, but resilience in a full sense of overcoming is not possible with HIV.

Qualitatively different from bearing or carrying traumatic memories, these women are quite simply, living with HIV. Symbolically, several refer to their undetectable viral loads. They say that the virus is asleep. So long as medication is available and a part of their daily routine, they are not even carrying around the virus in their blood. They live with HIV infection but are not burdened by its daily presence other than through adherence to antiretroviral therapy.

Biehl (2007) writes of living with HIV in Brazil. He places the struggles of marginalized groups in the setting of development and overall indicators of progress in the country as a whole. His work focuses on highly marginalized and stigmatized groups who have to overcome enormous social and structural obstacles to be “seen” by the country’s national healthcare system. These women also have a “will to live” but not in the desperate sense seen in Brazil. They are not left behind in treatment rollout and marginalized. Socially and economically they are behind men in all areas of the country, but not outside of the gaze of development and medical treatment for their disease.
9.5 Economic violence

Economics play an important role in women’s daily lives. According to these data, the primacy of economic concerns frequently outweighs those of both living with HIV and dealing with domestic violence. Women expressed that HIV is largely not an issue, unless one does not have access to money for transport to the clinic or money for proper nutrition to accompany the drugs. Likewise, domestic violence was not a reason to seek help unless there was an accompanying lack of money in the household. Both the data from women and from the providers illustrate this point: since most women seek help for maintenance and help with their children, rather than for other issues in the home. Economic deprivation often occurs in the context of other violence and is exacerbated by HIV, as the demand for cash is greater than it would be otherwise.

The act of deprivation is referred to in daily conversation in Uganda as “economic violence.” Like structural violence, there are physical and material consequences from economic violence even without an overt physical dimension. Unlike structural violence, however, the perpetrator is clear. One could argue that the act itself, like other forms of gender inequality is rooted within an unequal structure. Although this is true, it remains the case that the act itself is overt and occurs between partners. Importantly, the focus on domestic violence as an interpersonal action obscures the nature of economic violence as deprivation. In this way, the concept of economic violence theoretically bridges the two perspectives on violence (local interpersonal and structural). In local
settings, however, economic violence is clearly identified as being in the realm of physical domestic violence.

This is likely a recent phenomenon, especially in rural areas where cash is not always needed for women to function. When working as a subsistence farmer and trading for goods, women rarely needed cash when they were not allowed to work outside of the home. However, since all of the women in the study are currently receiving treatment, they have an increased need for access to money to find transport to attend the clinic and money for supplements such as multivitamins or Septrin.

Economic violence is particularly important in women’s discussion of their decisions to seek help. In situations of ongoing violence and conflict in a relationship women rarely sought formal help. Instead they turn to relatives or local leaders or religious advisors. However, the turning point for women who did choose to seek help formally through the police, courts, or service organizations was when household conflict had economic impacts. As soon as women did not have enough money to feed their families or to pay for children’s school fees, they were willing to look outside of their social network for resources and assistance. Admitting that one’s partner is not providing could be equally as shameful as publicly admitting to domestic violence in the relationship. However, economic concerns override the potential stigma and are the impetus for help seeking behavior.

Seeking help in the face of economic, rather than physical, violence is also strategic in Uganda. As seen above, many women are in informal marriages and
lack legal rights to maintenance from their partners. Also, domestic violence is not illegal and there are few sanctions against men in this regard. However, men are legally obligated to pay support for their children, regardless of whether or not they are married to the mother. Women who have children and seek help for economic violence, then, are much more likely to have a positive outcome than if they were to do so for domestic violence.

Women’s sources of strength frequently revolve around work and economic security (see Chapter 8). Women maintain their mental and physical health through knowing that they have a constant source of income, either on their own or through a partner. As one woman in Kampala described,

> How do I stay strong? It is one thing, I work and I work hard and I don’t spend time there saying, ‘now you see me, I have HIV- then me I have problems then from here.’ No, no, no. I put that behind me and now I have to also reach something on myself- I have to get food I have to survive, you know. And if I have to survive it is that I must do. So I started up my businesses. My mind works a lot.

(age 45, Kampala)

Her primary source of strength is knowing that she has a business and will be able to provide for herself. In this woman’s case, as with many others, deprivation in the form of economic violence can be as damaging as an assault. To lose the sense of security of being able to survive and pay for groceries and the needs of children can be devastating to women.

**9.6 Domestic violence in Global Perspective**

The data on domestic violence/ intimate partner violence in this research contributes to both the ethnographic literature and more applied epidemiological
and social research. There is a high degree of consistency between the quantitative and ethnographic results, and both are in accordance with general trends in the literature. The roles of alcohol, polygamy, and economic conflict in household violence are reaffirmed through this study.

Important from a prevention and public health standpoint, is the significant role that alcohol plays in these women's experiences of violence. Quantitative data show a partner's frequency of alcohol use and frequency of drunkenness to be highly correlated with all types of violence assessed. Women's narratives reveal the more nuanced role of alcohol as frequently being associated with increasing household income, or with a partner's behavior of being outside the home socializing and sometimes being unfaithful, rather than being attentive to the home. Other literature on the subject is in agreement, indicating the role of alcohol in deviant behavior in general and in household violence in particular (Harris 1994; Harvey 1994; Toren 1994; Moore 1994; Wade 1994). It stands to follow that interventions targeted at reducing household violence would target curbing alcohol use in a household. While it is not always the actual consumption and lowered inhibitions that cause conflict- alcohol is an undeniable component in household violence.

Other strong indicators of violence were variables suggesting economic control: whether a woman had refused a job for her partner; if her partner had taken the woman’s savings, and if the partner has ever refused to give the woman money. As just discussed, this deprivation itself can act as a form of violence and is often present with other forms of violence. The idea of sanctuary
and support for women is inextricable from economic independence. Women who felt they had enough money to leave a partner frequently did so,

Although other studies have found rural areas to have more violence than urban areas (WHO 2002), that did not consistently hold true in this study. Whereas women in Mbarara faced more sexual violence and severe threats, overall there were few differences in the incidence of violence between the two sites. However, in the questions which assessed women’s perceptions of gender equality and independent decision making ability (see Table 7 in Chapter 7), women in Mbarara scored significantly different than those in Kampala on several questions, indicating lower perceptions of equality and independence. For example, women in Mbarara were much less likely to respond that if a man mistreats his wife, others outside the family should intervene. This response is consistent with some traditional gender norms and the sentiment that to bring household matters outside the home brings shame to the family. But as discussed in Chapter 7, these differences between Kampala and Mbarara could potentially be due to the uneven effects of globalization. Social media messages about human rights and promoting women’s independence are much more common in Kampala. Women there have greater exposure to gender and development messages. While the promotion of rights may influence women’s beliefs about gender roles, it does not seem to significantly impact their reported experiences of violence.

9.7 Marriage
Woven throughout women’s accounts and interviews with providers and policy makers is the importance of marriage. Women seek protection in marriage for both legal rights and as fulfillment of their cultural ideal. Once married, women are not immune from conflict, infidelity, violence, or money problems. Instead, they have some leverage to respond to these issues through social and legal redress. Men who are married are expected to provide for their families, and if they are not doing so, can be required to by law.

Polygamy as a cultural practice is also highly associated with violence. The case studies show the psychological impact on women’s sense of worth and the practical impacts of less money and greater household expenses. Polygamy and other cultural practices reinforcing the lack of women’s decision making in a relationship contribute to overall low status of women in Ugandan society, particularly in rural areas, as is consistent with WHO findings. The assessment of perception of gender roles is also part of this constellation. Women in Mbarara had lower perceptions of gender equality than those in Kampala. Overall, only 28.5% of women reported belief in a strongly equal role for men and women in relationships, with power in decision making. The majority of women (56.0%) had a moderate view of gender equality, which is consistent with traditional gender roles of women as deferential in Ugandan society.

Other settings have found cultural norms of idealized gender expectations, low status of women, and overall norms of violence all to be factors contributing to violence (Counts 1999; Lateef 1999; Lambek 1999; McDowell 1999; McKee 1999; Toren 1994; Moore 1994; Wade 1994). Polygamy in other settings has
been argued to potentially be beneficial to women in terms of sharing work and bolstering social support (Kilbride 1994). But in Uganda, these women describe it as another dimension of gender inequality and it is consistently associated with conflict and violence.

Women’s view of marriage in this context is consistent with Counts and colleagues’ argument that sanctions and sanctuary are the most crucial factors in protecting women from domestic violence. Legal marriage with one partner provides women a safe haven in which they can have some recourse if the relationship becomes problematic. Legal sanctions would allow them to seek help from unsupportive partners, an option not available to those in informal unions. In a monogamous marriage, women also have more access to household resources which would have to be shared in cases where a man has more than one wife.

9.8 Summary

HIV/AIDS is a locally experienced, globally dependent disease. The key contribution of this research is to illustrate the context of women’s experiences of HIV with the compounded vulnerability of intimate partner violence in Uganda. This adds to current anthropological literature on globalization and health, linking the local and the global. Women’s daily treatment experience, help seeking behavior, and concerns other than health are possible only because of recent rollout and availability of treatment. Policies and service availability also influence the localized patterns of behavior and responses to both HIV and violence. This
research also contributes to the ethnographic body of literature on domestic violence. It confirms and expands on the role of alcohol, economic concerns, and marital arrangements in relationship conflicts.

CHAPTER 10: CONCLUSIONS

10.1 Findings Summary

This was a mixed methods study of women's vulnerabilities in Uganda, through the perspectives of policy makers, service providers, and HIV positive women. By using a framework of globalization this research highlights the new context of HIV, as it can now be lived with as a chronic disease. Likewise, it highlights the uneven impacts of globalization and illustrates the shifting development context in Uganda. Global processes have fueled the funding and distribution of life-saving treatment and governmental policies are making strides towards protecting women's rights. Still, women struggle on a daily basis. Living with HIV means having to seek out a reliable income to maintain treatment through clinic visits and proper nutrition, in addition to already present concerns of poverty and supporting a family. Intimate partner violence adds another dimension of suffering to women’s lives through physical and psychological injuries and strained relationships. Women in violent relationships often cannot rely on their partner's economic or emotional support. Services to assist women are hampered by a lack of resources and legal sanctions. Many rely on informal means of seeking help or endure hardship for the sake of their children.
10.2 Applications and Recommendations

These findings highlight several important considerations for social scientists doing research and for potential interventions. Foremost, marriage serves as a legal protection for women. Steps to increase formal marriage unions or give rights to those in cohabiting unions could serve to give women leverage to seek redress or to maintain support from a partner in the case of separation or divorce. The Domestic Relations Bill has unfortunately been debated for decades without consensus. A legal mechanism for women in marriage is consistently cited by both women and providers as crucial for being able to provide assistance and resources.

At the level of service provision, services are currently fragmented. Although all of the women in the study are currently enrolled in medical services, few also seek assistance for domestic violence or other familial issues. Often this involves going to other organizations, which may or may not be in the area, and may or may not be known to the women. The integration of social and medical services could potentially encourage women to utilize more social services than they are currently. Service integration has long been advocated, but is difficult to implement (Coetzee et al. 2004; Mayhew 1996). One means could be through the actual presence of social service providers at clinics, such as having a legal officer from a women’s legal support group present on clinic days. However, as in other cases where integration of HIV services has been attempted, there may not be room in the actual facilities and specific contingencies of grant based provisions of health services can limit the flexibility of programming (ibid.).
Another strategy to improve women’s access to social services would be to improve a system of referrals. Women attending clinics for HIV care could be screened through a short instrument during a required counseling session and referred for more counseling, legal support, to the police, or to other women’s groups. Based on these data, economic conflict, partner’s alcohol use and women’s familial history of violence are strong indicators for violence. With a few questions, these vulnerabilities could be assessed and the woman followed up with further to make recommendations and referrals.

Economic violence as a practical concern in intervention, development, and policy can have far-reaching consequences for women to address their other social concerns, as well as for targeting and reaching those most in need. These data indicate a strong association between economic dependence and conflict with violence. It follows that economic empowerment through microfinance, employment opportunities, training, and women’s groups can contribute to prevention of domestic violence. However, as this can also simultaneously increase women’s risk for violence in the home, it must be done in conjunction with other types of awareness raising or programs aimed at men’s behavior.

Economic independence also makes help seeking more possible, when women are less afraid to prosecute their partners for fear of losing their sole support. The newly passed (yet to be implemented) Domestic Violence Bill takes this into account, allowing those who have experienced violence to seek sanctions in a civil court, without criminal proceedings, and potentially receive monetary compensation for damages. The mere presence of sanctions and fear
of recrimination once the bill is implemented may also serve to prevent violence, just as social sanctions against violence have been found to have a protective effect in other settings (Campbell 1985; Counts et al. 1999; Levinson 1988; Mushanga 1977-1978; Websdale 1998).

Religion is woven into daily discourse in Uganda and already plays an important role for many of the women in this research. Prohibitions on alcohol and promotion of social support are the two most direct ways in which religion is helping women’s lives. The role of alcohol is consistently present in women’s accounts of violence, also significant in the quantitative data. The Islamic religion and most evangelical Christian churches prohibit the consumption of alcohol as a part of religious practice. Currently, many HIV clinics in Uganda allow or encourage religious practices within the waiting areas or on the clinic grounds. While men and women wait to pick up their drug refills or see a clinician, they are preached to or participate in gospel hymns. Counselors in the clinic encourage men and women to pray and attend their respective churches as a means of building a social support network and gaining hope in the face of illness. Several of the born again Christian churches in the country have advocated formal marriage for their members through “group weddings” where up to a dozen or so couples are married in a single ceremony and share the costs for the ceremony and reception.

Given the social significance of religion, it is an important consideration in developing interventions in the future. As a part of their ‘best practices’ manuals, UNAIDS gives the example of a faith-based group in Southern Africa that is
having significant impacts on prevention of HIV (2007). In Mozambique, Pfeiffer found that some of the evangelical churches where women and children seek healing have created a “community of mutual aid” and a safe space to congregate (2002:176). The data from the current study show that religion is an important aspect of the social fabric in Uganda. Further research is needed on the potential role of religion in interventions for women.

10.3 Future Directions for Research

At the time of research, speculation in the media only hinted at potential cuts and shortages in drug supplies. These are now a reality, particularly at the clinic in Kampala where this research was conducted. New patients seeking to enroll in antiretroviral treatment are being turned away and the length of time between clinic visits for current patients has decreased from months to weeks. The insecurity as felt by patients is not reflected in this work but is an important direction for future research.

When presenting the proposal and preliminary results from this work at clinics in Uganda, one question was inevitably raised by the audience: “what about men?” Women were selected as the object of this research because of their vulnerability and marginality in relation to men. Globally, the overwhelming majority of intimate partner violence is male-perpetrated. Though many women engage in mutual combat and others instigate violence, they are much less likely to inflict injury than men. Nonetheless, the male voice on intimate partner violence is one that is frequently absent in research. An interesting point of
exploration deriving from this study would be to include men’s perspectives on managing HIV treatment and relationships. Theirs would potentially balance women’s bias in portraying themselves as victimized and their partners in a negative light. Likewise, it would give insight into the dynamics of relationship conflicts. HIV is also transmitted through relationships and research giving voice to both partners can highlight the relational aspects of transmission, blame, and living with the illness.

Another emergent theme in this research that would be interesting for future study is that of economic violence. The data show strongly the importance of economic considerations in women’s daily lives and the motivation to seek assistance. Quantitative data also reveal a strong association between economic conflicts, such as a partner preventing a woman from working outside the home, and all forms of violence studied. This association is one worthy of more attention to understand the effects of economic decision making on household conflict and vice versa. Theories of decision making from behavioral economics paired with an ethnographic methodology could together capture a more holistic picture of how economic violence occurs within a home.

Women in Uganda continue to suffer from poverty and its related effects. The two aspects explored in this research of HIV and intimate partner violence overlap and are exacerbated in a setting of constrained resources. Women’s experiences are mitigated by global processes, local politics, service provision, cultural ideologies and interpersonal relationships. Further research and
interventions are urgently needed to address these issues and ultimately alleviate women’s suffering.
### APPENDIX A: MODIFIED WHO SURVEY (ENGLISH) USED FOR CLINIC INTERVIEWS

<table>
<thead>
<tr>
<th>ID NUMBER [ ] [ ] [ ] [ ]</th>
<th>DATE: D: [ ] [ ] M: [ ] Y: 200 [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCATION: KAMPALA</td>
<td>INTERVIEWER INITIALS ________</td>
</tr>
<tr>
<td>MBARARA</td>
<td>TRANSLATOR INITIALS ________</td>
</tr>
<tr>
<td>LANGUAGE: ENGLISH</td>
<td>TIME OF INTERVIEW:</td>
</tr>
<tr>
<td>LUGANDA</td>
<td>HOUR [ ] [ ]</td>
</tr>
<tr>
<td>RUNYANKOLE</td>
<td>MINUTES [ ] [ ]</td>
</tr>
</tbody>
</table>

### [1.0] RESPONDENT AND HER COMMUNITY

If you don’t mind, I would like to start by asking you a little about your community.

Where do you live? Neighborhood:

<table>
<thead>
<tr>
<th>QUESTIONS AND FILTERS</th>
<th>CODING CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>101.</td>
<td></td>
</tr>
<tr>
<td>Do neighbors in COMMUNITY NAME generally tend to know each other well?</td>
<td>YES  NO  DON’T KNOW</td>
</tr>
<tr>
<td>102.</td>
<td></td>
</tr>
<tr>
<td>If there were a streetfight in COMMUNITY NAME would people generally do something to stop it?</td>
<td>YES  NO  DON’T KNOW</td>
</tr>
<tr>
<td>103.</td>
<td></td>
</tr>
<tr>
<td>If someone in COMMUNITY NAME decided to undertake a community project (INSERT LOCALLY RELEVANT EXAMPLES) would most people be willing to contribute time, labor, or money?</td>
<td>YES  NO  DON’T KNOW</td>
</tr>
<tr>
<td>104.</td>
<td></td>
</tr>
<tr>
<td>In this neighborhood do most people generally trust one another in matters of lending and borrowing things?</td>
<td>YES  NO  DON’T KNOW</td>
</tr>
<tr>
<td>105.</td>
<td></td>
</tr>
<tr>
<td>If someone in your family suddenly fell ill or had an accident, would your neighbors offer to help?</td>
<td>YES  NO  DON’T KNOW</td>
</tr>
<tr>
<td>106.</td>
<td></td>
</tr>
<tr>
<td>I would now like to ask you some questions about yourself. What is your date of birth? (day, month, and year that you were born?)</td>
<td>DAY [ ] [ ]  MONTH [ ] [ ]  YEAR [ ] [ ]  DON’T KNOW YEAR</td>
</tr>
<tr>
<td>Question</td>
<td>Response Options</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>How old were you on your last birthday? (More or less)</td>
<td>Age (years)……[    ] [    ]</td>
</tr>
<tr>
<td>How long have you been living continuously in COMMUNITY NAME?</td>
<td>□ Number of years………………[    ] [    ]</td>
</tr>
<tr>
<td>□ Less than 1 Year</td>
<td>□ Lived there all her life</td>
</tr>
<tr>
<td>□ Visitor (at least 4 weeks in household)</td>
<td></td>
</tr>
<tr>
<td>Can you read and write?</td>
<td>□ YES</td>
</tr>
<tr>
<td>□ NO</td>
<td></td>
</tr>
<tr>
<td>Have you ever attended school?</td>
<td>□ YES</td>
</tr>
<tr>
<td>□ NO</td>
<td></td>
</tr>
<tr>
<td>What is the highest level of education that you achieved?</td>
<td>PRIMARY: _________ year</td>
</tr>
<tr>
<td>□ SECONDARY: _________ year</td>
<td></td>
</tr>
<tr>
<td>□ HIGHER: _________ year</td>
<td></td>
</tr>
<tr>
<td>Where did you grow up?</td>
<td>□ This community/ town</td>
</tr>
<tr>
<td>□ Another rural area/ village</td>
<td>□ Another city/ town</td>
</tr>
<tr>
<td>□ Another country</td>
<td></td>
</tr>
<tr>
<td>Do any of your family of birth live close enough by that you can easily see/ visit them?</td>
<td>□ YES</td>
</tr>
<tr>
<td>□ NO</td>
<td></td>
</tr>
<tr>
<td>How often do you see or talk to a member of your family of birth?</td>
<td>□ At least once a week</td>
</tr>
<tr>
<td>□ At least once a month</td>
<td>□ At least once a year</td>
</tr>
<tr>
<td>□ Never (hardly ever)</td>
<td></td>
</tr>
<tr>
<td>When you need help or have a problem can you usually count on family members for support?</td>
<td>□ YES</td>
</tr>
<tr>
<td>□ NO</td>
<td></td>
</tr>
<tr>
<td>Do you regularly attend a group or organization?</td>
<td>□ NONE…………………………………</td>
</tr>
<tr>
<td>□ Civic/ political/ union 1 2 3 4</td>
<td>□ Social work/ charitable1 1 2 3 4</td>
</tr>
<tr>
<td>□ Sports/ arts/ crafts 1 2 3 4</td>
<td>□ Economic savings club1 2 3 4</td>
</tr>
<tr>
<td>□ Women’s organization 1 2 3 4</td>
<td>□ Religious organization 1 2 3 4</td>
</tr>
<tr>
<td>□ Other ________________________ 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>a. Are any of these groups attended by women only?</td>
<td>□ YES</td>
</tr>
<tr>
<td>□ NO</td>
<td></td>
</tr>
<tr>
<td>What is your religion?</td>
<td>□</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>119. Are you currently married or do you have a male partner?</td>
<td>- Currently married</td>
</tr>
<tr>
<td></td>
<td>- Living with a man, not married</td>
</tr>
<tr>
<td></td>
<td>- Currently having a regular partner (sexual relationship), living apart</td>
</tr>
<tr>
<td></td>
<td>- Not currently married or living with a man (not involved in a sexual</td>
</tr>
<tr>
<td></td>
<td>relationship)</td>
</tr>
<tr>
<td></td>
<td>- Widowed</td>
</tr>
<tr>
<td>120. Have you ever been married or lived with a male partner?</td>
<td>- YES</td>
</tr>
<tr>
<td></td>
<td>- NO</td>
</tr>
<tr>
<td>121. Did the last partnership end in divorce or separation or were you</td>
<td>- Divorced</td>
</tr>
<tr>
<td></td>
<td>widowed</td>
</tr>
<tr>
<td></td>
<td>- Separated/ broken up</td>
</tr>
<tr>
<td></td>
<td>- Widowed</td>
</tr>
<tr>
<td>122. Was the divorce/ separation initiated by you, by your</td>
<td>- Respondent</td>
</tr>
<tr>
<td></td>
<td>husband/ partner</td>
</tr>
<tr>
<td></td>
<td>- Both</td>
</tr>
<tr>
<td></td>
<td>- Other ______________</td>
</tr>
<tr>
<td>123. How many times have you been married, or lived with a man?</td>
<td>- Number [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td>- NEVER</td>
</tr>
<tr>
<td>124. The next few questions are about your current or most recent</td>
<td>- YES</td>
</tr>
<tr>
<td></td>
<td>partnership. Do/did you live with your husband/ partner’s parents or</td>
</tr>
<tr>
<td></td>
<td>any of his relatives?</td>
</tr>
<tr>
<td></td>
<td>- NO</td>
</tr>
<tr>
<td>125. If CURRENTLY WITH PARTNER: Do you currently live with your parents</td>
<td>- YES</td>
</tr>
<tr>
<td></td>
<td>or any of your relatives?</td>
</tr>
<tr>
<td></td>
<td>- NO</td>
</tr>
<tr>
<td>126. Does/ did your husband/ partner have any other wives while being</td>
<td>- YES</td>
</tr>
<tr>
<td></td>
<td>married (having a relationship) with you?</td>
</tr>
<tr>
<td></td>
<td>- NO</td>
</tr>
<tr>
<td></td>
<td>- DON’T KNOW</td>
</tr>
<tr>
<td>127. How many wives does/ did he have (including yourself)?</td>
<td>- Number of wives [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td>- Don’t know</td>
</tr>
<tr>
<td>128. Are/ were you first, second… wife? Which number/position?</td>
<td>- Number/ position [ ] [ ]</td>
</tr>
<tr>
<td></td>
<td>- Don’t know</td>
</tr>
<tr>
<td>129. Did you have any kind of marriage ceremony to formalize?</td>
<td>- None</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What type of ceremony did you have?</td>
<td>Civil marriage, Religious marriage, Customary marriage, Other ________________</td>
</tr>
<tr>
<td>In what year was the (first) ceremony performed? (THIS REFERS TO CURRENT/LAST RELATIONSHIP)</td>
<td>Year………………..[ ][ ][ ][ ] Don’t know</td>
</tr>
<tr>
<td>Did you yourself choose your current/most recent husband, did someone else choose him for you, or did he choose you?</td>
<td>Both chose…………………………… Respondent chose…………………………… Respondent’s family chose Partner chose Partner’s family chose Other ________________</td>
</tr>
<tr>
<td>Did your marriage involve dowry/bride price payment?</td>
<td>Yes, dowry, Yes, brideprice, No…………………………………… Don’t know……………………………………</td>
</tr>
<tr>
<td>Overall, do you think that the amount of dowry/bride price payment has had a positive impact on how you are treated by your husband and his family, a negative impact, or not particular impact?</td>
<td>Positive impact, Negative impact, No impact</td>
</tr>
<tr>
<td>[2.0] GENERAL HEALTH</td>
<td>I would now like to ask a few questions about your health and use of health services.</td>
</tr>
<tr>
<td>How long have you been attending services at this clinic?</td>
<td>Less than 6 months, Between 6 months and 1 year, Between 1 and 3 years, More than 3 years</td>
</tr>
<tr>
<td>How long have you known you were HIV positive?</td>
<td>Less than 6 months, Between 6 months and 1 year, Between 1 and 3 years, More than 3 years</td>
</tr>
<tr>
<td>How did you come to find out that you were HIV positive?</td>
<td>Routine test, Antenatal screening, Was sick/showed symptoms, Partner was sick, Partner died, Friend recommended testing, Other, please specify:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>139</strong></td>
<td>How long have you been on ARV treatment?</td>
</tr>
<tr>
<td></td>
<td>□ Less than 6 months</td>
</tr>
<tr>
<td></td>
<td>□ Between 6 months and 1 year</td>
</tr>
<tr>
<td></td>
<td>□ Between 1 and 3 years</td>
</tr>
<tr>
<td></td>
<td>□ More than 3 years</td>
</tr>
<tr>
<td><strong>140</strong></td>
<td>Have you ever interrupted treatment?</td>
</tr>
<tr>
<td></td>
<td>(If YES, probe: Why? And For how long?)</td>
</tr>
<tr>
<td></td>
<td>□ NO</td>
</tr>
<tr>
<td></td>
<td>□ YES</td>
</tr>
<tr>
<td></td>
<td>If YES, For how long?</td>
</tr>
<tr>
<td></td>
<td>[ ] [ ] Days/ Weeks/ Months/ Years</td>
</tr>
<tr>
<td></td>
<td>WHY?</td>
</tr>
<tr>
<td></td>
<td>□ Lack of funds</td>
</tr>
<tr>
<td></td>
<td>□ Drugs not available</td>
</tr>
<tr>
<td></td>
<td>□ Work/ moving</td>
</tr>
<tr>
<td></td>
<td>□ Other, please specify:____________________</td>
</tr>
<tr>
<td><strong>141</strong></td>
<td>Is your CURRENT/MOST RECENT partner HIV positive?</td>
</tr>
<tr>
<td></td>
<td>□ NO………………………………………</td>
</tr>
<tr>
<td></td>
<td>□ YES………………………………………</td>
</tr>
<tr>
<td></td>
<td>□ DON’T KNOW……………………………</td>
</tr>
<tr>
<td><strong>142</strong></td>
<td>Is he currently on treatment?</td>
</tr>
<tr>
<td></td>
<td>□ YES</td>
</tr>
<tr>
<td></td>
<td>□ NO</td>
</tr>
<tr>
<td></td>
<td>□ DON’T KNOW</td>
</tr>
<tr>
<td><strong>143</strong></td>
<td>Since learning of your status, who have you told?</td>
</tr>
<tr>
<td></td>
<td>□ Partner</td>
</tr>
<tr>
<td></td>
<td>□ Parents</td>
</tr>
<tr>
<td></td>
<td>□ Siblings</td>
</tr>
<tr>
<td></td>
<td>□ Friends</td>
</tr>
<tr>
<td></td>
<td>□ Neighbors</td>
</tr>
<tr>
<td></td>
<td>□ Children</td>
</tr>
<tr>
<td></td>
<td>□ Coworkers</td>
</tr>
<tr>
<td></td>
<td>□ Other Relatives</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
</tr>
<tr>
<td><strong>144</strong></td>
<td>Who have you NOT told?</td>
</tr>
<tr>
<td></td>
<td>□ Partner</td>
</tr>
<tr>
<td></td>
<td>□ Parents</td>
</tr>
<tr>
<td></td>
<td>□ Siblings</td>
</tr>
<tr>
<td></td>
<td>□ Friends</td>
</tr>
<tr>
<td></td>
<td>□ Neighbors</td>
</tr>
<tr>
<td></td>
<td>□ Children</td>
</tr>
<tr>
<td></td>
<td>□ Coworkers</td>
</tr>
<tr>
<td></td>
<td>□ Other Relatives</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
</tr>
<tr>
<td>201</td>
<td>In general, how would you</td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Describe your overall health as excellent, good, fair, poor, or very poor?</td>
<td>Good, Fair, Poor, Very Poor</td>
</tr>
<tr>
<td>202. Now I would like to ask you about your health in the past 4 weeks.</td>
<td>No problems, Very few problems, Some problems, Many problems, Unable to walk at all</td>
</tr>
<tr>
<td>How would you describe your ability to walk around? Would you say that you have no problems, very few problems, some problems, many problems, or that you are unable to walk at all?</td>
<td></td>
</tr>
<tr>
<td>203. In the past 4 weeks did you have problems with performing usual activities, such as work, study, household, family or social activities? Would you say that you have no problems, very few problems, some problems, many problems, or unable to perform usual activities?</td>
<td>No problems, Very few problems, Some problems, Many problems, Unable to perform usual activities</td>
</tr>
<tr>
<td>204. In the past 4 weeks have you been in pain or discomfort? Would you say not at all, slight pain or discomfort, moderate, severe or extreme pain or discomfort?</td>
<td>No pain or discomfort, Slight pain or discomfort, Moderate pain or discomfort, Severe pain or discomfort, Extreme pain or discomfort</td>
</tr>
<tr>
<td>205. In the past 4 weeks have you had problems with your memory or concentration? Would you say no problems, very few problems, some problems, many problems, or extreme memory or concentration problems?</td>
<td>No problems, Very few problems, Some problems, Many problems, Extreme memory problems</td>
</tr>
<tr>
<td>208. In the past 4 weeks, did you consult a doctor or other professional or traditional health worker because you were sick? If YES: Whom did you consult? PROBE: Did you also see anyone else?</td>
<td>No one, Doctor, Nurse, Midwife, Counselor, Pharmacist, Traditional Healer, Traditional Birth Attendant, Other</td>
</tr>
<tr>
<td>209. The next questions are related to other common problems that may have bothered you in the past 4 weeks. If you had the problem in the past 4 weeks, answer yes.</td>
<td>No one, Doctor, Nurse, Midwife, Counselor, Pharmacist, Traditional Healer, Traditional Birth Attendant, Other</td>
</tr>
</tbody>
</table>
In the past 4 weeks, answer no.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Do you often have headaches?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Is your appetite poor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Do you sleep badly?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Are you easily frightened?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Do your hands shake?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Do you feel nervous, tense, or worried?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Is your digestion poor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Do you have trouble thinking clearly?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Do you feel unhappy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Do you cry more than usual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Do you find it difficult to make decisions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Is your daily work suffering?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Are you unable to play a useful part in life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Has the thought of ending your life been on your mind?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Do you feel tired all the time?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

212. In the past 12 months, have you had an operation (other than a cesarean section)?

| YES | NO |

213. In the past 12 months, did you have to spend any nights in a hospital because you were sick (other than to give birth)? IF YES: How many nights in the past 12 months?

| NIGHTS IN HOSPITAL...[ ] [ ] | NONE |

214. Do you now smoke?

| Daily | Occasionally | Not at all |

215. Have you ever smoked in your life? Did you ever smoke....

1. Daily? (smoking at least once a day)
2. Occasionally? (at least 100 cigarettes, but never daily)
3. Not at all? (not at all, or less than 100 cigarettes in your lifetime)
216. How often do you drink alcohol? Would you say:
   1. Every day or nearly every day
   2. Once or twice a week
   3. 1-3 times a month
   4. Occasionally, less than once a month
   5. Never

217. On the days that you drank in the past 4 weeks, about how many alcoholic drinks did you usually have a day?

218. In the past 12 months, have you experienced any of the following problems, related to your drinking?

<table>
<thead>
<tr>
<th>[3.0] REPRODUCTIVE HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now I would like to ask about all of the births that you have had during your life.</td>
</tr>
</tbody>
</table>

301. Have you ever given birth?
   Number of births…….[ ][ ]
   IF 1 OR MORE:…………….….
   None

302. Have you ever been pregnant?
   Yes
   No
   Maybe/ Not sure

303. How many children do you have, who are alive now?
   CHILDREN……….[ ][ ]
   NONE

304. Have you ever given birth to a boy or a girl who was born alive, but later died? This could be any age.
   YES
   NO…………………………………………

305. How many sons/ daughters have died? (This is about all ages)
   SONS DIED…………….[ ][ ]
   DAUGHTERS DIED…..[ ][ ]

306. Do (did) all your children have the same biological father, or more than one father?
   One father
   More than one father
   Don’t know/ No answer

307. How many of your children receive financial support from their father(s)? Would you say none, some, or all?
   None
   Some
   All
   N/A

308. How many times have you been pregnant—including pregnancies
   a. TOTAL PREGNANCIES…. [ ][ ]
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 309. Have you ever had a pregnancy that miscarried, or ended in a stillbirth? (PROBE: How many times did you miscarry, how many times did you have a stillbirth, and how many times did you abort?) | a. Miscarriages ..............  [   ]  
   b. Stillbirths ...............  [   ]  
   c. Abortions .................  [   ]  
   None                       |
<p>| 310. Are you pregnant now?                                              | YES ........................................ | NO ........................................ |
| 311. Have you ever used anything, or tried in any way to avoid getting pregnant? | Yes                             | No ........................................ |
| 312. Are you currently doing something, or using any method, to avoid getting pregnant? | YES                             | NO ........................................ |
| 313. What (main) method are you currently using?                        | Pill/tablets                    | Injectables                      |
|                                                                       | Implants (Norplant)             | IUD                             |
|                                                                       | Diaphragm/ Foam/ Jelly          | Calendar/ Mucus method          |
|                                                                       | Female sterilization            | Condoms                         |
|                                                                       | Male sterilization              | Withdrawal                      |
|                                                                       | Herbs                          | Other: ________________________ |
| 314. Does your current husband/partner know that you are using a method of family planning? | YES                             | NO | N/A- no current partner |
| 317. Have you ever used a condom with your current/ most recent partner to avoid pregnancy? | YES                             | NO |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>315. Has/did your current/ most recent husband/partner ever refused to use a method or tried to stop you from using a method to avoid getting pregnant?</td>
<td>YES, NO</td>
</tr>
<tr>
<td>316. In what ways did he let you know that he disapproved of using methods to avoid getting pregnant?</td>
<td>Told me he did not approve, Shouted/ got angry, Threatened to beat me, Threatened to leave/ throw me out of home, Beat me/ physically assaulted, Took or destroyed method, Other</td>
</tr>
</tbody>
</table>

**[4.0] CHILDREN**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>401. I would like to ask about the last time that you gave birth (regardless of whether the child is still alive or not). What is the date of birth of this child?</td>
<td>Day, Month, Year</td>
</tr>
<tr>
<td>402. What name was given to your last born child?</td>
<td>NAME</td>
</tr>
<tr>
<td>Is (NAME) a boy or girl?</td>
<td>Boy, Girl</td>
</tr>
<tr>
<td>403. Is your last born child (NAME) still alive?</td>
<td>YES, NO</td>
</tr>
<tr>
<td>404. How old was (NAME) at his/her last birthday?</td>
<td>Age in Years, If not yet completed 1 year</td>
</tr>
<tr>
<td>405. How old was (NAME) when he/she died?</td>
<td>Years, Months, Days</td>
</tr>
<tr>
<td>407. I would like to ask you about your last pregnancy. At the time you became pregnant with this child (NAME), did you want to become pregnant then, did you want to wait until later, did you want no (more) children, or did you not mind either way?</td>
<td>Become pregnant then, Wait until later, Not want children, Not mind either way</td>
</tr>
<tr>
<td>408. At the time you became pregnant with this child (NAME) your</td>
<td>Become pregnant then, Wait until later</td>
</tr>
</tbody>
</table>
| 409. | When you were pregnant with this child (NAME), did you see anyone for an antenatal check? | □ No one  
□ Doctor  
□ Obstetrician/ gynecologist  
□ Nurse/ midwife  
□ Auxiliary nurse  
□ Traditional birth attendant  
□ Other ________________________ |  
| 410. | Did your husband/partner stop you, encourage you, or have no interest in whether you received antenatal care for your pregnancy? | □ Stop  
□ Encourage  
□ No interest |  
| 411. | When you were pregnant with this child, did your husband/partner have preference for a son, a daughter or did it not matter to him whether it was a boy or a girl? | □ Son  
□ Daughter  
□ Did not matter |  
| 412. | During this pregnancy, did you consume any alcoholic drinks? | □ YES  
□ NO  
□ Don’t know/ don’t remember |  
| 413. | During this pregnancy, did you smoke any cigarettes or use tobacco? | □ YES  
□ NO  
□ Don’t know/ don’t remember |  
| 414. | Were you given a (postnatal) checkup at any time during the 6 weeks after delivery? | □ YES  
□ NO  
□ Don’t know |  
| 415. | Was this child (NAME) weighed at birth? | □ YES  
□ NO  
□ Don’t know |  
| 416. | How much did he/she weigh? | □ KG.………… [ ] [ ]  
□ Don’t know/ don’t remember |  
| 417. | Do you have any children with ages 5-12 years? How many? INCLUDING 12 YEAR OLD CHILDREN | □ NUMBER…… [ ] [ ]  
□ NONE…………………………………  
□ … |  
| 418. | How many are boys/girls? | □ BOYS………… [ ] [ ]  
□ GIRLS………… [ ] [ ] |  
| 419. | How many of your children currently live with you? (PROBE: how many boys/girls?) | □ BOYS………… [ ] [ ]  
□ GIRLS………… [ ] [ ] |
420. Do any of your children ages 5-12 years:
   a. Have frequent nightmares?  
   b. Suck their thumbs or fingers? 
   c. Often wet their bed?  
   d. Are any of these children very timid or withdrawn?  
   e. Are any of them aggressive with you or other children? 
   
   - NIGHTMARES  [ ]  [ ]
   - SUCK THUMB  [ ]  [ ]
   - WET BED  [ ]  [ ]
   - WITHDRAWN  [ ]  [ ]
   - AGGRESSIVE  [ ]  [ ]

421. Of these children (ages 5-12 years), how many of your boys and how many of your girls have ever run away from home?
   
   - BOYS…… [ ] [ ]
   - GIRLS…… [ ] [ ]
   - NONE

422. Of these children (ages 5-12 years), how many of your boys and how many of your girls are studying/ in school?
   
   - BOYS……… [ ] [ ]
   - GIRLS……… [ ] [ ]
   - NONE

423. Have any of these children had to repeat (failed) a year at school?
   
   - YES
   - NO
   - Don’t know

424. Have any of these children stopped school for a while or dropped out of school?
   
   - YES
   - NO
   - Don’t know

### [5.0] CURRENT OR MOST RECENT PARTNER

I would now like you to tell me a little about your current/ most recent partner/ husband.

501. How old was your partner on his last birthday?
   
   AGE……… [ ] [ ]
   Or: Age when died…[ ] [ ]
   In what year?: [ ] [ ]

502. In what year was he born?
   
   YEAR……… [ ] [ ] [ ] [ ]
   DON’T KNOW

503. Can he read and write?
   
   - YES
   - NO

504. Did he ever attend school?
   
   - YES
   - NO

505. What is the highest level of education that he achieved?
   (MARK HIGHEST LEVEL)
   
   - Primary….. [ ] [ ] [ ] year
   - Secondary.. [ ] [ ] [ ] year
   - Higher…… [ ] [ ] [ ] year
   - Don’t know

506. IF CURRENTLY WITH PARTNER: Is he currently working, looking for work or unemployed, retired or studying?
   
   - Working……………………
   - Looking for work/ unemployed
   - Retired ………………………
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF NOT CURRENTLY WITH PARTNER: Towards the end of your relationship was he working, looking for work or unemployed, retired, or studying?</td>
<td>☐ Student …………………………….</td>
</tr>
</tbody>
</table>
| 507. When did his last job finish? Was it in the past 4 weeks, between 4 weeks and 12 months ago, or before that? (FOR MOST RECENT HUSBAND PARTNER: in the last 4 weeks or in the last 12 months of your relationship?) | ☐ In the past 4 weeks  
☐ 4 weeks- 12 months ago  
☐ More than 12 months ago  
☐ Never had a job ………………………… |
| 508. What kind of work does/did he normally do?                         | ☐ Professional  
☐ Semi-skilled  
☐ Unskilled/ manual  
☐ Manual/ police  
☐ Other |
| 509. How often does/did your husband/partner drink alcohol?             | ☐ Every day or nearly every day  
☐ Once or twice a week  
☐ 1-3 times a month  
☐ Occasionally, less than once a month  
☐ Never ………………………………….. |
| 510. In the past 12 months (In your last relationship), how often have you seen (did you see) your husband/partner drunk? Would you say most days, weekly, once a month, less than once a month, or never? | ☐ Most days  
☐ Weekly  
☐ Once a month  
☐ Less than once a month  
☐ Never |
| 511. In the past 12 months (during the last 12 months of your last relationship), have you experienced any of the following problems, related to your husband/partner’s drinking? | ☐ Money problems  
☐ Family problems  
☐ Any other problems, specify: ____________________________________ |
| 512. How often does/did your | ☐ Every day or nearly every day |
husband/partner use drugs?  
- Once or twice a week
- 1-3 times a month
- Occasionally, less than once a month
- Never

513. Since you have known him, has he ever been involved in a physical fight with another man?  
- Yes
- No
- Don’t know

514. In the past 12 months (in the last 12 months of the relationship), has this happened never, once or twice, a few times, or many times?  
- Never
- Once or twice
- A few times
- Many (more than 5) times
- Don’t know

515. Has your current/most recent husband/partner had a relationship with any other women while being with you?  
- Yes
- No
- May have
- Don’t know

516. Has your current/ most recent husband/partner had children with any other woman while being with you?  
- Yes
- No
- May have
- Don’t know

[6.0] ATTITUDES TOWARDS GENDER ROLES

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There are no right or wrong answers.

601. A good wife obeys her husband even if she disagrees  
- AGREE
- DISAGREE
- DON’T KNOW

602. Family problems should only be discussed with people in the family  
- AGREE
- DISAGREE
- DON’T KNOW

603. It is important for a man to show his wife/partner who is the boss  
- AGREE
- DISAGREE
- DON’T KNOW

604. A woman should be able to choose her own friends even if her husband disapproves  
- AGREE
- DISAGREE
- DON’T KNOW

605. It’s a wife’s obligation to have sex with her husband even if she doesn’t feel like it  
- AGREE
- DISAGREE
- DON’T KNOW

606. If a man mistreats his wife, other outside of the family should intervene  
- AGREE
- DISAGREE
### 607. In your opinion, does a man have a good reason to hit his wife if:

- a. She does not complete her household work to his satisfaction
- b. She disobeys him
- c. She refuses to have sexual relations with him
- d. She asks him whether he has other girlfriends
- e. He suspects that she is unfaithful
- f. He finds out that she has been unfaithful

[ ] DON'T KNOW

<table>
<thead>
<tr>
<th>☐ YES</th>
<th>☐ NO</th>
<th>☐ DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 608. In your opinion, can a married women refuse to have sex with her husband if:

- a. She doesn’t want to
- b. He is drunk
- c. She is sick
- d. He mistreats her

[ ] DON'T KNOW

<table>
<thead>
<tr>
<th>☐ YES</th>
<th>☐ NO</th>
<th>☐ DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**[7.0] RESPONDENT AND HER PARTNER**

When two people marry or live together, they usually share both good and bad moments. I would now like to ask you some questions about your current and past relationships and how your husband/partner treats (treated) you. If anyone interrupts us, I will change the topic of conversation. I would again like to assure you that your answers will be kept secret, and that you do not have to answer any questions that you do not want to. May I continue?

### 701. In general, do (did) you and your (current or most recent) husband/partner discuss the following topics together:

- a. Things that have happened to him in the day
- b. Things that happen to you in the day
- c. Your worries or feelings
- d. His worries or feelings

[ ] EVER MARRIED/ LIVING WITH PARTNER

[ ] NEVER MARRIED/ LIVED WITH MAN/ SINGLE

<table>
<thead>
<tr>
<th>☐ RARELY</th>
<th>☐ SOMETIMES</th>
<th>☐ OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. HIS DAY</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B. YOUR DAY</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. YOUR WORRIES</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D. HIS WORRIES</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 702. In your relationship with your (current or most recent) husband/partner, how often would you say that you quarreled? Would you say rarely, sometimes, or often?

[ ] RARELY

[ ] SOMETIMES

[ ] OFTEN
I am now going to ask you about some situations that are true for many women. Thinking about your (current or most recent) husband/partner, would you say it is generally true that he:

- a. Tries to keep you from seeing your friends
- b. Tries to restrict contact with your family of birth
- c. Insists on knowing where you are at all times
- d. Ignores you and treats you indifferently
- e. Gets angry if you speak with another man
- f. Is often suspicious that you are unfaithful
- g. Expects you to ask his permission before seeking healthcare for yourself

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. SEE FRIENDS</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>B. CONTACT FAMILY</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>C. WANT TO KNOW</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>D. IGNORES</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>E. ANGRY</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>F. SUSPICIOUS</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>G. HEALTHCARE</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

The next questions are about things that happen to many women, and that your current partner, or any other partner may have done to you. I want you to tell me if your current husband/partner, or any other partner, has ever done the following to you.

A) If YES, go to B. If NO skip to next item

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Few</th>
<th>Many</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Insulted you or made you feel bad about yourself?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>b. Belittled or humiliated you in front of other people?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>c. Did things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling and smashing things)?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>d. Threatened to hurt you or someone you care about?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Has he or any other partner ever:

A) If YES, go to B. If NO skip to next item

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Few</th>
<th>Many</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Slapped you or thrown something at you that could hurt you?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>b. Pushed you or shoved you?</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Both</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>c. Hit you with his fist or something else that could hurt you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Kicked you, dragged you or beaten you up?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Choked or burnt you on purpose?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Threatened to use or actually used a gun, knife, or other weapon against you?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

706. Has he or any other partner ever:

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Physically forced you to have sexual intercourse when you did not want to?</td>
<td>Y  N  One  Few  Many</td>
</tr>
<tr>
<td>b. Did you ever have sexual intercourse you did not want because you were afraid of what he might do?</td>
<td>Y  N  One  Few  Many</td>
</tr>
<tr>
<td>c. Did he ever force you to do something sexual that you found degrading or humiliating?</td>
<td>Y  N  One  Few  Many</td>
</tr>
</tbody>
</table>

707. Have any of these experiences of violence ever affected your healthcare? IF YES, how?

- Unable to go to scheduled appointment
- Scared/ fearful to see doctor
- Partner prevented you from going
- Too injured to attend
- Partner took funds needed
- Other: (specify)_________________

709. You said that you have been pregnant TOTAL times. Was there ever a time when you were beaten or physically assaulted by (any of) your partner(s) while you were pregnant?

- YES
- NO

711. Were you ever punched or kicked in the abdomen while you were pregnant?

- YES
- NO

712. During the most recent pregnancy in which you were beaten, was the person who beat you the father of the child?

- YES
- NO
- DON’T KNOW
713. Were you living with this person when it happened?  □ YES  □ NO  □ DON’T KNOW

714. Had the same person beaten you before you were pregnant?  □ YES  □ NO  □ DON’T KNOW

715. Compared to before you were pregnant, did the violence get less, stay about the same, or get worse while you were pregnant?  □ GOT LESS  □ STAYED SAME  □ GOT WORSE  □ DON’T KNOW

716. IF MORE THAN ONE PARTNERSHIP, ASK: You told me that you have been married or lived with a man TOTAL times. Could you now please tell me a little about your husband/partner(s)? (Starting with you current or most recent partner)

<table>
<thead>
<tr>
<th>a. When did you start living together?</th>
<th>b. When did the relationship end?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF CURRENTLY MARRIED OR LIVING W/MAN START WITH 1, IF NOT START WITH 2</td>
<td>c. Did he physically or sexually mistreat you?</td>
</tr>
<tr>
<td>CURRENT PARTNER</td>
<td>YES⇒</td>
</tr>
<tr>
<td>MONTH: [<strong>][</strong>][__]</td>
<td>YEAR: [<strong>][</strong>][<strong>][</strong>]</td>
</tr>
<tr>
<td>NO, ON TO NEXT</td>
<td></td>
</tr>
<tr>
<td>PREVIOUS [1]</td>
<td>YES⇒</td>
</tr>
<tr>
<td>MONTH: [<strong>][</strong>][__]</td>
<td>YEAR: [<strong>][</strong>][<strong>][</strong>]</td>
</tr>
<tr>
<td>NO, ON TO NEXT</td>
<td></td>
</tr>
<tr>
<td>PREVIOUS [2]</td>
<td>YES⇒</td>
</tr>
<tr>
<td>MONTH: [<strong>][</strong>][__]</td>
<td>YEAR: [<strong>][</strong>][<strong>][</strong>]</td>
</tr>
<tr>
<td>NO, ON TO NEXT</td>
<td></td>
</tr>
<tr>
<td>PREVIOUS [3]</td>
<td>YES⇒</td>
</tr>
<tr>
<td>MONTH: [<strong>][</strong>][__]</td>
<td>YEAR: [<strong>][</strong>][<strong>][</strong>]</td>
</tr>
<tr>
<td>NO, ON TO NEXT</td>
<td></td>
</tr>
</tbody>
</table>

[8.0] INJURIES⇒ IF NO VIOLENCE, GO TO SECTION 10

I would now like to learn more about the injuries that you experiences from (any of) your partner’s violence. By injury, I mean any for of physical harm, including cuts, sprains, burns, broken bones or broken teeth, or other things like this.

801. Have you ever been injured as a result of violence/abuse by (one of) your (current or former)  □ YES  □ NO
### 802. In your life, how many times were you injured by (any of) your husband(s)/partner(s)?
- Once/twice
- Several (3-5) times
- Many (more than 5) times
- Yes
- No

### 803. What type of injury did you have?
- MARK ALL (DO NOT READ LIST)
- PROBE: Any other injury?

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>Yes</th>
<th>No</th>
<th>LAST 12 MONTHS/YES</th>
<th>LAST 12 MONTHS/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cuts, punctures, bites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Scratch, abrasion, bruises</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Sprains, dislocations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Burns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Penetrating injury, deep cuts, gashes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Broken eardrum, eye injuries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Fractures, broken bones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Broken teeth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 804. Did you ever lose consciousness? If YES: For how long? More or less than 1 hour?
- Yes, less than one hour
- Yes, more than one hour
- No
- DON’T KNOW/ NOT SURE
- Yes
- No

### 805. Were you ever hurt badly enough that you needed health care?
If YES: How many times?

<table>
<thead>
<tr>
<th>Times needed healthcare</th>
<th>Yes, but don’t know</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 806. Did you ever receive healthcare for your injury? If YES: All of the time or sometimes?

<table>
<thead>
<tr>
<th>Yes, Sometimes</th>
<th>Yes, Always</th>
<th>Not needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 807. For your injury, did you have to spend any nights in a hospital?
If YES: How many nights?

<table>
<thead>
<tr>
<th>NONE</th>
<th>Number of nights in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 808. Did you tell a health worker the real cause of your injury?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[9.0] IMPACT AND COPING
I would now like to ask you some questions about what usually happened when your partner was violent.  

**IF REPORTED VIOLENCE BY MORE THAN ONE PARTNER:** I would like you to answer these questions for the most recent (last) partner who used violence.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 901. Do you think that there are any particular situations that tend to lead to violence? | No particular reason  
When man drunk  
Money problems  
Difficulties at his work  
When he is unemployed  
No food at home  
Problems with his or her family  
She is pregnant  
He is jealous of her  
She refuses sex  
She is disobedient  
Other |

**PROBE:** Any other situation?  
**MARK ALL MENTIONED**

| 902. **IF SHE HAS CHILDREN LIVING:**  
For any of these incidents of physical violence, were your children present or did they over hear you being beaten? | Never  
Once or twice  
Several times  
Many times/ most of the time  
Don’t know |

| 903. During or after a violence incident, does (did) he ever force you to have sex? **PROBE:** Make you have sex with him against your will? | Never  
Once or twice  
Several times  
Many times/ most of the time  
Don’t know |

| 904. During the times that you were hit, did you ever fight back physically (or to defend yourself?) | Never  
Once or twice  
Several times  
Many times/ most of the time  
Don’t know |

| 905. Have you ever hit or physically mistreated your husband/partner when he was not hitting or physically mistreating you? | Never  
Once or twice  
Several times  
Many times/ most of the time  
Don’t know |

<p>| 906. Would you say that your | No effect |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>husband/partner’s violence has affected your physical or mental health? PROBE: Has it affected your health a little, or a lot?</td>
<td>A little, A lot</td>
</tr>
<tr>
<td>In what way, if any, has the violence disrupted your work or other income generating activities? MARK ALL THAT APPLY</td>
<td>N/A (No work for money), Work not disrupted, Partner interrupted work, Unable to concentrate, Unable to work/ sick leave, Lost confidence in own ability, Other</td>
</tr>
<tr>
<td>Who have you told about the physical violence? MARK ALL MENTIONED. PROBE: Anyone else?</td>
<td>No one, Friends, Parents, Brother or sister, Uncle or aunt, Husband/partner’s family, Children, Neighbors, Police, Doctor/health worker, Priest, Counselor, NGO/ Women’s organization, Local leader, Other</td>
</tr>
<tr>
<td>Did anyone ever try to help you? IF YES: Who helped you? MARK ALL MENTIONED. PROBE: Anyone else?</td>
<td>No one, Friends, Parents, Brother or sister, Uncle or aunt, Husband/partner’s family, Children, Neighbors, Police, Doctor/health worker, Priest, Counselor, NGO/ Women’s organization, Local leader, Other</td>
</tr>
<tr>
<td>Did you ever go to any of the</td>
<td></td>
</tr>
</tbody>
</table>
following for help? (READ EACH ONE)

- a. Police
- b. Hospital or health center
- c. Social services
- d. Legal advice center
- e. Court
- f. Shelter
- g. Local leader
- h. Women’s organizations (Use name)
- i. Priest/religious leader
- j. Anywhere else? Where?

**911.** What were the reasons that made you go for help?

**MARK ALL MENTIONED**

- Encouraged by friends/family
- Could not endure more
- Badly injured/ afraid he would kill her
- He threatened or tired to kill her
- He threatened or hit children
- Saw that children suffering
- Thrown out of home
- Afraid that she would kill him
- Other

**912.** Why did you not go to any of these?

**MARK ALL MENTIONED**

- Don’t know. No answer
- Fear of threats/ consequences/ more violence
- Violence normal/ not serious
- Embarrassed/ ashamed/ afraid would not be believed or would be blamed
- Believed not help/ know other women not helped
- Afraid would end relationship
- Afraid would lose children
- Bring bad name to family
- Other

**913.** Is there anyone that you would like to receive (more) help from? Who?

**MARK ALL MENTIONED**

- No one mentioned
- Family
- Her mother
- His mother
- Health center
- Police
- Priest/religious leader
- Other

**914.** Did you ever leave, even if only

**YES: Number of times left**
<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>overnight, because of violence? IF YES: How many times?</td>
<td>Never………………………………</td>
</tr>
<tr>
<td>915. What were the reasons why you left the last time?</td>
<td>No particular incident Encouraged by friends/family Could not endure more Badly injured/ afraid he would kill her He threatened or tried to kill her He threatened or hit children Saw that children suffering Thrown out of the home Afraid she would kill him Encouraged by organization Other: _________________</td>
</tr>
<tr>
<td>916. Where did you go the last time?</td>
<td>Her relatives His relatives Her friends/neighbors Hotel/ lodgings Street Church/ temple Shelter Other __________</td>
</tr>
<tr>
<td>917. How long did you stay away the last time?</td>
<td>Days (if less than one month) [ ] [ ] Months (if one month or more) [ ] [ ] LEFT PARTNER/ DID NOT RETURN/ NOT WITH PARTNER……………………..</td>
</tr>
<tr>
<td>918. Why did you return?</td>
<td>Didn’t want to leave children Sanctity of marriage For sake of family/children Couldn’t support children Loved him He asked her to go back Family said to return Forgive him Thought he would change Threatened her/children Could not stay there (where she went) Other ________</td>
</tr>
<tr>
<td>919. What were the reasons that made you stay?</td>
<td>Didn’t want to leave children Sanctity of marriage</td>
</tr>
</tbody>
</table>
In their lives, many women experience different forms of violence from relatives, other people that they know and/or from strangers. If you don’t mind I would like to briefly ask you about some of these situations. Everything that you say will be kept private. May I continue?

1001. Since the age of 15 years, has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER: other than your partner/husband) ever beaten you or physically mistreated you in any way? If YES: Who did this to you? PROBE: How about a relative? How about someone at school or work? How about a friend or neighbor? A stranger or anyone else?

FOR EACH MARKED: How many times did this happen? Once or twice (1), a few times (2), or many times (3)?

<table>
<thead>
<tr>
<th>Marked</th>
<th>Father</th>
<th>Stepfather</th>
<th>Other male family member</th>
<th>Female family member</th>
<th>Teacher</th>
<th>Police/soldier</th>
<th>Male friend of family</th>
<th>Female friend of family</th>
<th>Boyfriend</th>
<th>Stranger</th>
<th>Someone at work</th>
<th>Priest/religious leader</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

1002. Since the age of 15 years has anyone (FOR WOMEN WITH CURRENT OR PAST PARTNER: other than your partner/husband) ever forced you to have sex or to perform a sexual act when you did not want to? IF YES: Who did this to you? PROBE: How about a relative? How about someone at school or work? How about a friend or neighbor? A stranger or anyone else?

FOR EACH MARKED: How
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times did this happen?</td>
<td>Priest/ religious leader 1 2 3 Other: ____________________ 1 2 3</td>
</tr>
<tr>
<td>How old were you when you first had sex?</td>
<td>Age years (more or less) [   ][   ] Not had sex..........................</td>
</tr>
<tr>
<td>How would you describe the first time that you had sex?</td>
<td>Wanted to have sex Not want but had sex Forced to have sex</td>
</tr>
<tr>
<td>When you were a child, was your mother hit by your father (or her husband or boyfriend)?</td>
<td>Yes No Parents did not live together Don’t know..........................</td>
</tr>
<tr>
<td>As a child, did you see or hear this violence?</td>
<td>Yes No Don’t know</td>
</tr>
<tr>
<td>As far as you know, was your (most recent) partner’s mother beaten by her husband?</td>
<td>Yes No Parents did not live together Don’t know..........................</td>
</tr>
<tr>
<td>Did your (most recent) partner see or hear this violence?</td>
<td>Yes No Don’t know</td>
</tr>
<tr>
<td>As far as you know, was your (most recent) husband/partner himself beaten regularly by someone in his family?</td>
<td>Yes No Don’t know</td>
</tr>
<tr>
<td>How many sisters do you have, born to the same mother, age 15-49 years?</td>
<td>Sisters 15-49 years old.... [   ][   ] No sisters 15-49 years old........</td>
</tr>
<tr>
<td>How many of those sisters have ever been married or lived with a partner?</td>
<td>Sisters ever with partner...[   ][   ] None...............................</td>
</tr>
<tr>
<td>Have any of these sisters ever been beaten or physically mistreated by their husbands or some other male partner? IF YES, PROBE: How many sisters?</td>
<td>Sisters beaten ............[   ][   ] None Don’t know</td>
</tr>
</tbody>
</table>

**[11.0] FINANCIAL AUTONOMY**

Thank you for answering these very personal questions. Now I would like to change the topic a bit and ask you some question about things that you own and your earnings. We need this information to understand the financial position of women nowadays.
1101. Please tell me if you own any of the following, either by yourself or with someone else.

<table>
<thead>
<tr>
<th></th>
<th>Yes, self</th>
<th>Yes, Others</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Land</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Your house</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>A company or business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Large animals (cows, horses, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Small animals (chickens, pigs, goats, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td>Produce or crops from certain fields or trees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td>Large household items (TV, bed cooker, car)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td>Jewelry, gold, or other valuables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i.</td>
<td>Other property, specify ___________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1102. Do you earn money?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES: What exactly do you do to earn money? ASK ALL. SPECIFY:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Job____________________________________________________</td>
</tr>
<tr>
<td></td>
<td>Selling things/ trading________________________________</td>
</tr>
<tr>
<td></td>
<td>Doing seasonal work____________________________________</td>
</tr>
<tr>
<td></td>
<td>Any other activity, specify ____________________________</td>
</tr>
</tbody>
</table>

IF LIVING WITH MAN ➔ CONTINUE
IF WIDOWED OR SINGLE ➔ Q1108

1103. Are you able to spend the money you earn how you want yourself, or do you have to give all or part of the money to your husband/partner?

<table>
<thead>
<tr>
<th></th>
<th>Self/own choice</th>
<th>Give part to husband/partner</th>
<th>Give all to husband/partner</th>
</tr>
</thead>
</table>

1104. Would you say that they money that you bring into the family is more than what your husband/partner contributes, less than what he contributes, or about the same as he contributes?

|   | More than husband/partner | Less than husband/partner | About the same | Do not know |
|---|---------------------------|---------------------------|----------------|-------------|-------------|

297
<table>
<thead>
<tr>
<th>1105.</th>
<th>Have you ever given up/refused a job for money because your husband/partner did not want you to work?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1106.</td>
<td>Has your husband/partner ever taken your earnings or savings from you against your will? IF YES: Has he done this once or twice, several times, or many times?</td>
<td>Never</td>
<td>Once or twice</td>
</tr>
<tr>
<td>1107.</td>
<td>Does your husband/partner ever refuse to give you money for household expenses, even when he has money for other things? IF YES: Has he done this once or twice, several times, or many times?</td>
<td>Never</td>
<td>Once or twice</td>
</tr>
<tr>
<td>1108.</td>
<td>In case of emergency, do you think that you alone could raise enough money to house and feed your family for 4 weeks? This could be for example by selling things that you own, or by borrowing money from people you know, or from a bank or moneylender.</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

[12.0] COMPLETION OF THE INTERVIEW

1201. We have now finished the interview. Do you have any comments, or is there anything else you would like to add?

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

1202. I have asked you about many difficult things. How has talking about these things made you feel?

□ Good/better

□ Bad/worse

□ Same/no difference

1203. Finally, do you agree that we may contact you again (within the next month) for clarification or another interview?

□ YES

□ NO
FINISH ONE- IF RESPONDENT HAS DISCLOSED PROBLEMS/VIOLENCE
I would like to thank you very much for helping us. I appreciate the time that you have taken. I realize that these questions may have been difficult for you to answer but it is only by hearing from women themselves that we can really understand about their health and experiences of violence.

From what you have told us, I can tell that you have had some very difficult times in your life. No one has the right to treat someone else in that way. However, from what you have told me I can see that you are strong, and have survived through some difficult circumstances.

Here is a list of organizations that provide support, legal advice and counseling services to women in STUDY LOCATION. Please do contact them if you would like to talk over your situation with anyone. Their services are free, and they will keep anything that you say private. You can go whenever you feel ready to, either soon or later.

FINISH TWO- IF RESPONDENT HAS NOT DISCLOSED PROBLEMS/VIOLENCE
I would like to thank you very much for helping us. I appreciate the time that you have taken. I realize that these questions may have been difficult for you to answer, but it is only by hearing from women themselves that we can really understand about women’s health and experiences in life.

In case you ever hear of another woman who needs help, here is a list of organizations that provide support, legal advice, and counseling services to women in STUDY LOCATION. Please do contact them if you or any of your friends or relatives need help. Their services are free, and they will keep anything that anyone says to them private.

END. RECORD TIME OF END OF INTERVIEW:

HOUR [ ] [ ] MINUTES [ ] [ ]

INTERVIEWER COMMENTS TO BE COMPLETED AFTER INTERVIEW

______________________________________________________________________________
### APPENDIX B: TABLE FROM CHAPTER 7

Variables associated with types of violence and overall violence

<table>
<thead>
<tr>
<th>Variable (n valid)</th>
<th>Physical p value</th>
<th>Sexual p value</th>
<th>Verbal p value</th>
<th>Controlling P value</th>
<th>Total Violence Scale p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (200)</td>
<td>.431</td>
<td>.268</td>
<td>.540</td>
<td>.239</td>
<td>.446</td>
</tr>
<tr>
<td>Education (197)</td>
<td>.673</td>
<td>.846</td>
<td>.681</td>
<td>.673</td>
<td>.480</td>
</tr>
<tr>
<td>Group Membership (197)</td>
<td>.477</td>
<td>1.000</td>
<td>*.010</td>
<td>.561</td>
<td>.164</td>
</tr>
<tr>
<td>Religion (200)</td>
<td>.247</td>
<td>.092</td>
<td>.331</td>
<td>.443</td>
<td>.429</td>
</tr>
<tr>
<td>Times Married (198)</td>
<td>.271</td>
<td>.634</td>
<td>.385</td>
<td>.750</td>
<td>.425</td>
</tr>
<tr>
<td>Patrilocality (192)</td>
<td>.385</td>
<td>.466</td>
<td>.056</td>
<td>.108</td>
<td>.067</td>
</tr>
<tr>
<td>Matrilocality (192)</td>
<td>.070</td>
<td>.359</td>
<td>.235</td>
<td>.167</td>
<td>.279</td>
</tr>
<tr>
<td>Other Wives (178)</td>
<td>*.049</td>
<td>*.047</td>
<td>*.016</td>
<td>*.045</td>
<td>*.008</td>
</tr>
<tr>
<td>How Long Positive (200)</td>
<td>.568</td>
<td>.778</td>
<td>*.025</td>
<td>.473</td>
<td>.378</td>
</tr>
<tr>
<td>How Long ARVs (199)</td>
<td>.345</td>
<td>.405</td>
<td>*.070</td>
<td>.314</td>
<td>.056</td>
</tr>
<tr>
<td>Partner positive (129)</td>
<td>.530</td>
<td>.352</td>
<td>1.00</td>
<td>.532</td>
<td>.603</td>
</tr>
<tr>
<td>Overall Health Score (200)</td>
<td>.892</td>
<td>.486</td>
<td>*.034</td>
<td>.113</td>
<td>.323</td>
</tr>
<tr>
<td>Woman drinking (198)</td>
<td>.976</td>
<td>.192</td>
<td>.776</td>
<td>.817</td>
<td>.806</td>
</tr>
<tr>
<td>Partner Drinking (194)</td>
<td>.142</td>
<td>.293</td>
<td>**.000</td>
<td>**.001</td>
<td>*.002</td>
</tr>
<tr>
<td>Partner Drunk (194)</td>
<td>*.002</td>
<td>.099</td>
<td>**.000</td>
<td>**.002</td>
<td>**.000</td>
</tr>
<tr>
<td>Having deceased children (198)</td>
<td>.887</td>
<td>.116</td>
<td>.523</td>
<td>.564</td>
<td>.414</td>
</tr>
<tr>
<td>Total Pregnancies (200)</td>
<td>.755</td>
<td>.888</td>
<td>.099</td>
<td>.079</td>
<td>.366</td>
</tr>
<tr>
<td>Husband education (179)</td>
<td>*.003</td>
<td>.664</td>
<td>.551</td>
<td>.819</td>
<td>.088</td>
</tr>
<tr>
<td>Education difference</td>
<td>.199</td>
<td>*.015</td>
<td>*.040</td>
<td>.409</td>
<td>*.020</td>
</tr>
<tr>
<td>Husband working (195)</td>
<td>.694</td>
<td>.961</td>
<td>.489</td>
<td>.687</td>
<td>.566</td>
</tr>
<tr>
<td>Age first sex (296)</td>
<td>.583</td>
<td>.788</td>
<td>.130</td>
<td>.891</td>
<td>.444</td>
</tr>
<tr>
<td>Parents hit (180)</td>
<td>.200</td>
<td>.115</td>
<td>**.001</td>
<td>.492</td>
<td>*.004</td>
</tr>
<tr>
<td>Husband’s parents hit (119)</td>
<td>.252</td>
<td>*.012</td>
<td>**.000</td>
<td>.885</td>
<td>**.000</td>
</tr>
<tr>
<td>Own land (199)</td>
<td>.070</td>
<td>.392</td>
<td>*.031</td>
<td>.442</td>
<td>.135</td>
</tr>
<tr>
<td>Own house (199)</td>
<td>*.021</td>
<td>.260</td>
<td>**.001</td>
<td>.308</td>
<td>**.001</td>
</tr>
<tr>
<td>Own business (199)</td>
<td>.240</td>
<td>.961</td>
<td>.516</td>
<td>.671</td>
<td>.618</td>
</tr>
<tr>
<td>Own large animals (199)</td>
<td>*.024</td>
<td>*.008</td>
<td>.168</td>
<td>.118</td>
<td>*.046</td>
</tr>
<tr>
<td>Own small animals (199)</td>
<td>*.036</td>
<td>.390</td>
<td>*.018</td>
<td>.204</td>
<td>*.233</td>
</tr>
<tr>
<td>Own produce/ crops (198)</td>
<td>*.032</td>
<td>.568</td>
<td>.190</td>
<td>.667</td>
<td>.237</td>
</tr>
<tr>
<td>Earns money (198)</td>
<td>1.000</td>
<td>.507</td>
<td>.464</td>
<td>.547</td>
<td>.082</td>
</tr>
<tr>
<td>Who earns more (85)</td>
<td>.397</td>
<td>.481</td>
<td>.348</td>
<td>.699</td>
<td>.940</td>
</tr>
<tr>
<td>Ever refused job because of partner (125)</td>
<td>**.000</td>
<td>*.019</td>
<td>**.001</td>
<td>**.000</td>
<td>**.000</td>
</tr>
<tr>
<td>Husband take savings (111)</td>
<td>*.040</td>
<td>.087</td>
<td>*.011</td>
<td>**.000</td>
<td>*.002</td>
</tr>
<tr>
<td>Husband refused to give money (158)</td>
<td>**.000</td>
<td>**.000</td>
<td>**.000</td>
<td>**.000</td>
<td>**.000</td>
</tr>
</tbody>
</table>

Chi Square, *p<.05, **p<.001
APPENDIX C: Characteristics of the ethnographic sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean, range)</td>
<td>36.8 (21-55)</td>
</tr>
<tr>
<td>Level of Education n(%)</td>
<td>None 6 (15%)</td>
</tr>
<tr>
<td></td>
<td>Primary 22 (55%)</td>
</tr>
<tr>
<td></td>
<td>Secondary 11 (27.5%)</td>
</tr>
<tr>
<td></td>
<td>Tertiary/University 1 (2.5)</td>
</tr>
<tr>
<td>Married n(%)</td>
<td>Maried 11 (27.5%)</td>
</tr>
<tr>
<td></td>
<td>Not married 15 (37.5%)</td>
</tr>
<tr>
<td></td>
<td>Widowed 14 (35%)</td>
</tr>
<tr>
<td>Times married (mean, range)</td>
<td>1.42 (1-3)</td>
</tr>
<tr>
<td>Patrilocal n(%)</td>
<td>15 (37.5)</td>
</tr>
<tr>
<td>Matrilocal n(%)</td>
<td>12 (30)</td>
</tr>
<tr>
<td>Polygamy n(%)</td>
<td>25 (62.5)</td>
</tr>
<tr>
<td>Time positive (mean, range)</td>
<td>2 (0-4)</td>
</tr>
<tr>
<td>Time on ARVs (mean, range)</td>
<td>1.1 (0-3)</td>
</tr>
<tr>
<td>Partner positive n(%)</td>
<td>25 (62.5)</td>
</tr>
<tr>
<td>Overall health ranking n(%)</td>
<td>Low 20 (50)</td>
</tr>
<tr>
<td></td>
<td>Medium 18 (45)</td>
</tr>
<tr>
<td></td>
<td>High 2 (5)</td>
</tr>
<tr>
<td>How often drink n(%)</td>
<td>Drinks 6 (15.4)</td>
</tr>
<tr>
<td></td>
<td>Used to 10 (25)</td>
</tr>
<tr>
<td></td>
<td>Never 23 (57.5)</td>
</tr>
<tr>
<td>Pregnancies</td>
<td>4.25 (1-10)</td>
</tr>
<tr>
<td>Children</td>
<td>2.95 (0-8)</td>
</tr>
<tr>
<td>Partner education n(%)</td>
<td>None 4 (10)</td>
</tr>
<tr>
<td></td>
<td>Primary 12 (30)</td>
</tr>
<tr>
<td></td>
<td>Secondary 19 (47.5)</td>
</tr>
<tr>
<td></td>
<td>Tertiary/ University 3 (7.5)</td>
</tr>
<tr>
<td>Partner working n(%)</td>
<td>Working 38 (95)</td>
</tr>
<tr>
<td></td>
<td>Unemployed 1 (2.5)</td>
</tr>
<tr>
<td></td>
<td>Retired 1 (2.5)</td>
</tr>
<tr>
<td>Partner drinking n(%)</td>
<td>Every day 20 (50)</td>
</tr>
<tr>
<td></td>
<td>Once or twice per week 6 (15)</td>
</tr>
<tr>
<td></td>
<td>1-3 times per month 3 (7.5)</td>
</tr>
<tr>
<td></td>
<td>Never 10 (25)</td>
</tr>
<tr>
<td>Partner drunk</td>
<td>Most days 18 (45)</td>
</tr>
<tr>
<td>n(%)</td>
<td>Weekly 2 (5)</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
</tr>
<tr>
<td>Ever injured from violence n(%)</td>
<td>Yes 22 (55)</td>
</tr>
<tr>
<td></td>
<td>No 12 (30)</td>
</tr>
<tr>
<td>Anyone try to help n(%)</td>
<td>No 8 (20)</td>
</tr>
<tr>
<td>Ever leave n(%)</td>
<td>No 9 (22.5)</td>
</tr>
<tr>
<td>Earn money n(%)</td>
<td>Yes 32 (80)</td>
</tr>
<tr>
<td>Psychological Violence n(%)</td>
<td>Little or None 14 (35)</td>
</tr>
<tr>
<td>Verbal Violence n(%)</td>
<td>Little or None 14 (35)</td>
</tr>
<tr>
<td>Physical Violence n(%)</td>
<td>Little or None 3 (7.5)</td>
</tr>
<tr>
<td>Sexual Violence n(%)</td>
<td>Little or None 13 (32.5)</td>
</tr>
<tr>
<td>Total Violence n(%)</td>
<td>Low 5 (12.5)</td>
</tr>
<tr>
<td>Gender Scale n(%)</td>
<td>Low 9 (22.5)</td>
</tr>
</tbody>
</table>
REFERENCES

Abraham, Margaret

Adelman, Madelaine

Appadurai, Arjun

Asad, Talal

Babcock, Julia, Jennifer Waltz, Neil Jacobson and John Gottman

Badawi, Aboubkar

Baer, Hans A., Merrill Singer, and Ida Susser

Bauer, H, M Rodriguez, S Quiroga, and Y Flores-Oritz


Banta JE
2001 From international health to global health. Journal of Community Health. 26(2):73-76.

Beachey, RW

Beck, Ulrich

Bernt Hansen, Holger and Michael Twaddle (editors).

Biehl, Joao

Bohannan, Paul

Bradley, Candice and Thomas Weisner


British Information Services

Brokensha, David and Peter Little.

Broude, G and S Greene
Brown, Judith K.


Burbank, Victoria.

Burkey, Stan

Busby, Cecilia

Caldwell, John C and Pat Caldwell

Campbell, Jacquelyn

Chachage, Seithy L.

Chambers, Robert

CIA

Clark, Ian

Coetzee, David, Katherine Hilderbrand, eric Goemaere, Francine Mathys, and Merleen Boelaert.

Collins, Tea

Cornia, Giovanni Andrea

Counts, Dorothy, Judith Brown and Jacquelyn Campbell (editors).

Cunningham, James Frederick
Davis, Paula Jean.

Davis, Dana-Ain


Dilger, Hansjorg.

Doornbos, Martin R.

Draper, Patricia.


Ember, Carol and Melvin Ember

Epstein, Paul and Greg Guest
Erchak, Gerald

Escobar, Arturo

Evans-Pritchard, E. E.

Fallers, Lloyd

Fallers, Margaret C.


Farmer, P.

Feldman, D. A.

Ferguson, James

Fineman, Martha and Rotanne Mykitiuk, eds.


Green, E. C.  

Gukiina, Peter M.  

Gupta, Akhil and James Ferguson  

Gupta, Geeta Rao and Ellen Weiss  

Gutierrez, Emily and Carl Kendall  

Gutkind, Peter C.W.  

Giles, Wenona and Jennifer Hyndman (eds.)  

Hanson, Holly  

Harris, Olivia  
Harris, Richard

Harvey D.

Harvey, Penelope

Harvey, Penelope and Peter Gow.

Hattori, Megan Klein and F. Nii-Amoo Dodoo
2007 Cohabitation, marriage, and ‘sexual monogamy’ in Nairobi’s slums. Social Science and Medicine. 64: 1067-1078.

Ibembe, Peter

Inda and Rosaldo

Inhorn, Marcia C.

Janes, Craig
Jewkes, R, K Dunkle, M Nduna, J Levin, N Jama, N Khuzwayo, M Koss, A Puren, and N Duvvury

Jones, Sande Gracia

Justice, Judith

Kahuna, Valli Kalei

Kaiser Family Foundation

Karamagi, CA, JK Tumwine, T TYlleskar, and K Heggenhougen

Kaye, Dan

Keane, Christopher
Keck, Margaret E. and Kathryn Sikkink

Kelly, Robert J.; Gray, Ronald H.; Sewankambo, Nelson K.; Serwadda, David; Wabwire-Mangen, Fred; Lutalo, Tom; Wawer, Maria J.

Kilbride, Philip
1979 Barmaiding as a Deviant Occupation among the Baganda of Uganda. Ethos 7(3): 232-255

Kilbride, Philip Leroy and Janet Capriotti Kilbride.

Killingray, David

Kilpatrick, Dean

Kisekka, Mere

Kizza, Immaculate N

Klein, R., and B. Wallner
2004 Conflict, Gender, and Violence. Innsburck, Germany: Studien Verlag.

Koenig, LJ and J Moore  

Korbin, Jill  


Kuhanen, Jan  

Kuper, Adam  

Kyomuhendo, Grace Bantebya and Marjorie Keniston McIntosh  

Lal, Deepak  

Lambek, Michael.  

Lamphere, Louise, Helena Ragone and Patricia Zavella (eds)  
Lateef, Shireen.

Law and Advocacy for Women in Uganda (LAW-U)

Lee, Kelley

Lee, Kelley and Anthony Zwi.

Leiter, Anne Daugherty.

Lester, David


LeVine, Sarah.

Levinson, David.

Loue, Sana

Lyons, Harriet

Mamdani, Mahmood.

Marcus, George

Mayhew, Susannah

McClaurin, Irma

McDowell, Nancy.

McGillivray, Anne and Brenda Comaskey

McGrath, Janet, et al
2009 Expanding perspectives on expanding access to HIV/AIDS medications. Society for Medical Anthropology Meeting. New Haven, CT.

McKee, Lauris.

McKnight, David
2002 From Hunting to Drinking: The Devastating Effects of Alcohol on an Australian Aboriginal Community. London: Routledge.

Migdal, Joel S.

Miller, Barbara.

Mitchell, William.

Moore, Henrietta

Moore, Sally Falk.

Morsey, Soheir
Morton, Adam David  

Mugyenyi, Peter  

Mushanga, Tibamanya Mwene.  

Musisi, Nakanyike  

Nash, Jill  

Nguyen, Vinh-Kim.  

New York Times  

Obbo, C.  

Ong, A and S Collier (eds)  


Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S. L., and Rudd, R. 2002 Relationship power, condom use and risk among women in the USA. AIDS Care, 14, 798–800.


Renzetti, Claire

Richards, A.I.

Riehl, Jonathan

Robertson, AF

Rodney, Walter

Rosaldo, Michelle and Louise Lamphere, eds.

Saltzman, Linda

Roscoe, John.
Rundall SA, McGrath JW, Mafigiri DK

Rwabukwali, Charles

Saltzman, L.

Saunders, D.

Scaglion, Richard

Schoepf, Brooke G.

Scholte, Jan Aart

Shostak, Marjorie

Slater P and D Slater

Sokoloff, Natalie and Christina Pratt. Editors

Southall, Aidan W.

Southall, Aidan W. and Peter C. Gutkind

Stewart and Robinson

Stoller, Paul

Straus, Murray, Richard Gelles, and Suzanne Steinmetz

Thornton, Robert

Tibatemwa-Ekirikubinza, Lillian.

Toren, Christina

Tripp, Aili Mari.

Tsing, Anna

Turyahikayo-Rugyema, B.

Uganda AIDS Commission Secretariat

Uganda Bureau of Statistics and Macro International Inc. (UDHS)
2006 Uganda Demographic and Health Survey 2006. Calverton, Maryland, USA: UBOS and Macro International Inc.

UNAIDS


Uzoigwe, GN

van der Straten, Ariane, Rachel King, Olga Grinstead, Eric Vittinghoff, Antoine Serufilira and Susan Allen.

Wade, Peter
1994 Man the hunter: gender and violence in music and drinking contexts in Colombia. In: Sex and Violence: Issues in Representation and

Wallerstein, Immanuel.

Wallman, Sandra
1996 Kampala Women Getting By: Wellbeing in the time of AIDS. London, UK: James Currey Ltd.

Wawer, MJ, R Gray, D Serwadda, Z Namukwaya, F Makumbi, N Sewankambo, X Li, T Lutalo, F Nalugoda, and T Quinn

Websdale, Neil

Weisner, T.S., Bradley, C., & P. Kilbride. (Eds.)
1997 African families and the crisis of social change. Westport, CT: Greenwood Press/Bergin & Garvey

Whiting, John and Beatrice Whiting

Whyte, Susan Reynolds.

Wood, Kate, Helen Lambert and Rachel Jewkes.

World Health Organization (WHO)


2005  WHO Multi-country study on Women’s Health and Domestic Violence. Geneva, Switzerland.

Young, Crawford

Zorn, Jean.

Zraly, Maggie