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Sex, Gender, and Culture: The Emergence of Structural Violence While Seeking a Sexual Health Transformation in Uganda

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Abstract

With the 2nd highest fertility rate in the world and the 5th highest population growth rate, Uganda's ever increasing number of inhabitants is becoming a hindrance to the nation's ability to develop socially and economically. Despite the push for increased family planning services and sexual health services by the international community and national government, translating words into effective action has been met with cultural beliefs and behaviors blocking the road to changing sex practices within Uganda. Through conversations with the employees of Musana Community Development Organization in Iganga, Uganda, this research explores the complexity of the barriers standing in the way of an effective sexual health transformation in this East African nation. The results reveal just how deeply culture is embedded in the hearts and minds of the local people. The biggest deterrent preventing effective sex education is the gender disparity. Men, in particular, are reluctant to face their own participation in gender based structural violence. They are also reticent to see the need to become allies on behalf of the women in their community. Additionally, the research discloses the depth of the silence surrounding sex conversations with adolescents, opening the discussion regarding how to move away from teaching abstinence while maintaining cultural propriety.

TABLE OF CONTENTS

Chapter 1: Introduction

As I walk through the streets of Iganga, Uganda, not a moment goes by without a child running up to greet me enthusiastically. Child after child, they are bare-foot, half-naked, with food all over their faces and dirt smeared across their bodies. One after another, they keep coming endlessly. They are everywhere. Their presence seems to have increased over the years. I take a moment to focus on the women, sitting idly nearby. I recognize their glow of yet another pregnancy and contemplate their story. Every woman has one. Are the children growing inside them the result of gender inequalities and structural violence that casts a shadow over the lives of women in Uganda every day? Did they want this pregnancy to happen or is it another obligation towards their role as women in society? I have so many questions. As a nation, Uganda has been progressing in development, but it has a long way to go. How much of the gap in solving the high fertility and population growth crisis lies in gender inequalities? Is the high fertility rate and population growth standing in the way of this small landlocked nation from developing further? I have watched the news and read the newspapers pushing the multiple campaigns for preventative measures of unwanted pregnancies and sexually transmitted disease such as condom use, birth control, and family planning. Yet I wonder how effective these campaigns are considering the growing number of little faces, unwanted pregnancies, and hidden baby bumps I encounter on a daily basis.

Uganda has the 2nd highest fertility rate in the world with 6.2 children per woman. This East African nation also holds the 5th highest growth rate in the world at 3.2 percent per year (United Nations International Children's Emergency Fund [UNICEF], 2012). In fact, the population jumped from 33.6 million in 2013 to 37.8 million in 2014 (World Population Review, 2014). At this rate, the population is expected to increase fivefold, pushing Uganda to the top 10

most populated nations in the world by 2100 (Natakunda, 2013). The growth of population is not driven by the desire for more children (which has declined in the past 15 years), but by the lack of family planning and the high rate of unwanted births. Ministry of Health statistics show that three out of ten women in Uganda, who need to stop or space their next pregnancy, are not using any contraception. As a result, there are about 700,000 unplanned pregnancies in Uganda every year (Matler, 2013). Uganda also comprises the world's second youngest population after Niger with 50 percent of its people being under the age of 15 (Klein, 2013). When that 50 percent grows up and starts families of their own, the population will multiply even more.

It is important to recognize that Uganda has made significant progress over the past two decades within macro-economic and human development. According to the World Food Program (n.d.), the proportion of people living in poverty decreased from 38.8 percent in 2002/2003 to 24.5 percent in 2009/2010. However, Uganda continues to be one of the poorest countries in the world, with a Gross National Income (GNI) per capita of US$1,124, ranking 161st out of 186 countries on the 2013 United Nations Development (UNDP) Human Development Index (World Food Program, n.d.). Sixty seven percent of Ugandans are living on $1.20 to $2.40 per day (Anguyo, 2013). Illiteracy is also high in Uganda as 25.4 percent of Ugandans cannot read or write (UGO News, 2013). According to United Nations Educational, Scientific, and Cultural Organization (UNESCO) (2012), the dropout rate of primary school is also very high at 68 percent. A study by Demographic and Health Survey Education Supplement found that Universal Primary Education caused a 58 percent increase in primary education in just the first year; however, there was a 10 percent drop in the probability that an educated child in a public primary school could pass a reading test (UNESCO, 2012). In the rural areas of Uganda, 79.9 percent of homes are child-headed households. The rise in the proportion of child-headed

households and child laborers means a rise in percentages of the illiterate, early pregnancies, and related consequences such as infant and maternal mortality rates, increased incidence of those who are infected by sexually-transmitted diseases (STDs) and HIV/AIDS, and drug abuse (UNESCO, 2005). Also, 12 percent of marriages occur before the age of 15; 46 percent of marriages occur before the age of 18 (Schlecht, Rowley, & Babirye, 2013). These numbers mostly reflect the fact that girls are forced into arranged marriages, increasing the rate of illiteracy and school dropout. Considering all the aforementioned information, it remains obvious that Uganda requires a lot of improvement in multiple areas of development in order to provide for its people. The increase in population makes the task of developing even more daunting.

Uganda's challenges are not exactly being ignored. Sex education in particular is being pushed through campaigns and advertisements created by the international community, the Ugandan government, and non-government organizations. But how effective are these campaigns? Despite the increase of campaigns promoting family planning and sex education, fertility and population growth rates are still rampant. The obstacles getting in the way of effective education shed light on some of the cultural complexities surrounding sex practices and beliefs. Culture is a significant challenge affecting development, and the solution goes beyond the obvious promotion of sexual health and family planning services because the obstacles are deeply woven into social practices and beliefs.

As I have been exposed to Uganda's traditions, cultural norms, and social practices, I have recognized the prevalence and importance of sexuality on a deep level. Sex is everywhere in Uganda, from traditional dance, music, storytelling, and even traditional gender roles and responsibilities. Within these belief systems lies the foundation of obstacles preventing effective

sexual health transformation that include an opposition towards condom use and how sex remains a taboo topic. Although it is everywhere, sex is never talked about or even acknowledged publicly, preventing peoples' openness to seek sexual advice and services. Furthermore, the most important barrier is gender roles that define men and women's sexual responsibilities. Women continue to have less control over their bodies due to their inferior status within society. Indeed, there is a huge push for women empowerment by the international community, but this coincides with a lack of understanding of the cultural implications surrounding what women actually go through in societies like Uganda. Additionally, the push for such empowerment seems contradictory as the front-running nations in such campaigns, mainly the Western powers, are doing the most damage in creating the infrastructure that has given women a subordinate status reflected in their inferior sex roles, making them victims of structural violence. There has been a lot of talk by the international community about the need for change; however, how can words become action in creating effective change within local practice? With this, it is crucial to consider who defines policy agendas when tackling the sexual health transformation in Uganda, who implements them, and what is the local consensus surrounding these issues? Can we expect an effective sexual health transformation when the international community and Uganda's government fail to recognize cultural contexts they are immersed into and the struggles of the majority of women within Uganda? The quest, then, is to learn what locals have to say about sexual health in order for the Ugandan community to start overcoming obstacles towards a healthy and informed sexuality.

Chapter 2: Literature Review

Family Planning and Sex Education- A Step Forward in International Development

In 2000, the United Nations established the Millennium Development Goals (MDGs), which aimed to eradicate poverty by 2015. These goals included the eradication of extreme poverty and hunger, the achievement of universal primary education, the promotion of gender equality and empowerment of women, the reduction of child mortality, the improvement of maternal health, combatting HIV/AIDS, malaria, and other diseases, and ensuring environmental sustainability (United Nations Population Fund [UNFPA], n.d.). Although none of the original MDGs referred explicitly to family planning and sexual education, sexual health was recognized as having an essential role in achieving all of the aforementioned goals. In 2007, MDG 5.B was adopted by governments to achieve universal access to reproductive health, calling for the increase in contraceptive prevalence, providing prenatal care to pregnant women, lowering the adolescent birth rate, and reducing the unmet need for family planning. Later in 2009, MDG 5 included indicators of family planning, emphasizing its role in the promotion of maternal and child health (United States Agency for International Development [USAID], 2009). According to the United Nations Development Program, substantial evidence suggests that reduced population growth rate and investments in reproductive health, education, women's empowerment and gender equality reduce poverty. With this, universal access to reproductive health information and family planning services by 2015 was pinpointed as an essential component for achieving the MDGs. Furthermore, the Program of Action adopted at the International Conference on Population and Development (ICPD) in Cairo is based on the central premise that the size, growth, age structure and rural-urban distribution of a country's population have a significant

influence on its development projections and on the living standards of the poor (UNFPA, 2014d).

Cleland et al. (2006) reported that the promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32 percent of all maternal deaths and nearly 10 percent of childhood deaths, as well as contribute to women empowerment, universal primary education, and long-term environmental sustainability. The Population Reference Bureau also recognizes family planning as a best buy among health investments. Not only is it one of the most cost-effective and high yield interventions that exists today with the ability to reap immediate health benefits, it also can have a long term impact providing social and environment benefits that will extend to the future generations (Ashford, Clifton, Gribble, & Smith, 2009). With all of this in mind, it is important to remember the multiple dimensions of poverty. According to Anand and Sen (1997), "The need for multidimensional view of poverty and deprivation guides the search for an adequate indicator of human poverty" (p. 5). The multidimensions of poverty include health, education, and living standard. Impoverished people are not only deprived of income but of services, resources and opportunities. According to the United Nations Population Fund (UNFPA) (n.d.), the countries with the highest level of poverty also have the most rapid population growth and highest fertility levels. The countries that have invested in reducing fertility and mortality through universal health care, including reproductive health, have economically expanded. By investing in people, empowering women and men with education, equal opportunities and the means to determine the number, timing and spacing of their children, the conditions necessary to allow the poor to break out of the poverty trap are created, overcoming the multidimensions of poverty discussed by Sen (UNFPA, 2014d).

In the second half of the 1900s, the earth's population more than doubled to six billion. It is anticipated to grow to more than nine billion by 2050, with almost all of the net increase occurring in poor countries that are less capable of absorbing this expansion (Barot, 2008). If families were more in control of the number of children they have, population growth could be curbed, and poorer nations would have the opportunity to improve in many key developmental areas. One of the most valuable benefits of family planning and sex education is the enhancement of women's health and empowerment paving a way forward for nations' further societal advancements. Other benefits include creating a stronger family structure that can pull families out of poverty, saving the lives of children worldwide, adding to the security of nations in terms of providing for inhabitants, controlling sexually transmitted disease, and aiding in the sustainability of the environment.

Initially, it is essential to understand that poverty often carries a woman's face as women comprise the large percentage of people who live in poverty worldwide. The worst forms of poverty have been attributed to the lack of status, education, and opportunities for women leading them to early marriage and repeated pregnancies; a lack of basic health care facilities and family planning services leading to high child and maternal mortality; and agriculture credit and marketing policies that discriminate against women (Haq, 1995). As a result, research shows that women's empowerment through education, health care, family planning services, and access to means of production is the way forward in breaking the cycle of poverty (Haq, 1995). Empowering women in the Global South is the only realistic and long term solution to helping them and the countries they live in out of poverty. Offering women family planning services is a fundamental tool for empowerment as it can save their lives, give them control over the spacing of children, enable them to avoid unwanted pregnancies and illegal abortions, and further their

opportunity to get an education and enter economic productive roles within their communities.

With the increase of family planning, women's reproductive health improves significantly. Initially, it is important to recognize that women living in poverty face higher risks of maternal mortality because they are more likely to lack the services and health care for safe births (USAID, 2009). In the Global South, a woman's lifetime risk of dying due to pregnancy and childbirth is 1 in 75 compared to 1 in 7,300 in the Global North, making the risk almost 100 times higher. In sub-Saharan Africa, the risk is even greater as the risk of maternal mortality is 1 in 22. It is estimated that of the 536,000 maternal deaths that occur each year, 99 percent happen in the Global South, of which 86 percent are in sub- Saharan Africa and South Asia (Ashford, Clifton, Gribble, & Smith, 2009). Many of these deaths arise due to early pregnancies, coinciding with early marriage as young brides are pressured to have children early. According to USAID (2009), early childbearing is common in developing countries where women under the age of twenty years old and who belong to the poorest wealth quintile have much higher levels of early childbearing than those in the wealthiest quintile. There is strong evidence that very early pregnancies increase the risks of maternal mortality and suffering as young mothers often have not grown to their full height or pelvic size. Maternal death rates for young women ages 15 to 19 are twice as high as for older women. Girls aged 10 to 14 are five times more likely to die of maternal causes than women aged 20 to 24. Prevalence of early pregnancies is especially high in sub-Saharan Africa where surveys show that 28 percent of women aged 20 to 24 had given birth by age 18 (Ashford, Clifton, Gribble, & Smith, 2009). In addition, early pregnancy can decrease nutritional reserves in young girls, causing them to suffer from malnutrition, increasing the risk of maternal mortality (USAID, 2009).

Unintended pregnancies can also lead to serious health risks. An unintended pregnancy is

defined by the Center for Disease Control and Prevention (CDC) (2010) as "a pregnancy that is either mistimed or unwanted at the time of conception" (p.1). There are approximately 80 million unintended pregnancies occurring each year, of which 42 million end in abortion (Ashford, Clifton, Gribble, & Smith, 2009). An estimated 20 million of those abortions are performed in environments lacking minimal medical standards or by personnel lacking necessary skills, resulting in 67,000 deaths annually and a high prevalence of disability (USAID, 2009). In Africa, one-fourth of unsafe abortions are performed on young women aged 15 to 19. These unsafe abortions are one of the leading causes of deaths for teenage women (Ashford, Clifton, Gribble, & Smith, 2009). Family planning can prevent these high-risk and unintended pregnancies, and in the long run, save women's lives as it reduces the route to abortion and unsafe abortions at that (Barot, 2008). In the Global South, it is estimated that 137 million women who want to avoid pregnancy are not using family planning due to lack of knowledge about the risk of becoming pregnant, fear of side effects in using contraceptives, opposition of family planning from their husbands, family members, or religious leaders, or lack of family planning services (Ashford, Clifton, Gribble, & Smith, 2009). Theoretically, with effective family planning services, all these barriers could be overcome, preventing one in three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing all together if they have reached their desired family size (Ashford, Clifton, Gribble, & Smith, 2009).

On a human rights level, family planning enables women to control their own bodies and reproductive practices, promoting their own development as they are allowed to participate more socially and politically within their communities. As mentioned previously, early childbearing is common in the Global South often times while girls are still in school. In many societies, girls

are expelled from school when they are pregnant and if they return after giving birth, they face stigma and adjustment problems that affect further academic attainment. As a result, girls often lose the opportunity of getting an education, leading them to work in the informal sector where they are paid under the poverty line because they lack skills and education (USAID, 2009). According to the United Nations Population Fund, when women have fewer pregnancies, they receive more education and economic opportunities. Also, when they are more educated, they tend to have fewer children and participate more fully in the labor market. Both of these instances can lead to higher family income (UNFPA, 2014d). In addition, when women can negotiate their reproductive health decisions, they exercise their rights with men, which in return can lead to increased decision-making in their households. As a result, high fertility rates and low prevalence of contraceptives create a barrier for women to break out of poverty. With family planning, they are able to acquire control over their bodies and gain access to more opportunity through education and market opportunities (Haq, 1995).

Family planning and sex education are moreover essential in building socially and economically stronger families, helping them out of poverty. According to Barot (2008), it enables families to choose the number of children they want, as well as the timing and spacing, with a better ability to plan for their lives and the investment in their children's nutrition, health, and education, all of which feed into fighting the risk of falling into poverty. Cleland et al. (2006) also supported these claims through their findings that households with many children are more likely, over time, to become poor and less likely to recover from poverty than families with only a few children. They also found that children who come from large families are more likely to be malnourished and receive fewer educational opportunities than those from smaller families. USAID (2009) additionally reported that large family size affects how much the family invests in

children. For example, poor parents may not be able to afford to send all of their children to school. Often times they will only send their oldest and youngest sons for an education, keeping their daughters at home to care for younger siblings. Children resulting from unintended pregnancies also have a less likely chance of attaining an education than intended children (USAID, 2009).

Children from poor households are less likely to stay in school and perform poorly in their classes (USAID, 2009). On the other hand, many poor families choose to have multiple children in order to help with household chores and agricultural labor. These children lack the opportunity to gain an education, which in the long run becomes a burden to the family because as nations develop with the demand for highly educated and skilled workers, these families lose the prospect for these potential returns. According to the United Nations Population Fund (UNFPA) (2014d), because smaller families share household income with a smaller number of people, average per- capita income increases, giving families the ability to spend more on each family member.

In addition to providing families the means to invest in children's education, family planning also ensures better health for children, saving their lives. Although child survival has improved greatly, more than 9 million children in the Global South still die annually before reaching their fifth birthday (Ashford, Clifton, Gribble, & Smith, 2009). Ashford et al. (2009) showed that infant and child mortality rates decrease with family planning. For instance, family planning can help women wait at least two years before having another baby, reducing the risks associated to back to back births that lead to newborn, infant, and child deaths. As mentioned earlier, family planning can reduce early pregnancies, which can also reduce infant mortality. Infants born to adolescent mothers are at high risk of death due to premature birth, difficult labor,

and low birth rate (USAID, 2009). In fact, the mortality rate for infants of mothers under twenty years old is 35 percent higher than for infants of mothers between twenty and thirty years old (Ashford et al., 2009). With the increase of family planning services, these deaths of infants and children can be eliminated.

Fertility and development also have a significant link to security within nations. As populations expand, resources necessary for people's survival such as food, housing, education, and jobs may become scarce. With a more controlled population growth, nations can ensure a sufficient supply of those resources (Barot, 2008). According to the UNFPA (n.d.), lower fertility and slower population growth temporarily increase the relative size of the workforce, opening what they call the "demographic window" that results in higher productivity, savings, and growth. This window allows the working age population to make investments to spur economic growth and help reduce poverty, instead of using their savings to take care of dependents. Within another generation, the window closes as the population ages and dependency increases again. For poor nations, where fertility remains high, the demographic window will take time to open, but an increase in investments towards family planning and reproductive health can hurry its arrival and prepare for future economic improvement. The UNFPA (n.d.) also recognizes the economic slowdown and food security crisis that can be helped with a decrease in population growth.

The expansion of population is additionally affecting the environment with the increase of urbanization, increasing carbon emissions, deforestation, and the pollution of air and water (Barot, 2008). The UNFPA (n.d.) acknowledges with population control promoted through sex education and family planning services, the sustainability of the environment is better ensured. The United Nations General Assembly (1996) discussed how urban settlement holds a promise

to aid in the development and in protecting the world's resources through the ability to provide for large numbers of people. However, harmful growth patterns of production, consumption, and land use are hurting the natural environment. Contamination of soil, air, and water, the wasting of resources, and the destruction of natural resources are the result. Human settlements are causing a loss of biodiversity, limited water supply, sanitation, and drainage. They are also dependent on toxic and non-renewable energy fuel sources. All of these negative effects accelerate with the increased number of people and inhibit sustainable development (UN General Assembly, 1996). These forecasts and trends indicate that family planning can help limit population growth, aiding in environmental sustainability.

Sex education and family planning services lastly promote condom use protecting against sexually transmitted diseases including HIV/AIDS (Barot, 2008). Every day, more than 5,700 people contract HIV. Nearly 240 individuals get the virus every hour. In 2013, an estimated 2.1 million people were newly infected. Worldwide, there are now more than 35 million people living with HIV, 3.2 million are under the age of 15. Also, in 2013, 1.5 million people died of AIDS (amFAR, n.d.). More than two-thirds of the world's infected population lives in sub-Saharan Africa, where HIV/AIDS is mainly transmitted through heterosexual contact. Women are found to make up the higher share of new HIV cases because they are more susceptible to contracting the virus. In fact, 59 percent of adults with the sickness in sub-Saharan Africa are women (Avert, n.d.). In addition, 2 million children are living with the virus; 90 percent of these cases are due to mother-to-child transmission through pregnancy, birth, or breastfeeding (Ashford, Clifton, Gribble, & Smith, 2009). The UNFPA (n.d.) stated that the HIV pandemic is killing large numbers of people in their most productive years, increasing the ratio of dependents to the working age population. As a result, family planning is the most successful HIV

prevention measure because it can educate couples about the use of condoms, preventing transmission, and avoiding unwanted pregnancies for HIV positive couples. By reducing the number of HIV infections, the number of deaths from AIDS decreases.

Research clearly indicates the link between social and economic benefits and reproductive health through family planning and sex education worldwide. As a result, the international community has responded with multiple initiatives to help aid in developing a sexual health transformation in the societies that need it the most. Some of these initiatives will be discussed in the following section.

International Initiatives to Promote Family Planning

Internationally family planning and sex education has been recognized as a necessity to help not only developing nations advance, but has been acclaimed as vital for the continuation of the world's existence (Barot, 2008). The MDGs are one example of international efforts to help alleviate poverty, with some emphasis on universal reproductive health with MDG 5B. Other efforts include the Family Planning 2020 (FP2020) initiative, the advocacy toolkit created by USAID, the Program of Action agreed to at the International Conference on Population and Development, and International Planned Parenthood Federation programs. Through these initiatives, the international community aims to improve access to reproductive health services, in the long run, aiding in the development of nations.

FP2020 originated from the London Summit on Family Planning in 2012 when leaders from around the world committed to expanding access to high-quality contraceptives for 120 million women and girls in the world's poorest nations by the year 2020. More than 30 countries made commitments to FP 2020. Thus far, 77 million unintended pregnancies have been averted, 125,000 women's and girls' lives saved, and $1.3 billion US have been provided by donor

governments to go towards family planning. FP2020 functions through coordinating and building on already existing partnerships and architecture with organizations, frameworks, and mechanisms already in place at both the global and national level (FP2020, 2014).

The advocacy toolkit created by USAID (2010) was developed to assist countries in accelerating family planning advocacy efforts. The toolkit contains eight briefs: an update on population and family planning in sub-Saharan Africa, four briefs to aid in communication with influential audiences, two briefs on advocacy strategy development and working with the media, and a list of materials, manuals, and internet resources. The kit has step-by-step procedures in helping countries educate and mobilize advocacy programs that promote family planning with the goal of improving access to reproductive health services and lower high fertility and drastic population growth (USAID, 2010).

The Program of Action agreed to at the International Conference on Population and Development in Cairo, Egypt in September 1994, highlights four qualitative and quantitative goals. The conference included over 20,000 delegates from various governments, organizations, and agencies worldwide to discuss population issues including immigration, infant mortality, birth control, family planning, and the education and protection of women. The outcome of this conference was a framework similar to the MDGs. The goals include universal education in all countries by 2015, reduction of infant and child mortality, reduction of maternal mortality, and access to reproductive and sexual health services including family planning (UNFPA, 2014a).

International Planned Parenthood Federation (IPPF) works in 172 countries globally empowering women, men, and youth to access sexual and reproductive health information, education, and services through 65,000 locations. The services that IPPF supports include family planning, abortion, maternal and child health, and sexually transmitted infections and HIV

treatment, prevention and care (IPPF, 2013). Efforts made by IPPF help millions of the most vulnerable and impoverish populations avoid unsafe childbirth, unprotected sex, unsafe abortion, and STI and HIV related illnesses, stigma, and discrimination. A significant part of IPPF's efforts include fighting for policies that emphasize the right to sexual and reproductive rights on the local, national, and global level.

Overall, the international community has made progress in recognizing the importance of family planning and reproductive health in order to aid in the development of the Global South. As a result, the number of available services has gone up as women, men, and youth are slowly but surely receiving access to contraceptives and family planning programs. However, there are still extreme barriers standing in the way of sufficient success in a global sexual transformation. Although efforts are being made to push family planning on a global level, there is a gap in how the international norms that emphasize creating a sexual transformation can become local practice. The next section explores these challenges, emphasizing the disparity between international theories becoming local practice.

International Norms' Failure to Become Local Practice

The international community has recognized family planning and reproductive health as a critical component in the development of peripheral countries and the stabilization of the world's population. Pinpointing the need for sexual health transformation is a significant step; however, there is a gap in translating international norms into local practice. Understanding how norms are developed illuminates some of the challenges embedded in the process. Finnemore and Sikkink (1998) defined norms as standards of appropriate behavior, determining three processes needed to becoming globally accepted. These stages include the global norm emergence in which relevant actors and the general public become aware of the norm, followed by states

institutionalizing the norm and other states following it, whether they are convinced by it or not (as long as the powerful states approve it), and finally the implementation of the norm in domestic settings. This section links the difficulty of international norms translating to community action in multiple areas of development with the international push for a sexual health transformation and the barriers that exist in making this drive effective on the local level. The gap exists when considering who is defining international norms and policies, the clash of international norms in the contextualization process to match culture, the homogeneity that exists within international norms, as well as the contradictions that are presented through international norms.

The first criticism of international norms becoming local practice is the consideration of who is defining what constitutes a norm. In the research of MacKenzie and Sesay (2012), the authors claimed that "the story" of international norms is a Western, white version. This Western perspective claims that "agents" and "structures," referring to the states and the global norms, interact with equal exchanges, with a denial of the marked economic and political inequality between global actors. On the contrary, these international norms do not take into account the imbalances that exist within global economics in which nations in the Global South rely on international aid and conditional aid, constraining their own positions on international opinion. Zwingel (2012) discussed the difference between states that embrace the norm and states that accept it because of opportunism. These reactions to the norms pose very different outcomes in implementation. A number of studies have shown the weakness of poor nations within the conversation of international norms as they face international financial and trade institutions (Fall, 2001). They may accept norms, but that does not necessarily mean that they believe in them. Therefore, the controlling power of establishing norms and forming the political identity of

the collective falls in the hands of the powerful nations, not necessarily reaching very far into the peripheries of the collective (Hannerz, 1996). In addition, Kothari (2001) criticized how "local" knowledge is used in development policies as though it can be "found" and represented. More research acknowledges that with the claim of understanding the "local," in reality, development actors define and construct the local with their own biases and project objectives (Mohan & Stokke, 2000; Mackenzie, 2009).

Scholars have further discovered that with transnational organizing that intends to strengthen international dialogue with the goal of triggering domestic change, domestic movement actors have been excluded from the process (Friedman, 1999; Alvarez, 2000). However, it is the involvement of the domestic actors that transforms change into a reality; therefore, their involvement is essential. In Foley's (2004) research on gender equality in Malaysia, the scholars discovered that transnational women's networks had a lower impact on gender equality than nationally anchored efforts. It was the local efforts that had the greater effect. Risse, Ropp, and Sikkink (1999) supported this finding with the study's analysis of international norms' dependence on domestic and national actors, being that the success once again rests on the involvement of domestic and local actors. This accomplishment lies in the understanding of culture and context that domestic actors take into account while implementing international norms, leading to the next point, the essential component of contextualizing international norms to be culturally appropriate.

A significant barrier to the enactment of translating international norms from the global to the local is related to culture. Merry (2006) has focused her research on the need for local activists to translate global human rights into a language and content that fits with the context so it will be meaningful to people that exist thousands of miles away from where such laws are

created. She calls this appropriation and translation "vernacularization." A focus of her analysis is the contradictory demands placed upon the translators who get stuck in between the global and local contexts as well as the problems with power and agency. Merry mainly focuses on this discrepancy in terms of human rights, and more particularly with women's rights. Zwingel (2012) additionally concluded that the most important and challenging part in vernacularization is not to translate concepts into a legal framework, but into culturally understandable and acceptable norms for the context. The barriers in doing so rest in converting both cultural concepts and the sources of these concepts like language and customs into the correct system of meaning to enable cross-cultural understanding (Rubel & Rossman, 2003).

It is also key to consider how international human rights and domestic culture can clash within societies, creating a significant hurdle in the implementation of norms. Merry (2006) in particular, looked at the United Nations, NGO members, and state representatives that uphold universal standards of human rights that are considered by these powerful actors as non-negotiable. It is in these instances that culture and international norms conflict because cultures that protect human and gender rights are accepted and even valued whereas cultures that permit gender and human inequality are not. Furthermore, in the conversation about gender equality, Merry (2006) looked at cases in Hawaii and Hong Kong in which women think of themselves as mother, wives, and sisters whose rights are prescribed in kinship norms. Some of these cultural and gender roles limit their inheritance. With the movement to grant women inheritance rights, there lies an incompatibility regarding their role as wives, mothers, and sisters with that of autonomous citizens. If forced to choose between these two identities, these women may choose their cultural identity which could, in turn, cause them to lose the opportunity for their rights of inheritance.

International norms can moreover generalize culture through policies and action, coming across as being parallel to neo-colonialism. Kamrani (2007) argued that although existing NGOs are heterogeneous, they are advocates for a hegemonic framework that they pressure powerful state actors to grasp. These NGOs may as well be part of a hegemonic international coalition of international organizations, powerful governments, and donor organizations, imposing ‘‘liberal democratic and neo-liberal economic policies which by many in the developing world are seen as nothing more than colonizing projects”’ (p. 4). Analysis of international NGOs indicates that they receive a significant amount of international funding that is often conditional. As a result, instead of NGOs being innovative and proactive by themselves, they are the product of ‘pro-NGO norm” (Reiman, 2006). This neo-colonizing image has created a very low rate of acceptance by the local community (Bagic, 2006). In fact, NGOs may form on the premise of resisting international norms, fostering a culture of domestic counter-hegemony (Zwingel, 2012). Accordingly, some NGOs refrain from norms to prevent the appearance of hegemony. Savery (2007) also argued that the general pattern for diffusing norms within society is not productive. On the contrary, the different factors within the state need to be considered in relation to norms.

The contradictions that exist within international norms have also become an obstacle in accepting norms within domestic contexts. Merry (2006) questioned whether the idea of human rights is largely the creation of the Western world, parallel to imperialism. She identified human rights as a civilizing process, similar to the rhetoric of colonization, classifying them as contradictions of the West. She used the example of T-shirts baring slogans to protect human rights, acknowledging that these very t-shirts were most likely manufactured in sweatshops. This example portrays the contradictions of profiting from a t-shirt that advocates for human rights while simultaneously violating human rights as the existence of the t-shirt may be the product of

poor labor conditions. Additionally, with the push of international norms that support human rights, there lie contradictions with coinciding modernity. Uyl (2005) explained the reappearance of dowry in India as a reaction to the external influence of capitalism and materialism. The wealthiest families in India originally only practiced the tradition of marriage with dowry. However, with modern capitalism, dowry became a way of accumulating capital and spread to even the lower classes within Indian society (Alvarez, 2000; Friedman, 1999). This can be portrayed as contradictory as international capitalism expanded the practice of dowry, promoting the treatment of women as an item that can be bought and owned, while simultaneously the international community pushed for gender equality.

Contradictions that exist within international norms can further be revealed within the idea of culture and gender inequalities being barriers of norms becoming local practice. Culture has often been defined as local. However, the idea of the local as culturally bound and explicit is deceptive. Anthropologists have claimed that the production of culture on the contrary is always a transnational enterprise, as culture has been shaped in many ways by colonization and evolving into what it is today (Wilson, 1996). Merry (2003) recognized that when the international community defines culture as the primary source of women's rights violations, recognizing culture as belonging to the "other," it is contradictory because so much of culture has been shaped by transnationalization through colonization. Likewise, Savery (2007) looked at the push for international norms regarding gender equality, emphasizing the contradictions that exist in the gender biased corporate identity. Looking at institutionalized norms, there still exist gender hierarchies and differentiation that act as a barrier to the diffusion of norms pushing for gender equality. The contradictions, therefore, lie in the push for gender equality by institutions while simultaneously perpetuating the hierarchal gender dynamic (Tickner, 2001).

In summary, translating effective international sexual health norms into local practice is challenging. Central is the need to acknowledge who has shaped these norms and their embedded assumptions. The major actors are in fact primarily controlled by the West. The United Nations, International Planned Parenthood, etc. are mainly influenced by the Global North. Also, looking at how the international push for family planning is contextualized based on differences in culture is lacking. For example, pushing condom use in places that have cultural myths and opposition towards using condoms is not appropriate. In addition, most of the methods of pushing family planning and sexual health are in the form of what has been successful in Western societies. However, the generic Western methods cannot work in places that have different values regarding talking about sex or using different methods of birth control. Lastly, pushing a sexual health transformation, in a sense, is contradictory as the international community pushes women empowerment through campaigns and policies, yet the front-running nations in such campaigns are simultaneously feeding into the structural violence that leads to women's subordinate status. The next section will analyze structural violence and its effect on gender, reflected in women's inferior sex roles.

Structural Violence

While the expression of violence is often most noticeable at the relational level, violence theorists now argue that the origins of interpersonal violence is rooted in larger societal norms and practices. In 1969, conflict theorist, Johan Galtung, coined the term "structural violence" to describe the invisible phenomenon that often shapes the lives of the poor and marginalized. In his argument for structural violence, Galtung broadened the concept of violence from direct violence that takes place by an actor to indirect violence that lacks an actor but is embedded in the structural fabric of society. He explained that structural violence is "the difference between

the potential and the actual, between what could have been and what is," recognizing it as "unequal power and consequently as unequal life chances" (Galtung, 1969, p. 167 &171). He considers the lack of resources that help develop oneself to the full human potential, blaming the systematic exclusion of one's group. Direct violence, he contended, is horrific and its brutality gets attention. On the other hand, structural violence is indirect and is almost always invisible. According to Samantroy (2010), it is embedded in ever-present social structure and is almost normalized by routine and stability. The world does not recognize that this structural violence produces death and suffering as much or even more than direct violence. It just takes place slower and subtly, is more common, and is almost impossible to repair as it is rooted in societal structure.

Anthropologist and physician, Paul Farmer (2003), built on the idea of structural violence:

> Structural violence is one way of describing social arrangements that put individuals and populations in harm's way… The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people … neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress. (p. 2)

Structural violence, according to Farmer, refers to suffering that is "structured" by history and economic drive that through routine, ritual, or life in general, create norms or expectations within society and are pushed by human agency. It supports the idea that choices and opportunities are

limited due to racism, sexism, political violence, and grinding poverty. The idea of structural violence as described by Galtung and Farmer becomes key in understanding the various dimensions of violence.

Structural violence can be described as lacking access to power to protect oneself from detrimental effects of the economic, political, and social order. In the Global South especially, children are often times pinpointed as the most invisible and innocent victims of society's structural violence. If this is true, then so are their mothers (Samantroy, 2010). Looking at health care, political power, legal standing, and economic opportunity, females receive fewer benefits than men all around the world. This finding supports Galtung's (1969) argument of the link between structural violence with social injustice in terms of how society distributes resources unfairly, resulting in inequality especially between race and gender.

Gendered structural violence is deeply embedded in the historical established gender roles throughout human existence, as women have been inferior to men. Theorists have continuously attempted to explain the origin of this gender dynamic that leaves women as subordinate to men. For example, Mill and Mill (2009) offered a biological explanation for women's inferiority. They argued that the superior strength of men has existed since the very beginning of societal creation, holding that women's sexual attractiveness comes from "meekness, submissiveness resignation of all individual will into the hands of man" (Mill & Mill, 2009, p. 10). Main and Bachofen in the 19th century gave an anthropological view claiming that patriarchal authority was the original and universal system of social organization (as cited in Samantroy, 2010). A more critical Marxist theory established that private property weakened a woman's status, as she became the "slave" used for sex and child production (Samantroy, 2010). These theories portray the complexity of gender inequality. There are many factors involved in

the inferiority of women within societal structure reflecting historical power relations that include socio-economic forces, the family institution where men dominate their wives, sex roles, the belief of inherent superiority of men over women, and cultural sanctions of tradition where women and children were denied independent social status (Samantroy, 2010).

There are several ways gendered structural violence is revealed within particular ideologies of culture. Societies that have a strong patriarchal culture exemplify this claim. With patriarchal traditions like dowry and the male dominated belief in the weakness and dependence of females on their male counterparts, structural violence is revealed (Cross, 2013). In these societies, men are believed to have entitlement and ownership over women. The concept of men owning women not only gives them control over money and authority within the home but also gives them the power over women's sexuality (Samantroy, 2010). As a result, women are vulnerable to suffering due to their lack of voice, freedom to come and go as they please, domestic abuse, and even sexual violence. According to the U.S.A National Research Council Review, studies support the fact that men who come from patriarchal family structures that encourage traditional gender roles are more likely to become violent and perpetrators of domestic rape than men coming from egalitarian homes (National Criminal Justice Reference Service, 1996). Further, anthropological and ethnographic studies of violence reveal that the severity and prevalence of wife beating were higher in "machisto" cultures where male dominance, toughness, and honor were the norm. In fact, physical chastisement of wives was not only tolerated in these contexts, but also deemed necessary (Campbell, 1985). Additionally, religion can determine the gender gap and physical harm to which women are subjected (Cross, 2013). Samantroy (2010) revealed cultural principles that lead to legitimate violence against

women as religious and historical traditions have accepted the chastising and beating of wives within relationships.

The prevalence of violence against women worldwide, with one in every three women being beaten up, coerced into sex, or abused in other ways in her lifetime reveals how much of a public health issue it is, especially as the world pushes universal human rights (UNFPA, n.d.). The fact remains that these inequalities are difficult to destroy because the inferior role of women within many societies is deeply embedded within the system. Samantroy (2010) considered the argument that women's inequality, revealed in symptoms like violence, is rooted in the socio-economic and political context of power relations that is formed within patriarchal social relations and class that is dominated by male power. Through this system, the structural violence that women experience, due to such male dominated societal contexts, is obvious.

As anthropologists, sociologists, public health specialists, and political scientists have studied patriarchy, the public/private gap, and the both qualitative and quantitative violence, they have discovered that the structural elements that women face are factors within their suffering (Cross, 2013). Within multiple countries, especially within the Global South, gender inequality continues and women face inequity in access to education, work and economic assets, and governmental participation (United Nations, n.d.). This lack of opportunity reflects the structures of society. As a result, women are less capable of providing for themselves or fighting their way out of poverty; thus they suffer. International studies have supported these claims, linking the lack of opportunities to violence that women face. In Egypt, Yount (2009) found that women dependent upon their marriage and with little education were more likely subjected to abuse. In this instance, women's socio-economic status and education were structural factors in their vulnerability of becoming victims of violence. Additionally, in terms of employment, women

possess less job security than men, with fewer or no benefits. Consequentially, women are largely relegated to forms of employment that leave them vulnerable to poor working conditions, low wages, and even abuse (United Nations, n.d.).

The link between the achievements of the MDGs to social determinants such as gender equality is further evident as women continue to suffer from structural violence. According to Mukherjee et al. (2011), elevating the status of women was linked to achieving the MDGS; however, structural violence, in terms of gender inequality and the feminization of poverty, was a significant barrier in the MDGs success. Looking at maternal mortality alone, the roadblock is evident. In the late 1980s, 99 percent of the estimated 500,000 annual maternal deaths occurred in the Global South. Although this number has decreased to an estimated 350,000 pregnancy-related deaths per year, the number is still unacceptably high. The model that is used to describe the causes of maternal mortality is the three delays, all of which are embedded with structural violence: delay in the decision to seek care, delay in reaching care, and delay in receiving adequate care. Structural violence is revealed within these delays as first, women do not always have the power within their communities or families to leave their duties, or lack income for the cost of care. Next, there is a shortage of investment within health care systems causing long distances to travel. Lastly, the health system in the most needy areas often lack human resources, thus attention by a skilled health care professional is nonexistent (Mukherjee et al., 2011).

The most cost-effective, simple, and efficacious tool to reduce maternal mortality is family planning as it can lead to improvement in health and economic opportunities for women, countering the effects of structural violence. Mukherjee et al. (2011) discussed that a women's capability of controlling her body, and how many children she has, results in higher education attainment, increased employment rate, and more political involvement. Girls who do not go to

school or do not succeed in school are more prone to early pregnancy. Also, 25 percent of young women who leave school before finishing do so because of unwanted pregnancies. Delaying pregnancy, therefore, can increase educational attainment and reduce mortality. In addition, children coming from families with many children are less likely to go to school and more likely to drop out. With the increase of family planning, countries with high fertility rates could prevent 32 percent of maternal deaths and 10 percent of child deaths (Mukherjee et al., 2011). Unfortunately, the lack of family planning is still high and is linked to structural violence.

The consequence of gender roles and structural violence is severe, as it impacts not only the mental and physical well-being of women, but also their fundamental rights. Women who bear the responsibility of taking care of multiple children will often times put their children's health needs before their own. In addition, the system set in place by health facilities, like separating family planning services from routine care, with separate rooms, and wait lines, makes access to such services difficult (Mukherjee et al., 2011). Because of structural gendered violence, women who may want to use family planning are voiceless within their relationships. The violence caused by patriarchal structures of society towards women link directly to whether or not there can even be an open conversation about family planning and sexual health. Furthermore, the structure of the family leads to women's inferior sex role, which gives women less control over their sexual relationships (Samantroy, 2010). This sexual expectation can lead to unwanted pregnancy, sexually transmitted infections, and unsafe pregnancies and abortions.

Countries cannot reach their full potential without the societal participation of women. Structural violence towards women is standing in the way of development as it lowers women's participation due to increased subordination and subjugation established by the patriarchal system. The countries affected by this structural violence include Uganda, a nation that has

substantial potential to improve, but faces many roadblocks preventing development from occurring. A major one of these barriers is the lack of universal family planning that can lead to a sexual health transformation. The next section will look at Uganda as a nation and where it stands in development to further understand the implications and the need for a sexual health transformation within the social context of the country.

Uganda

The importance of sex education and family planning in the social and economic growth of peripheral countries reveals the need for a sexual health transformation in Uganda. According to the Millennium Development Goals (MDGs) Report for Uganda 2013, Uganda has experienced significant improvements in several areas of development as reflected in its progress towards the MDGs for 2015. However, Uganda also fell short in many of the objectives laid forth within the framework. These shortcomings are reflected in the high population and fertility rate in Uganda.

In response to the UN MDG call to eradicate extreme poverty and hunger, Uganda halved the proportion of people whose income is less than one dollar a day well ahead of the 2015 deadline. The national poverty head count declined to 24.5 percent in 2009/2010 from 56.4 percent in 1992/1993 (Kulabako, 2013). Also, significant progress was made towards improving nutrition. Underweight children under five years old declined from 25.5 percent in 1995 to 13.8 percent in 2011. Despite these improvements inequality continues to be a problem (Ministry of Finance, Planning, and Economic Development, Republic of Uganda, 2013). The bottom 20 percent of the income distribution accounts for only 6.2 percent of national consumption. Also, underemployment remains a concern because it creates a cycle of poverty that makes it

impossible for families to break out of the situations in which their families are stuck (Ministry of Finance, Planning, and Economic Development, 2013).

Achieving universal primary education is also lacking in Uganda as dropout rates and grade repetition remain high, and Ugandan children continue to fail in finishing the full course of primary school. According to UNESCO (2012), the dropout rate of primary school is at 68 percent. A study by Demographic and Health Survey Education Supplement found that Universal Primary Education caused a 58 percent increase in primary education in just the first year; however, there was a 10 percent drop in the probability that an educated child in a public primary school could pass a reading test (UNESCO, 2012). In 2009/2010, the net or on-time completion rate using the Uganda National Household Survey of 13 year-olds who had completed primary school was only 5 percent (Ministry of Finance, Planning, and Economic Development, 2013).

The promotion of gender equality and empowering women set by MDG 3 additionally experienced vast improvement in Uganda; however, it still has a long way to go. Affirmative action policies increased women's role in political decision making at all levels of society. The share of women in Parliament increased from 18 percent in 2000 to 35 percent in 2012. In the current cabinet, more than one third of senior ministerial portfolios are held by women, including within the health, finance, and education sectors (Ministry of Finance, Planning, and Economic Development, 2013). In terms of education, girls' enrollment improved significantly. As of 2010, there were more Ugandan girls attending primary school than boys. However, the increase of girls' education has declined in recent years at the secondary and tertiary levels. As of 2012, there were still only 85 and 79 girls for every 100 boys enrolled in secondary and tertiary education institutions (Ministry of Finance, Planning, and Economic Development, 2013).

Within the economic and social sphere, inequalities are still evident. Women still work seven hours less than men a week in economic activities but significantly more in domestic activities. Also, women are more likely to obtain low-value jobs within the agriculture, forestry, and fishing workforce at 55 percent compared to 45 percent of men, and 62 percent of women outside of the agriculture sector are informal employees contrasting the 55 percent of men (Ministry of Finance, Planning, and Economic Development, 2013). Furthermore, regardless of the type of work, women make only about half the wage that men do.

The reduction of child mortality targeted by MDG 4 and improving maternal health with MDG 5 also progressed but did not reach the goal of reducing under five deaths by 5 percent each year or the targeted reduction in maternal mortality for the 2015 deadline. Between 1995 and 2006, the under-five mortality rate fell from 156 per 1,000 live births to 137 with an average annual reduction only being 1.2 percent (Ministry of Finance, Planning, and Economic Development, 2013). However, the recent decline in under-five mortality from 2006 to 2011 falling from 137 to 90 per 1,000 live births was encouraging, making the rate 8.1 percent annually (Ministry of Finance, Planning, and Economic Development, 2013). Unfortunately, despite the progress, Uganda still fell short for overall child mortality improvement. In terms of maternal health, the proportion of births assisted by a trained health worker increased from 42 percent in 2006 to 58 percent in 2011. In addition, there was an improvement of postnatal care for women, moving from 27 percent in 2006 to 33 percent in 2011 (Ministry of Finance, Planning, and Economic Development, 2013). Contraception in Uganda doubled from 15 percent in 1995 to 30 percent in 2011, helping to prevent unintended pregnancies or closely spaced pregnancies. Despite this, universal family planning has a long way to go, and there is no statistically significant change in the maternal mortality ratio. According to a survey of 553

health facilities across Uganda, maternal mortality was mostly caused by hemorrhage (accounting for 42 percent of maternal deaths), obstructed or prolonged labor (22 percent) and complications from abortion (11 percent). Indirect causes included malaria (which was a factor in 36 percent of the maternal deaths recorded), anemia (11 percent) and HIV/AIDS (7 percent) (Ministry of Finance, Planning, and Economic Development, 2013). MDG 5 called for the reduction in maternal mortality by three quarters. As Uganda entered into 2015, the progress was at a standstill. Also, MDG 5.B called for universal access to reproductive health. Despite the increase in contraceptive use, the need for universal access is still widespread.

Combatting HIV/AIDS, malaria, and other diseases was also behind the 2015 deadline in Uganda. Improved access to treatment in Uganda reduced the number of deaths of HIV/AIDS; however, the prevalence rate among the 15 to 24 age group increased. Although Uganda made commendable progress in the 1990s in the fight against HIV/AIDs, there was a reversal in progress in recent years with the rising number of new infections. The rise in infections is attributed to high population and risky behavior (UNDP, 2013). Additionally, Uganda's largest public health concern remains malaria, causing poverty and low productivity. Fortunately, the rate of reported malaria cases decreased by 50 percent between 2006 and 2011. Additionally, there was a large decline in child deaths caused by malaria, moving down from 39 percent in 2008/2009 to 28 percent in 2011/2012 (Ministry of Finance, Planning, and Economic Development, 2013). Regardless of this improvement, the fatality of malaria and other diseases is still high.

Uganda's progress has been apparent but slow in regards to the MDG 7 targeting environmental sustainability. There has been a concentrated effort on the part of the government to integrate sustainable principles into policies and programs. Furthermore, there has been an

increase in access to safe water, basic sanitation, and improvement in the lives of slum dwellers since the 2010 MDG Report. Uganda does not contribute significantly to the global environment crisis in terms of carbon dioxide emissions and consumption of ozone-depleting substances. However, Uganda does struggle from loss of biodiversity due to land clearing for agriculture and wood extraction for energy. In fact, Uganda's land covered by forest has decreased from 25 percent in 1990 to 15 percent in 2010 (Ministry of Finance, Planning, and Economic Development, 2013). Another challenge for the environment is the rapid urban growth that has taken place over the past two decades that has overwhelmed urban planning capacity, leading to congestion and over pollution in those areas.

The MDG framework indicates that Uganda has made significant progress over the past two decades within macro-economic and human development; however, it still faces significant challenges. Uganda continues to be one of the poorest countries in the world, with a Gross National Income (GNI) per capita of US$1,124, ranking 161st out of 186 countries on the 2013 UNDP Human Development Index (World Food Program, n.d.). Sixty seven percent of Ugandans are still living on $1.20 to $2.40 per day (Anguyo, 2013). Illiteracy is also high in Uganda as 25.4 percent of Ugandans cannot read or write (UGO News, 2013). In the rural areas of Uganda, 79.9 percent of homes are child-headed households. The rise in the proportion of child-headed households and child laborers means a rise in percentages of the illiterate, early pregnancies, and related consequences such as infant and maternal mortality rates, increased incidence of those who are infected by sexually-transmitted diseases (STDs) and HIV/AIDS, and drug abuse (UNESCO, 2005). Also, 12 percent of marriages occur before the age of 15; 46 percent of marriages occur before the age of 18 (Schlecht, Rowley, & Babirye, 2013). These numbers mostly reflect girls forced into arranged marriages, increasing the rate of illiteracy and

school dropout. Considering all the aforementioned information, it remains obvious that Uganda requires a lot of improvement in multiple areas of development in order to provide for its people. The increase in population makes the task of developing even more overwhelming.

Uganda has the 2nd highest fertility rate in the world with 6.2 children per woman as well as the 5th highest growth rate in the world at 3.2 percent per year (UNICEF, 2012). In one year, the population jumped from 33.6 million in 2013 to 37.8 million in 2014 (World Population Review, 2014). At this rate, the population is expected to increase fivefold, pushing Uganda to the top 10 most populated nations in the world by 2100 (Natakunda, 2013). Uganda also comprises the world's second youngest population after Niger with 50 percent of the population being under the age of 15 (Klein, 2013). When this young population reaches reproductive age, the population will continue to grow exponentially and the development challenges that Uganda faces today will grow along with it. As it stands, the growth of population only causes individuals' suffering to increase impeding on Uganda's further development. Population, after all, is linked to all areas of development. Clearly exemplified within the failed MDGs, Uganda requires a lot of improvement in terms of providing education, health services, employment opportunities, and resources to its current population. From food demand and supply, social services such as health and education, economic opportunities, and environmental sustainability, population has a role in sustainable development, as a country needs to be able to provide for the growth of people.

With the high fertility rate and the young population in Uganda comes the dependency burden where few people are responsible to provide for a huge population. This dependency situation can later impact the savings, labor supply as well as human capital development of Uganda, which are all key to socio-economic transformation. The high unemployment rate

complicates this even more. Although the unemployment rate is only at 10 percent, the rate of underemployment is high and unemployment for Ugandan youth is at 65 percent (UNFPA, 2014b). The demand for rapid growth in job opportunities is one of the largest economic and social challenges facing Uganda. The path that the large youth population takes into the workforce will have a significant and long-term impact on Uganda's development. The substantial number of entrants into the labor market is increasing rapidly, and with over half the population under the age of 15, this number will continue to rise radically (Ministry of Finance, Planning, and Economic Development, 2013).

The good news is that the young people are better educated today than in the past, remaining in school for longer periods of time, but they lack the capability of fully utilizing higher levels of human capital. Five percent of the labor force attains higher education than required in their current employment, of which 19 percent live in Kampala, Uganda's capital city (Ministry of Finance, Planning, and Economic Development, 2013). There are between 600,000 and 700,000 new entrants into the workforce each year, yet net job creation is estimated to be only 10 percent of this (Ministry of Finance, Planning, and Economic Development, 2013). The imbalance between job opportunities and the demand for work is only going to grow. In order to curb this trend, economic opportunities are essential and the demographic transition must shift from high fertility to low fertility to reduce the youth dependency ratio. If fertility and population growth rate can be curtailed, this surge of young people entering their productive and reproductive years can present an opportunity for development as long as the government invests wisely in education, health, practical skills, and economic opportunities (UNFPA, 2014b).

If Uganda continues down the path that it is on, with persistent high child dependency ratios and poor economic performance, the country will only attain 30 percent of the progress

that is necessary to attain average global competitiveness. In comparison to countries that have capitalized on the demographic dividend, prioritizing employment economic reforms, investment in family planning, and education to accelerate fertility decline for human capital development provides Uganda the greatest chance to achieve socio-economic transformation (UNFPA, 2014b). Uganda's development will only be sustainable if the total value of physical, human, social and natural assets catches up and keeps pace with population growth (Ministry of Finance, Planning, and Economic Development, 2013). As a result, Uganda's population can be presented as the most crucial game changer in moving towards socio-economic transformation. The growth of population is not driven by the desire for more children (which has declined in the past 15 years), but by the lack of family planning and the high rate of unwanted births. Ministry of Health statistics show that three out of ten women in Uganda, who need to stop or space their next pregnancy, are not using any contraception. Consequently, there are about 700,000 unplanned pregnancies in Uganda every year (Matler, 2013). As a result, a sexual health transformation in Uganda is necessary to curb the population growth and develop Uganda further. Fortunately, steps are being taken to push such transformation through family planning and sex education initiatives.

The Push for Family Planning Services and Sex Education in Uganda

Internationally, sex education and family planning have been recognized to aid in the development of nations. On a national level in Uganda, many steps have been taken to educate people about preventative measures to avoid unwanted pregnancies and sexual transmitted diseases. For example, in the 1980s through the 1990s, the Ugandan government promoted the ABC approach to help with HIV/AIDS prevention. The ABC approach stands for: Abstain, Be faithful or reduce the number of sex partners, and/or use a Condom. In the 1980s, the

government used an aggressive media campaign following ABC, with a focus on abstinence. Then in the 1990s, the government accepted condom promotion and started emphasizing condom use alongside abstinence. The combination of strategies using the ABC approach with further emphasis on condom use helped rates of HIV infection drop from 15 percent in the early 1990s to 5 percent in 2001. Some researchers accredit the ABC campaign for the drastic drop in HIV prevalence; however, others criticize the approach because of its promotion of abstinence-only sex education (Avert, n.d.; Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006)

In addition, the Straight Talk mass media communication program is probably the most well known initiative pushing reproductive and sexual health. The Straight Talk program has been implemented in Uganda since 1993 (Adamchak, et al., 2007). The mass media program comprises three main materials: radio shows that are done in multiple languages, multilingual newspapers, and the English Young Talk newspaper. Furthermore, Straight Talk implements a wide array of school-based activities that are age appropriate and invests in community activities such as health fairs and supporting youth-friendly health care services. The Young Talk newspaper is aimed at primary aged children, the Straight Talk newspaper at secondary schools, and Straight Talk Radio Shows at older adolescents including illiterate and out of school young adults. The main goal of Straight Talk is to encourage young people to wait to have sex. According to youth, abstinence is the main message they obtain from the Straight Talk program. Surrounded by provocative and uncensored media on the radio and TV, Straight Talk offers a healthy alternative for those who do not wish to engage in sex (Adamchak, et al., 2007).

The Bill and Melinda Gates Foundation established the African Youth Alliance (AYA) program in 2000. The goal of the program was to create a comprehensive, integrated, and potentially scalable program to help improve adolescent sexual and reproductive health in

Botswana, Tanzania, Ghana, and Uganda. AYA collaborated with public and private sector organizations, providing youth-friendly services at clinics, building on local capacity, and integrating livelihood skills training. In addition, AYA helped coordinate policy and advocacy activities for sexual and reproductive health services at the local and national government level with institutional capacity building for its implementing partners. AYA represented the partnership between the United Nations Population Fund, Pathfinder International, and the Program for Appropriate Technology in Health with field interventions taking place between 2000 and 2005. The evaluation of AYA portrayed a positive impact on condom use, contraceptive use, partner reduction, and several self-efficacy and knowledge antecedents (Williams, Mullen, Karim, & Posner, 2007).

The World Starts With Me campaign was created in 2002 and 2003 by the World Population Foundation (WPF) and Butterfly Works, alongside SchoolNet Uganda. The campaign is a low-tech, computer-based, interactive sex education program aimed at secondary school students (Rijsdijk et al., 2011). The campaign combines multiple approaches to sex education including rights-based, health promotion, behavior change, and adolescent developmental approaches with the goal of supporting and empowering young people to make informed decisions about sex. The campaign also strives to provide accessible, non-judgmental, and responsive support according to what young people want. The program offers skill development in computer and creativity while at the same time focuses on sexual and reproductive health and rights (Rijsdijk et al., 2011).

Since December 2012, the United Nations Population Fund has been supporting the *If it is not on, it is not safe* campaign also with the aspiration to encourage Ugandans to use condoms. Different from other campaigns, this campaign focuses on female condoms, which are not

common in Uganda. The campaign exists through print, TV, radio, and interpersonal communication using entertaining content. The campaign has caused a lot of debate, especially from the religious community, which considers promoting condom use as encouraging promiscuity. However, the campaign has also received a lot of encouragement from international development organizations, such as USAID, who joined Danish International Development Agency (DANIDA) in support of the campaign in January 2014 (UNFPA, 2014b).

National and local level campaigns are also taking place. For example, in 2014, many local partners came together to support the *It Takes Two* campaign, highlighting the need for increased family planning services in Uganda. These partners include Talent Africa, Reach a Hand Uganda, COMMAT- Uganda, Partners in Population and Development- Africa Regional Office, Marie Stopes Uganda, and mobile provider, Airtel. The campaign aims to provide youth with the tools to reach policymakers in addressing family planning needs on issues such as teen pregnancy, sex education, and youth-friendly family planning services (Women Deliver, 2014).

The most recent campaign created by the Health Ministry and the United Nations Population Fund (UNFPA) was launched on July 13, 2014. The campaign is titled *Let Girls Be Girls* and aims to reduce teen pregnancy, maternal mortality among young women and girls, as well as the cost of post-abortion medical care by July 2015. The one-year program provides sex education to local communities, parents, students, and teachers on children's right to a safe and secure environment in their homes, schools, and communities, and provides free contraceptives in schools. Like many other sex education campaigns, *Let Girls Be Girls* has been criticized for promoting promiscuity and sexual relationships among youth (IRIN Africa, 2014).

Organizations and the Ugandan government have also been trying to incorporate community based approaches to promote family planning. The Health Communication

Partnership's, in collaboration with Ministry of Health, created Men Only seminars aimed at informing men about family planning. The Men Only Seminars were half-day events that included sporting events, movie clips, drama, training sessions, and the distribution of informative materials. Throughout these activities men were pushed to discuss the content and urged to converse with their partners about family planning. The communication tools provided at the seminars, as well as with other community based approaches, helped facilitate discussions about the population crisis, enabling men to face the burden of having large families while advising them to reflect on their roles as men (Health Communication Partnership, John Hopkins Bloomberg School of Public Health, & USAID, 2010).

Rampant growth in the Ugandan population that threatens the country's development is not going unnoticed. The Ugandan government, along with international and local organizations, have recognized the need for a sexual health transformation in Uganda. Questions remain regarding why the fertility rate in Uganda is still one of the highest in the world and why the population growth rate continues to increase despite the actions taking place with the goal of controlling it. The barriers standing in the way of an effective sexual health transformation will be addressed next.

Barriers Standing in the Way of Putting Education to Practice in Uganda

Considering the many campaigns listed above, it is evident that the Ugandan government, non-governmental organizations, and businesses are making significant efforts to educate the public on family planning and the prevention of sexually transmitted diseases. However, according to a variety of research, the effectiveness of these campaigns is questionable. There are still many obstacles standing in the way of controlling the drastic population growth in Uganda, with cultural barriers being among the most significant. Therefore, to gain a better understanding

of how to implement effective preventative education, it is essential to understand these cultural barriers impeding progress and how they act as obstacles. These barriers include, but are not limited to: beliefs and myths surrounding condom use; sex as a taboo, linked to religion and its push for abstinence; and gender roles, constructed by cultural expectations, social pressures, and beliefs surrounding how men and women fulfill their place through their masculinity and femininity.

Protection and contraceptive use. Promoting condom use has been a significant focus among sex education campaigns throughout Uganda, aiming to give adults the knowledge and understanding of the importance of using protection. However, these educational initiatives are not being translated into action. According to the 2011 Uganda Demographic and Health Survey, only 2.7 percent of the population reported that they use condoms regularly (UNFPA, 2014c). To understand why this gap exists, several studies have been conducted (Brawley, 2006; Nobelius et al., 2012; Nyanzi, Nyanzi, & Kalina, 2005). In the research done, Ugandan men and women indicated that the main reasons for not using condoms are: the expense of buying condoms; a lack of access to condoms; not wanting to lose pleasure in the sexual act; and the belief that condoms do not work.

Another common complaint regarding condom use across the board for men, women, and adolescents is that condoms can actually cause HIV and other STDS. Men, women, and adolescents often believe that holes exist within condoms, allowing semen to pass through and causing HIV, other STDs, and pregnancy (Katz et al., 2013; Nyanzi, Nyanzi, & Kalina, 2005; Pool, Kamali, & Whitworth, 2006). Some also believe, “The oily stuff on condoms is purposely infiltrated with HIV so as to infect several people” (Nyanzi, Nyanzi, & Kalina, 2005, p. 114). One investigation found that only 48 percent of interviewees had ever used a condom since

becoming aware of HIV/AIDS, and only 13 percent of condom users were using condoms regularly and for purposes regarding family planning. More than one third of the reasons participants gave for not using a condom related to being married, monogamous, or trusting a partner. This belief was discovered consistently for men, women, and adolescents. Condom use is not acceptable in Ugandan relationships defined as regular because their use represents distrust (Brawley, 2006; Katz et al., 2013; Nobelius et al., 2012; Nyanzi, Nyanzi, & Kalina, 2005; Pool, Kamali, & Whitworth, 2006). On the contrary, condom use is saved for casual relationships (Brawley, 2006; Nobelius et al., 2012; Nyanzi, Nyanzi, & Kalina, 2005).

Many other misconceptions, misinformation, and myths exist regarding condom use. Research by Nyanzi, Nyanzi, and Kalina (2005) discovered men's beliefs about condoms were grounded in such misinformation, including that "condoms are made by White men who want to depopulate Africa," "condoms cause skin irritation to the penis," "condoms lead to impotence in men," and "wearing two condoms at a go provides more protection than just one" (p. 114). There also exists a lack of knowledge in how to properly use condoms, making use, or proper use, less likely. Men expressed the belief that they could reuse condoms after washing them. Men furthermore communicated that contraception and protection are the responsibility of the women (Nyanzi, Nyanzi, & Kalina, 2005). Discordantly, the biggest barrier for women in condom use is the fact that it is the men who wear the condoms and often refuse to use protection (Nobelius et al., 2012; Pool, Kamali, & Whitworth, 2006).

Young men conveyed that one reason for avoiding condom use was their lack of skills and self-confidence, and that women's desire to use condoms was a ploy to trap unskilled men into revealing their ignorance (Nobelius et al., 2012). Other ideas regarding condom use refer to when women can be impregnated. Commonly, Ugandan men believe that "it is only the ejaculate

of the first round of sex in a single encounter that impregnates a woman. The second and third rounds of sex do not impregnate a woman" (Nyanzi, Nyanzi, & Kalina, 2005, p. 115). Therefore, the pullout method is common during the first round of sex, but no forms of pulling out or protection are used for the other rounds in a single encounter.

In addition, there is a misconception about using a condom when the girl is a virgin, with the belief being that the condom would burst within the girl (Nobelius et al., 2012). This relates to a common belief within Sub-Saharan Africa that condoms get "stuck" in womens' vaginas causing later fertility problems (Nobelius et al., 2012; Pool, Kamali, & Whitworth, 2006). It is also common for men to refuse condom use due to religious reasons, for example, being Catholic (Pool, Kamali, & Whitworth, 2006). Research has additionally discovered how adolescents regard condoms as unacceptable within the community because they reveal sexual activity before marriage (Pool, Kamali, & Whitworth, 2006). The levels of ignorance and unawareness of contraceptives are high as well among Ugandan adult men, as they often times believe contraception causes cancers or tumors, dries up the woman's womb, "burn[s] up vaginal lubrication," decreases sexual desire in women, prolongs menstruation periods (for as long as two months), "destroy[s] the eggs of a woman so that she becomes barren," "affect[s] a woman such that she bears only girls," causes cases of cerebral palsy within children, as well as mental retardation, congenital abnormalities, and other disabilities (Nyanzi, Nyanzi, & Kalina, 2005, p. 115).

Sex as a taboo. Another cultural barrier that exists in controlling population growth is how the conversation of sex, especially among adolescents, remains taboo within communities. Research has found that sex is seen as an adult privilege and that boyfriend-girlfriend relationships among youth are regarded as unacceptable within Ugandan communities. If youth

were to talk about their relationships, they would be in danger of ruining their reputation and being judged by their confidants, who could also reveal them to their families or lecture them on abstinence. Instead, there exists a "culture of silence" regarding youth talking to their parents about sex (Katz et al., 2013).

Adolescents communicate that the inability to speak with their parents about sexual and reproductive health issues exists for two main reasons. First of all, their parents would suspect them of being sexually active. Secondly, the discussion of sex between parent and child is described as culturally taboo because it "embarrasses" the child and is considered "bad mannered," as it may imply not just vulgarity, but moral transgression, obscenity, and even incest (Nobelius et al., 2012). In Nyanzi, Nyanzi, and Kalina (2005), men throughout Uganda, reflecting upon their childhood, criticized their parents for not informing them on sexual matters as children. The men recalled that any conversation related to sex with parents is usually in relation to a punishment because the child was known to be having a relationship with a girl, was caught in the act, or impregnated a girl. Along these same lines, young people are called to respect their elders. For this reason, conversing about sexual experiences with their elders, when it is so frowned upon in society, is out of the question. The youth, therefore, are limited in seeking advice and community health services and are uneducated as they become sexually active (Alternative Social Development, 2012).

Although talking openly about sex is culturally taboo, the government has implemented tools to teach about sex in schools, primarily focusing on abstinence. Policy makers created PIASCY (Presidential Initiative on AIDS Strategy for Communication to Youth) in 2002. The policy follows the ABC approach that helped lower the prevalence of HIV within Uganda in the 1990s through the concentration on abstinence. The language used in PIASCY is overtly

religious, referring mainly to conservative Christian values, but also includes Islamic ideas. "Virginity" and "respect of God," as outlined by PIASCY, are "some of the key values held by Ugandans," pushed within the Student Handbook created by the government that is used in the Ugandan curriculum (Iyer & Aggleton, 2013, p. 436). Sexual activity outside of marriage is characterized as immoral, dangerous, and ungodly. Through PIASCY, students participate in discussions and activities such as dances and dramas, which further promote avoiding sex outside of marriage and maintaining one's virginity (Iyer & Aggleton, 2013).

In secondary schools throughout Uganda, teachers strongly follow the morally conservative approach to sex education presented by PIASCY. Signs around secondary school compounds have included, "Virginity is a Virtue: Prevent Early Sex" (Iyer & Aggleton, 2013, p. 437). In these schools, teachers emphasize that students should abstain from sex for the sake of their education. They recognize that sex is inevitable as "nature starts demanding"; however, the students "have to control that!" (p. 438). When teachers do discuss sex outside of marriage, they do so in negative terms, describing it as "defilement." This method aligns with the conservative approach to sex education as outlined by PIASCY, intending to "control" young people's sex life and to promote "normal" forms of sexuality, in the form of procreative heterosexual marriages (Iyer & Aggleton, 2013). However, this approach is not appropriate in light of young Ugandan's experiences and attitudes about sex. In the PIASCY curriculum, sex before marriage is taught as taboo. This leads to youth practicing sex in secrecy, enlarging the risks of unprotected and uninformed sexual activity.

Because talking about sex is culturally taboo and the education system only teaches abstinence, there is very little support in terms of finding a safe place to discuss one's sexuality, especially for adolescents. The silence between youth and their communities regarding sex does

not mean that they are practicing abstinence. On the contrary, not being able to talk about sex with their teachers or families has led youth to continue having sexual relationships in secrecy without access to protection or contraceptives. The 2011 Uganda Demographic Health Survey discovered that 14 percent of females and 16 percent of males had their first sexual encounter before the age of 15. Fifty-seven percent of females became sexually active before the age of 18 (IRIN Africa, 2014). With no sexual health support system, teenage pregnancy rates are extremely high. The survey discovered that 24 percent of female teens have given birth already, are pregnant, or have had an abortion (IRIN Africa, 2014).

The question, then, is where do adolescents get their information about sex? Adolescent boys report learning about sex from older siblings and other male family members, who employ them as "middlemen" to carry messages to their girlfriends, help set up meet-ups, and deliver gifts (Nobelius et al., 2012; Nyanzi, Nyanzi, & Kalina, 2005). Men also report that it is their schoolmates who persuade them to begin having sex and sometimes even set them up with a girl. For men not in school, they depend on their friends around the neighborhood (Nyanzi, Nyanzi, & Kalina, 2005). Girls, likewise, report learning mainly from their peer groups. The problem with learning solely from peer groups is that their peers are equally uneducated, so their conversations are not very informative. This leads to the education of youth being acquired by eavesdropping, especially for young men. Youth overhear conversations where men discuss strategies for seducing girls, their multiple partnerships, ways to trick their partners out of using protection, and how pleasurable recent sex exploits were (Nobelius et al., 2012). Childhood games are also reported as promoting sex at early ages. Games include Hide and Seek, where a boy and girl hide with each other and explore each other's body parts, and Bride and Groom, where children act out a wedding, often times including the wedding night. Furthermore, children often witness

sexual intercourse between their parents at young ages because they share bedrooms, exposing them to sexuality without any conversation to understand it (Nyanzi, Nyanzi, & Kalina, 2005).

There are other informal sources for sexual education that include the "film," media, and the *ssenga*. The "film" is recognized as a common source for sexual education. The concept of the "film" refers to makeshift or semi-permanent structures that act as showrooms, where locals watch pornography, romance stories, and action movies. These "films" give men the opportunity to learn new sex styles, how to improve their love lives, and learn how to negotiate sex from women. Radio is another common source of information for men. Topics presented over the radio often include advertisements about condom use and family planning methods. Finally, the concept of the *ssenga* is a very important resource for Ugandans to learn about sex practices. Traditionally, the *ssenga* is the paternal aunt, and she is responsible for the discipline of all children, male and female, and to prepare girls for marriage. This preparation includes learning how to please their husbands sexually (Nyanzi, Nyanzi, & Kalina, 2005). Unfortunately, the traditional *ssenga* is not meeting the needs of the ever-changing role of being girls within society (Nobelius et al., 2012).

Gender roles. Gender roles within Ugandan society are the most detrimental barrier standing in the way of putting preventative measures to practice. Both men and women are pushed to follow certain gendered sexual practices. On the men's side, the study done by Nyanzi, Nyanzi, and Kalina (2005) explained a pressure to have sexual relations with multiple partners in order to endorse their masculinity. Men often justify their sexual actions with several myths. They refer to the origin of the Buganda tribe from one man, Kintu, claiming that they are all Kintu's grandsons and therefore excused for their immoral actions based on the universality of promiscuity. Additionally, men tend to believe that all men were made from the same material,

batuubajja mubbumba lyelimu (clay) or *muzirigiti* (a single tree). They use these two beliefs to validate that "what one man does, the others also do." There also exists a cultural myth about men's need for sexual activity defending promiscuity as proof of "manhood." In fact, there is an unwritten rule about how a boy becomes a man. The transition is marked by having sex (Nyanzi, Nyanzi, & Kalina, 2005).

Men further believe that their natural lust and high sex drive cannot be satisfied with one woman, indicating that "'real men' have sex often and have satisfying sexual encounters" (Brawley, 2006, p. 43). It is common for men to engage in multiple sexual relations if their wives are barren or are only producing girls, if he no longer finds his spouse attractive, if his wife no longer performs her domestic duties, or if his wife no longer sexually satisfies him. In these instances, his masculinity is being questioned and he has the right to fulfill his manhood by looking elsewhere (Brawley, 2006). For this reason, polygamy is a common practice in Uganda. It is also important to recognize that in traditional Ugandan societies, large families are valued. In fact, often times a man's worth is based on his number of wives and children. Reputation, thus, may contribute to a desire for multiple partners and children (IRIN Africa, 2014).

In Uganda, it is common for men to score more points for having sex with a new woman. In fact, some men even make bets to compete for particular women they may see on the street. In Nyanzi, Nyanzi, and Kalina (2005), 64 percent of men admitted to having multiple sexual relationships, including regular partners, casual partners, and commercial sex workers. They confessed that they would show off their multiple partners to their peers but would keep their promiscuity a secret from their steady partners, including their wives. As men, they believed that abstinence is unnatural and impossible. In fact, they believe in a common myth that abstinence causes severe disease. They associate abstinence with the old, poor, bewitched, ill, impotent,

mentally disturbed, or youth. The men believe so strongly in promiscuity that they refer to a widely believed myth about STDs, other than HIV/AIDS, signifying strength, bravery, and heroism. This myth comes from the soldiers that fought in World War II who returned from war with STDs. The men believe that these STDs indicated bravery and surviving from the war (Nyanzi, Nyanzi, & Kalina, 2005).

For women, their expected role within society includes taking care of all domestic activities, providing their husbands with multiple children, and satisfying them sexually. A woman's sexual role is enforced when she is still a young girl, through the common practice among the Buganda tribe of Uganda known as *Okukylaira ensiko*. The tradition is a sexual stimulus method of labia elongation, in which at young ages, girls place weights on their labia to make them long. The act is usually encouraged by the *ssenga*, or paternal aunt, and is believed to make intercourse more pleasurable for both the man and woman (Sseremba, 2012). Within Ugandan society, women also have more of a subordinate status and often times have no voice when it comes to intercourse. For example, with condom use, men will often refuse and women do not feel the right to insist in using protection (Scott, 2009). Culturally, men are the active sexual partners and women are assumed to be passive and expected to be compliant. Women fear asking their male partners to use condoms, apprehensive of giving the impression that they have multiple partners, or that they are unfeminine. Many girls believe that if they insist on condom use, men will pinch off the top of the condom to make it ineffective (Nobelius et al., 2012). In their study, Nobelius et al. (2012) discovered that the only times that it is acceptable for women to refuse sex is when they are pregnant, breastfeeding, or menstruating; other than in these instances, negotiation is difficult because the women are called to be obedient.

In another study done by Wolff, Blanc, and Gage (2000), it was discovered that men are generally reported to have more influence over sex, but that women can refuse under circumstances that include their education and urban residence. On the contrary, women's lack of education has led to financial dependence on their husbands restricting women's decision-making capabilities within the household, including sexual activity (Wolff, Blanc, & Gage, 2000). Similarly, the submissiveness of women to sex practices may depend on the bride wealth agreement. If a woman's family receives substantial dowry for her hand in marriage, this may lead her to obligations of pleasing her husband sexually. Moreover, women are often pressured to get married at young ages and do everything in their power to stay in those marriages in order to secure land and livestock for their families. In Uganda, it is not customary for women to inherit property. For this reason, women are expected to marry, commonly at young ages to keep their family's assets (Otiso, 2006). If they divorce, they are at risk of losing everything. As a result, they are pressured to uphold and stay in relationships by doing whatever is necessary, including pleasing their husbands sexually, even against their will.

Scholars have also discussed the double standard that exists in sexual activity in Ugandan society. Wolff, Blanc, and Gage (2000) recognized how women are expected to have control over their sexual impulses with silence, while men have a sex drive that is uncontrollable, powerful, and irrational, all of which they are not held responsible (Wolff, Blanc, & Gage, 2000). Men's initiations into sexual relationships are also accepted as normal. Muhanguzi (2011) found that on the contrary, girls' prompting of relationships or their expression of sexual desire is associated with "untrustworthiness," "prostitution," "desperation," "easy going behaviors," and "sickness from HIV/AIDS" (p. 716). Boys in Muhanguzi's (2011) study showed hesitation when it came to girls initiating a relationship, stating that it is the man's job to take this lead. In fact,

they referred to Bible teachings of creation, stating that "man was created first; he is the overall controller of everything, supposed to have desires and choose ladies" (p. 716). The male adolescents believed that their masculinity entailed sexual control, and that the girls were passive recipients of the boys' sexual advances, with no ability to make their own decisions and therefore, obligated to satisfy the boys' desires. As a result, girls' sexualities are suppressed, viewed as unimportant, and marginalized.

Women's and girls' vulnerability within sex is further evident in health risks, loss of education, abuse, and coercion. Girls face higher risk of contracting sexually transmitted infections, including HIV/AIDS, unwanted pregnancies and with it, the risk of abortion and even death. Furthermore, girls are at a disadvantage in comparison with the boys who impregnate them, as the boys are able to continue with their education. Usually when a girl is impregnated, she drops out of school (Muhanguzi, 2011). Additionally, Wolff, Blanc, and Gage (2000) found that women are expected to be faithful to their husbands and if they are not, they are subject to beatings, divorce, and withdrawal of financial support. Moreover, girls' submissive sexual roles increase their vulnerability to coercion or unwanted sex, which may lead to psychological and physical injuries. In their study, Ybarra, Bull, Kiwanuka, Bangsberg, and Korchmaros (2012) looked at the prevalence of sexual coercion among adolescents. They discovered that females were more likely to report victim-only experiences and males were more likely to report perpetrator-victim experiences. Female victims reported feeling too afraid to refuse sex with the risk of being physically forced, hurt, or threatened to have sex compared to male victims (Ybarra et al., 2012). In the Muhanguzi study (2011), female students acknowledged that when they rejected boys' invitations, male students and even teachers would harass them, reflecting immense pressure for girls to partake in sexual activity against their will. Girls in the study

explained that boys threatened to beat them, destroy their reputation, bewitch them, or even kill them for rejection. Some girls even spoke of their friends changing schools because of the extreme abuse they experienced after refusing to be involved with particular boys. The girls were reluctant to report their experience, as their male teachers were often times the culprits. With their teachers as the violators, the girls had little expectation that intervention would take place and feared being further victimized if they spoke up. If the girls agreed to have sex, the boys portrayed them as easy, sick, unsafe, or desiring economic benefits (Muhanguzi, 2011).

As a result, the gender dynamic that exists in Uganda surrounding conversations about sex reveals the complexity of overcoming the barriers standing in the way of a sexual health transformation. The roles of men and women are embedded deeply in the historical and social context of the nation. Along with the other obstacles discussed throughout this section, including the myths and beliefs surrounding condom use and sex as a taboo, these ideas regarding sex have fed into the enormous gap inhibiting an effective change towards a healthier sexuality. With the cultural implications that lie within these hurdles, overcoming them has been and will continue to be a challenge.

Moving Forward

On the international level, family planning and sex education has been pinpointed as an important contributing factor in development, as high fertility and population growth is impeding the economic and social progress within these societies. The call for a sexual health transformation is widespread. International and local programs have pushed multiple campaigns and initiatives to improve family planning and sex education in the poorest nations. However, looking at the persistent high fertility and population growth that continues to constrain

development, it is evident that the international perspective on family planning and sex education is not translating to local practice within societies that need change the most.

With one of the highest fertility rates as well as the fasted growing populations in the world, Uganda requires a sexual health transformation, but has experienced difficulties in seeing the international norms of family planning and sexual education advance. Converting these international models for sexual health into a domestic reality is difficult because of the multiple cultural barriers standing in the way. One of these obstacles is found in the societal expectations, social pressures, and beliefs surrounding gender, as men and women succumb to their duties within their masculinity and femininity. A significant piece of their gender identity revolves around sex, and for women in particular, their obedience in fulfilling their sexual duties is reinforced by structural violence that continues to victimize women daily. The purpose of the research presented in this report is to look more specifically at the cultural roadblocks impeding effective sex education and family planning services in Uganda, by discussing the barriers directly with local Ugandans. The research will oblige Ugandan men and women to step away from their cultural views of sex, and even separate themselves from their own gender, to come face to face with the existing tensions that prevent a sexual health transformation in their country. Together, men and women will be challenged to face sexual norms and ingrained gender roles, and to strategize a way forward to tackle the daunting increase in population and high fertility, which, in the long run, will move Uganda towards sustainable development.

Chapter 3: Method

Introduction

After spending five years living and working in Iganga, Uganda, I have learned a lot about the way of life and the culture of the local people. Over the years, I have invested time and effort into building relationships with people and have been welcomed into their communities. The relationships that I have developed range in gender, economic status, place of residence, and age. From young children, adolescents, young adults, to grown-ups, I have gotten to know multiple people in various walks of life. One aspect about the culture and the lifestyle that I have observed over the years that has sparked my interest is the sex culture. Sex is everywhere. You see it in the never-ending number of children that are constantly playing in the streets compared to the few adults nearby, the multiple baby bumps hiding under the women's dresses, the music, the dance, and in so many other places. Because of my observations, I started to inquire about sex practices with my closest friends and the more I asked, the more I discovered the complexity of sex within the culture.

I initiated conversations about sex with young teenagers who had become my family. They would deny the topic and any exposure they had ever had to it in relationships. I realize they were not telling me the truth, but as someone they respected, they could not be honest, since the subject was a taboo. Conversations with men and women were equally fascinating. Some of my male friends spoke of infidelity, defending their unfaithfulness with the common justification that men have a higher sex drive. If their partner did not satisfy them, they had the right to seek sexual satisfaction from other women. I talked to multiple single mothers whose ex-husbands abandoned them for other women, disowning their children in the process. I spoke to women my age who had caught their boyfriends and even husbands cheating on them in their own homes.

Everyone had a story. I started to connect all the information that I had accumulated and found a huge discrepancy between men and women. There was a significant gender dynamic within the conversation of sex.

Further, I recognized the consequences of large families and lack of family planning. I met women who had birthed ten children, but lost six to malnutrition and other diseases because they had no means to provide for them. I inquired with hospital administrators who explained one of the highest mortality causes they saw was the after-effect of unsafe abortions. I met families where the husband had four wives with thirty-eight children, of which only could afford to send a few of the large number to school. I saw how these people experienced the repercussions of the lack of family planning services, feeding into their poverty and neglect. Moreover, as I drove through the urban areas, I was faced with images of mass urbanization as people flooded into the cities. The conditions they lived in were poor and their social services were even worse or non-existent.

For my research, I wanted to look more into all the aforementioned observations as I got to know the people and living conditions of Iganga, Uganda. Sex is prevalent in the day-to-day routine of the people, and I aspired to learn more about how deeply it was rooted into their beliefs and behaviors. I additionally wanted to investigate its link to the hardships of the local people as it stands as an obstacle in development. I sought to discuss sex education and family planning and cultural barriers standing in the way of effective education in Uganda with the local people to both gain a better understanding of how they make sense of the continuous high fertility and growth rate within their community and to open up the conversation of finding a culturally appropriate and sustainable strategy for change. The relevancy of this study has broad implications for the community, especially because of the intersection of many significant socio-

cultural issues such as women's health, infant mortality, poverty, and gender roles. Through a discussion with the local people, the significance of these repercussions for the community would be exposed, opening their eyes to the importance of a sexual health transformation as it could lead to improvement in the sufferings their communities face daily.

I conducted my research through exploratory means, as the aim was to gain a concrete understanding of these critical social issues. My research design was ethnographic, non-experimental and qualitative in approach. Using a hybrid methods, data collection instruments used were demographic surveys, questionnaires, focus groups, an educational presentation, and participatory observation. Data within the focus groups was collected with two note-takers that cross-referenced their reports to obtain the results. Due to the limited resources within this rural setting, video and tape recordings were not available. The research was done in English with the opportunity for translation into the vernacular if needed.

Population/Sampling

Location. The population of interest in this study included Ugandan men and women (ages 18+). The sample was taken from the district of Iganga in Eastern Uganda. The following table (Table 3.1) offers an overview and detailed description of human development indicators in Uganda, as well as those that are specific to Iganga. The demographics provided that particularly relate to this study are high population density, rampant birthrate, and mass transmit implications for prostitution and HIV/AIDS.

Table 3.1.

Human Development Indicators in Uganda and Iganga

Uganda:	**Iganga:**
❖ Possesses the 2nd highest fertility rate in the world with 6.2 children per woman. ❖ Holds the 5th highest growth rate in the world growing 3.2% per year. ❖ Continues to grow in number with a population exceeding 37.8 million in 2014, up from 33.6 million in 2013. ❖ Expects to increase fivefold, pushing Uganda to the top 10 most populated nations in the world by 2100. ❖ Experiences about 700,000 unplanned pregnancies every year. ❖ Comprises the world's second youngest population after Niger with 50% of the population being under 15 years old. ❖ 79.9% of homes are child-headed households in rural areas. [a] ❖ 67% of Ugandans are living in poverty ($ 1.20-2.40 per day). ❖ 25.4% of Ugandans are illiterate. ❖ Has a primary school dropout rate of 68%. ❖ 12% of marriages occur before the age 15, 46% of marriages occur before the age of 18.[b]	❖ Sustains a population that is reaching 700,000 of which 80% live in rural areas. ❖ Comprises the highest percentage of Muslims in Uganda.[c] ❖ Remains a predominately polygamous region with a rampant birthrate (8 children per woman). [d] ❖ Exists on the main highway traveling from Kenya, making it a common stopping point for truck drivers, and causing a high rate of prostitution and the vulnerability to HIV/AIDS. ❖ Contains an 8% higher HIV/AIDS prevalence than the national 6.7% prevalence. ❖ Suffers from the major prevalent preventable diseases, including malaria, URTI internal worms, and HIV/AIDS material problems (These contribute to 60% of the ten killer diseases).

Note. Anguyo, 2013; DevelopNet Iganga-Uganda, 2007; Kaijuka, n.d., Klein, 2013; Malter, 2013; Natakunda, 2013; Embassy of the Republic of Uganda, 2012; Uganda Village Project, 2009; UGO News, 2013; UNESCO, 2005; UNESCO, 2012; UNICEF, 2012; Wilscon, 2011; World Population Review, 2014.

[a.] The rise in the proportion of child-headed households and child laborers means a rise in percentages of the illiterate, early pregnancies, and related consequences such as infant and maternal mortality rates, increased incidence of those who are infected by sexually-transmitted diseases (STDs) and HIV/AIDS, and drug abuse.

[b.] These numbers mostly reflect girls forced into arranged marriages, increasing the number of illiteracy, and school dropout.

[c.] Uganda, as a country, is predominantly Christian followed by Islam with 12%; Iganga has a high concentration of these Muslims.

[d.] A link between large/polygamous families with poverty, and the high level of household population (six to eight members), increases the difficulty of providing adequate coverage and quality of public services such as education, health and housing for families, especially for children.

With a rampant birth and fertility rate, high illiteracy, common occurrence of young marriages, significant school dropouts, and large number of child headed homes, the need for social improvement is evident for Uganda as a nation. The even higher fertility rate, commonality of polygamy, and high prevalence of HIV that exists in Iganga, emphasizes the greater adversities that may exist in the location of interest pinpointing the even more distinguished need for a sexual health transformation in Iganga.

Participants.

The design of this project reflects my own beliefs about engaging in community development. It is important to me to work alongside people, to assist them in identifying their own needs and vision for social change. The mission of Musana Community Development Organization is to inspire, empower, and enlighten the local people of Iganga to make a difference in their own communities. The staff of MCDO has been trained to analyze and diagnose problems within their community and to collectively strategize ways to transform the economic, educational, social, and public health tensions impacting their lives. They are trusted leaders within the community, have previous history of doing assessment and interventions, and are already change agents within their society. Because of this precedent, I chose to use employees from MCDO as my sample.

Based on voluntary participation, the number of staff involved varied from the surveys to the focus groups. A total of 8 women and 6 men participated in the survey. The following demographic tables (Table 3.2 and Table 3.3) give their age, family background, education level, occupation, current relationship status, and responsibility over dependents. A total of 9 women and 8 men participated in the questionnaires, 12 women and 11 men in the divided focus groups, and 15 women and 16 men in the joint focus groups.

Table 3.2.

General Demographics of Participants

Participant #/ Initials	Age	Tribe/ Origin	Religion	Setting	Education Level	Job
			Men			
1. ME	27	Musoga/ Iganga	Christian	Rural	O-Level Secondary School	Agriculture Worker
2. MJ	24	Musoga/ Magam.	Christian	Urban	University Certificate	Teacher
3. IN	24	Musoga/ Luuka	Christian	Rural	A-Level Secondary School	Teacher
4. SN	27	Musoga/ Kalim	Christian	Rural	University Certificate	Teacher
5. KR	23	Musoga/ Mbale	Christian	Rural	A-Level Secondary School	Teacher
6. MI	25	Geshu Bumoozi	Muslim	Urban	University Certificate	Teacher
			Women			
7. NI	38	Musoga/ Bumoozi	Christian	Rural	University Degree	
8. KD	23	Musoga/ Iganga	Christian	Rural	Primary Certificate	Teacher
9. NT	49	Musaga/ Iganga	Christian	Rural	O-Level Secondary School	Teacher
10. AS	25	Iteso/ Pallisa	Christian	Rural	University Certificate	Teacher
11. NJ	37	Muganda/ Nakalama	Christian	Both	University Certificate	Head of Welfare
12. NS	40	Muganda/ Busei	Muslim	Urban	Primary Certificate	Tailor
13. IR	48	Musoga/Nakavule	Christian	Rural	3 years of Secondary School	Tailor
14. AC	33	Japhad/ Bugiri	Christian	Both	University Certificate	Teacher

Table 3.3.

Family Dynamic of Participants Growing Up and Present

	Growing Up:		Today:		
Participant #	Raised in Polygamous Home/# of Wives	# of Children at home/ Siblings	Marital Status/ # of Wives	# of Biological Children	# of Dependents
Men					
1	Yes/ 4	20/?	Single	0	5
2	No	4/ ?	Married/ 1	1	2
3	Yes/ 3	19/ ?	Single	0	6
4	No	10/10	Single	0	3
5	Yes/ 2	16/16	Single	0	6
6	No	5/5	Single	0	5
Women					
7	No	6/6	Married/1	5	3
8	No	5/3	Married/ 1	1	4
9	Yes/4	18/14	Married/ 2	6	6
10	Yes/2	10/8	Married/ 1	1	2
11	No	17/7	Single	2	3
12	Yes/3	8/7	Married/1	10	7
13	Yes/4	12/6	Single	5	8
14	No	8/8	Married/1	1	3

The participants that took the demographics survey were of various ages. The men were all within the age bracket of 20-30 years old. The women ranged from 20-50 years old. The majority of both men and women were Christian with a few Muslims. The primary tribe was the local tribe of the region, Busoga, with a few Buganda, and individual Geshu, Iteso, and Japhadola. The majority of participants grew up in a rural setting, while a few lived in urban regions, and a few who divided their time in both urban and rural areas. The education of participants ranged from primary school certificates, Ordinary or Advanced level secondary school certificates, university certificates, and one university degree. The majority of participants were teachers, with a few tailors, one Head of Department, and one farm employee.

The family dynamic in which the participants were raised and live to this day sheds light on the high number of children within families and the inability to provide for all of them. Half of the participants grew up in polygamous households where their father had 2-4 wives. All of the participants grew up in homes with 4-20 additional children both siblings and other dependents. One of the six men were single, and all but two of the women were married, one being one of two wives. The married man was the only male to have children. All the women have children ranging from 0-10 in number. However, all of the participants, single and married, have other dependents ranging from 2-8 in number. Dependents reflect the inability of parents to care for all of their children, leaving the responsibility with other family members. The general demographics portray a range of backgrounds of the participants ranging from age, tribe, origin, religion, setting, education, and employment at MCDO. However, despite their background, all of the participants have several dependents. The size of their families exceeds the capacity to adequately provide for the needs of their children and illustrates the relevance of this conversation to their everyday lives.

Data Collection Strategy: "Insider" Facilitators

I administrated data collection with the help of two facilitators. The facilitators were local Ugandans who hold positions within the social work department of Musana Community Development Organization. The facilitators were chosen based on my relationship with them. Through my employment and position at MCDO, I have worked with the chosen facilitators extensively in the field, gathering health and demographical data in the communities surrounding Musana Community Development Organization. I have partnered with them in surveys and interviews, and have witnessed seminars they conducted within the communities surrounding MCDO. As I have observed their work and worked alongside them, I have gained a lot of respect

and comfort in working with them. They have wisdom and knowledge about life in Iganga, as one of their main responsibilities at MCDO has been to do needs-based assessments on individual families and in the community at large. In addition, they are fluent in both Lusoga and English, so they were able to translate questions that were better understood in the local language. Moreover, they are well known and well-liked by the staff at MCDO, making them easy to converse with and approach. Furthermore, one of them is male and one female, and as a pair they offered a balanced and exemplary teamwork feel for the staff in discussing a subject that has a significant gender dynamic. Along with their different genders, they were able to facilitate the gender appropriate focus groups separately. For the purpose of this study, they were trained extensively by me, the researcher, through informal method meetings, and detailed discussions of the main objectives of the research. I additionally involved them in the creation of the demographic survey, and the questionnaire, which was also used in the focus group discussions to ensure cultural understanding and propriety.

Operationalization

Throughout the data collection, three themes surfaced and were used within the data processing and analysis. Gender roles are the main focus, looking at how the men and women within the community perceive the general masculine and feminine responsibilities in society, the power dynamic within relationships portrayed in decision making about sex and sexual and domestic violence, sex preparation, and perceptions of promiscuity and sexual inactivity. The second theme discussed is the perception of sex education and practices of youth, considering elements such as sex education, adolescent relationships, and teenage pregnancies. The third theme is family planning and sexual health services, looking at the societal beliefs regarding

condoms, the perception of using condoms within relations, and access to family planning and sexual health services. Table 3.4 gives a summary of the themes.

Table 3.4.

Sex, Gender, and Culture: Themes and Dimensions

Theme	Dimensions
Gender Roles: Men vs. Women	• General gender roles • Power in relationships→ Decision making about sex, sexual and domestic violence • Sex preparation • Promiscuity/Sexual inactivity
Sex Education and Practices of Youth	• Educating youth • Adolescent relationships • Teenage pregnancies
Family Planning and Sexual Health Services	• Societal beliefs about condoms • Condom use in relationships • Family planning and sexual health services

Data Collection Process

Participatory observation. Because the premise of my study revolves around my experience of living and working in Uganda, participatory observation was used within my research. Marshalll and Rossman (1989) define observation as "the systematic description of events, behaviors, and artifacts in the social setting chosen for study" (p. 79). Observations allow the researcher to provide a "written photograph" in a sense through the description of the situation using the five senses (Erlandson, Harris, Skipper, & Allan, 1993). Schensul, Schensul, and Lecompte (1999) explain participant observation as "the process of learning through exposure to or involvement in the day-to-day or routine activities in the researcher setting" (p. 91). As I have lived amongst Ugandans over the years, I have gotten to know the local people

within the community of Iganga, and I have been able to study their day-to-day life and get an understanding for why they do things the way they do.

Throughout my time in Uganda, I have spent time sharing meals with families, visiting their homes, attending funerals and weddings, and celebrating holidays with them. When I began my research study during the summer of 2014, I formalized participant observation by keeping a field notebook. I also became more strategic in my observations and began to initiate conversations specific to sex roles, gender, and family planning. I took detailed notes, and summarized my observations over the course of the following three months.

Five stages of data collection. Once the participating employees of Musana Community Development Organization were selected through nonprobability methods, the researcher and trained examiners distributed information and consent forms to each participant regarding the research protocol (including dates, location, purpose of study). When consent forms were returned, data collection took place incrementally in five stages. The data was collected at MCDO's headquarters from December 17th to December 23rd when the majority of activities within the organization were on break for the Christmas holiday. The data collection process was broken up into five stages, summarized in the Table 3.5.

Table 3.5

Stages of Data Collection

Stage	Type of Method	# of Male Participants	# of Female Participants
1	Demographics Survey	6	8
2	Questionnaire	8	9
3	Gender Divided Focus Groups	11	12
4	Educational Presentation	16	15
5	Joint Focus Group	16	15

Stage 1: Demographic survey. Participants received a demographics survey intended to identify and assist in the differentiation among individuals within the sample. The survey addressed general information about each participant referring to his or her tribe, age, family, education, etc. Eight women and six men took the survey. The focus group facilitators were available if participants needed further explanation regarding the questions.

Stage 2: Questionnaire. The researcher and trained facilitators handed out questionnaires to introduce participants to the topic at hand. For the participants who were incapable of reading and writing, they were asked the questions orally by the facilitators in an interview style. The facilitators took notes on the responses. The female facilitator aided the women if needed and the male facilitator was available to aid the men. Nine women and eight men took the questionnaire. The questions were semi-structured with both short answer and open-ended questions that were established during the training sessions between the researcher and the facilitators. The facilitators ensured that the questions were understandable and socially appropriate.

I chose Questionnaire surveys for my Stage 2 method of research for multiple reasons. First, questionnaires can give a comprehensive view of attitudes, values, and beliefs of a population (Cargan, 2007). I wanted to use the questionnaires prior to focus groups to thus get an understanding of attitudes, values, and beliefs that exist within the communities of the participants without the influence of "group think" during the later focus groups. Additionally, questionnaires can be administered to large numbers of individuals simultaneously, taking less time (Cargan, 2007). Because the research was taking place over the holiday, the participants' as well as the facilitators' availability was limited. The questionnaire was chosen to provide an easier time commitment for all parties involved. Finally, with questionnaires, there is less pressure to respond immediately and participants are provided more comfort in expressing their

feelings regarding sensitive topics as they are not publicized (Cargan, 2007). For the majority of the participants, they had never discussed issues revolving around sex publicly. Sex is a culturally sensitive topic and could have made them very uncomfortable. The questionnaire provided them more time to contemplate societal beliefs and behaviors regarding sex and gave them an introduction to thinking about what otherwise would be a taboo conversation.

After data collection took place, the questions were divided into the three themes: Gender Roles: Men vs. Women, Sex Education and Practices of Youth, and Family Planning and Sexual Health Services as reflected in Table 3.5.

Table 3.5 ***Data Collection Questions***	
Gender Roles: Men vs. Women	1. What is the role/expectations of women in Uganda? In relationships, marriage? 2. What is the role/expectations of men in Uganda? In relationships, marriage? 3. Who makes decisions in a relationship about sex? 4. What are common beliefs about a man that has a lot of sex? About a woman that has a lot of sex? 5. What are common beliefs about a man that does not have a lot of sex? About a woman that does not have a lot of sex? 6. How do these cultural beliefs collide with religious expectations? 7. Are there any traditions surrounding sex preparation? 8. Is labia elongation common? Why does it take place? How do men feel without it? 9. Is sexual violence common in your society? What causes it? Do women report it? If no, why not? 10. Is domestic violence common? What causes it? Do women leave their husbands if they are abused? If no, why not? Is it reported? If no, why not?
Sex Education and Practices of Youth	1. How are adolescents prepared for sex? 2. What is the most appropriate way to teach adolescents about sex? -abstinence, condom use, birth control, etc. 3. How does society respond to teenage relationships? Are they encouraged? Are they ignored? Are they taboo? 4. Is there a safe place for adolescents to seek sexual advice? Who can they confide in? Are they accepted? What do you think is the repercussion of this? 5. Do you know of any young girls that have gotten pregnant in your community? What happened to them? How were they viewed? Who was blamed? How did her family respond? How can these instances be prevented?
Family Planning and Sexual Health Services	1. What are the different societal beliefs about condom use? 2. How is condom use perceived in serious relationships? 3. What reason do couples not use condoms? 4. When is condom use accepted? 5. Are people educated about sex and family planning? If yes, how? If no, what is lacking?

Stage 3 and 5: Focus groups.

Stage 3. Separate focus groups were held for men and women in Stage 3. The male facilitator led the men, and the female facilitator led the women. The purpose of these initial focus groups was to follow up on the questionnaire and to discuss more broadly the gendered perspectives of these critical issues. Participants were not sharing their own perspectives, per se, but rather the normative views of each gender group. For example, their discussion focused on the role of women in society, the role of men in society, sex education among adolescents (what is appropriate?), teenage pregnancies, sexual myths surrounding condom use, promiscuity, making decisions within intimate relationships, domestic violence, sexual violence, etc. There were two note takers present for the discussions. Not only did the note takers record perspectives and key discussion points, they also observed group dynamics such as disagreement, affirmation, and silencing. The results are based off of a cross reference of the two perspectives. The gender specific focus groups involved 12 women and 11 men.

Stage 5. Following the educational presentation, the men and women were instructed to mix themselves so they were no longer divided by gender. They were briefed that in this particular stage they were going to work as a team. A representative from the men presented the findings from the male focus group and a representative from the women presented the findings from the female focus group. Afterwards, similarities and differences in responses between the men and women were explored as well as interesting and/or new insights. Also, the joint group was asked to strategize for a way forward. The joint focus group with both men and women involved 15 women and 16 men. Note that the number of men and women varied from the previous stages as additional employees asked to take part in the conversation. (Musana has a very communal environment in which even during the holiday, staff members come and go. For

this reason, unexpected additions occurred within the joint session, adding more insight into the discussion.) Table 3.6 shows the questions asked in this combined group discussion.

Table 3.6.

Stage 5: Discussion Questions

1.	What were your findings within your groups?
2.	What similarities can you see between men and women's responses?
3.	What differences can you see between men and women's responses?
4.	In Uganda, what do you see as the biggest barriers for an effective sexual transformation?
5.	What are the best ways to tackle the issues discussed on a national level? Community level? As an organization, how can Musana help tackle these issues?

The reasoning for my choosing focus groups as a method revolves around their use in the aim to understand community dynamics and viewpoints (Laws et al., 2003). The benefits of focus groups are the provision of an environment in which a good understanding of collective social action can be obtained with the access of beliefs, behaviors, and attitudes that may be overlooked in individual questionnaires (Desai & Potter, 2006). Uganda is an extremely communal society. For this reason, in order to get a realistic grasp on the sex dynamic, understanding it in a social setting is key. Additionally, a fundamental element of social sciences is the comprehension of the extent to which individual and group identities and motives are influenced by various factors and other social groups (Giddens, 1991). Having the gender separate focus groups and then the joint men and women focus group, gave me the opportunity to study the gender dynamic fully as the energy and responses between the men and women, separate and joint completely transformed. For this reason, a significant part of my findings

depended on the social dynamic that the joint group portrayed regarding the social pressure and the beliefs and attitudes that were not present in the questionnaires, or in the divided focus groups.

In addition, part of my initial interest in the research revolves around the ineffective push for a sexual health transformation through campaigns and initiatives set forth by the international and national actors. However, going along with the flaws in international norms becoming local practice is the lack of local understanding. Recently, there has been a push to include participatory research techniques within the field of development in order to restore unequal power, positionality, and Eurocentricity that has commonly occurred while in the field within Global South contexts (Holland & Blackburn, 1998; Mikkelsen, 1995). The purpose of my research it to get a better understanding of the barriers standing in the way of an effective sexual health transformation by getting past the controversies of international norms being pushed out of cultural context, by discussing the issue with the local people. Focus groups have become an important process within participatory research, offering a more effective and rapid way of engaging with communities and understanding them (Desai & Potter, 2006). Furthermore, the purpose of MCDO is to inspire, empower, and enlighten the local people of Iganga in creating change within their communities. The staff of MCDO strategizes ways to transform the economic, educational, social, and public health tensions impacting their lives. Through the use of focus groups, the conversation of how as an organization, they could aid in an effective sexual health transformation was ignited.

Finally, through focus groups, people engage in ‘retrospective introspection’ in which they explore taken-for-granted assumption in everyday lives (Bloor et al., 2001). The practice of reflecting on particular ways of acting and daily routines is uncommon. However, through focus

groups, people are pushed to analyze their actions and routine. As I have mentioned previously, many of the topics addressed within the focus groups had never been spoken of before in a public setting. Participants were challenged to question the reality of gender disparities, how they approach the conversation of sex with their youth, and their beliefs and attitudes about family planning. After the focus groups, the majority of the participants thanked me for opening the discussion up, recognizing that it was something they had never openly examined, but proclaiming the importance of the conversation. Throughout the following week, staff members who were not able to participate shared their regret in missing the activity, and suggested a continuation of the study.

Stage 4: Educational presentation. After the gender separated focus groups, the men and women were brought together for a presentation that aimed to educate the participants on the importance of sex education and family planning on community development - underscored by Ugandan statistics. The purpose of this stage was to inform the participants of the importance of the topic and to pave a way forward to Stage 5, when they would be asked to reflect on the similarities and differences between the men and women and strategize for a way forward.

Data Processing and Analysis Procedures

Once all the data was collected through the written survey as well as the questionnaires, and focus groups, transcription took place. Because I used multiple data collection tools, I had to process each method independently prior to analysis. For example, information collected through the written survey and questionnaire was compiled word for word. Then, notes from the focus groups were compared and contrasted with the goal of being as close to verbatim as possible. If there was discrepancy, the note-takers discussed their findings and either agreed upon one understanding or both were shared in the summary transcript.

After all of the data was compiled from the surveys and questionnaire, and the transcripts were complete, I began the analysis process. The data processing and analysis occurred through grounded theory, which is used to identify categories and concepts within text that are then linked into formal theoretical models (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Grounded theory can also be described as a set of methods that "consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves" (Charmaz, 2006, p.2). The process as described by Bernard and Ryan (1998) includes, first reading the transcripted data, then identifying possible themes, followed by comparing and contrasting themes and identifying structure among them, and finally, building theory and checking it with the data. The important element is that the resulting theory is grounded in the data. The aim within grounded theory research is to understand social context through people's experiences and how individuals understand and bring meaning to their society. In my research, my aim was to start a conversation about sex with the local people of Uganda, to understand the social context of the barriers standing in the way of an effective health transformation in Uganda as well as expose them to the complexity of sexual health in their society in order to strategize for a way forward.

I began by creating typologies for the survey and questionnaire materials. For example, questions/answers were categorized into three general themes regarding sex in Uganda: Gender Roles- Men vs. Women, Sex Education and Practices of Youth, and Family Planning and Sexual Health Services as mentioned previously. Next, I went through each category and began to code. As codes became consistent, I began to merge them under the thematic headings, pulling out the different dimensions as outlined in the operationalization section of this chapter. In analyzing the data, I compared and contrasted the themes according to men vs. women's answers within the

questionnaires and divided focus group. I also analyzed the interactions between men vs. women within the joint group and used their discussion to further support the relevant themes in looking for a way forward.

Additionally, content analysis of these focus groups occurred through examining the verbal content of each question alongside the nonverbal reactions. Changes between the participants' answers within the questionnaires and the focus groups were acknowledged, as well as the spike in energy level portrayed in raised voices and change in position (standing up) within some of the topic matter.

Ethical Considerations and Safeguards

Before the research conducted within this study took place, it was approved by the Institutional Review Board in a proposal outlining the project. Also, because the study was done internationally and interculturally, a representative from Musana Community Development Organization approved the proposal. All participants signed consent forms and volunteered to take part in the study. No physical harm was done in this research; and all necessary conversations took place beforehand to ensure a cultural sensitive approach as not to offend participants emotionally, especially as the topic is considered culturally sensitive. All answers to questions were kept confidential when the data was recorded. The names of participants were additionally protected as to prevent any further embarrassment for answering the questions and participating in the group discussion naturally and honestly. A debriefing also took place to reward participants for taking part in the research.

Chapter 4: Results

In order to better understand the best way to tackle barriers standing in the way of an effective sexual health transformation in Uganda, the research in this project discussed issues surrounding sex education, family planning, cultural practices and beliefs that may prevent the public from applying safe sex and family planning measures with local Ugandans. Questionnaire surveys and focus groups revealed the depth of the issue as voiced by the staff of MCDO. The most prominent point of tension during the focus groups related to gender roles. There was a significant disagreement in perception between the men and the women. Using gender roles as a theme, I coded responses and found four consistent clusters which included general masculine and feminine positions within society, the power dynamic within relationships, sex preparation, and promiscuity/sexual inactivity. A second theme that emerged focused on sexual practices and education of youth. The particular concerns or coding clusters that emerged related to education for youth, adolescent relationships, and teenage pregnancies. The third theme was family planning emphasizing societal beliefs about condoms, the relational impact of condom use, along with general family planning and sexual health services. In this chapter, the data collected will be laid out in tables according to each theme and dimension.

Gender Roles: Men vs. Women

General gender roles: "Assistant-heads" and "heads." Traditional gender roles shape and influence how men and women participate in their society. Throughout the research process, women and men consistently articulated their community's expectations and perceptions about the roles men and women play. Their answers fell into three categories: roles within the household, roles within the community, and roles within intimate relationships. Table 4.1 reports the findings according to the female and male participants.

Table 4.1

Gender Roles According to Women and Men

	Roles of Women	Roles of Men
	According to Female Participants	
In the home:	❖ All household duties such as cooking and cleaning ❖ To bring up the children "morally, spiritually, and socially," teaching cultural norms, hard work, and respect	❖ The "head" of the household ❖ The "breadwinner," providing basic needs ❖ To provide security and protection ❖ To help teach discipline and cultural norms to the children ❖ To ensure the family is happy
In relationships:	❖ To marry men with good jobs ❖ To take care of the husband by cooking, cleaning, giving him multiple children, being of moral support, and sexually satisfying him	❖ To marry a good woman that can care for the family
In the community:	❖ To be hospitable to visitors	❖ To be social ❖ To secure the reputation of the family by having job, a home, and materials such as an expensive car
	According to Men	
In the home:	❖ To bear children ❖ To raise the children as "good citizens of tomorrow" ❖ To care for the home by cooking and cleaning ❖ To participate in decision making as "assistant heads in the family"	❖ The "head" of the household ❖ The "breadwinner," providing basic needs to the family ❖ To protect the home and the family o "If a snake enters the bedroom, the man is to take a stick and get rid of it." –SN, age 27.
In relationships:	❖ To satisfy men sexually	
In the community:	❖ To uphold the family reputation and protect the privacy of the family ❖ To show hospitality to clan members when they visit	

Power in relationships: Educated women "give headache." The data collected in the study revealed a power dynamic within relationships evident in sexual decision-making, and sexual and domestic violence.

Decision-making. Table 4.2 reveals the participants opinion on the decision-making power within relationships in terms of who *does* and who *should* determine when to have sex.

Table 4.2

Decision Making About Sex in Relationships

	According to Women	According to Men
Who *Does* Make Decisions About Sex in a Relationship?	❖ Men ○ "It is ALWAYS the men who decide."- NI, age 38 ○ "It is the man who decides!"- General Consensus ○ "The man decides. If a woman decides to have sex and the man is not interested, he will refuse to perform. But for him, even when the woman does not want, he ends up forcing her, so it is the man that decides. This might also cause fights at home more especially at night." –NS, age 40 ○ "If a man comes and is complaining of back ache or stomach ache… no sex, but if the woman does the same… sex!" –Group Consensus ○ "Women always have to be ready. Men's sexual desire is high. They are always ready!" –Group Consensus Note: When this particular question was raised during the focus group, the energy level between women drastically changed. Some women began to raise their voices, others stood up in exclamation. ❖ The women did express that the situation varies for employed women. If women are tired after a day of work, they explain that it can be a mutual decision.	❖ Both parties ○ "Otherwise men are accused of rape." –ED, age 27 ○ "If you come to my home and tell me I am violating her, it is against my rights. No!" -MI, age 25 ❖ Both parties but men have more influence
Who *Should* Make Decisions About Sex in a Relationship?	❖ Both partners ○ "In order to have a healthy relationship, both parties need to have a common understanding in decision making." –AC, age 33 ❖ Women ○ "It would be her way of protecting herself from the trap of conceiving, losing dignity, getting shame, and having/acquiring STDs for herself." -NT, age 49 ○ "However, if she speaks up against having sex, she risks the man becoming violent." –NS, age 40	❖ Both parties ❖ Men

Sexual and domestic violence. Sexual and domestic violence is a very common occurrence throughout Uganda. Table 4.3 and Table 4.4 portray the male and female perspectives surrounding the common abuse. Each table is broken down into the causes of incidents of sexual and domestic violence and the prevalence of reporting such violations.

Table 4.3

Causes and Reporting Sexual and Domestic Violence According to Women

Causes of Sexual and Domestic Violence:

- ❖ Women are men's property so men can do what they want
  - "Because men pay dowry to marry women, they consider women as property. For this reason, a man can do what he wants with his wife, especially when he is not pleased with her behavior." –FL, age 28.
- ❖ If a woman is disobedient
  - "It is common for a man to punish a woman by refusing to pay school fees, beating her, refusing to buy things for the house; she might even be raped." –NJ, age 37
- ❖ Men's drunkenness/drug abuse
- ❖ The way that women dress
  - "Sexual violence is like drug abuse for men because they cannot control their addictions to women. When girls and women go on putting mini skirts and trousers, they are bringing it upon themselves." -AS, age 25
- ❖ Men's high sex drive/when women deny sex
  - "Violence is caused by one partner refusing to avail sex to the other. Men cannot control their sexual desires. Sometimes they want to start when the children are still awake and if the women refuse- they end up fighting." –NS, age 40
- ❖ Poverty-When a man fails to provide for his family and the woman approaches him, she will be beaten
  - "When the man cannot fulfill the needs of the family and the woman asks for some help the man ends up fighting." -AC, age 33
  - "Yes, sometimes a man neglects to buy food for the home and if the woman talks about it, they end up fighting." -NS, age 40
- ❖ Forced or early marriage
- ❖ When the man has multiple wives/ partners
- ❖ To show their domination
  - "Some men want to show their women that they are strong." -AS, age 25
- ❖ Regret of marriage

Reporting Sexual and Domestic Violence

- ❖ Women do not report sexual and domestic violence due to fear of:
  - Separation and divorce
    - "Because they cannot provide for themselves or their children and have no property or assets." –NJ, age 37
  - Being tainted for marriage or remarriage
  - Being shamed by their community
  - Bribery within the system allowing their perpetrators to escape charges and then coming back to punish them
  - Stigma
- ❖ Women's inability to pay back the dowry
- ❖ They lack the knowledge of where to report cases of sexual violence
- ❖ If women can afford it, they will report, leading to divorce

Table 4.4

Causes and Reporting Sexual and Domestic Violence According to Men

Causes of Sexual and Domestic Violence:

- ❖ Misunderstanding and lack of communication
- ❖ Poverty/ unemployment of men
- ❖ Alcohol/drug abuse
- ❖ Greediness of men
- ❖ Lack of religion
- ❖ Self-contentment of men
- ❖ Men's uncontrollable sexual desire
- ❖ Poor dress code of women
- ❖ Lack of trust within a relationship
- ❖ If a woman is educated
    - "Women who are educated equally or beyond will give headache!" -MJ, age 24

Reporting Sexual and Domestic Violence

- ❖ Women do not report sexual violence due to the fear of:
    - Being shamed in the community
    - Losing their dignity
    - Isolation from society
    - Losing their family and marriage
    - Being abused by their husbands and community members
    - Raising their children alone, letting them suffer
- ❖ Women do not report because they are ignorant about the laws and where to report abuse
- ❖ Women do not report because they are unable to pay back the dowry
- ❖ Many women do not report abuse because it is seen as normal in society, so they do not think it is wrong
- ❖ Educated women are more likely to report
    - "Some literate women report, other illiterate women do not" -IN, age 24
- ❖ Further the men recognized the uncommon occurrence of men being the victims and reporting
    - " What about men? There were three cases of men reporting violations, so men do not fear to report when their women violate!" -ED, age 28
        - Note: This statement was followed by a lot of laughter

Sex preparation: The *ssenga*, uncle, and the father-in-law. The behaviors and ways of life regarding sex have a very deep history as many of the practices that the people perform today have been taking place for hundreds of years throughout Uganda. In the study, the participants referred to some of these practices surrounding the preparation of sex. Both the men and women discussed the aunties' and uncles' role in educating young men and women about intimacy, as well as the traditional role of the father-in-law. Table 4.5 breaks down these responsibilities.

Table 4.5

The Ssenga, Uncle, and the Father-in-Law and Sex Preparation

- The *ssenga*: the paternal aunt who has a detrimental role in preparing young girls for sex
  - In Eastern Ugandan tradition, the *ssenga* "tested out the husband first"
    - On the wedding night, the *ssenga* would escort the bride to the bed of the groom and have sex with him while the bride watched to learn the role of the woman
  - The *ssenga* is responsible for labia elongation: Trains young girls to put weights on their labia to stretch them out
    - The practice of labia elongation is done among the Busoga and Buganda tribes
    - It is said to increase sexual satisfaction for both the male and female during intercourse as it holds the penis firm, improves safety within birthing and delivering children, and keeps the vagina warm
    - "It is a sign of true womanhood." –General Consensus
    - "It caters for the central beauty of a woman." – General Consensus
    - "Men feel bad without it, especially when they have met women with it." –General Consensus
    - "It takes place because women want to be loved by men." –NS, age 40
    - "It is more appetizing and increases the sweetness of sex." –General Consensus
- The uncle: A week before the wedding in traditional culture, the uncle would prepare the man for intercourse through counseling and explanation
- The father-in-law: In Western Uganda, the bride spent one week in the home of the father of the husband who slept with the woman until she perfected the act- When she was good at satisfying the man sexually, the father-in-law gave his approval and sent her back to the husband

Promiscuity/sexual inactivity: "Blessed from God" or a "harlot." Much of what makes a positive reputation for both men and women is determined by sex practices or the lack there of. According to the participants in this study, men and women have very different societal images based on their sexual exploits. Table 4.6 considers how women and men are viewed in society in terms of promiscuity and sexual inactivity comparing the perspectives of the male and female participants.

Table 4.6

Societal Views of Promiscuity and Sexual Inactivity Among Men Vs. Women

	Image of Men	Image of Women
If they are known for promiscuous activity	❖ According to male participants: o "Strong, perfect, and healthy" o "Blessed from God" o Financially stable o "Energetic" o Depending on a man's sexual and financial ability, he should have as many wives as he can and have as much sex and as many children as possible ❖ According to female participants: o Arrogant o "One track minded" o They have no dignity o "Drunkards" o *Mbangaluzi*- meaning lustful o Vulnerable to HIV/AIDS, which could lead to death o It is acceptable within marriages only o The women acknowledged that men identify a multitude of sex as a sign of manhood and proof of strength- "They regard themselves as sexual artists." - NI, age 38	❖ According to male participants: o "Immoral, a prostitute, and has a lot of lust" o A "harlot" ❖ According to female participants: o Prostitute o Lustful
If they are known for sexual inactivity	❖ According to Men: o Weak o Unproductive o Abnormal o Cursed o Inept ❖ According to Women: o Impotent, but free from lust o Abnormal o Have less power	❖ According to Men: o Humble o Faithful o Trustworthy o Can be viewed as diseased and unable to produce children o If she does not please her man, she can be considered useless within the home, which can lead to divorce ❖ According to Women: o Have less power

Sex Education and Practices of Youth

Educating youth: "How do we control nature?". Because openly discussing sex publicly is taboo, the participants reflected on how adolescents are educated and prepared for sex revealed in Table 4.7.

Table 4.7

How are youth educated about sex/prepared for sex?

❖ They are not prepared or educated
- Culturally it is not common and not even allowed because "parents have a fear that in case sex is exposed to the adolescent, they will practice it" which "may lead to child headed families" or "cause STDs."
- It is not proper until the days leading up to marriage. Before then, girls are solely prepared for marriage through domestic chores and how to care for a home. The process of labia elongation does start at young ages, but the girls are not informed on the sexual parameters of its purpose.

❖ Although sex is culturally a taboo topic with adolescents, youth are told to feel free to seek counseling from:
- NGOs
- Seminars (i.e. Straight Talk),
- Medical Centers
- School
- Elders from the church or their clan- Traditionally, the most common way is through their *ssengas* and uncles

All these sources are considered 'safe places' for adolescents to seek sexual advice. In reality, a true 'safe place' does not exist. No matter where youth go, they are encouraged to abstain and if they want to become sexually active or express that they already are having sex, they will be judged and risk destroying their reputation.
- In schools, youth are educated about the use of condoms; however, this is done in a discouraging manner. They are taught that condoms are the resort of the failure "to control oneself."
- Participants emphasized the contradictions that lie within the spaces where youth *should* seek advice. One conversation went in the following manner:
  - "It is not right! We don't have a good place to learn about sex. I have never heard of sex education or a situation where students come to teachers." –SI, age 30
  - "Right now we don't have helpful people to speak about sex because schools discourage it. Yet, this is something that everyone does. Everyone will do it. They need to know when, how, and why." –SI, age 30

❖ Despite the silence and disapproval of conversing with adolescents about sex, youth practice it in secret.
- "It is the reason why we Africans have hidden relationships" (MU, age 23).

As a result, they seek information about sex from:
- The media: TV, the radio, and advertisements
- Their peers
  - "Who is youth feeling free with? Youth would seek advice from their parents, who are meant to talk to them, but they cannot go to their parents. Instead they go to their peers." –MU, age 23

Participants additionally debated the most suitable ways to educate youth about sex. Table 4.8 reports their ideas and beliefs.

Table 4.8

What is the most appropriate way to teach adolescents about sex?

According to the women:	According to the men:
❖ Abstinence o "If we teach contraceptive use as opposed to abstinence, we risk adolescents having relationships in secrecy, after all, how do we control nature? As a result it will cause problems for the parents."- IR, age 48 ❖ Use scare tactics when conversing about sex with youth by telling stories of people who have had intercourse and the consequences like contracting disease, or getting pregnant and being shamed from society or even dying o The women did discuss that although abstinence is the best way to teach youth about sex, they also needed to understand what they are abstaining from	❖ Abstinence: Being open about the topic of sex would just "add to desire" ❖ Use scare tactics of stories regarding the consequences of adolescent intercourse ❖ For adolescents from the age 12 to 15, abstinence is the best method ❖ For youth 15 years old and up, teaching condom use "can be effective" ❖ The majority of the men believed in the need for a truly safe place for youth to seek sexual advice referring to condom use- They explained: o "Everyone should know about condoms! What about the younger kids who are told to abstain but are running crazy? They need to know about condoms, even if they are only 12 years old." -DE, age 26 o "In Africa, we do not talk about sex. So kids are learning about sex by themselves and they do not know the effects. When a child shows the interest in knowing more about sex, it is important to sit the child down and let them ask questions. Advise them to use condoms. BE OPEN! Otherwise they are learning on their own and by peer groups. Explain to them the effects of sex, protected and unprotected." – MU, age 23.

Adolescent relationships: "Loss of dignity and respect." The participants also discussed fears and judgments that get attached to adolescents perceived as being sexually active. They also noted how parents and the community respond. Table 4.9 reports these views.

Table 4.9

Adolescent Relationships

Perception of adolescent relationships in the community:	Parents/Community Response:
❖ Relationships "lower the performance in memorizing" leading to poor grades ❖ It means there is "lack of religion" ❖ Adolescents will drop out of school ❖ Early pregnancies will occur ❖ Relationships create disregard of culture- leads to disrespect of parents and elders ❖ Relationships may force family planning methods (pills and injection, which are believed to destroy health) ❖ Causes STDs ❖ Lead to "loss of dignity and respect" within the community as those who are in adolescent relationships are seen as a "disgrace" within society	❖ Adolescent dating is ignored by parents who deny the possibility that their children are in relationships o It is only when young girls become impregnated that parents are forced to face that their children have been with "so and so"- Until then, it will be hidden from parents and parents will turn a blind eye to its occurrence ❖ To prevent teenage relationship, parents may limit the movement of their children, and encourage a modest dress code for girls ❖ Within peer groups, relationships are promoted, but in secrecy from adults and the rest of community

Teenage pregnancies: "Everyone knows a girl!". Due to the absence of safe places where youth can seek advice and sexual health services, the prevalence of early pregnancies is high. The participants explained how common it is for young girls to be impregnated, voicing, "Everyone knows a girl!" As a result the repercussions are severe. Participants reflected on the perception of teenage girls who become pregnant and the consequences of their early pregnancies portrayed in Table 4.10.

Table 4.10

Social Perception and Consequences of Early Pregnancies

Societal Perceptions of a Pregnant Girl: She is…

- A burden to the family
- Immoral
- Disobedient
- Undisciplined
- Failure
- A criminal
- She has lost her sense of purity and is seen as second handed, losing the appeal for marriage
- Useless
- A bad influences on other girls

Consequences:

- Stigmatization: They lose all sense of dignity and respect
- Shame upon the family and a negative reputation on the parents.- The parents are accused of not caring for, guiding, or counseling their children; condemned for giving the girl too much freedom and for being a poor example
- Their parents often disown them
- Parents will blame the schools or teachers for a negative influence
- Occasionally boys are blamed for seducing a girl and even are sometimes imprisoned
- The girl however is reprimanded the most for being careless about her life and her future
  - "In our society, the girl is always blamed." (MU, age 23).
- Abuse by parents and relatives until she gives birth
- Sometimes families deny the girl by sending her away- As a result, the child suffers immensely as the girl has no skills or way of providing for the child
- Young girls are often forced to marry the fathers of the babies; however, it is common for the young men to refuse them and ignore the situation all together
- Drop out of school
- Many seek unsafe abortions
- Many run away from home
- Although teenage pregnancies come as a shock and a burden for parents who respond negatively, they usually recognize how disadvantaged the daughter is in the situation and will help her eventually

Family Planning and Sexual Health Services

Societal beliefs about condoms and contraceptives: It's like "eating a sweet in a cavera". Despite the advertisements pushing condom use and encouraging family planning

services, the participants acknowledged some of the traditional and social beliefs around condoms that are standing in the way of their use.

Table 4.11

Participant Consensus of Beliefs Surrounding Condom Use and Contraceptives

Condoms:	❖ Prevent satisfaction during intercourse- "It's like eating a sweet in the *cavera* (wrapper)." –LA, age 23 ❖ Cause pain and are seen as harmful to the human body: lead to disease such as cervical cancer, impotence in men, sterilization in women, STDs like HIV (coming from the idea that condoms are infiltrated with HIV) or other sickness caused by the condom becoming stuck in the vagina (a perceived very common occurrence) ❖ Require prior knowledge of use ❖ Could lead to abuse if women request their use ❖ Are a symbol of mistrust within relationships;- should only be used with unmarried and casual sexual encounters ❖ Are a symbol of promiscuity, being a "womanizer," "immoral," a "prostitute"- "Most people in communities say condom use is against God's plan because God said to fill the world." –LA, age 23 ❖ "Were brought by the whites to make Africans not produce children." –MJ, age 24 ❖ Are expensive ❖ Are not locally found in rural settings ❖ Are ineffective because they are thought to have holes in them

Condom use in relationships: "Getting children by choice not by chance." When used within relationships, condom use has a very negative meaning. Participants voiced that condom use is customary in non-serious, casual relationships, extramarital affairs, or even teenage intercourse. When a couple stops using condoms, it means that they are committed to each other and is a promise to stay faithful within the relationship. Therefore, when condom use continues within marriage and serious relationship, it is has a very negative meaning. Table 4.12 portrays the participants' analysis of condom use within relationships.

Table 4.12 ***Perception of Condoms Within a Relationship***	
Negative View	❖ A symbol of unfaithfulness, mistrust, and lack of love ❖ A barrier between two partners, preventing the couple from becoming one ❖ Destroys the "sweetness of sex"
Is Accepted	❖ As a family planning method when the couple does not want to get pregnant, "getting children by choice, not by chance" ❖ When one partner is HIV positive and the other is negative

Family planning and sexual health services: Remaining a taboo. The push for family planning has increased the knowledge of people within urban settings, but the majority of people within rural settings still lack the education of sexual health. The participants acknowledged the exposure to family planning and sexual health services and some of the barriers standing in the way of their effectiveness shown in Table 4.13.

Table 4.13 ***Family Planning and Sexual Health Exposure and Barriers in Rural Communities***	
Exposure to Family Planning and Sexual Health Services Through:	❖ Programs set up by NGOs i.e.: Marie Stopes or Straight Talk ❖ Health Centers ❖ Advertisements: posters, magazines, the newspaper, the radio, and television
Barriers to Effective Exposure	❖ Lack of resources in rural areas ❖ Fear to talk about it, as it remains a taboo topic ❖ Men's pride to communicate about family planning

The data collected throughout the research process revealed essential components of the barriers standing in the way of an effective health transformation in Uganda. From the gender dynamic, to sexual practices and education of youth, to general family planning and sexual health services provided for communities, the participants were able to face societal practices

and perspectives of sexuality openly and honestly, breaking the silence of such a taboo topic. This chapter has laid forth their views on the major themes within their discussions. The next section will analyze these understandings and relate data findings to the original research questions.

Chapter 5: Discussion

The purpose of this study was to explore the complexity in reaching an effective sexual health transformation in Uganda. This was done by discussing cultural beliefs and behaviors surrounding gender and sex with the staff at MCDO. Comparing and contrasting the key conversation points between men and women about gender and sex revealed just how deeply the barriers go and how complicated it is to overcome normative cultural beliefs and practices. The biggest hurdle in reaching a transformation in sexual health behaviors and attitudes relates to gender dynamics and the ways those dynamics have been systematized into social and structural violence. The most prominent observation within the data surrounding feminine and masculine roles was the inability to speak about sex and gender objectively, especially in cross-group settings. There was an automatic and perhaps socially expected position that men and women took in the joint discussions, with the common prevalence of women being blamed for abuses, relational failures, and breakdowns in intimate relationships. However, when joint focus group discussions shifted towards brainstorming steps that their community could take towards transforming sexual health practices, participants were able to move away from personalizing the issues. They came face to face with the embedded gender dynamics within their culture, the ways attitudes and beliefs may impede this transition, and the long road ahead in making effective and sustained change within their community.

Gendered Structural Violence

Women in the study were consistent and candid in their view that women in Uganda experience continuous suffering in their intimate relationships and sex. They indirectly discussed the structural violence that they endure on a daily basis. They also were unanimous in opinion that women lack decision-making power in sex within intimate partner relationships. If

they refuse sex from a man, they are subject to sexual and domestic violence. Women further articulated their inability to report or leave their husbands or partners because of their subordinate social and economic status. They noted, in particular, their incapacity to provide for themselves, their children, or to pay back the dowry. Because men pay dowry to marry women, they consider wives as property. For this reason, the men feel entitled to do what they want to their wives. Since women lack the resources to break away from their husbands, they are exceptionally vulnerable and may face violence and injustice. With little to no recourse, they suffer in silence.

Due to the male dominated system that exists within Uganda, women are economically and socially disadvantaged. Gender identity itself becomes the source of vulnerability and suffering. As a result of being victims within culturally structured violence, women submit to their inferior roles inside intimate and familial relationships despite their own feelings or even the abuse that they may undergo. The female participants in this study especially identified the suffering of young girls who may become pregnant as teenagers. Young girls may be coerced into early sex or simply succumb to pressure by boys because they have been enculturated to submit. If they become pregnant, they suffer even further by being beaten and shamed by their community. Some girls may run away or seek unsafe abortions, but these choices threaten their lives even more. Because of their inferior status within society, female participants shared that women and girls suffer in relation to sex throughout their entire lives. Additional crosscutting issues related to their substandard sex roles are health complications due to multiple pregnancies, maternal mortality, and their lack of access to health and social services. The inverse relation to the amount of children they bear and their economic means places them at an ever-increasing

risk. Women's poverty escalates with the multiple dependents they are required to bear and care for.

The conversation about decision-making in sex progressed to a discussion about polygamy in which women described their unfair circumstances. During an inter-group focus group, when women argued that men tend to use force if a woman does not comply with having sex, the men retorted that they do not have to use force because they can simply seek sexual satisfaction from other women. As I listened to this turn in dialogue, I probed the male participant who had asserted this claim to clarify his position. He acknowledged that seeking satisfaction from other women, when marital sex is not enough, is very common in Uganda. As he reasoned, it is not necessary or enjoyable to force women to have sex because it is so easy for men to find other partners. At this point in the discussion, the women became tense and upset. One woman stood up and proclaimed, "Yes, even if is he married. Men have women that no one knows about. Even when couples are wedded in the church, men go in secret. Couples survive because they have outside relationships that satisfy their urges" (AC, age 33).

During the inter-group focus group, both the men and the women acknowledged how common unfaithfulness is, and in so doing, they also revealed the trap in which women exist. The accepted belief that men have an uncontrollable sex drive has, in turn, reinforced their dominance and limits the choices and options for women. These women face a social, physical, and emotional bind. They may be forced into unwanted sex or they may feel compelled to have sex even if they do not want it. The alternative is to take the blame if their husband or partner participates in an extra-relational affair. Since unfaithfulness was unacceptable to these women, their duty was to comply in order to save their marriage. While this seemed to be the conclusion many of the women in the study had made, the tone in their voices revealed pain by this accepted

practice. NI (age 38) pushed the group even further when she hypothetically asked, "How do women feel about getting other wives? Before it was duty, but now what?" This question emphasized not only the pain and anger that women feel as a result of the beliefs and practices related to men's inability to curb their natural sexual desire, but also some of the current contradictions.

Historically, women have had to accept men's unfaithfulness because they had no rights and because it was their duty. The alternative they faced was to break from their marriages with little or no means to provide for themselves or their children. Due to the intensity of international gender rights discourse and global human rights advances, awareness has heightened and women's subordinate status within Uganda has become exposed. The women in my study are faced with the decision of which path to take. International norms tell them to stand up for themselves and to claim their rights. It is no longer their "duty" to submit to male demands or desire. In reality, however, the traditional structures within Ugandan society remain wherein women continue to be vulnerable, dependent, and inferior to men. This reality was reflected in the participants' expression of fear to report or leave their husbands if they were being sexually or domestically abused. The economic and social repercussions were overwhelming. As a result of their social reality and despite the international call for equality and empowerment for women, structural violence and socially embedded gender inequality was holding these women back.

Failure to Be Objective

Part of my reasoning for choosing employees from MCDO as the sample for my research was because of their previous training. They have all been actively involved in analyzing and diagnosing the issues within their community that feed into poverty and exacerbate the

unfortunate circumstances in which so many people live. I believed in staff members' ability to think critically and objectively about the plaguing social issues that their community faces. My assumption about their ability to discuss such a taboo topic openly and critically ended up being correct. What I learned, however, was that they were not able to let go of their identities as men or women, and to think objectively about sex or the barriers standing in the way of effective family planning. Although these men hold multiple identities such as being a father, a businessman, a teacher, and a Ugandan, when it came to discussions about sexual barriers, they spoke primarily from their masculine social position. Their inability to hold multiple perspectives was especially true in reference to gender disparity. My analysis of the data reveals that men, in particular, showed signs of denial, especially as it related to women's experience of sex roles and suffering.

Men, at times, were able to acknowledge the domestic and sexual abuse of women and in a few instances made inferences related to disparity in gender roles. Their overall acceptance that women experienced suffering as a result of this disparity, however, was lacking. This tendency towards denial was especially prevalent during the inter-group discussions. The male participants were deficient in their ability to objectively discuss the perceptions that women gave of their own experiences. In response, they became defensive or even claimed their own victimhood. This dynamic shifted when I reframed the discussion and invited them to work as a problem-solving team. As long as the men could stand separate from the implications of gender disparity within their community, they were not defensive, but if the group discussion became more personalized, the debate recommenced and reenacted the enormous division between men and women.

At the start of the joint focus group, the participants were each asked to present the salient discussion points that had been raised within their gender specific groups. When the female representative presented the women's perspective, male participants became immediately defensive. There was particular tension related to who makes decisions about sex in relationships; the men would not acknowledge their own power within sexual affairs. They were adamant that both men and women make decisions about sex. One man, SI (age 30) spoke up and explained, "Traditionally, yes – men decided when, why, and how to have sex. When he wanted not when the woman wanted. Now women entice men." The men were persistent that it is women who tease and seduce men. They pinpointed women as the ones who desire and initiate sex, and cast themselves in the role of victims. Women in the joint focus group, however, argued, "Ladies will die silently" and that "men are so rude and rough" (FL., age 28). They proclaimed that when women are not in the mood that men use force "even if they are dirty." Interestingly, when men were alone in their own group, they were able to discuss decision making in sexual affairs without defensiveness. They were more ambivalent, stating that both parties make decisions regarding sex but also acknowledged that men have more influence. However, when the women's views were revealed in the combined social setting, the men's views shifted quickly. They became self-justifying and argued that women actually seduce them. They re-cast the women's perceptions of being victims to male victimization instead.

Additional gender disparity was revealed during discussion about domestic and sexual violence. Although male participants were protective about their sexual rights and proclaimed their victimhood, both male and female participants were in agreement regarding the prevalence and causes of rape. They were also in accord in their recognition for why women do not report

rape. During the intra-group discussion among men, division began to emerge related to rape within marriages. When the two groups came face to face, this particular issue became even more problematic. In the male-only focus group, there was general consensus that both parties must jointly agree to have sex or otherwise "men are accused of rape". However one vocal participant, MI (age 25) expressed, "If you come to my home and tell me I am violating her. It is against my rights. No!" MI's candor was telling and pointed to a very controversial debate that is currently taking place in Uganda's political discourse.

Uganda's Marriage and Divorce Bill has been on the docket since 1964. The bill covers a wide range of issues surrounding marriage, divorce, and gender issues such as bride wealth, female circumcision, and the rights of cohabiting couples. Clause 114 of the bill refers to marital rape, giving rights for spouses to refuse sex. The bill has been consistently rejected because it challenges the traditional understanding of marriage and property. MI's frustration is couched in a long and controversial debate about the bounds of marriage. His statement expresses his right to have sex with his wife and his adamant stance against anyone claiming that activating that right would violate her. Not only does his claim reveal his own personal beliefs about marital rape, but it also underscores why the bill has received a pushback from Ugandan men. To them, the bill challenges their masculinity and their perceived right to have sex with their wives.

Within the conversation about rape, the men's hesitancy to acknowledge women's suffering re-emerged as did their male-victim narrative. In fact, some of the men went so far as to cast themselves as victims of rape. Within the male-only groups, as well as the joint group sessions, men publically stated, "Even women rape." Male participants pushed the conversation further, arguing against the women's responses about why rape was underreported or not reported. They attempted to debunk the notion that women do not generally seek help, and

weakly countered that "Yes, some women do report! If only 1% of the time, it is still reported!" (SI, age 30). There was no denial that women are subject to rape or that it is a very common occurrence. Especially within their individual groups, men were able to acknowledge this prevalence. In front of the joint group, however, the men's feelings transformed, and instead of validating the experience of women, they denied their suffering.

During the educational presentation, I revealed multiple statistics about Uganda's development and why, from an international perspective, family planning has become such a significant health and policy concern for the country. I referred specifically to the high fertility rate and drastic population growth occurring within Uganda. In the follow-up discussion after the presentation, I combined the information collected and discussed within the separate gender groups, and asked all of the participants who they thought suffered the most in Uganda. The women immediately responded that it is Ugandan women who suffer the most. The men, however, would not acknowledge women's suffering and argued that children were the most vulnerable population. As I listened to the discussion between the women and men, and compared it to the male-only focus group, it became clear that the men were not able to step out of their ascribed social identities. They were not able to think objectively about sex and the barriers standing in the way of effective family planning in front of women. It was difficult for them to recognize men's role in women's suffering or the fact that women suffer in general. Even when I invited them to work collectively as a team, the conversation drifted quickly back into a male vs. female debate. In fact, some of the opinions that the men had originally shared in their questionnaires and male-only focus groups were opposite to those being shared in the post-presentation session. It was clear that discussion about the causes of women suffering generated threat to these men. What this revealed to me was that even though the men were educated and

informed about the importance of gender equality, and even if they might agree with it in many ways, culturally defined gender roles and a traditional masculine viewpoint were still ingrained in them. Having to face their female counterparts and discuss, on an equal playing field, gender disparity caused them to feel threatened and it generated defensiveness.

Failing to Let Go

As part of my research strategy, participants examined their own perceptions about gender roles privately, but were then asked to share their experiences in various social settings. Even though I know all of these participants personally, I was able to observe them lose their individuality and automatically resort to gender-norm behaviors whenever they moved into public discussion. The women were very hesitant to discuss sex amongst themselves and were even shyer when the men were present. In their gender-specific focus groups, the women avoided discussing their responsibility regarding pleasing men sexually or submitting to them, until they were asked directly. Even with a direct question, they were tentative and embarrassed. As rapport grew in the group, they eventually began to feel freer and opened up about the different practices and behaviors expected of women. It was clear that it was not common for them to publically share their feelings and concerns.

A different dynamic emerged during the joint focus group. The men began to tease women when the women described male decision-making power within relationships as it pertained to sex. When the women began to talk about men's high sexual desire which led to their demand for intercourse, their male counterparts began interrupting them by saying, "Not only men have sexual desire! What about women?!" (IN, age 24). The men kept arguing and described how women also wanted sex, as they would often tease and entice men. When this happened, the women in the group shut down. They became visibly uncomfortable and even

denied having sexual desire as the men pushed further. The men even referred to labia elongation and how it is not only a gift to please men, but that it is intended to increase the sexual stimulation for women as well. At this point, the women sat down and put their heads down in shame.

Men, on the contrary, were very open to discussing sex and even congratulatory with others who they perceived as being sexually active. During the intra-group discussion, when asked the question, "What is a women's role in society?" LA (age 24) immediately stood up and proclaimed, "To please men sexually!" Throughout the focus group, men would slap each other on the back and give high fives for bold answers that placed men above women. Additionally, when they talked about instances when a man's masculinity was challenged, they laughed hysterically as though it could never happen to them. There was also some mild ridicule. For example, when a participant mentioned that men were raped, the rejoinder was that "They report rape, and if they can report then so can women!" (ED, age 28). To this, the men responded with uncontrollable snickers as though it was absurd to even think about such a violation to their manhood.

Both the men and the women succumbed to gender-appropriate behaviors in ways that underscored the double standard in gender dynamics. Traditionally, women are not supposed to have sexual desire or to discuss matters of sex. When the men teased them that they did not have sexual desire, the women did not know how to socially respond. Initially they countered the teasing, but then eventually became quiet. Additionally, the immediacy and levity in some of the men's responses within the mixed social groups was quite different from their approach to the questionnaires. This pinpointed the peer pressure that exists within male circles where sex remains proof of manhood. This dynamic was especially evident in the manner in which they

discussed male rape – laughing and treating it like an impossible situation. To them, the idea of any man getting raped went against their fundamental masculinity.

Gender roles were also illuminated within the discussion about the best ways to educate youth about sex. Women participants were adamant that abstinence was and always would be the best method to teach adolescents. Although many of the men originally agreed that abstinence as the best approach, as discussion continued, they began to shift their positions. They recognized the importance in having an open conversation with youth and the need to instruct them about condoms and contraceptives. These gendered perspectives may point back to the traditionally appropriate roles of men and women. According to the women, they are accountable for raising children "morally, spiritually, and socially" and believe that if something goes wrong, it is their responsibility. It is also possible that women are hesitant to discuss sex with children for fear that it might encourage sexual experimentation. If their child becomes pregnant or gets caught having sex, this might indicate that they failed in their ascribed duty. Either way, women face social ridicule, so the safest route is to teach abstinence.

Women as a Scapegoat

The analysis of the questionnaires and focus group discussion indicated a consistent pattern that women are held responsible when something unfortunate happens. As one woman, AS (age 25) explained, "When things go wrong, I am to blame." This tendency to blame women was attached to domestic altercations and sexual violence. One participant attributed poverty as the main cause of abuse. If a family is lacking in basic needs and the woman broaches the subject with her husband, she faces abuse. This inevitably leads to her trying to find alternative ways to meet the needs of her family in silence and bearing the brunt of the economic misfortune. As it relates to sexual violence, both men and women participants defended men's

ability to control their sexual desire, emphasizing women's complicity in their own rape due to the clothes they wear.

Just as women in Uganda are often blamed for relational ills in their families, there seems to be a contrary dynamic of refusing to acknowledge the positive roles that they do play in building the home because such recognition threatens masculinity. Within the men's intragroup discussion, an outlier participant made the comment that "It is the woman who makes a home, not a man. A man establishes the house" (RA, age 33). In response, a few of the other men began to argue and self-justify saying "Who told you that? It is the man!" (MI, age 25). "We men, we don't have homes?" (LA, 24). "You cannot marry when you don't have a home as a man" (SN, age 27). By saying that women are the ones who make the home, RA threatened the masculinity of men in giving women praise for their contributions to the home. The men were unwilling to link any success of their households to women, but instead attributed positive achievements to their own efforts. In this social narrative, when something good happens, men get the credit, and whenever something goes wrong, women are to blame.

Facing the Gender Disparity

Research data revealed the complexity behind gender disparity and how this impacts men's defensiveness related to sex practices. Any finger pointed at men threatened their masculinity and their roles within society. There is an expectation that men are to be the leaders within their community as well as inside their homes. Public acknowledgement of women's pain and the men's perpetration or contribution to that suffering casts a shadow on their reputation and diminishes their positive influence on society. For this reason, they refuse to recognize women's anguish or the role they might play in that suffering. According to the women, if they do express sadness, those feelings are reinterpreted as an indictment against the men. As an

automatic reflex, the men defend their masculinity and status within the society by denying or invalidating the women's experience and perspective. Although individual men were able to recognize and empathize with the pain of women as revealed in their personal responses, and even at times during the intra-group focus group, when they came face to face with the women themselves, the men changed their positions.

Men were also resistant to women striving for empowerment in society. This dynamic was particularly noted in relationship to male perceptions of women becoming more educated. Women who were evolving and becoming stronger were seen as threatening. In fact, men explained that it was not uncommon for spousal abuse to rise in relation to a woman's educational standing. MI (age 24) expressed how, "Women who are educated equally or beyond the man will cause headache!" An educated woman threatens the man's power and their control. In response, abuse is used to re-establish male dominance. This resistance, coupled with the aforementioned defensiveness related to acknowledging the plight of women, points to men's avoidance of change. When questioned about the fear of change related to male and female roles, the men were open about their fears. They believed that when women gain education and power, they will "treat men like rubbish." It was their perception that with more power, Ugandan women would abuse their higher standing within society and mistreat men. As a result, men were hesitant to accept the change, fearing the social disequilibrium this could bring and the impact upon their traditional ways of relating to women.

Throughout the project, women expressed their anger and shared their pain. Twenty years ago, it is unlikely that these discussions or the expression of such strong feelings would have been openly shared. Even today, it is highly unlikely that in some rural areas of Uganda, these intra group and inter-group dialogues could take place. More recently, however, the

international focus on women's empowerment and equality has opened the door for women's voices to be heard. Light now shines on the global epidemic of gendered violence. For these reasons, the educated men and women within this research were able to at least acknowledge the disparity between gender roles and the prevalence of male to female violence. Nevertheless, when face to face with women, men remained silent, argumentative, or in denial about these dynamics because if they admitted the disparity they would be admitting the need for change. In a society where men can have sex with as many women as they want, and dominate them when they feel threatened, there is not much incentive to change. What became illuminated for me was the complexity of social change, and the relationship between gender roles, sex, and violence. If the most critically thinking and open-minded men in the community were unwilling to face women's insubordinate roles within society and the importance of social equality, the task of approaching men in villages, where there has been minimal exposure to women's rights, appears daunting. The road to social transformation is a long one, and it will be difficult. I am pleased that at least within Musana Community Development Organization, the conversation has opened. It is a start.

"What Do We Do Now?"

During the joint discussion focused on how to best move forward, and ways in which MCDO could assist in improving sexual health within Iganga, the participants' first point of conversation was the need to increase access to family planning. Male participants explained that men are generally skeptical of coming to seminars regarding family planning, and they proposed setting up male-only workshops in the village. In particular, they felt it was important to target men who were "most stuck in their ways." They also talked about the need to fight the negative stigmatization of condom use and to also educate people about the safety and

importance of condom use. In their opinion, the media and advertisements for family planning focus primarily on urban communities. The impact and reach of those educational initiatives on outlying communities was minimal. Men also emphasized the need to normalize conversations about sex. In order to accomplish these goals, they identified the need for training as an essential component to family planning in Iganga. Although family planning services claim to offer "safe" space, a place free of judgment and bias, this had not been the historical experience of participants. They believed that by diligently training sexual health teachers, a truly safe space could, instead, be created.

The conversation about educating youth, however, remained tense. Culturally, it would never be accepted to give youth condoms. Participants inquired about the ways children are taught sex education in the United States. They were curious about how another country attempted to tackle such a deeply value laden issue. At this point, I explained that it depended upon the family, but from my own personal experience, parents are fairly open. I emphasized that there is a wide spectrum of child rearing practices in the United States, so that it was difficult to generalize. It is my opinion that U.S. parents have more control over what their children are exposed to and face less risk that their children will begin experimenting. In Uganda, however, controlling the sex culture is difficult because it is such a part of everyday life. Additionally, the communal aspect of Uganda culture incorporates adults and children in the same spaces. Children are automatically exposed to sex, and it is quite logical that they would practice what they see. The research participants did recognize that if, as a community, they kept teaching youth to abstain from sexual activity, adolescents would simply continue having sex in secret. For them, the dilemma they faced was the belief that if they taught youth about sex, it

would encourage sexual activity, which is culturally unacceptable. The participants were at a loss for the way forward, and questioned, "What do we do? Do we go against culture?"

Although a specific solution was not identified, the participants' eyes were opened to how intertwined healthy sexual practice and sex education were. Through their conversations with each other, they started comprehending the collision between cultural propriety and moving toward positive change and sexual health. Again, there was no specific answer found during our focus group discussion; however, opening up the conversation was essential, and it served as a beginning point. They all hoped to continue the conversation and voiced commitment to working towards a solution.

Limitations

Although the results of the research offer valuable insight into the complexity of barriers hindering movement towards effective family planning and sexual health services in Uganda, there were limitations within the study itself. These limitations include but are not restricted to the lack of generalizability, the time restraint, the method of data collection, and the possible bias of the researcher.

The external validity within the research is debatable. First, the sample within the research was solely inclusive of employees from Musana Community Development Organization in Iganga, Uganda. The majority of the participants were teachers within the organization and come from similar educational backgrounds. Further, the men in the sample were from the same age group. Therefore, it is hard to generalize the results based on the limited sample. In comparing the data collected throughout this research with other reported studies within the literature review, however, the results of this study reflect previous research results in which there were larger sample sizes that included participants from various backgrounds. The

alignment with previous research improves the reliability of this research data. The limited sample is mainly due to the time restraint of gathering the information. Because the majority of data collection occurred over a few days during Christmas holiday, it was difficult to motivate more members of MCDO's staff to participate. An additional by-product of the holiday season was that conversations throughout the focus groups were rushed and even cut short because of the limited amount of time designated for each stage of the research.

The data collection methods of questionnaires and focus groups were valuable and generated rich information. However, the restraints in recording data throughout the focus groups may have limited the results. Because voice recordings and video tapings were not used, the data collected was restricted to observations and interpretations from the perceptions of two note takers. It was not feasible for them to account for 100 percent of the dialogue, which further impacted the veracity of findings. It was my intention to use both video and tape recordings but due to a power outage on the days leading up to and during the focus groups, it was not possible. To offset this limitation, the note takers shared their notes, discussed their observations, and generally found agreement in their interpretation of events.

Finally, it is important to acknowledge my own positionality within the study. In this case, the researcher was a white, American female, who is an advocate for women's rights and empowerment. Throughout my time in Uganda, I have extensively worked with women and have a very deep passion for their move towards equality. While my aforementioned analysis is fully based on the data collected throughout this particular research project, it has also been influenced by my years of participation, observation, and conversations with local people. As I analyzed the data, I consciously challenged my objectivity alongside this history and my own feminist feelings regarding gender disparity. To ensure that my findings were unbiased and

objective, I discussed the results and analysis with the project facilitators, two additional Ugandan men, and another American female who has married into the Ugandan culture. They looked over the notes and affirmed the fairness of my interpretation.

Future Research Suggestions

The research presented in this study opened a dialogue about sex, gender, culture, and ways to seek transformation towards sexual health in Uganda. Through conversation with the employees from MCDO, the complexities and social barriers impeding successful family planning and sexual health services were revealed. The embedded cultural beliefs and behaviors surrounding gender roles and sex were expressed, even in a group of Ugandans who are educated leaders, and have already been actively involved in social change within their community. This reveals the extent of the hard work ahead. If the men in this study could acknowledge the suffering of women yet refuse to take responsibility for their actions, the implications are profound. Successfully moving the discussion into rural communities where stronger traditional values are expressed and where there is less education will be immensely difficult. The Musana employees discussed the need for male-focused seminars in the most rural areas as a strategic and appropriate way to educate communities about family planning. The goal of these seminars would be to fight the stigma of condom use and to educate the people about the safety and necessity of contraceptives. The participants additionally discussed the importance of informing and training teachers on the best practices for discussing sex with adolescents. I suggested the importance of supplementing these participants' proposals by continuing intra and inter-group conversations regarding the gender disparity. As members of these groups gain understanding, they can move to the next level of being agents of change by becoming trained community educators and hold seminars throughout the area.

Part of the mission of MCDO is to empower Ugandans to "be the change" they want to see in their communities. If the men in Musana's leadership base are being called to go into the field and educate community members about the need for social transformation, they themselves need to practice that change. As the research revealed, at this point, they may understand the disparities, but are not yet willing to act on changing them. In my opinion, recognition and validation of perspective is critical to healthy social relationships, and until the staff is able to listen to each other fully, and without argument, we will not be able to move forward as a collaborative team. A future strategy that might assist in this process is to continue doing intra-group work wherein less defensiveness and reactivity takes place. Educating in a mono-group setting may open up the possibility for a different level of accountability and honest discussion. I believe people need to feel safe before they are able to change. Creating an atmosphere that is less threatening may encourage this shift. Continuing to work with intra and inter-group dialogue among community leaders who have already been exposed to the importance of sexual health transformation and gender disparity offers promise for deep-seated individual and communal transformation. As individuals discuss and acknowledge these disparities together, they may start to believe in the cause and fight together for change. As a result, they will lead by example, acting out MCDO's call to "be the change" in advancing gender equality and sexual health transformation in Iganga.

Chapter 6: Conclusion

The international community has highlighted the importance of family planning and sexual health services as a critical focus because of how population growth and high fertility rates in the world's poorest nations impede development growth. With the 2nd highest fertility rate in the world and the 5th fastest growing population, Uganda's ever-increasing number of inhabitants has become a hindrance in the nation's social and economic growth. Despite the push for increased family planning and sexual health services by the international community and the national government of Uganda, transforming words into action has been difficult. Cultural beliefs and behaviors have been blocking the road to an effective transformation of sexual health and gender disparity around the country. Through the conversations with the employees of Musana Community Development Organization, this research aimed to grasp the complexity of the barriers standing in the way of effective social change. The results reveal just how deeply culture is embedded in the hearts and minds of the local people. The biggest deterrent of culture that is preventing effective sex education is the disparity between genders, followed by sex as a taboo topic when conversing with adolescents, and finally the beliefs and behaviors revolving around the use of condoms.

The participants within the research were educated and trained to think critically about the needs of their community at large. However, when male participants were faced with gender disparity as the biggest barrier standing in the way of a sexual health transformation, their objectivity diminished. They were incapable of discussing the issue or problem solving ways to move past it. Throughout the research process, women spoke candidly about the ways they suffer in intimate partner relationships; they also referenced the structural violence that permeates and defines their lives. Although men were able to privately acknowledge the

suffering of women, in public settings they denied it and reverted back to a culturally normative masculine response.

Results of the study reveal that many Ugandans do not lack knowledge or understanding about gender disparity or sexual health. Instead, findings suggest that a significant barrier to social change remains rooted in traditional attitudes, beliefs, and behaviors related to gender roles. Men, and perhaps to some degree, women fear change. The implications for how a more gender equal society may impact intimate relationships, families, traditions, and power seems to have paralyzed participants' ability to think creatively and sensitively about the future.

It would be simplistic to frame my analysis as representative of masculine or patriarchal hegemony; I would also run the risk of perpetuating an outsider and Western perspective on to the data. Perhaps the intersection of Ugandan history, culture, religion, gender, sex, and sexual traditions is more complex. Although a push for family planning and sexual health service is essential in order for initiatives to be more effective, these dynamics need much closer consideration. Western models, rife with an individualistic approach to rights, insensitivity to cultural expressions, and a lack of understanding of how religious and spiritual traditions permeate Ugandans' everyday lives, have been largely ineffective. As the "heads" of their households and leaders of society, Ugandan men have the biggest role in transforming the gender dynamic within their communities. In my opinion, their acknowledgement, support, and leadership are the first and necessary steps towards sexual health transformation. There is a need to sensitively educate men in ways that will not unduly threaten their social roles but that will, instead, transfer their culturally sanctioned leadership to that of becoming allies for women. They are a critical to the empowerment of women and making gender equality a reality.

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APPENDIX A

INVESTIGATION INVOLVING HUMAN PARTICIPANTS
Informed Consent

Title of Research Project:

Sex, Gender, and Culture: The Emergence of Structural Violence While Seeking a Sexual Health Transformation in Uganda

Description of the Research Project:

This research project looks to approach the contradictions that lie within the campaigns to promote family planning and sex education and the cultural ingrained practices and mindset of the Ugandan tradition with a group of locals. By talking to the people of Iganga, Uganda, the research aims to answer the question, to what extend are cultural barriers standing in the way of an effective sexual health transformation within Uganda and how can the Ugandan community start to overcome these obstacles to further develop as a nation?

Because the subjects in this study are being asked to discuss a cultural sensitive topic with honesty and vulnerability, the participant's consent (your approval) is needed. Please read through the following description and sign to accept your participation and show your understanding of what is being asked of you.

Description of Participant's Role:

Within this research, you will be asked to:

- Fill out a basic information survey about yourself
- Answer questions in a questionnaire regarding your community's view on gender roles, sex, and cultural beliefs and practices
- Participate in focus group activities referring to gender roles, sex, and cultural beliefs and practices regarding sex
- Participate in an educational seminar/presentation on sex
- Discuss effective sex education and family planning, and possible solutions

Your participation will require a:

- Maximum of 5 hours for the focus group activities, educational seminar, and follow up discussion plus the time spent filling out the survey and questionnaire

Risks:

- There are no risks to the participants involved in this study. However, you will be asked to open up about a culturally sensitive topic involving gender roles, as well as sexual beliefs and practices.
- Because participants are being questioned on a sensitive subject, the social worker at Musana Community Development Organization will be available for counseling if the process is uncomfortable or distressing and participants need further support.

Benefits:

- As a team, Musana Community Development Organization's employees will start a much needed discussion regarding the depth of high fertility rate and population growth in Uganda referring to culture, as well as brainstorm steps the organization can take in providing an effective sexual health education.
- Participants will be provided a meal during the focus group activities

Researcher

This research project is being conducted by:
Leah Pauline
Address: Busei Sub-Parish, Iganga, Uganda
Telephone number: 0788619466
E-mail: leahpauline@musana.org

Research Advisor

Teri Murphy
Address: 2811 NE Holman Street, Portland, OR 97211
Email: temurphy@cu-portland.edu

Confidentiality and Security:

With the use of a coding system, all information will be published in its aggregate form and there will be no publication of information that will link your participation with the data. Anonymity and confidentiality of each participant will be maintained and all study materials will be secured in a locked cabinet or secured electronic repository and maintained for 3 years.

Consent to Participate:

I, _____, do hereby, freely and without compensation, agree to participate in this study. I also confirm that I am over 18 years of age. Furthermore, I have been informed of the nature of the study and what is expected of myself. The researcher, Leah Pauline, has explained the research and answered all questions to my satisfaction. I understand that I can withdraw myself from this research project at any time without penalty or prejudice. Should I have any questions at a later time, I can contact the research team.

Date:_____

Signature: _____

APPENDIX B

Stage 1: Demographic Survey- Individual Participants' Information

Basic Information:

- Name:_____
- Gender: _____ Age:_____
- Tribe:_____

  Religion:_____

History:

- Where are you from:_____
- Did you grow up in rural or urban setting? _____
- Who raised you? Mother, Father, Grandmother, Grandfather, Aunt, Uncle,

  Other:_____
- Did you grow up in a polygamous household?_____

  If yes, how many wives did your father have? _____
- How many children were in your home? _____

  # of brothers and sisters:_____ # of other children:_____
- Education Status:

No school Primary Certificate O-Level Certificate A-Level Certificate

University Certificate University Degree Masters Degree

Present Day Information:

- Role at Musana Community Development Organization:_____
- Are you married or single? _____
- If Applicable: # of wives:_____ # of children:_____

  # of dependents other than your children:_____

APPENDIX C

Stage 2 and 3:
Interview Questions and Focus Group Prompts

1. What is the role/expectations of women in Uganda? B. In relationships, marriage?
2. A. What is the role/expectations of men in Uganda? B. In relationships, marriage?
3. Who makes decisions in a relationship about sex?
4. How are adolescents prepared for sex?
5. What is the most appropriate way to teach adolescents about sex? -abstinence, condom use, birth control, etc.
6. How does society respond to teenage relationships? Are they encouraged? Are they ignored? Are they taboo?
7. Is there a safe place for adolescents to seek sexual advice? Who can they confide in? Are they accepted? What do you think is the repercussion of this?
8. Do you know of any young girls that have gotten pregnant in your community? What happened to them? How were they viewed? Who was blamed? How did her family respond? How can these instances be prevented?
9. Are there any traditions/religious practices surrounding sex preparation? Give examples…
10. What are the different societal beliefs about condom use?
11. How is condom use perceived in serious relationships?
12. What reason do couples not use condoms?
13. When is condom use accepted?
14. Are people educated about sex and family planning? If yes, how? If no, what is lacking?
15. What are common beliefs about a man that has a lot of sex? About a woman that has a lot of sex?
16. What are common beliefs about a man that does not have a lot of sex? About a woman that does not have a lot of sex? Are there physical side-effects?
17. How do these cultural beliefs collide with religious expectations?
18. Is labia elongation common? Why does it take place? How do men feel without it?
19. Is sexual violence common in your society? What causes it? Do women report it? If no, why not?
20. Is domestic violence common? What causes it? Do women leave their husbands if they are abused? If no, why not? Is it reported? If no, why not?

Stage 5: Follow up Questions for Discussion with Joint Focus Groups

1. What were your findings within your groups?
2. What similarities can you see between men and women's responses?
3. What differences can you see between men and women's responses?
4. In Uganda, what do you see as the biggest barriers for an effective sexual transformation? (Lack of education? Cultural beliefs? Practices? Traditions? Gender roles? Resources?)
5. What are the best ways to tackle the issues discussed on a national level? Community level? As an organization, how can Musana help tackle these issues?