Policy and Management Challenges to Women's Realization of the Right to Health in Polygyamous Marriages in Uganda

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Abstract

Polygamy remains one of the key topics in various societies of Uganda. Whereas the government of Uganda has put policies to ensure safe childbirth, good health care for women and good family planning practices, there are still many cases of violation of women's sexual and reproductive health rights in polygamous marriages. United Nations reported in 2016 that more than half a million women die in pregnancy or childbirth annually, and 99% of those cases are in developing countries. WHO reported in 2016 that 50% of polygynous women are less willing than their monogamous counterparts to use contraception. Health of women in polygamous marriages is compromised by repeated pregnancies spaced too closely, often as the result of social pressures including production of male children (Trowel, 2014). The study was conducted in Arua, Buikwe, Gomba, Jinja, Mayuge, Namayingo and Iganga districts of Uganda and aimed to investigate the policy challenges to the realization of the right to sexual and reproductive health of women in polygamous marriages in Uganda. The study employed a case study design collecting qualitative data using interviews, focus group discussion and document review. Data was analyzed using thematic analysis. The findings revealed that polygamous marriages are in violation of women's rights suggesting a recommendation that polygamous marriages should not be considered a human right as long as it puts women's universal human rights at risk. Further, after analyzing the findings, the researcher made recommendations including that: decision and policy makers should consider prefacing laws prohibiting polygamy with the international legal obligations, accompanied with policy arguments requiring states to modify such practices.

Key words: **Polygamy, Sexual reproductive health rights, realization, instruments**

Introduction

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. Reproductive rights rest on the recognition of the basic right of all individuals to decide freely and responsibly the number, spacing and timing of their children based on credible information in context of quality sexual and reproductive health and rights (Tamale, 2014). Sexual and reproductive health and rights is the concept of human rights applied to sexuality and reproduction (Amira, 2005). The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (Article 16) reiterates women's rights in deciding "freely and responsibly" on the number and spacing of their children, access to information, education and means to enable them to exercise these rights." CEDAW (Article 10) further specifies that women's right to education includes "access to specific educational information to ensure the health and well-being of families, including information and advice on family planning". The Platform for Action from the 1995 Beijing Conference on Women established that human rights include the right of women to freely and without coercion, violence or discrimination, have control over and make decisions concerning their own sexuality, including their own sexual and reproductive health.

The provision of reproductive, prenatal and postnatal health care services is a critical part of the right to health, comparable with the core obligations that are subject to immediate effect, rather than progressive realization under Article 12, Section 1.1 of The International Covenant on Economic, Social and Cultural Rights (ICESCR). Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide when and how (Ekirikubinza 2001, Muhanguzi 1996, Ekirikubinza, 1999).

Specific Objectives of the Study

The objectives of the study were:

- To evaluate the legal provisions and their practical application pertaining to sexual reproductive rights in Uganda.
- To assess the impact of the right to sexual and reproductive health of women and men in polygamous marriages in Uganda.
- To investigate available measures and good practices that might be of relevance to improving sexual reproductive rights of men and women in polygamous marriages

Polygamy in Uganda's Situation

Under the 1995 Constitution of Uganda, there are numerous laws that have been enacted to protect the rights of women and fight gender inequality in Uganda. For example, Article 32 (2) provides that the laws, cultures, customs and traditions which are against the dignity, welfare or interest of women or any other marginalized group or which undermine their status, are prohibited by this Constitution. The Children's Act (amended in 2016) under Chapter 59 puts into effect the Constitutional provisions on children and emphasizes the protection of the child by upholding their rights. The Domestic Violence Act (2010), is another gender-friendly piece of legislation in Uganda. The Ugandan defilement law within the Penal Code Act (originally enacted in 1950 and which Uganda inherited from British colonial rule), has undergone several metamorphoses to include increasing age of sexual consent from fourteen to eighteen years in 1990. The 1990 edition of the law is very clear in the sense that it is not only illegal for a man to have sexual intercourse with a girl regardless of consent under the age of eighteen years, but also punishable by death.

Perhaps there is no more blatant way of illustrating male sex-right than the practice of polygamy. As argued by Mayambala (1996), polygamy is against the spirit of equality between men and women because it allows one spouse (the husband) unilaterally to fundamentally change the quality of the couple's family life. Although civil law has banned polygamy in many societies, there is still room for men to take new wives without the consent of their existing wives. This practice renders women inferior and subject to men and introduces poverty and poor quality of life by reducing each member's share of the available family resources. Additionally, polygamy threatens women's lives as competition to please husbands forces many of them to give birth to more children than they would have delivered in normal conditions, exposing them to risk of complicated pregnancies especially in advanced age.

Rationale of the study

Whereas polygamy is illegal in Christian and Civil marriages as per the 1995 Constitution of Uganda, it is not the case in Mohammedan and Customary marriages. The extent of risk involving multiple marriage partners remains undocumented. Government policies to ensure safe childbirth, good health care for women and good family planning practices notwithstanding, cases of violation of women's sexual and reproductive health rights in polygamous marriages are frequently reported.

The WHO (2016) noted that 50% of polygynous women are less willing than their monogamous counterparts to use contraception. Health of women in polygamous marriages is consequently jeopardized by repeated pregnancies and shared infections (Trowel, 2014), blamed mainly on social pressure. Women who have not borne children may be cast out of marriages on the assumption that they and never their husbands, are infertile. About 31% of the women in polygamous marriages in Uganda have been subjected to forced sterilization and forced abortion (UNICEF Report, 2017). Although some work has been done on the link between polygamy and sexual reproductive health, prior empirical work has given little consideration to the possibility that the effects of polygamy may not be uniform in all societies. Extant research may not fully assess the effect of polygamy on survival if the interactional dynamics are ignored. It is the aim of this study to address these concerns and contribute to the limited available knowledge.

Literature Review

Sexuality

According to the *Options for Sexual Health Handbook* (2008), sexuality is not just about sex, though people usually define sexuality in terms of genitals, what people do with them, and who they do it with. Sexuality involves and is shaped by many things including knowledge, attitudes, beliefs and practices. Human sexuality can be viewed from different perspectives according to different scholars. According to Tamale (2013), people may not view sexuality through a single lens. Rival views of how sex matters in our pluralistic society often mean that there are few shared understandings, conventions or rules of engagement. It is little wonder that there is so much pain arising from misunderstanding and so many unmet expectations in the sexual realm today. Sexuality is a central aspect of humanity encompassing sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships (Tamale, 2017). While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors (WHO, 1995). Deon (2011) reiterated that sexuality is what one does with another person sexually, arguing that in most African societies, sexuality is driven by personal agency and inevitability perspectives. The ideas are supplemented by Kaler (2014) who noted that in an inevitable perspective, sexuality is part and parcel of humanity. Problems experienced due to sexuality are neither malicious nor intentional and people simply do not foresee consequences or understand the effect they are having on others and this may

be the case with polygamous marriages in Uganda.

Sexual health

Health is a broad concept which can embody a huge range of meanings from the narrowly technical to the all-embracing moral and philosophical positions (Verstraelen-Gilhuis 2012). Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (Verstraelen-Gilhuis 2012). The holistic perspective presented by Hoad (1986) describes sexual health as a state in which the individual has a repertoire of necessary resources for healthy life. Nordenfeldt (2017) also pursues similar reasoning and describes good sexual health as related to the extent to which individuals can realize their vital goals under normal circumstances. In bridging the gap, sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence.

Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements (Remo, 2015). Greli (2016) defines sexual rights as; the human right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health free of coercion, discrimination and violence. Sexual rights include access to sexual and reproductive health care services, right to seek, receive and impart information related to sexuality, sexuality education, respect for bodily integrity, right to choose their partner and to decide to be sexually active or not, consensual sexual relations, consensual marriage, right to decide whether or not, and when to have children and pursue a satisfying, safe and pleasurable sexual life (Dedan, 2014).

Reproductive rights

The inequity in reproductive health is a compelling concern for international actors especially from the perspective of social injustice. There is no area of health in which inequity is as striking as in reproductive health (Gwajja, 2016). Dedan (2014) notes that reproductive rights relate to individuals' ability to control and make decisions about their life which will impact their reproductive and sexual health. According to international consensus no new rights have been created (Health Systems, 2012). Reproductive rights are understood to be entitlements to protection, and essential as a precondition for the ability to exercise other rights without discrimination. Reproductive rights mean considering governmental obligations under the human rights documents in a whole new light (Gwajja, 2016). Rights are considered as the rights to education, health and social services in relation to all of the well-known causes of maternal mortality. A government which fails to provide education, health and social services to young women of reproductive age could well be found to be in violation of these rights currently recognized as part of reproductive rights.

Reproductive Health

Reproductive health promotion encompasses behaviors essential for countering STIs including HIV/AIDS and unwanted or unplanned pregnancies (UNFPA, 2016). It encompasses many tasks performed in primary care such as provision of contraception, condoms and safer sex advice, psychological counseling and other aspects of mental health care; secondary care such as seeking treatment for STIs, and tertiary care to restore sexual activity (Curtis, 2015). Sexual and Reproductive Health (SRH) promotion includes promotion of gender equality, SRH rights and empowerment in sexual matters. In adolescents, SRH promotion also recognizes the role of families and communities besides the health facilities (Terez, 2014). Thus, SRH promotion has a social perspective which should challenge the social norms and values that undermine people's autonomy to control over their SRH (Tones and Tilford, 2016). Sexual health promotion can prevent potentially unhealthy situations such as unwanted pregnancies, STIs, deviant (socially unacceptable) sexual behaviors and sexual abuse. It can also enhance individuals' quality of life by improving self-esteem, communication and relationships with family, community and sexual partners all of which are crucial for health promotion. In this respect therefore, placing sexual health promotion within wider social, political and cultural contexts and aiming to eliminate the cultural constructions of sexuality that increase the risk of males or females to SRH problems through the elimination of the influences of homo-sociality, stigma or gender differences could be essential in an effort to promote sexual health. Such conceptualization of sexual health promotion informed an understanding of reproductive health promotion programming in Uganda.

Legal Provisions and Right to Sexual Reproductive Health

The government has an obligation to respect, protect, and fulfil human rights relevant to SRH since reproductive health and rights are a global concern and international instruments protecting them, especially the reproductive rights of women, exist to direct government agencies and institutions towards observation of global SRH standards (Pearson, 2006).

Reproductive health rights are founded on a number of international agreements, including human rights instruments such as Bill of Rights, Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), Convention on the Elimination of Racial Discrimination (CERD), African Charter on Human and Peoples Rights (African Charter) 2004, Convention Against Torture (CAT), ICPD Declarations among others (Steiner, & Cates, 2006). Article 10 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the assistance to be given to the family which is the natural and fundamental unit of society. Article 10(2) provides that special protection should be accorded to mothers during the period before and after childbirth. Unfortunately, Uganda entered a reservation on 10(2) indicating that the circumstances obtaining in Uganda do not render it necessary or expedient the imposition of obligation in this particular article. *The African Women's Protocol* requires State Parties to ensure women's right to health by promoting and respecting the right to choose the method of contraception and to have family planning education (Article 14 (1) (c) and (f)). The concluding observation of the committee mandated to monitor ICESCR in response to Uganda's periodic report in 2008 urged Uganda to consider the removal of the reservation on Article 10(2) since it perpetuates violation of women's rights. Laws relating to women's legal status reflect societal attitudes that will affect reproductive rights and such laws often have a

direct impact on women's ability to exercise reproductive rights.

CEDAW's Article 2 requires that all parties commit to eliminate all forms of discrimination in public and private institutions. Similarly, CEDAW's Article 4 authorizes the adoption of special measures that would create temporary inequality in favor of women. Luyimbazi (2016) noted that many Ugandans indulge in an indefinite multiplication of wives, while on the other hand, there are those who condemn polygamy as the most despicable practice. Given the centrality of polygamy in shaping family life in the region, it is not surprising that the literature is replete with studies that have assessed its link with reproductive-related outcomes such as fertility and contraception (Mbugua, 2016). Unfortunately, the polygamy-child survival nexus has garnered less attention among the urban populace in Kampala. Although some work has been done on the link between polygamy and sexual reproductive health, previous empirical work has given little consideration to the possibility that the effects of polygamy may not be uniform in all societies. It is the aim of this study to address these concerns and contribute to the limited available knowledge.

Methodology

This study was qualitative. An unstructured interview guide was adopted. The qualitative approach helped to investigate the "what", "where" and "when", but also the "why" and "how" of decision making. The research design adopted was a case study. The study population comprised of women and men and in both polygamous and monogamous marriages, religious leaders, local council executive committee members, university lecturers, elders, community liaison officers, health officers, police officers in charge of Family affairs, probation officers, sub-county chiefs, sub county chairpersons and sub-county community development officers (CDOs). A total of 232 study participants were selected of whom 142 were female and 90 were male. Simple random sampling was adopted in sampling the residents. For health officials, and community development officers, lecturers and judicial officers, purposive sampling was applied. Data was sorted and analyzed using content thematic analysis.

Empirical Findings

Countrywide, the Demographic Health Survey (DHS) (2017-18) reported that 62 percent of women and 52 percent of men are married, 18 percent of the married women have co-wives and 9 percent of married men have more than one wife. Polygamous marriages decreased from 21 percent in 2010 to 18 percent in 2016-17 for women and from 10 percent to 9 percent for men. Older women are more likely to have co-wives than younger women and women in rural areas are almost twice as likely to be in polygamous marriages as those in urban areas (DHS, 2017-18).

Education indicators show that less educated and poor women are more likely to have co-wives. Similar to women, men with less education in low wealth income households show more likelihood of having more than one wife (DHS, 2015-16). Although polygamy is recognized by the Law of Marriage Act (1971) as the union in which the husband may marry another woman or women (Section 9: 3), its impact on the right to health has come under question.

The Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated that women's right to health includes their sexual and reproductive health.

Although there have been numerous attempts to outlaw polygamy in Uganda, the first of which was in 1987, none of the active proposals have been passed by parliament. Polygamy was challenged in the Constitutional Court in a petition brought by MIFUMI in January 2010. According to the Mifumi petition, it is hypocritical and unfair for the state to allow men to marry as many women as they want but bar women from taking more than one husband. However, our society is such that it is men that take wives.

Although many laws and policies have been drafted to outlaw polygamy, many have failed at the first stage. Current polygamy laws in Uganda apply to people differently because Uganda recognizes four types of marriage: customary, church and civil, Muslim and Hindu. Section 12 of the Customary Marriages Registration Act and Section 2 of the Mohammedans Act validate polygamy. The Domestic Relations Bill was officially drafted in 1987 and reintroduced in 2008 when President Museveni called for its "speedy passage". On March 29, 2005, over 1,000 Ugandan Muslims rallied against a proposed bill that would require a husband to seek permission from his first wife before marrying any more women. The bill was shelved and similar proposals are yet to be made (Bwogi, 2018). The Marriage and Divorce Act provides that in polygamous marriages, matrimonial property acquired by the husband and the first wife are owned in common by the husband and the first wife; but all subsequent wives take interest only in the husband's share of property.

Tamale (2013) notes that polygyny constitutes an infringement of women's right to reproductive health care. Notably, polygamy had never before Tamale (2013) been categorized as one of the factors which affect the reproductive health status of women. The environment in Uganda has not been sympathetic to the development of women because of the patriarchal nature of the society and the practice of polygamy being embedded in patriarchy.

Uganda's commitment

Sexual and reproductive health rights (SRHR) are sensitive and controversial issues in international human rights law and among the most important rights guaranteed in various treaty documents clearly delineating government obligations to protect these rights. Implementation of these rights at the regional level is shaped by the socio-cultural beliefs and practices that determine the extent to which the rights are respected, protected and realized. Uganda's commitment to address SRHR for women is within the broad legal framework. SRHR for women is a human rights issue in terms of the right to life (Article 22), liberty and security (Article 23); the right to health, respect for human dignity and protection from cruel, inhuman and degrading treatment or punishment (Article 24); the right to privacy of person (Article 27); the right to a fair hearing (Article 28); the right to education (Article 30); family rights (Article 31); the right to access information (Article 41); and the right to freedom from any harmful cultural practices (laws, customs, beliefs) that are against the dignity, welfare or interest of women (Article 33 [6]). The Constitution of the Republic of Uganda provides for non-discrimination and equality for all, as well as protection and promotion of women's rights

(Articles 20, 26, 30, 31, 40 [b and c] and 50). Under the National Objectives and Directive Principles of State Policy, the Constitution commits the state to take all practical measures to ensure the provision of basic health services to the population.

Reproductive health, maternal health care and fertility

The proportion of respondents who wanted to stop childbearing was higher in polygamous marriages than in monogamous unions, among both wives (54% vs. 46%) and husbands (61% vs. 39%). Similarly, both partners reported wanting to stop childbearing in 37% of polygamous husband-wife pairs, but in only 27% of monogamous pairs. None of these differences were significant, however, after adjustment for the older age and higher parity of polygamous respondents. Men and women in polygamous marriages were more likely than those in monogamous unions to think that their fertility preference matched that of their spouse. In reality, agreement in fertility desires and prevalence of contraceptive use was lower among polygamous than monogamous couples. Clandestine contraceptive use featured more in polygamous than monogamous marriages. Among husband-wife pairs in which the wife reported contraceptive use, 61% of monogamous husbands, and only 39% of polygamous husbands also reported use of contraception. Women in polygamous marriages face many barriers in accessing family planning services: some common to all women, such as stock shortages and opposition from sexual partners, and some specific to women with disabilities, such as negative attitudes of health care personnel.

A woman involved in polygamous marriage noted, "I was told by a medical officer to avoid birth control, stating erroneously that birth control could result in the birth of a child with a disability. As a result, I stopped taking birth control"

A respondent similarly opined,

> *Low contraceptive use means that more and more African women are at risk of unwanted pregnancy and unsafe abortion. The lack of access to contraception diminishes decision making about sexual activities. In the developing world, women's reasons for not using contraceptives commonly include concerns about possible side-effects, the belief that they are not at risk of getting pregnant, poor access to family planning, and their partners' opposition to contraception (Probation Officer).*

Although data indicated the odds of contraceptive use were lower among couples in which only one spouse wanted to stop childbearing than among those in which both partners wanted to stop, the results did not differ substantially according to the sex of the partner who wanted to stop. However, the odds of use were reduced to a greater extent when polygamous women and men disagreed about continued childbearing than when monogamous partners disagreed. Among polygamous couples, monogamous couples or both, contraceptive use was negatively associated with age and positively associated with level of education and number of living children. If the husband had HIV, monogamous couples were more likely to practice contraception, whereas polygamous couples were less likely to do so.

Gibbin (2018) noted that continued gender inequality throughout Africa, particularly in more rural and traditional communities has a significant effect on prevention of unwanted pregnancy and women's access to family planning services and care. Women's partners, spouses or other family members may discourage them from using contraception. In many communities, women cannot seek medical treatment without the permission of their husbands, mothers-in-law, or other family members, even when they may be experiencing severe complications. This practice often delays the woman's access to care and can lead to serious complications or death, having unwanted children and many other health challenges.

The findings of this study suggest that although polygamous couples are at least as likely as monogamous couples to want to stop childbearing, the translation of preferences into behaviour is not strong, leading to a lower use of contraception. While the study was not designed to elucidate the reasons for this, the ability of women in polygamous marriages to share responsibilities with their co-wives softens the impact of having an unplanned birth and may reduce women's motivation to practice contraception.

In general, women with infertility agreed that within polygamous households there are many tensions and disputes between the different parties involved: the husband, the co-wives and the children. While women commonly mentioned verbal conflicts, few admitted that they experienced physical violence from the co-wife or husband. This study established that there were many women with infertility issues who said they had a good relationship with their husbands and co-wives who respected and supported them with their daily household chores. These women regularly referred to their faith and situated the practice of polygamy in a religious framework saying "The prophet had four wives and we are following in his footsteps".

In polygamous marriages women who were more likely to conceive were in a vulnerable position when their husband died. In Bugembe Jinja a predominantly Moslem area, local interpretation of Sharia law was often followed closely when it came to polygamy and fertility concerns. "Moslem men are justified to take another woman if the first one is infertile", a respondent said. It was explained that men often referred to their religious right and duty to have multiple wives. When the woman with infertility was the first wife of the husband, it might be difficult for her to sustain the culturally expected position as the manager of the household. This is explained by the already weak position of the woman in the household resulting from fertility problems. Women more likely to conceive talked about a negative self-image and stress in polygamous marriages. A respondent noted, "When I go to the compound I get sad and angry because of the attitude of my co-wife." Reaching an agreement about polygamy before getting married remains difficult for women even when they are highly educated and have a secure job.

Several women associated their husband's decision to engage in a polygynous marriage with their fertility problems. In this study, three women with infertility encouraged their husband to take another wife. One of them said she wanted to have a co-wife so she would be able to share the responsibilities of the household and have more freedom to travel. The second woman wanted her husband to remarry since she was beaten severely due to her infertility and hoped this would decrease the pressure on her to become pregnant, but her husband never

remarried. The third woman expressed how her husband supported her during her fertility problems and said that she hoped that having a co-wife would make her womb jealous. Several women with infertility in polygamous marriages were not informed about their husband's decision to marry a second, third or fourth wife until the day of the marriage itself, which was an upsetting experience. A respondent noted that, "my husband knows that more than me, sometimes he would marry them without letting me know." In most situations, the decision to engage in polygamy was made by the husband, sometimes under pressure of his family who also deemed it very important that their son sires children. These findings resonate with the view of anthropologists and feminist scholars stressing that culture and religion can be both a source of oppression and support for women (Tamale, 2017). Individuals are able to contest, change and conform to aspects of their culture and religion, resulting in diverse and sometimes contradictory experiences and discourses. Although, in general, polygamous marriages had a negative influence on the social, financial and emotional well-being of many women with infertility, the practice is not a topic of public debate. Most of the interviewed women with infertility thought it was unlikely that the practice would change and found infertility the major challenge in their life. They wanted to have more opportunities to empower themselves and better access to reproductive health care to prevent and cure infertility. The strength of this study is that, being a qualitative study, it delved into real-life experiences showing the complexities of polygamous marriages from the perspective of women with sexuality challenges including infertility.

Polygamy and HIV/AIDS

The Ugandan Constitution is, doubtlessly, a victory for women in its explicit guarantees of non-discrimination on the basis of gender, sex, pregnancy, marital status, the right to be free from both public and private violence, and the right to bodily and psychological integrity. Yet, despite the triumph of equality at the constitutional level, marriage is often the site of women's legal, social, and sexual subordination, as well as vulnerability to domestic violence and HIV/ AIDS, all of which are exacerbated by poverty. Although it is well-known that Uganda faces one of the fastest growing rates of HIV/ AIDS in the world, it is less widely known that women in Uganda are significantly more likely to be HIV-positive than men. In this study, disclosure of one's HIV status appeared to be a significant issue causing marital instabilities in polygamous marriages. The findings reveal that all the interviewed women had disclosed their HIV test results. A large proportion of the women (45%) disclosed to an adult family member; 37% disclosed to a parent; and 35% disclosed to a spouse. Other women disclosed to friends (23%), children (7%) and religious leaders. The majority of the women disclosed at will (77%) while the rest (23%) felt they were pressurized. 36% were pressured to disclose by health workers and 31% by family members. Others were pressured to disclose by people living with HIV (12%), non-HIV people (7.2%), neighbors (2.7%), spouses (9%) and friends (5.4%). Disclosure was associated with abandonment, discrimination and stigma even at a point of accessing health services as illustrated in the following voice, "Stigma is a major issue; they do not access health services, so they might not very well follow what you are telling them."

Three women of Dolwe sub-county, Namayingo district who were in polygamous marriages did not disclose their HIV status to their husbands. They would breast feed their

babies up to two years, exposing them to HIV infection, because they feared to reveal their HIV status to their husbands. The key reason for not disclosing was fear that partners would abandon or blame them for infecting them and subject them to domestic violence.

Findings revealed that women living with HIV are sexually abused or coerced into unprotected sex when they try to insist on safe sex. Women do not only face rejection and hostility from husbands but also from their relatives, especially the in-laws.

> A respondent found to be HIV-positive in 2016 never revealed her status to her husband. She explained: *"I am married but I came alone. I never informed him. He said, 'if I know you're positive I'm going to kill you'. We used to quarrel. He beat me. I never talked about it". (FGD Dolwe SC, Namayingo district).*

Another respondent explained why she felt compelled to conceal her test results despite her husband's own HIV-positive status:

> *I got tested in 2017. I went to get tested. I didn't tell him. The type of person he is scared me. I had no idea how to approach him. I was scared to tell him I was HIV-positive." Some women managed to attend HIV/AIDS clinics secretly or joined support groups without their husbands' knowledge.* **(Interview, Dolwe SC, Namayingo district)**.

This implies that an HIV-negative man may chase his wife if she is found to be HIV-positive.

Polygamy and Mental Health

Mental health problems resulting from polygamy can be more pervasive than meets the eye. Survivors themselves may not realize that their emotional problems are related to sexuality. Women's distress was exacerbated by the latent hostility and aggression between co-wives which includes snide remarks and threats, covert competition, and accusations of witchcraft and poisoning.

Polygamy and Abortion

With the exception of the African Women's Protocol, the right to safe abortion under the international human rights system has mainly evolved from interpretations provided by treaty-monitoring bodies. The criminalization of abortion impacts negatively on the sexual autonomy of women in Africa. The WHO Report (2017) reveals that highly-restrictive abortion laws are not associated with lower abortion rates. Highly-restrictive abortion laws are associated with significant levels of unsafe abortion-related mortality and morbidity. A local leader discussing abortion noted,

A woman aged 40 years in a polygamous marriage was held at Mafubira police station for allegedly procuring an abortion where the victim died after she developed complications. The woman was said to have terminated the pregnancy by swallowing some chemical. She was locked at the police station. Police said she developed complications while at the police station, was rushed to hospital and died on the way. The experts argued that if the police had

immediately taken the woman to a health care professional, instead of holding her in remand at the police station, she could have survived **(Local Leader at Mafubira village).**

This incident clearly demonstrates the impact of criminalization of abortion on women's health and lives. Legal obstacles to the provision of safe abortion services give women little choice but to resort to unsafe abortion when faced with an unintended pregnancy.

Quality of Maternal Health Care

Findings indicate that the quality of maternal health services in the study areas remains an issue of concern. The lack of basic supplies such as cotton wool, pads, gloves, syringes, surgical blades, material to wrap babies, anaesthesia, disinfectant, medicines, bed sheets, and blankets; dirty and unhygienic conditions are some of the key quality issues that have been highlighted.

Women in polygamous marriage noted husbands can't afford to support the multiple wives due to the high cost of hospital delivery, especially the fees charged at health centres. The nurse-in-charge at Buphadengo health centre II noted that women who experienced life-threatening pregnancy complications that could not be handled at the centre often resist being referred to private Hospital because they cannot not afford.

Polygamy and Family Planning

The findings showed that the most popular method of family planning was the injection as reported by the majority of the participants, followed by implant and sterilization. The literature across the different countries in Africa reveals that a number of women in polygamous marriages are sterilized without their consent. Evidence from the case studies of women who had experienced forced sterilization, interviews and discussions with other women and men and key informants revealed a number of effects of forced sterilization on women and their families. These effects are attributed to their inability to give birth which is negatively perceived by the communities.

When asked about sterilization, a respondent noted that;

> *Sterilization affects sexual relations including reduced sexual desire, painful sexual intercourse and feeling weak. My sexual relationship is no longer the same; I am no longer happy. All the time we are quarrelling and at times I ask myself: do others feel the same? I am not sexually active. It has affected me because my body is very weak. (Nurse: Buphadengo HC II)*

The intention to use contraceptives among women in polygamous marriages remains wanting. It was found out in this study that the intention to use contraceptives among non-users varies dramatically and this reflects in the results. Women in some polygamous marriages have shown no intention to use contraceptives even when they were likely to use them. Previous studies (Caldwell,2000; Bankole,2004; Fadeyibi, 2013; Ogu Agholor & Okonofua, 2016) generally found that more children mean more wealth and that explains non-use of contraceptive methods in less developing countries. Though this study shows that women who had more than three

living children had the intention to use contraceptives, this might be a result of an increase in the cost of childbearing, parent's psychological benefits of having few successful children and access to family planning services.

It was found that individual characteristics such as maternal age, marital status, parity, maternal education and wealth status could to some extent statistically explain the variations in women intention to use contraceptives. Despite this limitation, this study and other previous studies have emphasized the need to examine factors beyond individual characteristics and also suggested holistic approach for implementing family planning programmes.

Conclusion

Polygamy places women and girls at greater risk of violating their SRHR like contracting HIV/AIDS when their husbands have multiple sexual partners. The protection of women's rights is central to the HIV/AIDS strategies of government and international donors. The government should not use traditional practices or the sanctity of the family to ignore the plight of these women and to abdicate its responsibilities under national and international law.

Reproductive health contributes enormously to physical and psychological wellbeing. Ultimately, it is only a healthy population that can ensure a sustainable economic development in a stable democratic environment.

Recommendations

The government should enact new laws that promote and protect the rights of women in polygamous marriages as proposed by article 6 of the Protocol on the Rights of Women in Africa in order to afford women greater equality before the law, protect women from violence, uphold women's sexual rights, and ultimately minimize women's vulnerability to HIV and AIDS and other sexual related health challenges.

The Government of Uganda should continuously assess the national response to reproductive health concerns and HIV-AIDS to facilitate timely adjustment of implementation.

The Government of Uganda should ensure sustainable economic development in a stable democratic environment to guarantee service delivery and to limit disease, abuse, exploitation, unwanted pregnancy and related consequences including death.

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