

**GENDER RELATED FACTORS INFLUENCING THE UTILIZATION OF
SEXUALLY TRANSMITTED DISEASE TREATMENT SERVICES:
A CASE OF NYENDO-SENYANGE DIVISION,
MASAKA DISTRICT**

BY

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DECLARATION

(i) I, Kasozi Lawrence, declare that this dissertation is my original work, except where acknowledgement is done and that it has never been presented anywhere else for the award of any degree.

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APPROVAL

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DEDICATION

To my late father John Mary Kasozi who died just a day after my recess term exams for this award on 21.09.2005 and my loving mother Mrs. Jane .F. Kasozi.

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I am grateful to my colleagues, especially classmates of Master of Arts in Population and Development 2004/2005, who have been instrumental in encouraging me to finish the course as scheduled.

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ABSTRACT

Sexually Transmitted Diseases (STDs) are infections which are spread from one person to another through sexual intercourse. This problem of Sexually Transmitted Diseases calls for concern because of the way they spread and the failure by the patients to adhere to treatment guidelines. STDs take two, a man and a woman having a union. This study concentrates on the gender related factors that influence the utilization of Sexually Transmitted Disease treatment services.

The objective of the study is to examine how access and control over resources influences accessibility and utilization of STD treatment services. In this aspect the study has to assess how power relations influence access and use of the STD treatment services, to assess how the gender division of labour influences access and use of the STD treatment services and finally to assess how other factors i.e. social, cultural, knowledge and attitude affect access to and use of STD treatment services.

The overall objective of the study is to find out the factors that influence the utilization of Sexually Transmitted Disease Treatment services. The study further examines the hindrances to equal access and utilization of STD treatment services between males and females.

A questionnaire was administered to a total of 160 respondents, both female and male of ages 15years and above and 40 key informants were interviewed. Nyendo-Senyange division was purposively selected and a multi-stage sampling design was used. The study was descriptive in nature and used qualitative and quantitative methods of data collection.

The findings of the study showed that gender relations (division of labour, access and control over resources and power relations) highly influenced utilization of STD treatment services.

Though partner notification was found to be important, the issue of being regarded unfaithful created a hindrance to utilization of STD treatment services. The education level for females was noted to be lower than that of male respondents, probably due to dropping out of school.

The study recommended sensitization of men on problems of women, community outreach programs, subsidizing of private clinics that treat STDs, increased Information, Education and communication (IEC) and policy formulation, all geared towards testing and treatment of STDs.

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Sexually Transmitted Diseases (STDs) is a term that describes a group of infections, which are spread from one person to another through sexual intercourse. Before the 1950s, these STDs were commonly referred to as venereal diseases deriving this name from Venus, the Roman goddess of love, thereby implying a disease from love making (Wistreich 1992).

The world over, improvement of reproductive health, STDs including HIV and AIDS has been at the fore front. At the end of May 2003 the US Senate passed “The United States Leadership against HIV/AIDS, Tuberculosis and Malaria Act of 2003”. This five years US\$ 15 billion initiative commonly known as the “Global AIDS Act” was signed into law by President Bush on May 27, 2003 and constituted the longest single monetary commitment the USA has ever made to deal with the AIDS pandemic in Africa (DC-National HIV prevention conference Atlanta, Georgia-July 27 – 30th 2004).

On the African continent analyzing the impact of AIDS epidemic on organization, business and economy, the level of STDs has doubled. The year 2001 marked 20 years since the first infection of AIDS epidemic was identified. During the 1970s, HIV began to spread silently and unnoticed. There are 33.6 million people in the world living with HIV/AIDs of whom 23.3 million are in Africa. In 1999 there were 5.6 million new infections of which 3.8 were in Africa (WHO report 12999).

World Health Organization report (1995) noted that countries, developed and developing, have designed projects aimed at improving STD treatment services. However, in developing

countries, especially Africa, these services remained hardly accessible and utilized because of long distances to where they are located, the cost of services and transport. Also the quality of services was very poor because of lack of trained staff, lack of essential equipment and drugs. These have greatly contributed to few people especially women accessing and utilizing STD treatment services.

There are different types of STDs and they include; gonorrhoea, syphilis, Chlamydia, trichomoniasis, chancroid and herpeszoster. Sexually Transmitted Diseases (STDs), also referred to as sexually transmitted infections (STIs) are among the many health problems threatening human existence. The World Health Organization (WHO report, 1991) observed that STDs are among the major causes of illness in the world. The report revealed that the exact size of the problem is unknown, but there is at least one new STD consultation per 100 persons per year in industrialized countries, while in many developing countries, STDs complications rank among the top 5 diseases for which health care services are sought. Worldwide, figures would be higher if age-specific consultation rates were available for the age group 15 – 44.

Sexually transmitted diseases do not discriminate against persons or social classes. The risk of acquiring sexually transmitted diseases increases as the number of sexual partners an individual has increases (Owega and Thorup 1995). Sexual behavior and attitudes, availability of facilities for early diagnosis, treatment and contact tracing are among several factors that influence the spread of STDs.

The World Bank and WHO report (1995) compared the cost effectiveness of various public health programmes and concluded that prevention of STDs is one of the most cost-effective investments in the health sector. However, the task of ascertaining the prevalence, causes and consequences of reproductive tract infections (RTI) in developing countries, Uganda inclusive,

was complicated by many factors. These factors include limited published studies of reproductive tract infections, lack of testing of other STDs and thus considering tests of classical STDs such as gonorrhea and syphilis. In addition, most studies focused on specialized groups such as prostitutes or clients of STD clinics and therefore did not provide data that could be generalized to large proportions. Also UDHS (1995) noted that many people especially women, because of lack of information, tended not to seek treatment and also failed to report recent STDs because of social stigma associated with the disease.

Symke (1992) noted that though AIDS handover-shadowed other STDs because of its fatal impact, the magnitude of the STDs was still high. AIDS brief (1995) approximated that 557 million people were infected with sexually transmitted diseases worldwide, excluding AIDS. In developing countries, STDs were responsible for a high rate of death and are second to maternal mortality for women aged 15 – 44 years (WHO report, 1995). Studies conducted among women visiting family planning obstetrics and gynecology clinics, reported incidences of STDs of up to 12 percent of women in Asia, 18 percent in Latin America, and 40 percent in Africa. In Africa alone, cases of syphilis, chlamydia, gonorrhea, and herpes ester had been widely reported.

According to Davies (1950), in Uganda documented problems of STDs date back to early colonial days. The existence of syphilis epidemic was first reported between 1896 and 1908. Sexually transmitted diseases have since then continued to affect the Ugandan population. Abongomera (1987) further observed that statistics from government hospitals during 1970 – 71 indicated that approximately 2% (130,000/7.8 million) of the patients treated at the various government units during that period were diagnosed with gonorrhea, which is just one type of STDs.

The incidence of STDs varies between men and women; women suffer more from sexual transmitted diseases (STDs). STDs are symptomatic in women, which impedes early detection and timely treatment. In Uganda, STDs are a serious problem. They have been identified as co-factor in HIV transmission (UDHS, 1995). In 1993, The STDs control program was merged with AIDS control program to form the STD/AIDS control program (ACP) and charged with the control of STDs as a way to curb the fast spread of STDs.

The occurrence of STDs and failure to diagnose them early could lead to considerable medical and emotional consequences on people's lives. Such consequences include cervical cancer, neurological complication, hospitalization and even death (Ntozi, 1989). Gonorrhoea often causes pelvic inflammatory disease (PID) in women and epididymitis and urethra stricture in men leading to infertility and sub fertility in both sexes with the accompanying social and psychological results of being childless (Arya and Osoba,1983).

Adadevoh (1974) carried out studies in Africa and noted that some areas in East Africa, for example, Eastern Kenya, Buganda and Teso in Uganda and Western, Eastern and Swahili areas in Tanzania, suffer from problems of infertility and sub-fertility as a result of sexually transmitted diseases. In some communities in Central Africa, up to a third of women in the child bearing years are infertile, with 80 percent of that infertility being caused by STDs. STDs in mothers at the time of pregnancy have a great effect on children and reproductive tractinfections put the unborn child at a risk of low birth weight, congenital abnormalities, blindness, pneumonia, retardation and even death. Also according to WHO and UNICEF (1991), in a study carried out in Nigeria, estimates showed that between 35 and 50 percent of stillbirths are due to syphilis. In another study, when maternal syphilis was reduced by 40% over a five years period, there was a two-thirds reduction in adverse pregnancy outcome. According to Okello (1997) annual returns from Uganda government health units in 1997 indicated that STDs were

responsible for 6.6% of the outpatients' attendance. The actual prevalence was likely to be higher because this excluded patients who attended private health units bearing in mind that up to 45% of the outpatients visit private clinics. In addition, only 31.4% of the men with STDs obtained health care from government health units. This trend means that this percentage of people who turned up for treatment at government units is just a small fraction of all people who were sick. The other reason is that some patients who experience symptoms of STDs do not seek health care at all as noted by Asiimwe-Okiror (1995). But King (1980) observed that the actual incidences or prevalence of STIs was difficult to ascertain in most countries and it could be several times higher than the reported rates.

Despite great strides of advancement in modern medicine regarding STD diagnosis and treatment, STDs still pose a major worldwide public health problem. Among the communicable diseases, STDs are the commonest diseases reported by the majority of countries and continue to occur at unacceptable high levels, particularly among women. It was further noted that in 1995, there were 333 million cases that suffered from the four major curable STDs which include, gonorrhoea, syphilis, Chlamydia and trichomoniasis of ages 15 years and above. Out of the 333million cases, there were 12 million of syphilis, 62 million of gonorrhoea, 89 million of Chlamydia and 170 million of trichomoniasis according to UNDP (1998).

From the above background information, it is evident that the provision of effective services in diagnosis and treatment of STDs is an essential component of the control and prevention of STDs. In order to be effective, STD treatment services must reach the majority of the people using them and have to be accessible, acceptable and affordable.

1.2 STATEMENT OF THE PROBLEM

Sexually transmitted diseases are a serious problem in the world. WHO estimates that 150 – 300 million curable sexually transmitted infections occur annually (AIDS bulletin, 1995). In Uganda, STDs are among the top ten diseases in the adults attending outpatient clinics in government and private hospitals and clinics (MFPED, 1995).

Though the level of sexually transmitted diseases is higher in males than it is in females, females suffer the complications more (health of young people, 1993). The reason for the above may be due to the fact that males seek medical attention earlier because their symptoms usually appear earlier, unlike in females where infections may not show any symptoms, or the symptoms may occur well after damage (Kirumira 1993). Because of delayed symptoms, access and utilization is also delayed leading to serious damage. However, access and use of STD services especially by women may also be influenced by gender related factors, for instance gender division of labour assigns women more workload than men (UNICEF, 1992); the kind of society in which we live, that is, it is male-dominated and thus men control most of the resources and benefits; the aspect of decision making in the household which is, in most cases, made by men.

Most of the studies on STD treatment services are general, i.e. about all the factors and none of them have examined gender-related factors and their influence on access and utilization of STD treatment services especially by women. Therefore, this study examines gender-related factors influencing access and use of STD treatment services.

1.3 OVERALL OBJECTIVE

To establish the gender related factors that influence the utilization of sexually transmitted diseases treatment services in Nyendo-Senyange division.

1.4 SPECIFIC OBJECTIVES

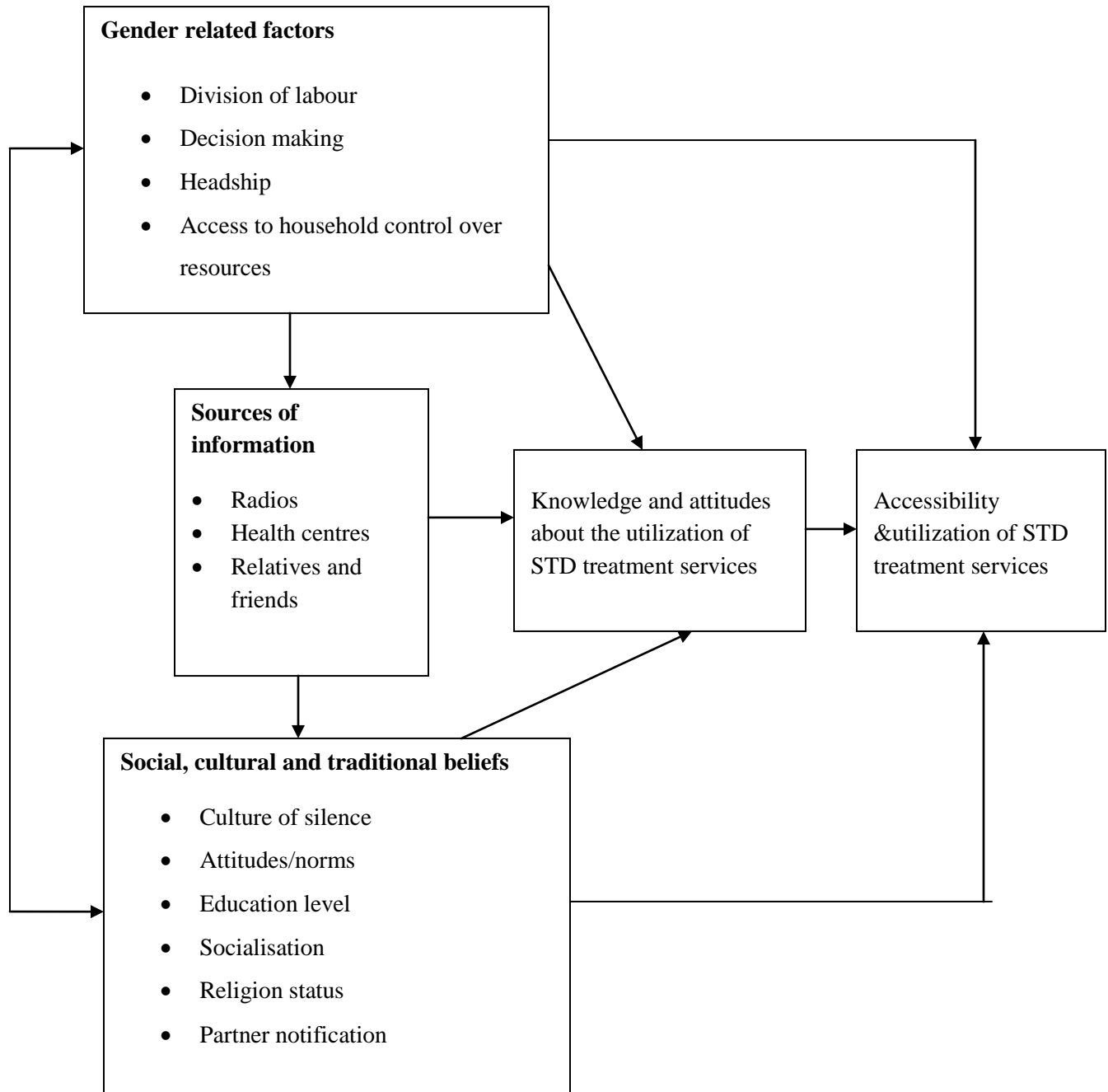
1. To examine how access and control over resources, influences accessibility and utilization of STD treatment services.
2. To assess how access to and control over resources influences access and use of STD treatment services.
3. To assess how decision making amongst couples influences access and use of STD treatment services.
4. To assess how gender division of labour affects access and use of STD treatment services.

1.5 SIGNIFICANCE

The study was carried out in order to identify the factors, which hinder equal opportunities in access and use of STD treatment services. This will assist the health managers and planners to deliver improved STD treatment services to both men and women.

1.6 CONCEPTUAL FRAMEWORK

Showing possible factors that influence access and utilization of STD treatment services



The study was conceptualized on the basis that gender relations were inherent in society and thus had an influence on the access to and use of STD treatment services. Hence, gender variables

like division of labour, power relations (decision making) and resource control among partners were given due consideration.

It is also considered that socio-cultural factors and traditional beliefs are vital for access of STD treatment services. Considered under this, within society, with specific reference to culture, different people/sexes are socialized differently and this is likely to impact on access and use of STD treatment services. In addition, the level of education, marital status, religion, attitudes and the culture of silence surrounding STDs is most likely to influence the utilization of treatment services.

This too is likely to be impacted upon by the gender variables, which have an implication on utilization. The gender variables, socio-cultural factors, and sources of information, are likely to influence people's knowledge and attitudes towards utilization of treatment services.

1.7 ORGANISATION OF THE DISSERTATION

This dissertation consists of five chapters. Chapter one focuses on the introductory part of the study and this consists of the background to the study, the research problem, the objectives, significance and conceptual framework. Chapter two provides literature review, which consists of four major themes, namely: knowledge of STDs, socio-cultural factors and gender related factors (access and control over resources, division of labour and power relations). Chapter three provides the methodology that was used in the study, which includes the study design, scope of the study, study population, sample size and selection, methods of data collection and the procedure and data analysis. Chapter four presents and discusses the findings of the study considering gender in relation to the objectives and conceptual framework of the study. Lastly Chapter five contains a summary of the findings, conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews literature related to STD treatment and health services, particularly gender related factors influencing accessibility and utilization of sexually transmitted disease treatment services. In this case, gender division of labour, access to and control over resources and decision-making, are given due consideration. Review of the factors related to health seeking behavior is also done under this chapter and these are referred to as socio-cultural factors.

2.2 MALE AND FEMALE VULNERABILITY TO STDs

The World Bank Report (1993) estimated that the burden of communicable diseases, including STDs in developing countries was about twice as high in female than in males aged 15 – 44 years. The burden of STDs in women alone, accounts for 9% of the reproductive age bracket compared to 1.5 in the men in the same age bracket. Acan (2001) in her study on gender stereotyping in Arua, noted how it had contributed to the vulnerability of women to STDs.

The Alan Guttmacher Institute (2004) reported that knowledge regarding STDs has dramatically increased in Uganda.

The 2000-2001 UDHS data reveals a universal knowledge of HIV/AIDS among the adolescents, but knowledge about other sexually transmitted diseases is still limited among the ordinary people. Complaints raised by pregnant women in Kenya included the poor organization in health care facilities generally, long waiting times, delays in opening the clinics, poor attitudes and poor communication skills of health workers (Leavens 2002, Mubyazi 2005).

The burden of STDs is not fairly distributed between sexes. Women bear a grossly disproportionate share; they are more susceptible to infection and experience symptoms, complications and secondary ascending infection much more than men (WHO report, 1994). World Health organization report (1998) noted that the frequency of STDs is higher among the single, divorced and separated people than among the married. In addition, the report noted that young people are likely to seek health care for STDs. Despite higher levels of sexual mobility in most societies, as measured by the average of number of sexual partners, women are often blamed for the spread of STDs. In some languages, STDs are even called the women's disease as noted by Dixon (1991). It is further stated that STDs among heterosexuals often describe female sex workers as reservoirs of infection while neglecting to recognize the explicitly male demand for the services of a sex worker, as well as their refusal to use condoms, and their role in spreading the infection to other women.

Sexually transmitted diseases have an additional element of the shame and humiliation for many women because they are considered unclean, whereas for men, traditionally, it was a sign of potency hence women tend not to talk about the disease. The culture of silence surrounding STD patients can compromise women's health as noted by Sogbetum (1977), and hinder them from effective utilization of treatment services.

2.3 FACTORS INFLUENCING UTILISATION OF STD TREATMENT SERVICES

Asiimwe (1995) noted that there are different reasons as to why patients with STDs who experience different symptoms, did not seek health care services. According to UBOS (2001), better educated people are likely to be attended to by a doctor than less educated people. This can be attributed to the financial and social security that such people enjoy in comparison to less educated women who are financially dependent on their spouses, family and societal prejudices. Brotman (1991) reasoned that utilization of various sources of health care will depend on

perception and beliefs people attach to the nature of illness and value placed on a given facility. However, Philips (1990) counted that there is no systematic order in health seeking behavior and utilization of treatment services. Anderson and Staugard (1986) noted that in developing countries, the physical and social accessibility to health services has a particularly large influence on its use. Kanyesigye (1996) observed that in Uganda, apart from geographical and physical factors, other factors such as age, status, beliefs, income and educational level influence people's use of health services.

Mulder (1994) noted that most women regard vaginal discharge to be normal, and in this case they first seek home remedies before approaching health professionals. It was further observed that women first concentrate on personal hygiene, use of herbs, advice from a female community elder or traditional healer who usually gives herbal medicine or clay (emmumbwa in Luganda). Some could seek the services of a witchdoctor if they suspect they had been bewitched or cursed.

2.3.1 Social and Cultural Factors

Kuteesa (1994) noted that the education level of a person influences their use of health facilities. Since education exposes an individual to modern culture, it is more likely that the use of health facilities is proportionate to the level of education because educated people will know the benefits of using health services. In addition, they are more likely to have access to sources of information like radios, newspapers and televisions. Kuteesa's study was carried out on mothers and not on STD cases which is the focus of my study.

Dixon (1991) further pointed out that the sex and marital status of a person have a great influence on his or her use of health services. It is noted that, it can be difficult for unmarried as well as for married women to ask a man to be tested for an STD, to seek treatment, or even to use condoms especially where the use of condoms is linked to promiscuity. Fears of social

consequences often take propriety over fears of health consequences, making infected women reluctant to inform their male partners of their diagnosis, and non-infected women reluctant to inquire about the health status or other sexual involvements of the men they live with. For many women, the perceived risk of being beaten, divorced, abandoned, or losing a source of emotional or financial support, far exceeds the perceived health risk of acquiring STDs. Although he raised important issues, he did not consider gender related factors like division of labour and the influence it may have on accessing and using STD treatment services.

Lubwama (1996) noted that culture conveys images and values about men and women and roles appropriate for them. In so doing, society has socialized women to be silent and not to talk much. A woman who keeps quiet is a good one. So goes the culture and tradition; some societies have a saying that, “A man speaks twice and a woman once”. Because of the socialization process, many people, majority of whom are women, tend to be silent about diseases, especially those related to sexual organs.

Ogden and Bantebya (1996), in their book “Kampala women getting on well though in times of AIDS”, said that the home treatment of STDs in terms of use of herbs is a different matter; it is about shame and secrecy because the disease stems from moral transgression. They concluded that STDs should be treated in secrecy unlike other illnesses. Similarly, de Zoysal et al (1984), in a study carried out in rural Zimbabwe, had a similar observation that home treatment was the commonest form of health care and comprised of the use of indigenous herbal, sugar and salt solution, instead of the formal treatment used in the hospital.

In India, inhibitions about drawing attention to the body can be so great that even female health workers must rely upon verbal accounts of the symptoms of women who will not find it easy to tell each and everything (UNDP, 1995). A similar observation was made by Mulder (1995) in

which most women said that they feared health workers to intimidate them. The expressions of guilt and denial that people with STDs go through, hinders them from accessing and utilizing treatment. Social stigma prevents women more than men from coming forward to have STDs treated. Lubwama (1996) noted that beliefs of people have a decisive factor in the pattern of use, especially to the uneducated and to a less extent the educated. If some people's culture, beliefs, and practices support skepticism and distrust for medical use, they are less likely to seek medical care.

Harrison (1983) found out that the Hausa and Fulan of Nigeria were strongly opposed to antenatal care and also had misconceived ideas about drugs used in clinics. Such beliefs and practices in the Nigerian community explain why some women did not use health services. The above study concentrated more on antenatal services and did not tackle the access and use of STD treatment services, i.e. whether a mother is pregnant or not, thus my study concentrates more on gender-related factors.

Sexuality is a taboo subject in most societies in Uganda and unprotected sexual activity in males and females leads to infection with STDs, often resulting in devastating effects on future fertility. Cluver (1951) observed that STDs are one of the serious conditions about which most infected people prefer to be silent and this is partly why determination of world incidences and prevalence is an almost impossible task. STD infections are characterized by counter accusations amongst couples. As Nakku (1998) noted "instead of accusing each other, instead of feeling worried and guilty, take courage and speak out".

The culture of silence surrounding STDs, that in most cases hinders people from accessing treatment, must be broken not only by women, who often place their own needs after those of their husbands, children and other family members, but also by health professionals and the

international health and family planning communities (WHO report, 1997). From the above findings, there was need, therefore, to ascertain whether the culture of silence was a result of men and women and thus having an influence on access and use of STD services.

Distance from home to health facilities explains the reluctance of people's access to health services (UNDP, 1995). In addition, Janzen (1978) carried out a study in Zaire and found that patients were in position to access and use health services only if they were adults, capable of walking and usually males.

Caste (1993) noted that in Rwanda, women in the highland areas were observed to respond less to children's illness as compared to those in low lands, probably because of the relative distance to the health centre. In a similar study carried out in Burkina-Faso by Develay (1996), he concluded that there was no significant difference in access to and utilization of health services between people staying in urban zones and those staying in the rural zones. These studies were general and were done elsewhere and not in Uganda. My study looks at gender related factors influencing access to and use of STD treatment services.

Studies done on health seeking behavior indicated that there are various reasons that influence and hasten the process of seeking for treatment. Jacobsen et al, (1993) noted that the severity of urinary symptoms predicts a man's decision to seek medical care. Similarly, Develay (1996) revealed that the illness characteristics (type, length and severity) were principle determinants of health seeking behaviors. Murlder (1994) found out that STDs with visible ulcer, pain or yellow discharge (pus) were more likely to be perceived as diseases and hence influenced the patient to seek treatment faster than patients with other signs.

Walker (1997) carried out a study in Masaka on assessment of private sector provision of STD treatment services within the framework of Masaka intervention trial and found out that the attitude of health care workers towards STD patients was satisfactory, though it was highly variable, depending as much on the patient's ability to pay, appearance, relationship with the practitioner and genuine kindness and behavior of the health worker.

2.3.2 Access to and Control over Resources

Literature on access to and control over resources reveals that, men control most of the resources and women have limited access to and authority over resources. Barton and Bagenda (1993) found out that men own everything including women as their property, thus giving an explanation as to why women have less powers over incomes earned irrespective of their bigger participation in household income generating activities. World Bank (1993) pointed out that even the so-called educated women are not any better, because household obligations always change in favour of men. Russo (1993) noted that as women increased their incomes, men decreased their spending on family maintenance thereby shifting the cost to women.

Cultures where male dominance is pronounced, men are the ones who have control over resources; women have no autonomy in matters of economy and this affects their access to and utilization of health services. A study done by Csete (1993) in Rwanda, observed that women's control of various categories of household expenditures, had some influence on their treatment. In addition, it has been observed that the cost of care and transportation are major determinants of access to treatment (Develay, 1996) hence it is those who have the resources that easily go for treatment. Another study in Swaziland by Yodes (1989) reported that following a fee increase at government hospitals, the average attendance decreased at government facilities by 32.4% and increased at mission facilities by 10.2%. This resulted in a significant drop in the treatment of STDs from government facilities. Furthermore, a study conducted in Kindu rural health zone in

Zaire by De Bethune et al. (1989) reported a sharp drop inpatients' utilization of health services following an introduction of health fee. Castel (1993) carried out a study in rural Mali and noted that women, as subordinates of men, had a problem of finding work outside the home and thus remained dependent on men. As a result they had limited financial resources at their disposal which in turn influenced their decision to seek treatment when the child fell sick, what kind of treatment they would opt for, and how to pay.

Kettel (1996) noted that poverty was the cause of health risk and this was generally far greater for women than men. The reason of women having a bigger risk was because women were far more likely than men to be poor since women worldwide in every income category, owned less resources (material and financial) than men; worked long hours and earned less income; and had limited control over resources. In addition, Baden and Miward (1995) noted that household resources were preferentially allocated to males especially in terms of health care, education and nutrition. It was therefore important to find out whether these findings were similar even for STD cases.

Smyker (1991) stated that, more than one billion people, most of them women, live in extreme poverty. These people are likely to be the poorest of the poor, and hence being poorer usually means, among others, not being able to get health care when needed (even if it is free, the cost of transport or medicine can put it out of reach). Access to and control over resources, especially the cost of care and transportation, can influence access to treatment services. However, all the above studies did not determine how cost may affect female utilization of STD treatment services different from males. Thus the effect of cost of services on female and male utilization of health services, especially STD services, was re-examined.

2.3.3 Power Relations

Decision-making has been identified as one of the major factors depriving people of health services. WHO report (1991) observed that gender inequality in decision making places women in a vulnerable position and hence becoming soft targets for infections or transmission of STDs. Dixon (1991) also argued that in societies where a belief in male supremacy coexists with restrictive social structures that limit women's economic, social and legal independence, men often maintain strong control over female sexuality. The concept that family matters are a private business gives husbands a license to treat women as they wish behind closed doors. Women have little or no decision-making rights over their sexuality. He noted that a woman in Sri Lanka had this to say "What is the good of refusing a husband's sexual demands; they will never let us alone. If we refused, they would go to some other women and then what will become of my children and me".

Snyder (1995) found out that in Tunisia, jewels are passed down from mother to daughter as a source of cash and this is an example of independence from husband's power in decision making. So where women have some control over resources they have some autonomy to decide on how to allocate them. Ravidrani (1990) also found out that, women in South India, who got a chance of working for wages, had considerable influence on their husbands, as far as decision making on health issues was concerned. He further observed that on several occasions, these working women did not wait for their husbands to decide whether to visit a doctor. Sometimes they went without their husbands' consent because they were able to pay for the services by themselves.

A study in Swaziland on safe motherhood by de Zoysa (1984) reported that husbands made all economic decisions that affect households while women made decisions on maintaining cleanliness in their home. Natukunda and Nalwanga (1988) further pointed out that, there is low

participation of women in decision making because of male dominance. A similar view was also expressed by Russo (1993) who noted that women have not benefited much from development because of their limited authority in households to decide on vital issues, which concern them. Tong (1989) from a feminist perspective, pointed out that the radical feminist on gender and sexuality argue that socially constructed gender and reproductive roles restrict a woman's identity and behavior. Sexuality is a crucial issue in feminism because males tend to dominate and be aggressive to prove male domination and female submission. He further advanced his argument that sexuality is a locus of male power. This study highlighted that power relations were related to STD treatment services, which was the focus of this study. In addition, the Beijing UN Conference (1995) noted that women who have the ability to control resources who can think and reason, have higher chances of making positive decisions on their health aspects without interference from other members of the household.

2.3.4 Gender Division of Labour

This relates to different work that men and women do as a consequence of their socialization and accepted patterns of work within given contexts. The women roles include reproductive, productive and community services. Reproductive roles include bearing and nurturing children. Moser (1993), noted that “the man of the family, as the breadwinner”, is primarily involved in productive work outside the home, while the woman as a household and ‘homemaker’ takes overall responsibility for the reproductive and domestic work involved in the household”. Because of the dual roles ascribed to women, they may have less time to access and use health services.

In a baseline survey on utilization of health treatment services in Bangladesh, 58 house-wives were interviewed and 43 of them revealed that they did not have enough time for medical care because they worked twelve to thirteen hours per day without rest. Fifteen mentioned working

throughout pregnancy until pain started, since they could not secure enough maternity rest (Concern report, 1995). On the other side, male participation in reproductive roles is limited and even when they fall sick; it is the responsibility of women to take care of them. The study also went on to determine the influence of women to men on the use of health services and found out that men were 2.7 times more likely than women to be influenced to seek health care by a member of the opposite sex. The study never went into details to show how gender roles influenced access and use of health services. Thus the basis of this study was to help understand the gender division of labour on utilization of STD services.

2.4 KNOWLEDGE ABOUT STDs

Knowledge about most STDs is significantly high according to the UDHS (1995). UDHS (1995) observed that 75% of women and 88% of the men know about gonorrhoea, while 58% of men and 53% of women knew about syphilis. Accessed information has proved that women with more schooling have a higher propensity to seek treatment services (Meknonnen, 2002). Atuyambe (1998) observed that in Rakai, it was 30% of in-school and 43% of out of school adolescents knew the symptoms of syphilis. There was need therefore, to study the levels of knowledge about STDs among men and women and relate it to utilization of sexually transmitted diseases. Nabuuma (2001) observed that the disclosure problem is a hindrance to knowledge about STDs and HIV/AIDS in families. Some husbands do not inform their wives early enough to begin medication. They just take drugs from offices.

Research on attitudes towards STDs, is extremely minimal, although many studies like the UDHS (1995) have concentrated on people's attitudes towards condom use and the synergist relationship between STDs and HIV. In addition there has not been research done in Masaka district to document gender related factors and their influence on access and use of STD treatment services.

Lyons (1997) in a study about drug shops in Uganda and men with arthritics found out that the knowledge about syphilis and gonorrhoea was well over 90%, although this percentage markedly decreased for other types of STDs. In the same study, 81% of the respondents felt that STD patients are not different from other patients, probably suggesting that their treatment should be integrated in the general referral health systems. Similarly, Jacobsen (1993) carried out a study in Valero, India and noted that lack of awareness among patients with STDs was associated with illiteracy and socio-economic status, because health education had reached the majority of the people. Hence this study investigated people's knowledge about factors influencing people's use of STD treatment services that they were noted as seen in the chapter above.

2.5 CONCLUSION

In conclusion, there is a lot of research carried out on sexually transmitted disease in the world and Uganda. However, just a few of them have ever considered whether gender related factors have an influence on access and use of STD treatment services, which is the main focus of this study.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter describes the methodology used in the study. It includes scope of the study, design, study area, study population, sample size and procedure, sample selection, data collection and data analysis methods.

3.2 SCOPE AND STUDY POPULATION

The study was conducted in Nyendo-Senyange division in Masaka district. Men and women residing and working in this division were selected to be respondents and key informants of this study. This area of study was selected because, looking at Masaka, this division is more populated with a high risk of acquiring the scourge. The study population took into account both men and women who were 15 – 49 years, who reside or work in Nyendo-Senyange division. Key informants included medical personnel and STD patients who went for treatment to both private and health units in the division.

3.3 NYENDO-SENYANGE DIVISION

Nyendo-Senyange division is a semi-urban area, and one of the divisions of Masaka district. According to Rwabogo (1998), Nyendo-Senyange division has an area of 25sq.km and it has a population of 29,824 as projected in the 2001/2002 census data. It is approximately 2km from the centre of Masaka town. Medium and high income earners inhabit Nyendo-Senyange division. The public health centers in the division include Kitovu hospital and Kasana health centre and over 10 are private clinics.

3.4 RESEARCH DESIGN

The study was cross-sectional and descriptive. Qualitative research methods and quantitative approach (descriptive statistics) were used for elaboration. It was also gender balanced and people were studied in relation to accessing and using STD treatment services. Respondents who were 15-49 years were interviewed. Respondents were also selected regardless of socio-economic and socio-cultural backgrounds.

3.5 SAMPLE SIZE

The sample size was 200 people with 160 respondents and 40 key informants (It comprised of both men and women, in order to have a representative sample).

3.6 SAMPLE SELECTION

This was conducted using a multistage sampling technique to arrive at potential respondents. The sample was made up of people who had suffered from STDs and sought treatment, those who suffered and never sought treatment or those that had never experienced the infection. Nyendo-Senyange division is made up of two (2) parishes. These parishes have both public and private health centers where Kitovu has a specific STD clinic, hence services are available. From the 2 parishes in the division, eight (8) villages were selected using simple random sampling. All the households in the 8 villages were numbered and then the households were selected using simple random sampling from which male and female respondents were interviewed. Twenty (20) respondents were selected from each village, bringing the total to 160 people. Ninety two (92) were female and 68 males. Forty (40) key informants from the division were selected purposively from both public and private health units. These included twelve (12) medical personnel, four (4) pharmacists and twenty four (24) STD patients from the division. Since medical personnel were few and ever busy, purposive selection was used. STD patients

who visit these health clinics were contacted as they came for treatment until when the number required was realized.

3.7 DATA COLLECTION METHODS

3.7.1 Introduction

Qualitative and quantitative data was collected for this study. A questionnaire was used to collect data from respondents while an interview guide was administered to the key informants. Two research assistants were employed for the fieldwork.

3.7.2 Qualitative Data

For qualitative research, semi-structured questionnaires were administered to the 160 respondents. The study was mainly qualitative in the sense that it intended to find out men and women's perspectives and attitudes about factors influencing people's access and use of STD treatment services. The interviews were in English and where necessary the research assistants did translations. The interview took not more than 20 minutes per respondent.

For the key informants, an interview guide was employed. The key informants included 24 STD patients, 12 from Nyendo and 12 from Senyange, six men and six women. Health workers were also interviewed as key informants.

3.7.3 Quantitative data

A semi-structured questionnaire was also administered for quantitative data in order to find out the characteristics of men and women and what influence gender related factors had on access and use of STD treatment.

3.8 DATA COLLECTION PROCEDURE

A letter from the Head of the Department of Population Studies was given to the researcher introducing him. The letter was presented to the Local Councils in Nyendo-Senyange. It was also presented to the pharmacists, the administrators, public STD clinics and to the private clinics that were visited. The researcher also had to give verbal explanation to the respective bodies and respondents. Interviews were done at the respondents' homes, health centers and work places.

3.9 DATA ANALYSIS METHODS

The quantitative data was analyzed using the Statistical Program for Social Sciences (SPSS) computer program. Codes were entered into the computer and points generated and then used to describe the relationships among variables. Content analysis on qualitative data was done thematically. The following themes were used: socio-cultural, gender relations, knowledge and attitudes. The results obtained from above complemented the quantitative data generated from the questionnaires to get final results.

3.10 LIMITATIONS OF THE STUDY

The researcher encountered a number of problems in conducting the study. The main limitation was that of getting the actual or real answers due to the sensitivity of the topic. The nature of the study involved soliciting personal information, which most women, unlike men, are often reluctant to give. Therefore, the data collected may have been, in one way or the other, affected. In addition, respondents, out of this suspicion about why and how the information was to be used, at times, withheld, distorted or omitted important information. But more probing tactics like asking the same question in a different way were used.

3.11 ETHICAL CONSIDERATION

Having presented the introductory letter from the Head of Department of women and Gender Studies, the respondents were asked whether it was alright for them to be interviewed. Respondents were, in addition, assured of the confidentiality of their responses. They were free not to answer any questions they chose not to.

CHAPTER FOUR

PRESENTATION AND INTEPRETATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the findings, whose aim was to examine the gender related factors influencing utilization of STD treatment services. The study composed of one hundred and sixty respondents who were 15 – 49 years. There were 92 females and 68 males. The original plan of the research was to have an equal number of male and female respondents, but this was not possible. The female respondents outnumbered male respondents, probably because most men do work (paid employment) and hence women were the majority in the domestic sphere. The study also took into account 40 key informants from Nyendo-Senyange Division. From the division, there were four pharmacists, 12 medical personnel and 24 STD patients from the division. The public health centers included Kitovu Hospital and Kasana health centre. Relating the findings of the study to the literature and even other studies, most of the findings are presented in a gender-disaggregated form. Data for males and females is presented separately to allow for the proper analysis of the gender issues. The findings from both qualitative and quantitative data are presented concurrently to allow the two types of data to supplement each other. The analysis and discussion of the findings are also presented concurrently to avoid repetition. The findings are presented in a descriptive manner using percentages.

4.2 DESCRIPTION OF RESPONDENTS

The background characteristics of the respondents according to this study play a vital role in enabling the reader understand the nature of the respondents. They also have a crucial influence on the control of resources, decision making and shaping women and men's responsibilities in households in as far as the use of health services, for STDs in this case, are concerned.

The characteristics studied include age, marital status, religion and ethnicity, occupation and education level.

4.2.1 Age Composition of Respondents

Table 4.1: Distribution of respondents by background characteristics

Age group	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Age Group						
15 – 25	14	8.0	24	15.0	38	23.8
26 – 36	46	28.6	54	33.8	100	62.4
Over 36	8	5.0	14	8.8	22	13.8
Total	68	42.4	92	57.6	160	100.0
Marital Status						
Married	60	37.5	60	37.5	120	75.0
Widowed	-	-	4	2.5	4	2.5
Single	8	5.0	28	17.5	36	22.5
Total	68	42.4	92	57.6	160	100.0
Region						
Central (Baganda)	54	33.8	82	51.3		
Western	6	3.8	6	3.8		
Eastern	6	3.8	2	1.3		
Northern	2	1.3	2	1.3		
Total	68	42.5	92	57.5		
Educational level						
Never went to school	8	5.0	-	-	8	5.0
Primary	44	27.5	4	2.5	48	30.0
Secondary	34	21.3	46	28.8	80	50.0
Post-Secondary	6	3.8	18	11.0	24	15.0
Total	92	57.5	68	42.5	160	100.0
Religion						
Catholics	34	21.3	46	28.8		
Protestants	18	11.3	42	26.3		
Moslems	10	6.3	2	1.3		
Others	6	3.8	2	1.3		
Total	68	42.5	92	57.5		
Gonorrhoea	48	30.0	60	37.5	108	67.5
Syphilis	20	12.5	32	20.0	52	32.5
Total	68	42.5	92	57.5	160	100.0

Source: Primary Data

As indicated in Table 4.1 above, most of the respondents were in the age bracket of 26 – 36, which represented 62.4% of the respondents, followed by age group 15 – 25 with 23.8%. Those of 36 years and above were the least. It is noted from the table above that altogether, female respondents were more than the male respondents. The reason for more female respondents was because, as explained earlier, female respondents were majority at home in the domestic affairs where the interviews were conducted. In all age groups, there were more females than males, possibly because of the lower age of marriage for the females as Sohoni (1995:31-34 UDHS, 1995) observed. Age was therefore found vital in obtaining a variety of views concerning access and use of STD treatment services.

4.2.2 Marital Status of Respondents

The above findings show that majority of the respondents, i.e. 75% were married while 22.5% of the respondents were single, and of whom 5% were male and 17.5% were females. Only 2.5% of the respondents were widowed. There were no widowers, probably because men tend to have more than one women and when they lose one wife, they would have another and remarrying is easy for them. Married respondents were more, probably because marriage plays a fundamental role in society in access to resources and even as far as social status in society is concerned. The proportion of female respondents was slightly higher than that of the male among the unmarried. The marital status of the respondents was noted to have a great influence on utilization of STD treatment services. Married women depended on their husbands for money in case of an infection and permission to go for treatment.

4.2.3 Region of origin of respondents

From Table 4.1, majority of the respondents from the division were Baganda, who formed 85%, and these comprised of 51.25% female and 33.75% male. These were followed by those from

the western region, of which 3.75% were males and 3.75% females. Those from the eastern region comprised of 3.75% females and 1.25% males and lastly the northern region formed the least with 1.25% and 1.25% females and males respectively. The Baganda formed the majority probably because the study was carried out in the central region where the dominant tribe is Baganda. It was difficult to leave out the other tribes and hence were grouped in the region of origin. The western included Batoro, Banyankole, Bakiga, Bamba and Banyoro. The eastern included Basoga, Bagishu, Bagwere and Basamya. Northern region included the Acholi, Itesot, Langi and Karamojong. The other tribes were in small numbers because they mainly come to the central region to look for employment opportunities and always go back to their home areas.

As shown in the Table 4.1 above, majority of the respondents were of secondary level, where 21.25% were females and 28.75 were males. Those in primary followed with 27.5% females and 2.5%. Respondents of post-secondary level were 3.75% for females and 11% for males. Those that had never attended school came last with 5% and none for males.

4.2.4 Religious Background

Table 4.1 above indicates that the Catholic respondents formed the majority (50%) and these were followed by the Protestants (37.5%), Moslems formed 7.5% and other categories(5%). Religion and ethnicity were considered because they were likely to affect household gender relations, thereby influencing utilization of STD treatment services. Since religions have their own teachings on sexual issues, like no extra marital relationships, there was need to establish whether these teachings had an influence on the male and female respondents in as far as use of STD treatment services was concerned. It is worth noting that the results from the study showed that these had no influence on utilization of STD treatment services. Instead, gender relations were similar, no matter what the tribe or religion the respondents belonged to.

As shown above, the proportion of female respondents who dropped out of school at primary level was higher than that of male respondents. Also only female respondents indicated as never went to school. This can be explained by gender roles that girl children are made to perform household chores such as cleaning, cooking, baby-sitting, early marriages and teenage pregnancy, hence dropping out of school while the boys are busy attending school. It is very difficult for females after all these stacks to resume their education. On the other hand, the proportion of males with higher levels of education (secondary and post-secondary) was high. The reason for the above could be the fact that more females than males drop out at lower levels. The results in these divisions are similar to what World Bank (1993) observed in other parts of Uganda. Men are more favoured in terms of education and career development. The emphasis for girls is on marriage and hence they are provided with basic education. With regard to these findings, much as gender roles in affecting effective utilization of STD treatment services is of great importance, education level was noted to be of great influence. Almost all the respondents noted that lower education levels have an effect on utilization of health services, STD services inclusive. The reasons given included: people with lower education levels have limited knowledge of what to do. It is not even possible for such a person to read the health posters pinned around. Even the UDHS (1995) pointed out that, one's level of education is highly likely to affect many aspects of one's behavior, such as low fertility due to contraceptive use. In addition, it was also noted that in most cases, educated people have higher chances of employment opportunities and thus exposed to more than the less or uneducated people, giving them more chances of utilizing STD treatment services. In this case therefore, gender relation is not only a problem that needs to be tackled; education across gender is a vital factor that should not be ignored especially for women. Worth noting, however, is that the low education attainment is to a large extent a result of gender related factors.

4.2.5 Occupation of Respondents

One hundred and twenty respondents (75%) were involved in business. Women were mostly involved in small-scale businesses like selling charcoal, tomatoes, onions, and even small shops. However, men were found to engage mostly in large-scale businesses like large shops and other businesses. There were 12 teachers and out of these, only 4 were women and these taught in lower classes, which is an extension of the domestic sphere. However, even those women who engaged in the above activities noted that they first did domestic work like childcare, house cleaning and even after work, they had to prepare food. In this regard, the occupation of respondents influenced utilization of STD treatment services because of limited time due to multiple roles. This concurs with Moser (1993) who noted that dual roles of women consume the most amounts of time and opportunities for other activities.

4.3 KNOWLEDGE AND ATTITUDE (KA) OF RESPONDENTS ABOUT STDs

One of the objectives of this study was to examine people's knowledge and attitudes about STDs and STD treatment services. As a result, a detailed investigation was done concerning the knowledge and attitudes of respondents. It was quite obvious that the majority of the respondents, i.e. 144, knew about STDs. Regarding knowledge on types of STDs, the most common STD excluding AIDS was gonorrhoea with 60 (37.5%) of women and 48 (30%) of men spontaneously reporting knowledge of the disease. And also 20 (12.5%) men and 32 (20%) women mentioned knowledge of syphilis. However, some women, out of probably shyness, first said they did not know any STDs. This was recognized when female respondents were asked such questions as: "Do you know any STD?" One of them responded, "I have never suffered from any STD" while shying away. And when asked, "Do you know about syphilis and gonorrhoea?" She answered, "I know but I have never suffered any of them."

In this regard therefore, it was recognized that knowledge of some people was established by asking the same question a little differently. It was noted that only the educated group who,

because of their knowledge of the disease, could differentiate the common STDs from other STDs like Chlamydia and genital herpes.

About 128 of the respondents (80%) indicated that people with STDs are seen as outcasts, promiscuous or prostitutes and unfaithful to their partners. However, some of the respondents noted that though these people are observed/described in the above ways, there is a significant difference between men and women. This is in the sense that for men, it may not be such a big deal as for a woman.

4.3.1 Partner notification

In the study, partner notification was investigated and the majority of the people approved of informing their partners when one had an STD, especially the married people. In fact 144 respondents (90%) and 38 of the key informants 95% (patients of STDs, pharmacists and medical workers) thought that person with an STD should inform his/her sexual partner about their condition.

The reason respondents gave for this notification of a partner was to ensure that partners get treatment so as to avoid re-infection. This is in line with WHO (1991) which observed that like other communicable diseases, the control of STDs cannot be achieved merely by the treatment of people presenting to health facilities with signs and symptoms or by treating one of the spouses, but by both.

They also stated that it was useless to treat yourself without your sexual partner. In fact one married man had this to say:

“I have two wives, but when I suspected of having an infection I had to tell both of them. I did not mind their reaction, that is, thinking that I had got it outside our marriage, but my point was to have the tree of us treated.”

Another reason that respondents had for partner notification was that they would be able to protect the baby from the infection. This is similar to Costa and Latif A.S (1981) who noted that pregnancies in women with certain sexually transmitted disease like syphilis may end in fatal death, neonatal death or the birth of a child with congenital syphilis. The neonate born to a mother with Chlamydia and gonorrhea infection may acquire a Chlamydia and gonorrhea eye infection at the time of birth that can lead to blindness if not promptly and adequately treated. From the findings, in relation to utilization of STD treatment services, it was noted that, though respondents knew the importance of partner notification, especially the married people, some of the respondents revealed that they could not tell their partners especially the women for fear of being regarded unfaithful. This was similar to the findings of Bukumbi (1996) who noted that there was limited communication between spouses, especially on issues related to reproductive health and sexually transmitted diseases. Wives feared to raise such issues to their husbands because they did not want to raise suspicion.

4.3.2 Source of information on Sexually Transmitted Diseases

Respondents were asked to reveal their sources of information on sexually transmitted diseases. Out of the total sample population, 55.2% mentioned radios, 30.8% health centers, 8% mentioned relatives/friends, and 6% other sources.

A number of respondents reported that they got information by visiting health centers. Women visited health centers more than men, being caregivers and also because of their reproductive roles. In addition, women were more likely than men to accompany sick children to health centers, owing to their gender roles assignment. One woman said: "If it was not for pregnancy, I would not have known about syphilis, and its effect on the baby. But when I went for antenatal,

they requested me to be tested for syphilis and other urinal infections. The results were found to be positive and I had to be treated.”

4.3.3 Gender Roles and utilisation of STD Treatment Services

The concept of division of labour in as far as this study is concerned, was very vital. This is because the research aimed at, among other things, examining women’s multiple roles and their influence on the utilization of sexually transmitted disease services. It is noted that multiple roles on the part of female respondents demanded a lot on their side and hence it was necessary to ascertain whether female respondents were willing to take off time to seek treatment in case need arose. In order to come up with a proper conclusion, respondents, both men and women, were asked to reveal the responsibilities which they usually perform daily.

All the female respondents (57%) interviewed revealed that they perform productive roles like: small-scale businesses like shop-keeping and sale of small items from home like charcoal, reproductive roles which include child care, bearing and rearing/nursing, socializing etc. and domestic/household chores like cooking, fetching water and ensuring that the home is clean. On the other hand, there were no males mentioned doing domestic roles. In fact the majority of males work outside the home, for example carpentry, teaching, business i.e. self-employed. The ascribed reproductive roles to women keep them in the domestic sphere. Domestic work is either unpaid for or low paying or many times the product of women’s work is consumed without payment. On the contrary men’s work tends to be in the public sphere, socially prestigious and better paid for (Moser, 1993).

It was therefore realized that even women, in this case business women and teachers have to perform their household chores before and after office work, hence heavily loaded and burdened to effectively utilize health services as may be required. Many women always postpone going

for treatment while the infection advances, resulting into more complications, as confirmed by Dixon (1991). One of the key informants (health worker – nurse) pointed out that women hardly go to health centers for some reproductive tract infections. Instead, many of them confide in their relatives and depend too much on local herbs. This is not so different from Mwaka (1994), who noted that because of the many household responsibilities, women fail to get from home to seek for modern care. They resort to herbal treatment until the illness becomes severe.

The multiple roles according to the findings are, therefore, a significant contribution to low utilization of STD services. This concurs with what Oakley (1974) observed that the domestic role is exclusive to women, is associated with economic dependence, is regarded as non-work and takes priority concerns of women. Also Young (1984) mentioned that this is not simply a process of gender differentiation in workload of men and women but rather the beginning of subordination of women as a gender.

4.3.4 Access to and Control over resources and the influence on utilisation of STD services

Another gender issue that was examined was that of access to and control over resources and benefits. This was important in that the researcher wanted to find out how this issue relates to access and utilization of STD treatment services. The researcher was interested in knowing the extent of control over financial and physical resources by both men and women in the households and the resultant influence on utilization of services. The researcher first considered the main sources of family income, i.e. land, chicken, goats and business. With regard to these findings, it was evident that one half of the sample (50%) earned their income from petty trade business, salary/wages. This was probably so because the study took place in a semi-urban setting whereby a few people own land, and hence depend mainly on salary and small businesses.

However, respondents reported that control over resources is by men unless the woman is single. This is in line with World Bank (1944) where half the world's population receives one tenth of the world's income, account for two thirds of the world's working hours and own only one hundredth of the world's property, and Natukunda and Nalwanga (1988) also revealed that where resources are controlled jointly, it was noted that there is a final boss. One respondent who had a share in controlling the family resources with her husband said:

“A man is always a man whether he has control or not. I have to get his final view about use of money for health services.”

In such an instance, it is noted that a wife accepts to become subordinate to her husband and cannot act on her own. It is difficult to make a positive change. This is probably because of the socialization process where women are subordinated to men. Therefore, to argue that utilization of health services will increase when women control resources only is misleading.

Due to the fact that men control most of the resources, both in the community and household, it was noted that most of the respondents interviewed relied on men in order to get money they needed for either transportation or fee charges for treatment in case of suspecting an infection while others preferred to be silent about the diseases or terming it as a “kigalanga”, hence using traditional medicine. Sexually transmitted diseases are quite a sensitive issue whereby having access and controlling of resources may influence one's use of the treatment services. These are diseases that many people especially women end up keeping quiet about, because of social stigma. However, those who open up to their husbands revealed that in case of an infection, their husbands were co-operative and assisted them when need arose. But if the husband was not co-operative it would be difficult for the women to have funds at their disposal to go to the hospital, especially if she did not have a single income and being only a housewife. This is in line with

Natukunda and Nalwanga's (1988) assertion that women as compared to their counterparts have less control over crops for sale, although they contributed the biggest proportion of labour.

Women's economic dependency increases their vulnerability to HIV and hinders their access to treatment. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favours, less likely that they will succeed in negotiating protection, and less likely that they will leave a relationship that they perceive to be risky and less likely that they will seek treatment.

The most disturbing form of male power, violence against women, contributes both directly and indirectly to women's vulnerability to HIV. In population-based studies conducted worldwide, aware from 10 to over 50 percent of women report physical assault by an intimate partner. And one-third to one-half of physically abused women also report sexual coercion.

A review of literature on the relationship between violence, risky behavior, and reproductive health, conducted by Heise and colleagues (1999) shows that individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs. This relationship is also apparent in the findings from a study conducted in India. In this study men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who had not. And men who reported STD symptoms were 2.4 times more likely to abuse their wives than those who did not (Martin et al. 1999). And from other research, we also know that physical violence, the threat of violence, and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky.

Additionally, data from a study conducted in Tanzania by Maman, Mbwambo, and colleagues (2000) suggest that for some women the experience of violence could be a strong predictor of HIV. In that study, of the women who sought services at a voluntary HIV counseling and testing centre in Dar-es-Salaam, those who were HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were negative.

In addition to increasing the vulnerability of women and men to HIV, the power imbalance that defines gender relations and sexual interactions also affects women's access to and use of services and treatment. For example, the Tanzania study conducted by Maman, Mbwambo and colleagues (1999) found that there were gender differences in decision-making that led to the use of HIV voluntary counseling and testing services. While men made the decision to seek voluntary counseling and testing independent of others, women felt compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing VCT services.

Women's social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma and discrimination associated with HIV infection. HIV positive women bear a double burden; they are infected and they are women. In many societies, being socially ostracized, marginalized and even killed are very real potential consequences of exposing one's HIV status. Yet, HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child.

In a recent study conducted by researchers in Botswana and Zambia, in collaboration with researchers from ICRW, men and women expressed concern for women who test positive because they felt that men would be likely to abandon an HIV positive partner. On the otherhand,

it was expected that women would initially get angry with an HIV positive partner, but ultimately accept him.

How is one to overcome these seemingly insurmountable barriers of gender and sexual inequality? How can we change the cultural norms that create these damaging, even fatal, gender disparities and roles?

It is easier now to explain the why and what with regard to gender, sexuality, and HIV/AIDS, but there is less known about the how – how to address these issues in a way that has an impact on the epidemic. It must be said, however, that this relatively little information on the how is not due to a lack of innovation and trying. Although there are still no clear-cut answers and there is very little data to establish the impact of the efforts that have been tried, it is possible to look back and identify clear-cut categories of approaches – approaches that fall at different points on a continuum from damaging to empowering.

To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interventions should, at the very least, not reinforce damaging gender and sexual stereotypes. Many of our past and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection. This poster, in which a sex worker is portrayed as a skeleton, bringing the risk of death to potential clients, is an example of the latter which, from experience, we can predict, probably succeeded in doing little other than stigmatizing sex workers, thereby increasing their vulnerability to infection and violence. There are many other examples of such damaging educational materials. A particularly common type is one that exploits a macho image of men to sell condoms. No amount of data on the increase in condom sales is going to convince me that such images are not damaging in the long run. Any gains achieved by such efforts in the

short-term are unlikely to be sustainable because they erode the very foundation on which AIDS prevention is based – responsible, respectful, consensual, and mutually satisfying sex.

4.4 DECISION-MAKING AND UTILISATION OF TREATMENT FACILITIES

Here, the study examined decision-making and utilization of sexually transmitted disease services as an important aspect of gender relation. The study aimed at finding out how decision-making in the household influences access and utilization of STD treatment services. Emphasis was placed on whether the female and male counterparts equally made decisions about the use of the resources in the home for health purposes, and in particular, STDs. Respondents were asked to reveal who in the family decides on where and when a person (family member) should seek treatment in case of an infection. And also how much to spend and what means of transport to use.

Table 4.2: Decision-making for Treatment

Decision making	Hospital		Clinic		Pharmacy		Traditional	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Husband	36	81.8	4	9.1	2	4.5	2	4.5
Wife	10	23.8	20	47.6	6	14.3	6	14.3
Both	20	58.8	6	17.6	4	11.8	4	11.8
Self	8	20.0	10	25.0	20	50.0	2	5.0
Total	74	46.3	40	25.0	32	20.0	14	8.8

Source: Primary Data

From the table above, it is evident that the husbands make most of the decisions compared to women; where the husband makes decisions, 22.5% preference was given to hospital, followed 2.5% clinic, 1.5% pharmacy and 1.5% traditional herbs. Whereas where the wife makes decisions, the clinic was the most preferred with 12.5%, the hospital with 6.25%, pharmacy with 3.75% and traditional herbs with 3.75%. Where decision is made by both, hospital had the

highest percentage with 12.5%, the clinic followed with 3.75%, pharmacy with 2.5% and also the traditional healer with 2.5%. Where an unmarried person made the decision, the pharmacy had the highest percentage of 12.5% followed by the clinic with 6.25%, hospital with 5% and lastly traditional herbs with 1.25%.

It was clearly revealed that less than a third (22.5) of the respondents declared that where the husband exclusively does the decision-making, the hospital is preferred. On the other hand, it is only 6.3% where the wife makes the decision. This may be because in the hospital especially government hospital, treatment services are free and where there is paying, the fee is affordable.

However, female respondents explained that where the issue concerns a man i.e. if he was the one infected, he might not even notify the wife where he is going to seek treatment from. Most likely it is a private hospital/clinic and this is because he is in control over the income (even then, he has the income at his disposal).

Where the decisions are made jointly, it was also revealed that the hospital was the most preferred place with 12%, a decision that might be influenced by the husband. These findings reflect patriarchal thinking and practice, which influence people's level of decision making in matters of health.

Therefore, in reference to Young (1994), women's decision making power over major issues in their social lives is limited by virtue of their status (marriage). Therefore, men make most of the decisions in a family. This situation puts married women at a disadvantage because it strengthens the dependence syndrome on one hand while on the other hand, the male counterparts may decide to choose cheap sources with poor quality services which endangers reproductive health. Where the wife makes the decision, the clinic is the most preferred place

with 22.5% compared to 2.5% where the husband makes the decision. This is so because clinics are always within easy reach and are convenient to the women since they are always busy with domestic roles and cannot afford spending long hours in hospital. More so, where a single person makes the decision, it is revealed from the table that the pharmacy is preferred with 12.5% followed by the clinic with 6.3%. The findings revealed self-treatment of some people. Use of herbs or traditional healers was the least in all categories. This may have been so because with STDs, modern medicine is the best.

Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favours men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behavior, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural and economic forces that determine the distribution of power.

Research supported by ICRW and conducted by researchers worldwide has identified the different ways in which the imbalance in power between women and men in gender relations curtails women's sexual autonomy thereby increasing their risk and vulnerability in the HIV/AIDS pandemic.

In many societies there is a culture of silence that surrounds sex that dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive in negotiating safer sex.

The traditional norm of virginity for unmarried girls that exists in many societies, paradoxically, increases young women's risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Virginity also puts young girls at risk of rape and sexual coercion in high prevalence countries because of the erroneous belief that sex with a virgin can cleanse a man of infection and because of the erotic imagery that surrounds the innocence and passivity associated with virginity. In addition, in cultures where virginity is highly valued, research has shown that some young women practice alternative sexual behaviors, such as anal sex, in order to preserve their virginity, although these behaviors may place them at an increased risk of HIV.

Because of the strong norms of virginity and the culture of silence that surrounds sex, accessing treatment services for sexually transmitted diseases can be highly stigmatizing for adolescents and adult women.

In many cultures because motherhood, like virginity, is considered to be a feminine ideal, using barrier methods or non-penetrative sex as safer sex options presents a significant dilemma for women.

4.4.1 Gender Division of Labour and its influence on Utilization of STD Treatment

According to the 40 informants and secondary data, men dominated headship of households. Even those who still stay with their parents indicated that their fathers were the heads of the family. This originated from the cultural setting of African societies where the man is the head of the family.

Women headed a few households and these were mainly for the unmarried. It was, therefore, noted that headship revealed patriarchal settings that are prevailing in society. The reason why

headship was vital in this study was because headship is an important factor in determining resource allocation, availability and use. Headship influenced utilization of STD treatment services in such a way that the household heads determined how much to use and where to go for treatment.

Division of labour in the household was primarily based on gender. The men dominated the public sector and work in the fields or elsewhere outside the home. The women occupied the domestic sector, by managing the household and providing service for its members. Regarding decision making in the household, the husband enjoyed absolute power.

Traditionally, Chinese girls married early – as soon as possible after puberty. Marriage brought about drastic changes in women's lives but not so in men's. Once a woman married, she had to leave her natal home and live with her husband's family. A frequent meeting with members from natal family is improper. The first duties for a woman were to her husband's parents, and secondly was she responsible to her husband. Unfortunately, tension and conflict between mothers-and daughters-in-law was frequent. The power, however, always lay with the mother-in-law due to her superiority of generation and age and the emphasis on filial piety.

Regardless of her hard work for her husband's family, the daughter-in-law was seldom counted as *zi-jia-ren*, nor could she enjoy favoritism, especially if she had no son. As an outsider, without a son to secure her status, a woman was doomed to powerlessness. The head of the family might demand that his son take a concubine, and the wife could only cooperate.

The Marriage Laws of 1950 and 1980 in China and the revisions of Civil Code in Taiwan have helped to raise the status of Chinese women. The average age at marriage has been rising for both men and women. Once married, women do not change their surnames. They also have full

inheritance rights with men. Mandatory formal education and participating in paid labour market altogether increase wives' power to achieve a more egalitarian style of decision-making and domestic division of labour. This phenomenon is more predominant in cities than in rural areas, and is more common in China than in Taiwan.

Despite the significant progress, the persistence of tradition still restricts women to inferior status. Wives' full-time paid employment does not guarantee that their husbands will help with household chores. Many young couples begin their marriages by living with the husband's instead of the wife's parents. The mother-in-law/daughter-in-law relationship remains difficult. Visiting the natal home frequently still causes conflict between these two women.

The differential treatment of the child on the basis of gender began at birth. The birth of a son was greeted joyfully. Daughters, in contrast, were usually deemed liabilities. They experienced a much greater risk of being sold out to act as servants, concubines or prostitutes. Infanticide often happened.

The Chinese were tender and affectionate toward small children. Discipline was held to a minimum (Levy 1971). Through story-telling, for example, young children learned to obey their parents and older siblings and, more importantly, to devote themselves to be filial. At the age of three or four, some restrictions began, as did segregation by gender. Boys were under their fathers' direct supervision and girls were inducted into women's tasks. Education for girls was considered unnecessary and even harmful.

4.5 PEOPLE'S EXPERIENCES ON STDs AND WHERE THEY SOUGHT TREATMENT

One of the issues raised in this study was to find out people's experiences and where they sought treatment. From the research it was noted that more women suffered from STDs than men. The men mentioned in particular to have suffered from syphilis and gonorrhoea. This could be explained by the fact that men control the resources, and hence they can afford to go even where services are not free or where they are expensive. Two male respondents explained that they have never suffered from STDs but did not seek treatment from any health centre. They however noted that they used local/traditional/herbal medicine as advised by friends.

Twenty four male respondents explained that they have never suffered from STDs but noted that in case they did, they would seek treatment and would as well inform their partners. Out of 92 female respondents, 72 respondents explained that they had never suffered from STDs, especially syphilis. Twenty four of them reported that they sought treatment from government hospitals, while twenty two respondents revealed that they sought treatment from private clinics. Six respondents were noted to have treated themselves by buying drugs from pharmacies and two said they used traditional herbs. Eighteen respondents reported that they suffered from STDs but did not seek treatment, for they revealed that they feared to expose themselves. In addition they feared to tell their partners. Twenty female respondents explained that they have never suffered from any STDs.

4.5.1 Problems faced by People seeking STD treatment services

In this section, the researcher found it necessary to seek people's opinion on whether STD patients do face problems in accessing and using STD treatment and services, in case they are victims. Indeed, many people, especially women, face problems and as such have a life full of uncertainty because of failure to address them. Problems considered were: lack of money,

transport costs, no spousal support, lack of knowledge of what to do and the fear to expose themselves.

According to Nakimuli (2001), it was noted that lack of finances was indeed a problem for women, as they became dependent on their husbands to provide them with money without which they remained with their infections. A key informant (nurse) at a private clinic stated that:

“Many women come to this clinic with reproductive health problems but after visiting the doctor, they fail to pay the consultation fee and at the end of the day even fail to purchase the medicines that are given to them because of lack of money. We started advising them to go to public hospitals and referrals like Kitovu and Kasana, but may end up saying, ‘If we get transport’. In this regard, many women have remained untreated.”

The reasons being that STD is associated with prostitution; others said that they hate exposing their private parts to people. One woman had this to say;

“I hate exposing my private parts to other people and inserting of fingers really makes me sick.”

This is similar to what Semwogerere (1995) noted that some women preferred self medication because they were unwilling to expose their private parts to the male gynecological doctors, and even to the mid-wives and nurses who were considered as young girls fit to be their daughters. Women thus preferred to treat themselves in secrecy. In this regard, many women who may suspect themselves of having an infection may end up not getting treatment. Another factor observed from this study was that of not knowing that one had an infection. One gentleman explained;

“I had a problem of pain while passing urine and when I went to a doctor at a private clinic, he gave me treatment and asked me to take my wife too. However she reported that she did not feel any pain or discomfort, but after checking up, the doctor found out that she too was infected.”

In this case therefore, women need much more education and information about STDs than they are getting now. They must be accompanied by more ready access to diagnostic and therapeutic services. Men tend to seek diagnosis and treatment earlier because their symptoms are more obvious and because it is usually easier for them to go to health facilities where treatment is available. More so, some women faced problems of uncooperative husbands. In this case, female respondents revealed that some men don't follow the instructions as advised by the medical personnel. One woman reported:

“When I discovered that I could be having an infection, I went to seek medical treatment. When I returned home and informed my husband for the need for treatment, he accepted. Unfortunately he did not follow the doctor's advice of not having unprotected sexual intercourse and after two days of treatment he insisted we have unprotected sex. I had no option and up to now we are still infected and all because of male power play.”

These findings are similar to Dixon's (1990) in which she noted that it is difficult for married women to suggest condoms with their partners. From this study, as noted before, it was also found out that the way society perceived the STD was a problem to many people especially women. STDs are in most cases perceived as diseases from promiscuity and as such many people may fail to go for treatment fearing this perception by the society. A saved lady of 42 years had an experience to share:

“During the days when I was married, I suffered from STDs not because I was a prostitute but because my husband was very unfaithful. I however sought treatment and was treated. In those old days, I experienced a lot of itching in my private organs and some relatives in whom I confide, referred to this as a sign of promiscuity

“Obulwaddebwenafuna nga nkyali mu buvubuka buttuse mu bukadde”

In addition, other people fear to be associated with the disease and as such end up treating themselves and yet the infection continues to spread. A key informant (STD patient) had an experience to share:

“For 10 years, I led a life with a lot of pain in the lower abdomen and lots of itching in the private parts. I could not tell anyone for fear of what they would think. So I treated myself in secrecy until it was too much for me and that is when I discovered that STD clinic at Kitovu. I just hope I will be fine.”

This case is probably just one out of the many who are infected. It reveals that some of the people (especially women) live continuously with discomfort and pain and hence utilization of STD health services is likely to leave many people especially women with abnormalities, some being irreversible.

The influence of religion was another factor to be considered in this study. Respondents were interviewed on the teachings of religion on extra marital relations and the influence of religious teachings on accessibility and utilization of STD health services. Almost all respondents noted that religion leaves no room for extra marital activities. For the Christians, it was noted that the teaching is one man one woman. For the Moslems, there is room for up to four wives if all are treated equally. On the influence of STD treatment services, many noted that religion actually

has little influence on the access and use of STD treatment services if one has been faithful. However, if the infection is suspected to have been acquired outside their marriage there is likely to crop up a misunderstanding that can't be sorted out.

Nevertheless, some respondents noted that there is however, a slight difference between men and women. For men having extra marital affairs is not accepted, but socially it is not taken as a big deal, yet for women, it is perceived as promiscuity and society regards it as unacceptable. This illustrates powerlessness of women in marriage as opposed to their authoritative male counterparts.

On cultural beliefs, it was revealed and reported that there are no cultural beliefs that can hinder someone suffering from STDs from using such health services. They stated that a lot of campaigns on STDs are world-wide and as such many people are awakened only that they may not afford the costs of treatment.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents a summary of the findings, conclusions and recommendations of the study whose overall objective was establish gender related factors that influence accessibility and utilization of STD treatment services.

The objectives of the study were to examine how access to and control over resources influence accessibility and utilization of STD treatment services; to examine how power relations (decision-making) may influence men and women in accessing and using STD treatment services; to examine how gender division of labour, which affected time use of either genders (men and women) and the activities they were involved in, influenced accessibility and utilization of STD services.

The study explored other factors such as socio-cultural factors, knowledge and attitudes and how these affected effective utilization of STD treatment services whereby the educated persons were more likely to use the STD treatment services more than people with lower education. The marriage status had an influence on utilization of STD treatment services due to the fact that it influenced decision-making in the household and many women depended on their husbands on decision-making regarding utilization of STD treatment services.

It was noted from the findings that the occupation of a person influenced the utilization of STD treatment services, in particular, men, with their type of work that is self-employed, whereas women were constrained because of the multiple roles, hence allowing them to have enough time to visit STD treatment services in case of sickness. This is a clear indication of how division of labour in the household limits women's effective utilization of health services.

Majority of the respondents knew the importance of partner notification, especially the married people. However some of the respondents especially women revealed that they could not tell their partners when suffering from the disease for fear of being sent out of their homes i.e. power.

It was noted that decision-making (power relations) could affect utilization of STD treatment services in a way that most of the decisions are made by men except for unmarried people. Men were identified as biased towards cheaper sources of health treatment with poor quality services that endanger women's reproductive health. Women noted that they had limited access and control over resources and in most cases depended on men for money in case of an infection, which affect their effective utilization of STD treatment services.

5.2 FINDINGS

The study revealed that there was a culture of silence surrounding STDs because of the stigma attached to the diseases, hindering many people from utilizing STD treatment services. The socialization process of men and women was noticed to have an effect on this silence. Also many respondents noted that women do not seek STD treatment services because their symptoms take long to show and sometimes they are unaware of the infection.

All respondents were knowledgeable about STDs with a slightly higher proportion of male respondents reporting knowledge of syphilis and gonorrhoea. They mentioned promiscuity and multiple partners as the major cause of STDs among couples. Women mentioned more of unfaithful husbands who always brought them the infection. Regarding sources of information, it was observed that women were more likely to access STD health information from health centers as compared to the men who mentioned more of the radios.

As far as constraints to effective utilization of STD treatment services was concerned, women mentioned most of the problems like lack of money for medication, transportation, lack of spouse support, not knowing that they have the disease and even not feeling comfortable to expose their private parts. Regarding gender roles and utilization of STD treatment services, the analysis of the study reveals that utilization of STD treatment services was highly influenced by gender roles, and this, according to the findings, is due to the competing heavy work load women have to perform without rest. In addition, taking off their regular duties such as child rearing and other domestic chores was a constraint to women unlike men.

Gender-related factors were found to highly influence the utilization of STD treatment services. Likewise, all other factors like education level, partner notification, occupation, culture of silence and marital status were also found to have a relationship to gender related factors in influencing the utilization of STD treatment services. The study concludes that power relation control of resources and divisions of labour have a negative influence on female use of STD treatment services.

5.3 CONCLUSION

Let me conclude by urging all of us to ensure that the term empowerment of women becomes more than just a linguistic icon, whose meaning is inversely proportional to its use! Empowering women and guaranteeing them their economic and social rights is not an option. In the AIDS epidemic it prevents deaths. It ensures that one of the greatest barriers to the health of populations and to economic development -- gender inequality -- is eliminated. Empowering women is not a zero-sum game. Power is not a finite concept. More power to women does not translate into less power for men. Empowering women, strengthening their agency as actors and

decision-makers in their own lives, and guaranteeing their rights increases the power of women, as well as that of households, communities and entire economies.

5.4 RECOMMENDATIONS

Given that the findings showed that women may not take up opportunities because of limited access to resources and division of labour, I would recommend that understanding of gender relations should be made part and parcel of counseling and treatment since some clients may not have gone back to treatment centers because of being abused or shouted at.

Gender relations and STD related behavior must be taken into consideration in policy planning and service delivery of better health. In the study, it has been found out that most of the STD patients utilize public health centers because they lack money for private health centers. The government should look for ways in which to subsidize private STD clinics so that they can also be accessible to low income earners especially women.

1. The findings clearly show that gender related factors such as division of labour, power relations and control over resources constrain women from using health treatment services. Therefore a study on female condom use as a preventive measure should be considered. The study should aim at finding out the cost, knowledge, acceptance and flexibility to different sex styles of different parts of Ugandan culture.
2. There is need for intensified information system, education and communication (IEC) activities to improve health awareness, desired changes in knowledge/awareness, attitudes and behavior (including health seeking behavior) directed towards the presentation and control of the major health problems especially STD treatment services

and in promoting healthy lifestyles. Most of these education materials should be translated in various local languages.

3. There is need to strengthen Primary Health Care (PHC) programs and referral systems. The community outreach mechanisms should be strengthened to provide basic laboratory and treatment services where information on PHC and referral system should be availed to clinics health workers.
4. There is need to empower women economically. The income generating projects at present do not favor all categories of women. The poverty alleviation programs available do not make specific reference to women despite their vulnerability to poverty and ill health. Hence there is need to target women as a disadvantaged group. The government could realize this through securing low interest soft loans for women. This will eventually strengthen women's bargaining power in the distribution of household financial resources towards STD treatment services. They can be able to meet the costs even when their husbands are not around or do not have money.
5. Men should be sensitized about the problems which women face in their daily lives especially about multiple roles. Government should invest/support the new innovations like Men As Partners (MAP) where men accompany women to health centers whenever women go there. This will help men realize the problems which women face.
6. There should be improvement of STD service delivery to cater for men and women. Men need exclusive clinics where they can be counseled and treated of STDs. Men tend to keep quiet and don't tell their wives yet STDs are more infectious to women. These

exclusive clinics will promote gender relations and dialogue among couples so that they can easily communicate about the health problems affecting them.

5.5 PROPOSALS FOR FUTURE RESEARCHERS

The study was carried out in Masaka district and in only one division. It would be better if the study is extended to other regions of Uganda given that the population of Uganda is heterogeneous but homogeneous within regions; it will give a better basis for the conclusion for the whole country.

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