Antenatal Care and Couples' HIV Testing in Rural Northern Uganda: A Gender Relations Analysis

American Journal of Men's Health
2017, Vol. 11(4) 811–822
© The Author(s) 2015
Reprints and permissions:
sagepub.com/journalsPermissions.nav
DOI: 10.1177/1557988315602527
journals.sagepub.com/home/ajmh

Sarah Rudrum, PhD, John L. Oliffe, PhD, and Helen Brown, PhD

Abstract

HIV rates continue to increase among heterosexual couples in many countries including Uganda. This article examines approaches to antenatal care and heterosexual partners' HIV testing in Amuru subcounty, northern Uganda, drawing on findings derived from fieldwork and interviews. The study findings reveal how institutional structures influence the uptake of HIV testing amid power dynamics, wherein many male partners refuse to be tested. Discussed are the coercive approaches to HIV testing in which couples' participation in HIV testing is leveraged by connecting testing to future maternity care. This article advances understandings about how heterosexual gender relations at the local, regional, and global levels affect the health of women, men, and families in Amuru subcounty.

Keywords

HIV testing, gender relations, institutional ethnography, antenatal care, postconflict, Amuru, sub-Saharan Africa

In Uganda as a whole, 7.3% of people are HIV positive (Uganda Ministry of Health, 2011). However, the upheaval caused by recent conflict and displacement in northern Uganda has contributed to high rates of HIV. In the north, HIV rates are almost double those in the rest of Uganda (Westerhaus, Finnegan, Zabulon, & Mukherjee, 2007). Pregnant women's HIV rates are also high—11.3% among women accessing formal antenatal care (ANC) at a major northern hospital—a pattern attributed to the conflict induced “social and economic crises, food shortages, population displacement and reduced access to health care and prevention services” (Fabiani et al., 2006, p. 590). Related to this Patel et al. (2014) indicated that postconflict, 12.8% of young adults (15–29 years old) in Gulu district, neighboring Amuru district, are HIV positive.

The epidemiology of HIV in Amuru has influenced ANC for women and their partners, particularly HIV testing protocols and practices. Throughout Uganda, focused ANC is offered, an approach adopted by the World Health Organization (WHO) with the objective of providing ANC within a small number of visits (a minimum of four; Conrad et al., 2012). In Amuru subcounty, an important feature of ANC is the antenatal card. The card is issued to women and includes health information pertinent to their pregnancy, delivery, and postnatal care. Throughout Uganda, HIV testing for pregnant women and their male partners—couples' testing—is offered at the first ANC visit, with the primary purpose of preventing mother-to-child transmission (PMTCT).

At a national level, couples' testing is administered on a provider-initiated testing and counseling basis as a health service that patients can opt out of, in contrast to the voluntary counseling and testing approach of the 1990s which reflected human rights discourses (Vernooij & Hardon, 2013).¹ The purpose of this change was to boost the number of people being tested:

Low testing rates throughout sub-Saharan Africa have been attributed to this client-initiated VCT approach, and in the mid-2000s public health officials called for a routine opt-out approach to HIV testing, whereby tests would be routinely performed on all patients accessing healthcare services, unless the patient “expressly declined.” (Vernooij & Hardon, 2013, p. S554)

Despite the right to decline testing, couples' testing was implemented within Amuru in such a way that it was generally understood to be compulsory. This article examines how heterosexual gender relations influence ANC HIV testing in Amuru.

University of British Columbia, Vancouver, British Columbia, Canada

Corresponding Author:

Sarah Rudrum, Contract Faculty, Institute for Gender, Race, Sexuality and Social Justice, University of British Columbia, 038-2080 West Mall, Vancouver, British Columbia V6T 1Z2, Canada.
Email: srudrum@mail.ubc.ca

Study Setting

Amuru subcounty is a rural area of northern Uganda recovering from conflict. The region is 99% Acholi by ethnicity (Finnström, 2008). The Acholi make up approximately 5% of the Ugandan population (Finnström, 2008). Acholi people are predominantly Catholic, Protestant, or otherwise Christian, with a small (approximately 0.5%) Muslim minority (Finnström, 2008). Amuru district was created in 2005 and was formerly part of Gulu district. It is located northeast of Murchison Falls National Park and south of the border with South Sudan. Described as a “dirty war” for its targeting of civilians and use of terror as means of warfare (Finnström, 2008), the conflict between the Lord’s Resistance Army in northern Uganda and the government’s Uganda People’s Defense Force spanned two decades, from 1986 to 2006. The war was characterized by the abduction of children, mass forced displacement, and the indiscriminate killing of civilians (Branch, 2011; Dolan, 2011; Finnström, 2008). Dolan (2011) describes the conflict as having created an overall reversal of fortunes for the Acholi people of northern Uganda, who experienced the destruction of their livelihoods alongside witnessing the atrocities of war. Over 60,000 children and youth were abducted over the course of the war (Baines & Stewart, 2011; Westerhaus et al., 2007). Abducted girls’ and women’s experiences of forced marriage and other sexual violence invoked lasting trauma and injury. Boys and men also experienced wide-ranging violence that impaired their physical, mental, and social well-being. Alongside abduction, a major feature of the conflict was the forcible displacement of the majority of Acholi civilians into internal displacement camps. Accommodation was flimsy and crowded. Poor conditions led to disease (Finnström, 2008).

Since the camps disbanded, the process of return has been a “complex, arduous and protracted” process characterized by poverty, food insecurity, and lack of access to resources including health care and education (McElroy, 2012, p. 19). In Amuru, the chief local economic activity was subsistence agriculture. The majority of adults and older children worked in the fields and gardens, plowing, planting, and harvesting with hand tools. The wartime theft of cattle and destruction of mango trees, and the need to reclaim fields, paths, and waterways that had overgrown in the years of displacement, limited the subsequent scope of agriculture. Land disputes between local families and between residents and government or corporate interests also greatly complicated the return process. Overall, widespread poverty and an accompanying lack of infrastructure affected people’s day-to-day lives in Amuru. Poor roads and a paucity of operational health facilities rendered services costly and less accessible.

Figure 1. Men and antenatal care poster.

The English translation is “Responsible men go early with their wives for antenatal care. Test together with your wife for HIV so that you prevent transmission of the virus to the unborn baby still in the womb.” This poster was displayed outside the outpatient ward at Lacor Health Centre III, Amuru.

Background: Couples’ HIV Testing During ANC in Amuru

In Amuru subcounty, women and their husbands were instructed to attend the first ANC appointment together, as was identified by both childbearing women and health worker participants in the current study. Within Amuru subcounty, the purpose of having male partners attend the first ANC appointment was twofold: to test for HIV in order to PMTCT and plan for care and to promote men’s understandings of and involvement in pregnancy, according to Jonas, a health administrator who participated in the study. Outreach visits to villages and public signs and posters exhort men to accompany their partners to ANC. Large metal signs at the turnoffs to health centers read, “If you love your wife, then go together with her to the hospital when she is pregnant.” Similarly, Figure 1 features a poster displayed in a health center’s outpatient ward showing a man doubling a pregnant woman on a bicycle, with the caption: “Responsible men go early with their wives for antenatal care. Test today together with your wife for HIV so that you prevent transmission of the

virus to the unborn baby still in the womb.” These signs and posters call on men to be responsible, honest, and loving citizens through accompanying their wives to ANC and testing for HIV. Such messaging plays to some masculine ideals, including men’s protector and provider roles within the family. However, from a heterosexual gender relations viewpoint, persuading men to act on these messages often relies entirely on the women’s ability to convince or coerce their male partner to be tested.

While male involvement is key to couples’ testing and can provide important benefits, Larsson et al. (2012) highlighted significant challenges for implementation of couples’ testing. The pressures on relationships arising from testing can be serious: “Women who test for HIV without their partner’s knowledge or consent and turn out to be HIV positive have difficulty disclosing and face a number of potential negative reactions from their partners, including blame, and abandonment” (Medley, Mugerwa, Kennedy, & Sweat, 2012, p. 361). Similarly, a man’s status is greatly reduced by being known to have HIV and that, along with other aspects of the stigma accompanying the disease, can fuel men’s reticence to be tested.

Throughout sub-Saharan Africa, health systems are challenged to identify HIV during pregnancy in order to PMTCT, and sometimes resort to coercion (Hardon et al., 2012), such as was the case for women testing in Malawi (Angotti, Dionne, & Gaydos, 2011). Coercive practices have been given new weight in Uganda by the recently passed HIV Prevention and Control Act (2014; Devi, 2014). This Act criminalizes HIV transmission, allows health workers to disclose patients’ status, and makes HIV testing mandatory for HIV testing and their partners. As laws criminalizing HIV transmission are replicated in sub-Saharan countries (Grace, 2015), it is likely that others will also make HIV testing compulsory for pregnant women and their intimate partners. Already, “Guinea’s HIV law makes HIV tests mandatory before marriage; and Sierra Leone’s HIV law explicitly criminalizes a mother living with HIV who exposes her child or fetus to HIV” (Pearshouse, 2014). The stakes for understanding how compulsory testing affects access to care and violence in intimate relationships are therefore high.

Method

This article draws on qualitative fieldwork undertaken in Amuru, northern Uganda, as part of a study investigating maternity care, including ANC. The study was approved by the University of British Columbia’s Behavioural Research Ethics Board and by Lacor Hospital’s Ethics Review Board, the Uganda Council of Science and Technology, and the President’s Office in Uganda. Using institutional ethnographic (IE) methods, the study included

fieldwork, observations, and participant interviews. The first author, a female Canadian researcher of British ancestry, spent 7 months in 2012 conducting the research while in Amuru living at a rural health center. The interviews focused on maternity care and were conducted in two stages: first, 35 women, with at least one child under 2 years old were individually interviewed, and subsequently 10 additional women with at least one child participated in focus group interviews. The women ranged in age from 18 to 41 years ($M = 27$).

Second, 22 lay and professional health workers, including traditional birth attendants, community volunteers, nurses, midwives, and administrators were interviewed individually and in focus groups. Both informal and formal health workers were included because both employees of the formal health system and participants at the village level (such as traditional birth attendants and members of the village health team) were likely to play a significant role, because their roles might overlap, and because, at the outset of research, it was unknown whether childbearing women in Amuru made a clear distinction between formal and informal sources of maternal care and labour support. As it transpired, birthing women did tend to refer to a large group of varied health workers as *daktari*, a Swahili¹ word meaning doctor. During this research stage, 15 health workers who were part of large groups including the village health team and traditional birth attendants were engaged in focus groups numbering five participants. Seven participants were interviewed one-on-one, including those with stand-alone roles (the district health officer, the clinical officer in charge, and the public health officer) and those who had a small number of colleagues in similar roles (two midwives and two nurses of different cadres). The goal of these subsequent focus groups and interviews with health workers was to explore the link between mothers’ insights into how support for childbirth is coordinated locally, and the work processes of those involved in providing health support for birthing women. While general questions were included so that health workers could describe the care they provide and any challenges they meet in providing it, the primary focus of these interviews was determined by the contents of the initial interviews with birthing women. In every case, the question of men attending ANC for HIV testing was discussed. Interviews with couples or male partners were not conducted, in order to offer women in these close-knit villages the safety and security to speak about their relationships as they related to the focus of the study—maternity care. All participants are referred to using a pseudonym.

Interviews conducted in Acholi were translated and transcribed and checked for accuracy; interviews conducted in English were transcribed verbatim. All the interview data and field notes were integrated and read to

identify patterns and themes. The data from interviews and field notes were then coded and organized using a qualitative analysis software program, HyperResearch. Particular attention was paid to texts, defined in IE as written or graphic materials that can be reproduced, and are used in coordinating translocal activities. That is, texts produced in one place are understood as being influential in coordinating activities and knowledge in a different place (Smith, 2006). Two texts discussed in this article are the Local Council I (LC I) letter and the ANC card.

The data were analyzed inductively to derive a thematic representation. Consensus was reached on the themes through discussions among the three authors. Illustrative quotes and field notes were selected to represent of the findings. As gender relations and multilevel power dynamics were important themes, an intersectional approach was used to guide analyses about power and control (Doyal, 2009; Hankivsky et al., 2014). This approach was used in the current study to identify aspects of interrelational, political, and normative power at play in shaping maternity care, including couples' HIV testing. Previous gender relations and health research conducted by Oliffe, Han, Ogrodnick, Phillips, and Roy (2011) and a review by Bottorff et al. (2010), guided our theorizing of the findings wherein participants' alignment to, and acceptance of, a range of masculine and feminine ideals relating to health were richly described in the traditions of IE.

Findings

Introduction

The study findings focus on the information shared by childbearing women and health care workers about couples' HIV testing during ANC. Childbearing women from six villages, who varied by age and number of children, shared their insights related to HIV testing practices, focusing on their intimate relationships and their health care. Childbearing participants had monogamous and polygynous relationships with the men they spoke about. Health care worker perspectives detailed related service provision issues to further clarify perspectives around male partner's practices in the context of policy and service environments.

Women on Men's HIV Testing. While the husbands of some participants willingly attended ANC appointments and underwent HIV testing, many women suggested that men in general and their husbands were reluctant to be tested. When participants' husbands willingly agreed to attend the first appointment and test for HIV, it was for their own sake and that of their families. For example, Monica said

her husband "thinks of his health." Men's reluctance was accounted for in various ways, including a lack of interest in what was perceived as a women's health issue, fear of testing positive for HIV, and suspicion or prior knowledge of having HIV. Anne, a 32-year-old mother of four, explained that despite attempts to involve her husband, the responsibility for the health of the fetus as well as her own well-being resided entirely with her:

When you tell some men to go together with you to the hospital, he doesn't accept. You can force him, but he will still refuse. Then you get your own way of going alone to get a [ANC] card. [. . .]. If you don't go for a check-up yourself he doesn't care. He just sits. Women just struggle for themselves alone.

Evident here and among many women's accounts was their lack of power to contest such arrangements and behaviors, which ultimately left many participants to access and negotiate their ANC alone. The men's behaviors were not always consistent, yet their ultimate control over being tested (or not) permeated the participants' accounts. For example, Sara's husband had agreed to attend ANC during their most recent pregnancy, but had refused during an earlier pregnancy. She recounted his assertion that because he was not sick, testing was futile—recalling his quip, "nothing takes me to the hospital." She believed, however, that he feared he did in fact have the virus and that "he would rather not know."

Denial also featured wherein men did not understand or accept the potential benefits of knowing they were HIV positive. Faith, who was 38 years old and had five children said, "there are men when they already know their status as positive, they will not want to be supported by hospital, some may start to go [for ANC and HIV testing], but nearing the hospital they disappear." Leah, a 28-year-old mother of five, shared a story about a man who tested but avoided getting the results:

It happened to my neighbor, who has just delivered. They went to be tested and the man disappeared when it came to results, so I actually don't know how she delivered or whether he asked [health center staff] for forgiveness and received [HIV test] results.

Embedded here and in many women's narratives were connections between the men's inactions and the implications for the ANC women subsequently received. Specifically, the ANC was contingent on the women having an ANC card, which in turn was dependent on the husbands' willingness to test for HIV. Without men's cooperation, women might miss essential care, as a focus group participant, Betty, a 32-year-old mother of five who was raising five additional children, emphasized:

Another benefit of going to hospital with the man is that once you are tested, you, the woman, is given some medicine that is said to help even the baby. So the pain is, when the man runs away and you miss it. Like the vitamins, because they give like three types of drugs which you swallow and it is not good to miss all when the men run away.

Leah's neighbor's husband had made some effort to secure ANC for his wife by testing—but his avoidance of getting the results may have ultimately jeopardized her access to securing care.

Participants also linked men's tendency to have extra-marital sex and to avoid HIV testing to alcohol abuse. Penny, a 29-year-old mother of five, described alcohol addiction as similar to a contract, in which it was difficult to break: "Alcohol is a difficult issue to handle, because even if you stop a man he will not listen. Alcohol is just like a contract that people have signed." She said that alcohol use was a reason men "mess around." Men would binge drink and avoid coming home as a means of avoiding testing, or would arrive at the hospital too drunk to receive the test as Betty shared: "Some will be drunk and, smelling alcohol, the nurse will send you away."

As was the case for many in the region, both Penny and Betty had suffered war-related trauma and situated their ability to cope with pregnancy, ANC, and birth in this context. Penny said that during two of her pregnancies, an evil spirit (cen) would come to her in quiet moments, and tell her "[Penny], you are going to die in childbirth." She attributed this to the many who had been killed nearby and whose remains were allowed to go unburied for some time. During the war, Betty's husband had been beaten with a machete across his back and neck and left for dead. He suffered ongoing disability as a result. As the two were raising five children of relatives who had died during the conflict as well their own five children, Betty found it difficult to rest during pregnancy and her husband likewise was unable to avoid activities proscribed by health workers. Such war-related strains on families and relationships contributed to the difficulty of complying with the expectations of health care providers.

Childbearing women participants tended to view couples' testing in positive terms, despite the challenges they described about engaging their husbands. Fidelity—even within the context of some men having multiple wives—was under scrutiny when being screened for HIV. Mildred, a 38-year-old mother of five, suggested that a negative test was a sign that her husband had been faithful to herself and her co-wife:² "The time we began staying with my co[-wife], we went and tested and found that up to now, he has not yet added anybody on to the two of us." Kelly, a 19-year-old mother of one, also explained that couples' testing eased her mind:

When I was pregnant and it had just begun, I thought that I was HIV positive, a disease that people fear so much . . . we had tested and had found out that we were not HIV positive, but only fear existed because my husband is not very morally upright.

By extension, linkages between men's infidelity and HIV also emerged to fuel tensions within the women's relationships. The threat of violence further inhibited Ugandan women's efforts to lobby their husbands to test for HIV. Complicating this, to test alone, the women also risked being accused of bringing the illness into the family if they tested positive for HIV. For example, Leah shared that, "If you went alone he would change to say he was healthy so you are the one who brought the sickness." Confirming this concern over who was responsible for initially contracting HIV, Annette, a 26-year-old mother of three, suggested that couples' testing and counselling reduced the potential for intimate partner violence:

Another benefit of going to hospital with the man is that when you find you are positive you can be counseled together, and it is helpful, because if the woman finds she is positive it becomes difficult to tell the man and that is why we hardly tell them. That is why the medics tell us to go together—so that after we may get support and live positively. You may come back and tell him your positive status and he cuts you with a machete and you die. So it is better to know together—he could actually even have brought the sickness.

Health Worker Perspectives About ANC and HIV Testing

Health workers in Amuru advocated for couples' HIV testing during ANC, as Gloria, a midwife in her 30s, suggested: "At least they know their status. Some may go 2 years without testing, but when you are pregnant, you must [test]." She explained the goal and rationale underpinning the government program:

Gloria:	Pertaining to men coming to ANC, that one is based on the government program where by 2015, no babies will be born with HIV infection.
Researcher:	Right.
Gloria:	Now in that, they are suggesting, they feel if they can make all males, it is a routine and it is a must for all males to be tested. Because I can be negative and my husband can be positive. I can get it anytime during pregnancy.

However, as the District Health Officer, Peter, explained there were many challenges to effectively implementing that policy:

It's a national policy, a Ministry of Health policy they have come up with. But the challenge is how to get the men in the health facility. He is not going to come. There was a time they tried to put it as a regulation that any mother who comes with a husband is attended to first. What they discovered later on was that it was no longer the wives bringing their husband, but they were bringing any male. So we find if a mother is coming for ANC, there is a boda-boda transporting her . . . [laughter] that [the motorcycle-taxi driver] would be the husband. So the whole policy lost meaning.

The tactic of using men as proxy husbands revealed the women's strong desire to receive ANC, but also signaled that there are powerful male norms and ideals influencing men's actions and inactions in which both affected women's access to ANC and delivery care.

In line with the childbearing women's accounts, health workers confirmed men's reluctance to test for HIV as being driven by factors including fear, tendency to see pregnancy as a "woman's problem" and logistics round transport. Dorothy, a nurse aide, explained the challenges persuading men to attend:

Dorothy: Say, you tell them [husbands] about antenatal care, some of them may refuse. So some say there's no transport, others they say it's not their problem.

Researcher: It's not their problem.

Dorothy: Yeah, because they are not the one who is pregnant.

Dorothy also conceded that men might be reluctant to test because they did not want their positive HIV status known, or because they believed that their wife's test would suffice for knowing his status. She explained that many men told their wives, "If you are positive, it means I am positive. And if you are negative, I am negative. Because we are one." In appraising such actions Dorothy intimated her feeling that "they [men] are so negligent . . . they want to neglect their wives."

Peter, the District Health Officer, offered a less judgmental view, adding context about the reasons men were reticent to test. Gendered norms of behavior were influential in governing men's view that their role in pregnancy should be limited, Peter argued. The lack of privacy at the health center and the pressures of child care and farm work at home also contributed to low male participation. When asked about men who employed various tactics to avoid testing Peter said that:

Those things happen. It's strongest in the cultural upbringing. And also the other thing is the situation, the environment in the health center is not attractive for men. You are going into one room which is full of women only, a man sitting there would definitely feel out of place, is one. Then from the

cultural point of view, a man who is seen moving with the wife, moving in the antenatal, and accompanying the wife everywhere, there is belief in the culture that this man has been overpowered by the woman.

Peter also explained that poverty, poor infrastructure, and subsistence-level agriculture meant that families "cannot bring a whole couple. At least one person has to stay back to look after the children, the property, and things like that."

In terms of heterosexual gender relations, it was apparent that male and female health workers interpreted the men's reluctance to test differently. Male health workers tended to fill higher status administrative roles, and they conceded, and to some extent asserted the legitimacy of culturally informed masculine ideals driving many men's practices. While they understood that gendered dynamics influenced the uptake of testing, the male health care participants had less direct contact than the nurses and midwives who interacted with the women affected. Female frontline staff members were more likely to contest dominant masculine cultures and relate to the relational struggles faced by their female patients with services and their husbands.

Policy and Practice

The national and local approaches for ANC and HIV couples' testing respond to global efforts and policy goals to reduce maternal mortality, including the Millennium Development Goals. In the local implementation of global goals, approaches are sometimes modified such that actions that can protect women's rights, safety, and access to ANC and delivery care are often disregarded. Such was the case in how the compulsory approach to couples' testing was enacted and its subsequent impact on women's access to ANC and delivery care. As Vernooij and Hardon (2013) note, Uganda's Ministry of Health policy echoes the WHO in explicitly stating the right to decline testing. The 2005 guidelines stated "patients always have the right to accept, reject or to defer testing. Routine testing is not mandatory" (quoted in Vernooij & Hardon, 2013, S557). The voluntary and coercion-free approach to HIV testing espoused by the WHO was not implemented in Amuru subcounty. Since 2012 when research was carried out, the new HIV Act (2014) makes such testing mandatory. Indeed, much of the ANC practices ran counter to the WHO and UNAIDS (The Joint United Nations Program on HIV/AIDS) guidelines detailed below:

Patients must receive adequate information on which to base a personal and voluntary decision whether or not to consent to the test, and be given an explicit opportunity to decline a

recommendation of HIV testing and counselling without coercion. (WHO, 2007, p. 33, as cited in Angotti et al., 2011, p. 308)

Instead, ANC and HIV testing and counseling were imposed as mandatory, and coercive measures were employed to implement couples' testing. Among participants, mothers and most health care workers shared views that couples' testing was compulsory. A range of health center practices made partner testing appear to be compulsory. These practices included the following: the LC I letter, an explanatory letter from a local political leader required to be submitted to the health center by women whose husbands refused to or could not participate; the punishment of men who did not participate or rewarding of men who did participate; and delays in accessing care and the threat of being denied care for women whose husbands did not participate. These local strategies were reportedly effective in increasing male participation in HIV testing during ANC; yet these coercive strategies were determined to negatively affect gender relations and access to ANC and delivery care.

The LC I letter functioned as a text governing access to ANC and delivery care. The letter was to outline the reason for the husband's absence, and generally stated that he was dead or in jail, whether or not this was in fact the case. The LC I letter was a hurdle for women whose partners refused to attend ANC for HIV testing but who wanted to continue with ANC. Women were the primary means through which men were recruited; they were told to bring their husband to ANC. This created work and struggle for childbearing women, as those with reluctant husbands would have to negotiate at home, and, if that failed, go to the LC to make their case.

Gloria, a midwife, described the LC I letter as an additional step to take after educating communities about men's attendance at the first ANC appointment:

So pertaining to the men, in order to come with their women to antenatal care, that one first of all we just health-educate them generally, about the goodness of attending antenatal with their partners together. [. . .] secondly, if a mother comes without the partner, we, at least me, we inquire her to get the letters from the LC [. . .] On that she will find is very difficult, and then she will go back to the husband and say "let's go to the hospital" and then they will come.

She went on to say, "that is the only way we could make them at least try their best." In identifying the difficulty of getting an LC I letter, Gloria made it clear that the requirement was a way to exert pressure on women in order to facilitate men's involvement. It was understood that women were likely to face challenges in leading their husbands to care, but the approach was adopted regardless.

This letter functioned as a text, which in Smith's (2006) words is a written or graphic material to coordinate activities translocally. It played a role in guiding and governing pregnant women and their partners' activities at home and in their village with extra-local goals at the health center, and, beyond that, national and international goals for HIV prevention. Via the requirement of this letter, the health center's policies and staff practices were influential in guiding women's actions. Through the letter, an ideology of mandatory testing was promulgated despite the absence of a policy to such effect.

An additional strategy used by one village leader was to require any man who refused to attend ANC and test for HIV with his wife to do community service, usually slashing the tall grass surrounding a village compound or path. This type of punishment was also extended to people who refused to have their homes sprayed with insecticide, a Ministry of Health initiative to prevent malaria. Such strategies affected pregnant women through local politics, gendered relations, and the interdependence of couples for accessing ANC. In other situations, rewards were sometimes offered as a means of encouraging male participation. Amy, a nursing assistant, said that "mama kits," a bag of baby basics given to women who delivered at a health center, were a form of encouragement for men as well as women: "Now that thing [the mama kit] has encouraged those husbands and the wives, to encourage themselves to come to hospital." Furthermore, she described an example in which the soap from the mama kits had been provided directly to men who attended ANC:

I remember one day, it was antenatal day, and those women were coming eh, and many men even accompanied their wives, there were like 20, 25 [. . .]. Afterwards, in charge [the clinical officer in charge, Jonas] told us that now, those bars of soap which have been left there in store, the ones for Red Cross, now you give them each and every man you give one bars of soap, one bar of soap. [. . .] And that is one side, we always motivate them. . . . you always give to them so that they encourage them to visit health center regularly.

This strategy, while seen by health workers as an effective form of motivation, exacerbated the scarcity of mama kit supplies contributing to a divisive unpredictability around the supply and distribution of nongovernmental organization goods.

Gloria, a midwife, answered a question about when the health center had started to implement couples' testing during ANC by saying: "It was since before, but no one really put a male focus on it. Until when we said *without a man we are not going to give you a card*. They will try now" (Italics added). She was aware that women who wanted to give birth at the health center were unlikely

to opt out of ANC and would do their best to comply. When asked “Do you think women ever avoid antenatal care because of this policy, or not?” she replied:

They can't avoid, because they know that when they come in labor, or in case of any problem, they need antenatal care, they have to have the card. All of them in the village know that without antenatal care it is not easy to go for delivery when they are in labor.

The ANC card, seen as a key to delivery care, was withheld by health workers to coerce women into negotiating their husbands' participation. The interpretation and implementation of the written policy around couples' testing in this regard reveals a variety of diverse tactics among health care providers. In essence, by appealing to women's nurturing ideals around protecting their unborn child through receiving ANC, many females were forced to contest gender masculine norms and patriarchal power. Though well intended, invoking women to action under the guise of implementing policy aimed at securing couples HIV testing was ill conceived, naive, and imbued with risk.

Discussion

Despite the biotechnical (Rose, 2007) character of HIV testing and PMTCT methods, HIV testing takes place in the context of gendered power differentials that shape social relationships, including those among heterosexual couples and between health workers and patients. A theoretical perspective that examines how multiple social and structural factors overlap and constitute systematic power relationships through the analysis of oppression and privilege is intersectionality. Intersectionality “requires consideration of the complex relationships between mutually constituting factors of social location and structural disadvantage so as to more accurately map and conceptualize determinants of equity and inequity in and beyond health” (Hankivsky et al., 2014, p. 2). As Doyal (2009) has noted, intersectionality is emerging as an important paradigm for qualitative researchers working with “oppressed and marginalized women” (p. 177) and has particular significance for those seeking context-specific interventions. In examining power relationships, we draw on intersectionality theory in order to convey how across multiple dimensions social, structural, and ideological forces simultaneously affect couples' relationships and access to ANC resources for women. The strategy of requiring women to be responsible for men's participation in ANC and HIV testing obscured the reluctance men often expressed and the difficulty women therefore had in bringing partners.

When the real challenge of getting men tested is obscured and the practice of HIV testing is constructed as

women's responsibility, the systemic and structural context within which testing and counselling practices are enacted can be overlooked. Researchers interested in the processes via which neoliberal health systems shift responsibility toward individuals and away from systems have identified responsabilization as a key feature (Rossiter, 2012). Responsibilizing women for the health care of their family members reified gendered divisions of the labor of care and left women vulnerable in negotiations with their husbands. Responsibilization strategies including the LCI letter requirement and the practice of tying delivery care to husbands' participation in HIV testing made these women accountable for their husbands' participation or failure to participate. Interrelated features of power that shaped the impact of a compulsory approach to couples' HIV testing included institutional power, gendered power within intimate relationships, and the normative power to define relationships and family. Since the findings were based on the perspectives of childbearing women and health workers, we draw on these perspectives to understand the power dimensions at play. In the future, we look forward to research that engages to men directly about couples' testing and gender dynamics.

Institutional Power

Health centers and health center staff held considerable power in comparison with their clients. Health centers were spaces of authority, with brick and mortar buildings, in contrast to the hand-built, grass-roofed huts where rural people lived. Unlike other women and men, health workers typically wore uniforms. There was a class dimension to this power dynamic, since health workers were salaried and educated, in contrast to the financial hardship and illiteracy or poor education of the majority of rural clients. Health workers were relied on as people's sole or primary source of health knowledge and information. Participants saw health workers as having the power to deny, as well as provide, health care.

These intersectional dynamics of power limited the extent to which pregnant women could, or were likely to, enact agency. For example, it would be difficult for a woman to assert that she wanted to continue ANC regardless of a husband's participation, or to state that she had no partner and was unwilling to provide a letter to that effect in order to receive care. Furthermore, women did not have sufficient information to know that such a response would have been within their rights. Such power dynamics, alongside particular policies and practices, acted to limit women's agency and shape the coercive—and risky—context for HIV testing, prevention, and disclosure.

While it was made difficult for women with reluctant partners to attend ANC, those who wanted a facility-based delivery nevertheless had to persevere, since ANC

was understood by the participants as a gateway to delivery care. This was exemplified by the requirement to produce an ANC card when arriving for delivery. The purpose of requiring women to keep their ANC card was to record their personal and health information in order to facilitate future care; however, this requirement was also leveraged by health workers to ensure women's compliance with health center expectations. This strategy exemplified the use of coercive power, in which care at the time of birth was framed as an entitlement women had to earn, rather than a service to which they had a right.

Gendered Power and Intimate Relationships

Gendered power relations within marriage and gendered expectations of men's and women's roles shaped the impact of couples' testing during ANC. These power relations also constituted the social context of HIV prevention, testing, and disclosure during pregnancy. Gendered power dynamics were prominent in both the childbearing women's and health workers' data.

While this analysis focuses on practices surrounding the goal of PMTCT through testing, the second goal—raising men's awareness of and value for women's health during pregnancy—exemplifies how health policy has discursive effects that are both clinical and social. Health providers worked to be a part of men's shifting gender roles in relation to maternity care and birth; however, much of this took place via men's female partners or via responsabilization messaging that failed to account for social and relational factors structuring men's reluctance.

When discussing the difficulties participants faced in bringing their husbands to ANC, it is necessary to recognize that gender norms within Acholi culture are neither monolithic nor static. Participants shared stories of husbands whose involvement was difficult or impossible to negotiate, as well as husbands who approached pregnancy with support. Women shared stories of partners who resisted participating in health care as well as of partners who supported their health care. Thus, explaining women's efforts to have their partners tested or men's reluctance to test cannot be on the basis of culture (for a discussion on the limits of culture as an explanatory tool, see Abu-Lughod, 1991). In other words, the tendency to invoke culture as the reason for these realities obscures how other forms of power are at play to shape relationships and lifeways of the Acholi people.

While the reluctance of some men to test can be regarded as irresponsible by their partners and by health workers, another way of understanding it is to recognize that HIV is feared within the community (as elsewhere), and that learning of a positive status is challenging and life changing. Longstanding commentaries about Western men suggest that their collective reticence to access health care

in general is fueled by men's desire to be seen as invincible and their disregard for screening in the absence of symptoms (Courtenay, 2000; Ritvo et al., 2013). However, in the context of HIV testing for Amuru men, much was at stake for a man who was known to harbor the HIV virus. Participants suggested that their husbands feared difficulties "wooing" other women outside their marriage if they tested positive for HIV. In this regard, some men risked losing their ability to attract multiple partners and opportunities to demonstrate their sexual prowess—and this often outweighed their concerns for protecting the health of their partner and unborn fetus. Furthermore, couples' HIV testing occurred within a context that could be difficult for men, in terms of ongoing social distress as people struggled with land conflict, lack of access to resources, and fear of disease outbreaks in the aftermath of conflict. Alcohol dependency can be partly understood as a response to traumas survived during the conflict period as well as the subsequent economic and social impacts on day-to-day life, and is linked to intimate partner violence (Annan & Brier, 2010). Examining the links between the conflict and displacement and how masculinity is expressed, Oosterom (2011) writes that during the protracted conflict:

Unable to meet societal expectations, men became frustrated, which was described by some as prompting feelings of humiliation. This caused various social and psychological problems, such as alcoholism, suicide attempts, and engaging in violence in fights or domestic violence and also caused some men to join the armed forces. It could also lead to the perpetration of psychological violence, through the suppression of the less powerful, such as women and youth. This has affected women's position in Acholi society [. . .]. (p. 400)

Shifting gender roles affected the gendered division of work and power dynamics in intimate relationships in ways that made life more difficult for women (Omona & Aduo, 2013; Oosterom, 2011). Oosterom (2011) notes that domestic violence increased during the war and was still prevalent in the postconflict period: "One woman stated succinctly: 'As long as there is no peace in our homes, the war is not over'" (p. 404).

Approaches to health care must consider gender relations within the historical and intergenerational effects of conflict. Women were exhorted to seek formal care provision during pregnancy, yet the approach to care presented disincentives and barriers to their participation. MacKian (2008) writes of Uganda: "[a]lthough the current policy climate aims to encourage women to utilise formal health provision, they are often the least able to negotiate access effectively" (p. 112). Just as a husband's support is crucial for women during pregnancy and around birth, the consequences of an unsupportive, difficult, or violent

marriage can be amplified during this time. Finally, while men's reluctance can be understood in terms of how gender relations play out within marriages, it is also shaped by forces that include the lack of resources and infrastructure to ensure overall health and well-being, as well as health center practices, politics, and priorities.

Efforts aimed toward HIV prevention need to intersect with efforts to counter gender violence. Larsson et al. (2012) assert that despite WHO emphasis on integrating gender into health policy, "gender aspects in terms of decision-making power and women's financial dependency on their male partners is rarely integrated in policy development and implementation" (p. 74). Gender-sensitive implementation, they suggest, might target men directly, such as through peer-education or clinics, instead of through their pregnant wives. Westerhaus et al. (2007) emphasize the importance of reaching men:

HIV prevention programs must also target men. In northern Uganda, displacement has compromised male gender roles, creating frustration that manifests itself in violence against women. HIV prevention programs must acknowledge these realities and attempt to counter this violence by working with men to reshape their gender roles in ways that are acceptable to both men and women. (p. 1185)

Instead, the approach to HIV testing during ANC in Amuru subcounty acknowledged the importance of men's role and participation, yet reinscribed gendered power dynamics within intimate relationships by placing this responsibility solely within the domain of women's lives.

The Power to Enforce Normative Relationship Standards

The power to define intimate and family relationships in normative terms was also at play the approach to couples' HIV testing in Amuru. Beyond heteronormativity, the approach to couples' testing contributed to a culture of exceptionalism around single mothers by assuming there was, or requiring there to be, a husband. It reinscribed heterosexual monogamous marriage as a social norm, by assuming that every pregnant woman was in a marriage or a marriage-like relationship, as well as by ignoring the context of polygamy. Polygynous relationships were relatively common in this area. However, women's co-wives were not targeted for testing or counseling, or referred to by health workers in relation to ANC or HIV testing. The failure to incorporate polygamous family arrangements into HIV testing and counselling means that co-wives who are susceptible to HIV exposure via their spouses, or whose HIV status might present a factor in the PMTCT of HIV, are ignored in favor of maintaining a normative or conservative view of marriage and relationships.

LC I letters did not typically state that the husband had refused to attend; instead, the letters tended to make the assertion that the husband was either dead or in prison, whether or not this was in fact the case. This reinforced the assumption was that in every instance of pregnancy, there was an involved male partner who acknowledged paternity and was in a marriage-like partnership with the mother. However, of course, this is not always the case. Acero, a study research assistant, said that she believed pregnant women would prefer not to share their single status, saying "you don't put out your own eye" (similar to not airing one's dirty laundry). The way "husbands" are brought into ANC reaffirms Christian, patriarchal family norms by reiterating a two-parent heterosexual family as normative. Creating additional negative consequences for single mothers exacerbates the stigma and exceptionalism directed at women who are alone due to unwanted pregnancies, family breakdown, or an absent partner. Requiring the involvement of local leaders in the case of men who were reluctant to attend ANC and test for HIV at once policed women whose families did not fit a certain norm or whose husbands refused to comply, and reinforced the sense that this participation was compulsory rather than voluntary.

The disjuncture between a model described as voluntary and a local implementation of testing as compulsory has been identified elsewhere in sub-Saharan Africa. Vernooij and Hardon's (2013) study of health worker's understandings of PMTCT testing in central Uganda reported that they treated women's HIV testing during antenatal as compulsory. In Malawi, researchers examined perceptions of HIV testing during pregnancy and reported that despite an official policy indicating that women must be informed of their right to refuse to test, "rural Malawians [did] not perceive HIV testing as a choice, but rather as compulsory in order to receive antenatal care" (Angotti et al., 2011, p. 307). Participants in Amuru also perceived couples' testing during ANC to be "an offer you can't refuse" (Angotti et al., 2011). Angotti et al.'s (2011) study, which focused on Malawi women's (and not couples') testing, identified a "dissonance between global expectations and local realities of the delivery of HIV-testing interventions" (p. 307). Such dissonance affects women's personal relationships and care.

Access to care is already challenging for women in Amuru; it is curtailed by the poverty, transportation problems, and lack of access to resources that characterize seeking care in this rural, postconflict, community. The importance of PMTCT notwithstanding, encouraging male participation in ANC and HIV testing should not come at the expense of birthing women's participation in ANC and facility-based delivery. Within focused ANC, the number of visits, four, is already minimal. Missing visits means that opportunities to treat complications,

identify high-risk pregnancies, or otherwise meet women's needs are lost, putting maternal-child health at risk. Furthermore, rather than emphasizing that ANC care, couples' HIV testing, and delivery care are interconnected aspects of health care for pregnant women, this strategy makes each stage of care appear to be contingent on the prior stage. For women experiencing a barrier to couples' testing, this barrier is reproduced at later ANC appointments and at the time of delivery.

Together, the requirement of the LC I letter, punishing or rewarding husbands, and delaying or threatening to refuse care created a compulsory environment for couples' HIV testing during ANC. These measures manipulated men into participating in ANC and testing, often indirectly via pressure on their wives. However, practices that promoted male participation did not directly address the social and logistical barriers to male participation, nor were they amenable to the challenges women faced in persuading them.

Conclusion

The value placed on rights and access to health care, and the attention paid to social setting and relationships within which policies are implemented, powerfully shape outcomes of public health interventions. With regard to HIV testing practices in Malawi, Angotti et al. (2011) reported that when considered in terms of women's individual rights, routine testing practices were "imperfect at best and counterproductive at worst" (p. 314) and argued that "the social relations in which HIV testing occurs in rural Malawi may not represent the idealized notions assumed by global or national policies" (p. 314). Similarly, in Amuru subcounty, when the broader picture of rights, social relations, and access to care is considered, the current policy and practice approach to HIV testing during ANC falls short. Compulsory testing practices in Amuru meant that women were held responsible for persuading men to test and were then required to live through the consequences associated with positive status and disclosure, or of male refusal to attend. In the context of institutional, patriarchal, and normative power, a compulsory approach to testing resulted in additional work for women, and the potential for blame, violence, and curtailed access to care. This is important to consider in relation to the new HIV Transmission Control Act, which legislates couples' testing as compulsory. Understanding gendered power dynamics and other intersectional dimensions of HIV testing contributes to critical knowledge that can inform maternity care practice and policy within low resource and postconflict contexts, such as Amuru subcounty.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The research that this article was based on was supported by a University of British Columbia Four Year Fellowship and by a Liu Institute for Global Issues Bottom Billion fieldwork scholarship.

Notes

1. While the mother tongue of the Acholi is Acholi (Luo), widely spoken throughout northern Uganda, English and Swahili are both official languages. Swahili is widely understood in East Africa and people sometimes use Swahili loanwords when speaking other languages.
2. Polygynous marriages are commonplace in this area, (Westerhaus, 2007; Patel, 2012) including among the study participants.

References

- Abu-Lughod, L. (1991). Writing against culture. In H. L. Moore & T. Sanders (Eds.), *Anthropology in theory: Issues in epistemology* (pp. 466-479). Malden, MA: Blackwell.
- Angotti, N., Dionne, K. Y., & Gaydos, L. (2011). An offer you can't refuse: Provider initiated HIV testing in Malawi. *Health Policy and Planning*, 26, 307-315. doi:10.1093/heapol/czq066
- Annan, J., & Brier, M. (2010). The risk of return: Intimate partner violence in northern Uganda's armed conflict. *Social Science & Medicine*, 70, 152-159.
- Baines, E., & Stewart, B. (2011). "I cannot accept what I have not done": Storytelling, gender and transitional justice. *Journal of Human Rights Practice*, 3, 245-263.
- Bottorff, J. L., Kelly, M. T., Oliffe, J. L., Johnson, J. L., Greaves, L., & Chan, A. (2010). Tobacco use patterns in traditional and shared parenting families: A gender perspective. *BMC Public Health*, 10, 239.
- Branch, A. (2011). *Displacing human rights: War and intervention in northern Uganda*. Oxford, England: Oxford University Press.
- Conrad, P., De Allegri, M., Moses, A., Larsson, E. C., Neuhaan, F., Müller, O., & Sarker, M. (2012). Antenatal care services in rural Uganda: Missed opportunities for good-quality care. *Qualitative Health Research*, 22, 619-629.
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50, 1385-1401.
- Devi, S. (2014). Uganda takes "another step backward" with HIV bill. *Lancet*, 383, 1960.
- Dolan, C. (2011). *Social torture: The case of northern Uganda, 1986-2006* (Vol. 4). New York, NY: Berghahn Books.

- Doyal, L. (2009). Challenges in researching life with HIV/AIDS: An intersectional analysis of Black African migrants in London. *Culture, Health & Sexuality*, 11, 173-188.
- Fabiani, M., Nattabi, B., Opio, A. A., Musinguzi, J., Biryahwaho, B., Ayella, E. O., . . . Declich, S. (2006). A high prevalence of HIV-1 infection among pregnant women living in a rural district of north Uganda severely affected by civil strife. *Transactions of the Royal Society of Tropical Medicine & Hygiene*, 100, 586-593. doi:10.1016/j.trstmh.2005.09.002
- Finnström, S. (2008). *Living with bad surroundings: War, history, and everyday moments in northern Uganda*. Durham, NC: Duke University Press.
- Grace, D. (2015). Criminalizing HIV transmission using model law: Troubling best practice standardizations in the global HIV/AIDS response. *Critical Public Health*, 25, 441-454. doi:10.1080/09581596.2015.1049121
- Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., . . . Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International journal for equity in health*, 13(1), 1-16.
- Hardon, A., Vernooij, E., Bongololo-Mbera, G., Cherutich, P., Desclaux, A., Kyaddondo, D., . . . Obermeyer, C. (2012). Women's views on consent, counseling and confidentiality in PMTCT: A mixed-methods study in four African countries. *BMC Public Health*, 12, 26.
- Larsson, E. C., Thorson, A., Pariyo, G., Conrad, P., Arinaitwe, M., Kemigisa, M., . . . Ekström, A. M. (2012). Opt-out HIV testing during antenatal care: Experiences of pregnant women in rural Uganda. *Health Policy and Planning*, 27, 69-75. doi:10.1093/heapol/czr009
- MacKian, S. C. (2008). What the papers say: Reading therapeutic landscapes of women's health and empowerment in Uganda. *Health & Place*, 14, 106-115.
- McElroy, T. (2012). *Early childhood before, during and after war and displacement in northern Uganda* (Doctoral dissertation). Retrieved from <https://circle.ubc.ca/handle/2429/42115>
- Medley, A. M., Mugerwa, G. W., Kennedy, C., & Sweat, M. (2012). Ugandan men's attitudes toward their partner's participation in antenatal HIV testing. *Health Care for Women International*, 33, 359-374.
- Oliffe, J. L., Han, C. S., Ogrodniczuk, J. S., Phillips, J. C., & Roy, P. (2011). Suicide from the perspectives of older men who experience depression: A gender analysis. *American Journal of Men's Health*, 5, 444-454.
- Omona, J., & Aduo, J. R. (2013). Gender issues during post-conflict recovery: The case of Nwoya district, northern Uganda. *Journal of Gender Studies*, 22, 119-136.
- Oosterom, M. (2011). Gender and fragile citizenship in Uganda: The case of Acholi women. *Gender & Development*, 19, 395-408.
- Patel, S., Schechter, M. T., Sewankambo, N. K., Atim, S., Kiwanuka, N., & Spittal, P. M. (2014). Lost in transition: HIV prevalence and correlates of infection among young people living in post-emergency phase transit camps in Gulu District, Northern Uganda. *PLoS ONE*, 9, e89786.
- Pearshouse, R. (2014). *An epidemic of bad laws: Building resistance*. Retrieved from http://unlockinghiv.com/?page_id=288
- Ritvo, P., Myers, R. E., Paszat, L., Serenity, M., Perez, D. F., & Rabeneck, L. (2013). Gender differences in attitudes impeding colorectal cancer screening. *BMC Public Health*, 13, 500.
- Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton, NJ: Princeton University Press.
- Rossiter, K. (2012). Talking Turkey: Anxiety, public health stories, and the responsibilization of health. *Journal of Canadian Studies/Revue d'Etudes Canadiennes*, 46, 178-195.
- Smith, D. E. (Ed.). (2006). *Institutional ethnography as practice*. Lanham, MD: Rowman & Littlefield.
- Uganda Ministry of Health. (2011). *2011 Uganda AIDS Indicator Survey*. Retrieved from http://www.health.go.ug/docs/UAIS_2011_FACT_SHEET.pdf
- Vernooij, E., & Hardon, A. (2013). "What mother wouldn't want to save her baby?" HIV testing and counselling practices in a rural Ugandan antenatal clinic. *Culture, Health & Sexuality*, 15(Suppl. 4), S553-S566.
- Westerhaus, M. J., Finnegan, A. C., Zabulon, Y., & Mukherjee, J. S. (2007). Framing HIV prevention discourse to encompass the complexities of war in northern Uganda. *American Journal of Public Health*, 97, 1184-1186.