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Social norms, Power relations, and Negotiations in Decision-Making on the use of Sterilisation by Women Living with HIV in Eastern Uganda: A Qualitative Study

Social norms, Power relations, and Negotiations in Decision-Making on the use of Sterilisation by Women Living with HIV in Eastern Uganda: A Qualitative Study

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Abstract
Failure to translate women's desire into increased sterilisation use has been associated with inequitable social norms in patriarchal contexts that grant men control and decision-making authority and relate womanhood to motherhood and child care. This study adopted a multiple case study design to explore the experiences of women living with HIV(WLHIV) in negotiating social norms to implement decisions on getting sterilised. The integrated social-ecological framework was utilised to understand how social norms may intersect with multiple contextual factors to limit or facilitate women's agency in deciding to end their reproduction. Data were collected using open-ended interviews with fourteen purposefully selected sterilised WLHIV, aged 15-49 years, from two public health facilities in Tororo district. Women's narratives of contraceptive decision-making experiences were audio recorded, transcribed, and analysed inductively and deductively using thematic content analysis. Results revealed that the decision to get sterilised is complex and influenced by the interaction between social norms and other factors such as access to information about the sterilisation method, health status, social support from family members, peers, and health workers, institutional policies, and the general socioeconomic condition in the country. The study recommends that healthcare providers should enhance the knowledge and skills of WLHIV and their social networks to assert control over inequitable structures and relations of power through a shared decision-making approach to contraceptive counselling. Family planning programmes should also increase access to free sterilisation services.

Introduction

The human immunodeficiency virus (HIV) epidemic remains a global challenge to public health. HIV prevalence among adults in Uganda is 5.8% and is higher among women (7.2%) than among men (4.3%) (Ministry of Health, 2020). HIV/AIDS programmes have focused on increasing access to antiretroviral therapy in all regions with high HIV prevalence. Antiretroviral treatment and contraceptives are used as reinforcing mechanisms to prevent unintended pregnancies and mother-to-child transmission of HIV. Although new vertical transmission rates were reduced to 2.8 per cent, breakthrough transmission rates after breastfeeding account for 14 per cent of all new infections (Uganda AIDS Commission, 2021). Family planning programmes are increasingly encouraging women to use long-acting and permanent contraceptive methods (LAPMs), which have the highest effectiveness. Female sterilisation is a highly effective permanent surgical procedure involving cutting or blocking the fallopian tubes and the most accepted method of

contraception worldwide. In Uganda, thirty-eight per cent of women aged 15-49 years wish to limit childbearing (Uganda Bureau of Statistics & ICF, 2017). Women living with HIV (WLHIV) in rural areas who want to restrict childbearing have expressed an increased desire for female sterilisation use (Lutalo et al., 2015). However, only 2.7 per cent of all women use female sterilisation as a method of contraception. Most women prefer injectables (19%) and implants (6%).

The failure to translate willingness to terminate childbirth into increased sterilisation use has been related to the interaction between personal factors such as lack of knowledge, misinformation, and fear of side effects (Anita, Nzabona, & Tuyiragize, 2020; Olakunde et al., 2018). Gender-restrictive social norms in inequitable and male-dominated kinship structures and their power outcomes place the burden of family planning on women and prevent them from meeting their reproductive goals (Atekyereza, 2020; Namasivayam et al., 2022). Inequitable gender norms that determine acceptable masculine and feminine behaviour and male-female relationships contribute to low levels of modern family planning use and unmet needs for modern family planning.

Social norms are unwritten behavioural rules and beliefs shared by people in a given society or group and determine what is considered "normal" and appropriate behaviour (Cislaghi & Heise, 2020; Mackie et al., 2015). Social norms are measured based on the belief about what individuals think others commonly do (the "is" norm) and what behaviours other people approve and disapprove of (the "ought"); they are perceived to exist in people's minds (Cialdini et al., 1991). The norms are entrenched in individual perceptions and agency and apply within reference groups due to expectations of social rewards, such as praise and acceptance in a group or punishments, such as ostracism, rebuke or insult regarding a particular behaviour (Cislaghi & Heise, 2020; Mackie et al., 2015). The disapproval of neighbours, friends, peers, and family members may influence contraception decision-making more than the couple's or household decision-making patterns (Anita et al., 2020; DeRose & Ezeh, 2010). Gender norms are a subset of social norms defined as socially constructed beliefs and rules about individuals' proper masculine and feminine behaviour (Cislaghi, 2020).

Deciding whether or not to have children, the number of children one wants to produce, and whether to involve partners in decision-making are crucial strategic life choices (Kabeer, 1999; International Conference on Population and Development, 1994). Women can be empowered to make these strategic life choices by accessing resources through multiple social relationships in various institutions in society, gaining consciousness of choices beyond the behavioural expectations placed upon individuals and groups, improving individuals' capacity to determine action, setting reproductive goals and acting upon them by transforming negative social and gender norms (Kabeer, 1999; Mackie et al., 2015). Women can control the social contexts they are embedded in through decision-making processes such as resistance, accommodation, negotiation, deception, subversion, and manipulation (Kabeer, 1999).

While social and gender norms are known to influence women's access to family planning services, no study, to the best of our knowledge, has explored how they intersect with multiple contexts in the communities where WLHIV, who are at high risk of getting unplanned pregnancies, to influence their contraceptive decision-making experiences. This study aims to explore the experiences of WLHIV in navigating social and gender norms that support high fertility and allocate higher contraception decision-making power to men to end their reproduction by getting sterilised. The study explores explicitly whether the decision to get sterilised can be linked to higher or lower power obtained through inequitable social and gender norms.

Theoretical Framework

The study utilises the integrated social-ecological framework developed from improving Bronfenbrenner's ecological model that emphasises the role of the interaction and interdependence between people and their environments (Bronfenbrenner, 1977; 1979). Cislaghi and Colleagues (Cislaghi, Manji, & Heise, 2017) modified Bronfenbrenner's ecological model. They created the

flower model to visually represent the synergistic influence of the individual, micro, and macro level domains on each other, as well as on behaviour and outcomes.

The Institute for Public Health (2017) adapted the flower model and developed The Flower of Sustained Health: An Integrated socio-ecological Framework for Normative Influence and Change. The integrated framework posits that interaction between internal and external environmental factors influences individual decisions and actions and depicts social and gender norms as embedded in the social-ecological levels. Power is placed at the centre and assumed to underlie social and gender norms, social-ecological levels, gender dynamics and health outcomes. The socio-ecological framework has been adopted to examine the barriers and facilitators to female sterilisation (Olakunde et al., 2018). In addition, the World Health Organisation (2017) proposes that HIV/ AIDS researchers should adopt the social-ecological framework to contribute to an understanding of the multilevel factors that affect the capacity of women living with HIV to access sexual and reproductive health and HIV services and information. This study adopted the integrated framework to explore how the social and gender norms located at the centre of multiple levels of the social-ecological domains and their power outcomes act as barriers or facilitators to women's empowerment and agency in implementing their goals of ending reproduction in contexts that cherish high fertility.

Methods

Study Design

The qualitative study adopts a multiple case study design to understand the numerous multilevel contexts that influence contraceptive decision-making. The approach was chosen because it emphasises the importance of comprehensively understanding complex phenomena in the participants' natural contexts (Creswell, 2013). The study adopted a constructivist approach, which assumes that people's meanings of their experiences are subjective, multiple, and varied (Creswell, 2013). We used this approach to examine the physical, social, cultural, political, and systemic contexts in which the WLHIV's interpretations of their contraception decision-making experiences were located.

Study Setting and Period

The researchers selected participants from post-natal and HIV clinics in two public health facilities in the Tororo district. Mulanda Health IV and Kamuli Health Centre III provided the cases for other public health facilities in Uganda. The two public health facilities were chosen because they were located in one of the districts where Reproductive Health Uganda (RHU), a non-governmental organisation, was implementing the Breaking Barriers to Access (BBA) to family planning and other Sexual and Reproductive Health Services projects. The BBA project was implemented between 2017-2020 (BBAI) and from April 2021 to March 31st, 2024 (BBAII). The project aimed to strengthen public health systems, increase demand, and create awareness for family planning and other Sexual and Reproductive Health Services (SRHS). Long-acting reversible and permanent methods of contraception (LAPMCs) were provided to under-served and hard-to-reach women and men of reproductive age in the districts of Tororo, Butaleja and Busia. Data were collected between October 2021 and April 2022.

Study Sample

The inclusion criteria were women living with HIV, within the reproductive age group 15-49 and sterilised. Fourteen participants of a variety of ages and years living with HIV were identified with the assistance of healthcare providers at Mulanda, Kamuli health centres and RHU and purposively selected to participate in the study. The saturation point was reached when the data collected formed patterns and themes, and new data no longer revealed new properties.

Data Collection Methods and Procedures

Data were collected using an unstructured, in-depth interview guide with open-ended general questions and probes. The interview guide included questions about whether the participants'

decisions on sterilisation were influenced by their partners, family members, health workers, and other social networks. Interviews were done in Japadhola, the dominant local language used in Tororo districts, or English. The interviews were audio recorded and written in diaries to ensure accurate documentation and reliability of the information collected. Immediately after each discussion, the research team would review the interview guide, identify unclear questions that required further probing, and detect the point when no additional information was forthcoming to understand the main themes.

Data Analysis

The research team transcribed and word-processed all the interviews from the tape recorders and diaries. Because the interviews were broadly focused, the researchers adopted an inductive approach to identify themes related to how the interviewees described the gendered power dynamics related to division of roles, access to resources and decision-making. Constructs and related themes emerged from the interpretation of transcripts of the interviews and field notes through thematic content analysis (Hsieh & Shannon, 2005). Then, a coding scheme was developed manually by assigning codes to recurrent topics and text segments that made the same sense. The relationship between the codes (manifest content) was identified and merged into categories of codes with related meanings (Graneheim & Lundman, 2003). The researcher and the research assistants consulted on an as-needed basis and agreed on the conceptual framing of the themes. The themes connecting the codes (latent content) were identified to examine the underlying beliefs and ideologies assumed to inform the manifest content and reported descriptively (Braun & Clarke, 2006). The researchers reviewed all the texts to determine suitable quotations to describe the findings. The integrated socio-ecological framework provided an overarching deductive thematic framework to categorise our inductively generated themes.

Ethical Considerations

Written informed consent was obtained from each participant before the in-depth interviews, and thumbprints were obtained from illiterate participants. Participants were assured of confidentiality and told that their participation was voluntary and that they had a right not to answer any questions they may find intrusive. Female research assistants were recruited to carry out interviews with WLHIV to reduce emotional and psychological harm. Codes and pseudonyms were used during data analysis and report writing to ensure anonymity. The study was approved by the Makerere University School of Social Sciences Research Ethics Committee (MAKSS REC04.21.437) and cleared by the Uganda National Council for Science and Technology (SS1044ES). Further administrative clearance was obtained from RHU and the health facilities where data was collected.

Study Findings

The results are structured around two major themes: 1. Social and gender norms influencing the division of labour and access to resources; 2. Social and gender norms influencing social support and agency in sterilisation use. Six major sub-themes emerged: household chore performance roles, beliefs about sexuality, provision and childcare roles, male partner support, avoiding male partner involvement in decision-making, and peer and family influence.

Description of the Socio-demographic Characteristics of Participants

In total, the study included 14 sterilised women who fell in different age groups: 30–34-year-olds (n=2), 35–39-year-olds (n=4),40-44-year-olds (n=5), 45-49-year-olds (n=3). Most participants had been sterilised within 0-4 years (n=10), 5-9 years (n=2), and 10-14 years (n=2). The mean age of participants was 40.6 years. The school attendance status for the participants was None (n=6), Primary level (n=4), Secondary (n=3), More than secondary (n=1). The marital status was Married (n=9), Cohabiting (n=1), Single (n=2), and Widowed (n=2). The number of children women had was 1-5 (n=7) and 6-10 (n=7). The mean number was 5.6 children. Regarding religion, the proportions were Catholics (n=13) and Born-again (n=1).

Social and Gender Norms Influencing the Division of Labour and Access to Resources

Household chore performance roles

Participants expressed mixed views, attitudes, and beliefs about female sterilisation as a method of contraception due to the roles and responsibilities assigned to them as part of the family labour force, which translates into engaging in heavy, unpaid workloads, such as digging and splitting firewood. Participants navigated community pressures and misconceptions and got sterilised because they perceived the sterilisation method as relieving them of the anxiety about getting unplanned pregnancies and improving their health.

> I was hesitant about getting sterilised because my friends told me that I would not be able to dig a lot after undergoing the procedure, and farming is my primary source of income… I later realised that getting sterilised was the best alternative, given the health and financial challenges I was experiencing *(Participant, with four children, Malanda HC IV).*

Beliefs about sexuality

Most participants said women are discouraged from getting sterilised due to the myths surrounding its effects on women's sexual libido. Failure to satisfy their husband's sexual desires was associated with negative sanctions from partners, such as intimate partner violence, refusing to provide financial help, infidelity, and marrying other women. Some women insisted on undergoing the sterilisation procedure and were surprised when they did not experience any sexual challenges. Some reported enjoying sex without the fear of getting unintended pregnancies.

> I am glad I decided to get sterilised because I did not experience any complications… The sterilisation method does not cause side effects such as excessive bleeding because it does not affect hormones. Even the sexual relationship with my husband has not been affected *(IDI with a 42-year-old with six children, Mulanda HCIV).*

Women who were knowledgeable about the benefits of using the female sterilisation method were more likely to utilise their self-efficacy to navigate societal expectations and get sterilised.

> There are these myths that when you are sterilised, your sexual libido will reduce, and you will become cold in bed. However, the sterilisation process involves only cutting the fallopian tubes, and the whole reproductive system remains intact. So, you still enjoy sex like any other woman *(IDI with a 41-year-old Mulanda HCIV).*

Provision and childcare roles

Participants mentioned that in their community, men are socially expected to provide basic needs for their families and make contraception decisions, while women produce and care for the children. Most participants spoke about the shift in gender roles where women had taken over the men's role of providing for the family. Men were perceived to have limited involvement in child upbringing. Participants stated that the financial costs of providing for children during challenging economic times empowered them to choose not to passively adhere to existing norms of having many children.

> … I realised that looking after four children was challenging. Women in the village settings do all the work; you carry the pregnancy, deliver the baby, find the clothes and food, and when the time for starting school reaches, it is the mother again. *(IDI with a 41-year-old, Mulanda HCIV).*

Another participant explained that health challenges and childcare roles encouraged her to get sterilised.

> I first used the implant, but I bled a lot. Since I am HIV positive, I feared that bleeding may affect my health. I am glad I got sterilised because I was able to care for my last child without worrying about getting another pregnancy. (Interview with a 36-year-old, Mulanda HCIV)

Childbearing role

Participants' negative attitudes towards sterilisation were influenced by the social pressure on women to bear many children. Most participants adhered to the cultural expectations associated with bearing many children by becoming sterilised after attaining the desired family size and having produced children of both sexes.

> I was sterilised and have not experienced any regret. Maybe I would still wish I had more children if I did not have both boy and girl children. However, given a choice, I would advise women to use long-term reversible methods because you never know; they may decide to have more children in the future. *(IDI with a 41-year-old Mulanda HCIV).*

Social and Gender Norms' Influence on Social Support and Agency in Sterilisation Use

Male partner support

Most married women enjoyed egalitarian relationships and made joint contraceptive decisions with their partners. Some participants implemented their fertility intentions by initiating the decision to get sterilised and later communicating their choices to their partners. Overall, participants noted that their partners supported their decisions to get sterilised.

> My husband always blames me for producing many children and wonders why I cannot use family planning like other women. So, when I decided to get sterilised, he was thrilled and even escorted me to the health centre *(IDI with a 38-year-old, Mulanda HC IV)*

Avoiding male involvement

Five out of the fourteen participants accessed sterilisation services without the permission of their husbands. The women who covertly sterilised said that they knew that their husbands would not allow them to get sterilised and anticipated violence or divorce if their husbands discovered that they had undergone the procedure. Some participants decided to get sterilised and later informed their partners, and they were supportive.

> I underwent female sterilisation because the implant I was using did not match my body and caused me much bleeding, which is risky since I am HIV positive. I could not inform my husband and family about my decision because they would not allow me to take such a risk. When my husband discovered that I was sterilised, he got annoyed and abused me. I left his home and returned to my parent's home with my children *(IDI with a 36- years-old Mulanda HCIV)*

Peer influence

Five out of the ten participants who consulted their peers mentioned that they were discouraged from getting sterilised. The other five said their peers encouraged them to use methods of their choice. The information from social networks included the benefits, side effects, and myths and misconceptions about family planning methods. Knowing about others who successfully got sterilised without experiencing severe side effects convinced women to view sterilisation as a safe contraceptive method. Some participants mentioned that the myths and misconceptions about methods are based on false information passed on from one woman to another.

> My friends were against sterilisation, claiming it causes complications and women lose sexual feelings. Others ask, "What will you do if you remarry and your partner wants children"? I decided to get sterilised because I did not want to produce more children *(Interview with a 39-year-old widow, three children, Kamuli HCIII).*

Family members' influence

Participants spoke of family members, including parents, grandparents, and siblings, supporting or discouraging them from using sterilisation as a method of contraception. Siblings were more supportive of the participants' decisions to get sterilised, while parents and grandparents were against sterilisation and expressed values that support high fertility.

> … I told my parents that I was going to visit some friends, but I went to the health centre and underwent the sterilisation procedure. My father was unhappy with my decision because he wanted me to have more children. I did not listen to him because I knew how hard it was to raise the children I already had *(Interview with a 49-year-old with 7 children).*

Discussion

The study findings suggest that restrictive social and gender norms that ascribe different roles and entitlements to power and privilege among men and women influence the participants' contraceptive decisions. However, the participant's perceptions and behaviour towards contraceptive use indicated that the norms that value and support high fertility were shifting due to pressure from emerging supportive norms that entail spacing, taking good care of one's children and providing them with basic needs such as education was (Bukuluki et al., 2024; Kane et al., 2016; Nalwadda et al., 2010).

This study indicates that negotiating the social norms related to childbearing calls for a change in the contraceptive decision-making power relations between couples. Joint contraceptive decision-making has been reported to increase the use of permanent methods of contraception (Leyser-Whalen & Berenson, 2013). Most of the participants in the current study consulted their partners after deciding to get sterilised, and they supported their decisions. The findings seem to agree with previous studies suggesting that social norms related to men as the main contraceptive decision-makers may relax and give women more opportunities to enact individual agency to implement contraceptive decisions (Bukuluki et al., 2024; Kane et al., 2016). However, the fact that women had to consult their partners even after deciding to get sterilised suggests that some women's reproductive agency is still constrained by the inequitable social norm of men as the significant decision-makers, perpetuating inequitable power relationships between men and women in contraceptive decision-making (Kane et al., 2016).

Some participants viewed contraception decision-making as their human right and mentioned the benefits of sterilisation, such as boosting their health and well-being by preventing unintended pregnancies due to its permanence. The findings show that some of the participants who were covertly sterilised experienced intimate partner violence (IPV). Nevertheless, other studies suggest that the covert use of contraceptive methods can reflect some level of empowerment or a form of agency where women deliberately negotiate social expectations and norms (Kibira et al., 2020; Bukuluki et al., 2024).

Study participants mentioned that broader structural constraints and stressful life events, such as the unfavourable economic situation in the country and the high poverty levels in the community, empowered them to negotiate the social norms that promote high fertility by getting sterilised. The findings align with previous studies, which suggest that the women's self-efficacy and agency in making decisions on getting sterilised may be obtained through the assessment of the constraints placed upon them by societal expectations and life stressors such as uncertainty and instability of sexual relationships. Similarly, Lopez (1993) and Leyser-Whalen & Berenson (2013) conclude that women who recognise the constraints placed on their fertility options by the limited economic resources, domestic responsibilities, social expectations, uncertainty and instability in sexual relationships and problems with using some contraceptives may feel that female sterilisation is their only choice. Large families may fail to provide necessities for their children due to the high standard of living, unfavourable economic conditions and poverty (Atekyereza, 2020; Kane et al., 2016; Potasse & Yaya, 2021).

The findings shed light on contraceptive decision-making behaviour involving individual and collective agency. Previous studies have found that peers, family members, parents, neighbours, and health workers influence the decisions on sterilisation use (Anita et al., 2020; Olakunde et al., 2018). Some scholars argue that testimonies from social networks may influence contraception decisions more than the couple's household decision-making patterns (Anita et al., 2020; DeRose

& Ezeh, 2010; Olakunde et al., 2018). The participants in the current study tended to resist the influence of social networks that were reinforcing restrictive gender norms and decided to get sterilised.

The study findings agree with scholars who propose the dynamic integrated social-ecological framework to explore how social norms intersect with the ecology of factors to motivate people to comply with harmful practices (Cislaghi & Heise, 2018). Individual and structural problems are interdependent and require collective action at multiple levels to transform structures and institutions that engender and reproduce inequalities and injustices in contraceptive decision-making.

Conclusion and Policy Implication

Empowering women to access rights-based family planning services calls for paying attention to the social and gender norms which intersect with multi-layered contexts to influence the meaning attached to specific methods of contraception, such as sterilisation. Family planning programmes should adopt integrated and gender-sensitive approaches that pay special attention to meeting the needs and preferences of groups of people whose agency and autonomy are overshadowed by social and gender norms that allocate inequitable power in accessing resources and decision-making to men and women in homes, communities, and healthcare settings. Community-based support groups involving male partners, family members, and peers can be used as allies to dismantle inequitable social and gender norms. Finally, public-private partnerships should be exploited to provide comprehensive and integrated sexual and reproductive health services and reliable information through facility-based and community outreaches. Increasing access to information and services is critical for creating supportive decision-making settings and expanding possibilities for women's agency and autonomy in making reproductive decisions, such as ending their reproduction by getting sterilised.

Study Limitations

This study had some limitations, including interviewing a small sample of participants and not involving their partners, which means the results may not be generalisable to the whole population. Despite the limitations, the study points out the inequitable social and gender norms that intersect with inequitable structures of discrimination and privilege to act as potential barriers and facilitators to the use of sterilisation as a method of contraception. Further research needs to explore the decision-making experiences of men who use vasectomy.

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Data Availability Statement

The data generated and analysed through this study is not publicly available due to the need to protect the respondents' confidentiality. However, the instruments used in this study can be availed at a reasonable request.

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