



**COLLEGE OF BUSSINESS AND MANAGEMENT SCIENCES SCHOOL OF  
STATISTICS AND PLANNING**

**DETERMINANTS OF SAFE SEX NEGOTIATION AMONG MARRIED WOMEN IN  
RURAL AREAS OF UGANDA**

**BY**

**NAKIRAMBA OLIVER**

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**A DISSERTATION SUBMITTED TO THE SCHOOL OF STATISTICS AND PLANNING  
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UNIVERSITY**

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### DECLARATION

I, Nakiramba Oliver, declare to the best of my knowledge that the current research on "determinants of safe sex negotiation among married women in rural areas of Uganda" is my true effort and any reference to scholarly and other materials has been acknowledged.

Signed..........

Date: 01/10/2023

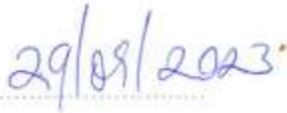
NAKIRAMBA OLIVER.

2000709086

**APPROVAL**

This dissertation of Nakiramba Oliver has been approved as partial fulfillment of the requirements for the award of the degree of Bachelor of Science in Population Studies at Makerere University.

Signed.....

Date.....

DR. ALLEN KABAGENYI

Department of Population Studies,

School of Statistics and Planning,

College of Business and Management Sciences (CoBAMS).

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I take this opportunity to thank my classmates who have guided me through the writing of the dissertation from the start.

**MAY GOD BLESS YOU ABUNDANTLY.**

## **ABBREVIATIONS AND ACROYNMES**

AIDs	Acquired Immunodeficiency syndrome
HIV	Human immunodeficiency Virus
LMICs	Low- Middle Income Countries.
SSN	Safe Sex Negotiation
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SSA	Sub-Saharan Africa.
UDHS	Uganda Demographic Health Survey.
AGYW	Adolescent Girls and Young Women
UNFPA	United Nations Fund for Population Activities.

## TABLE OF CONTENTS

DECLARATION .....	<b>Error! Bookmark not defined.</b>
APPROVAL .....	<b>Error! Bookmark not defined.</b>
ACKNOWLEDGEMENTS .....	iii
ABBREVIATIONS AND ACROYNMES.....	iv
LIST OF TABLES .....	vii
ABSTRACT.....	viii
CHAPTER ONE: INTRODUCTION.....	1
1.1 Background of the study.....	1
1.2 Problem statement. ....	2
1.3 Objectives of the study .....	3
1.3.2 Specific objectives.....	3
1.5 Significance of the study. ....	3
1.6 Hypothesis .....	4
1.7 Scope of the Study.....	4
CHAPTER TWO: LITERATURE REVIEW.....	5
2.1 Introduction .....	5
2.2 Global statistics.....	5
2.3 Factors associated with safe sex negotiation .....	5
2.3.1 Age of the respondent .....	5
2.3.2 Alcohol consumption .....	6
2.3.3 Wealth index .....	6
2.3.4 Religion .....	7
2.3.5 Education level.....	8
2.3.6 Mass media.....	9
2.3.7 Occupation .....	9
2.3.8 Comprehensive HIV/AIDS knowledge.....	10
2.3.9 Place of residence.....	10
CHAPTER THREE: METHODOLOGY .....	11

3.1 Introduction .....	11
3.2 Data source .....	11
3.3 Study area .....	11
3.5 Variable description and measurement.....	12
3.6 Data Analysis.....	13
3.6.1 Univariate analysis .....	13
3.6.2 Bivariate analysis .....	13
3.6.3 Multivariate Analysis .....	14
3.6.5 Ethical consideration.....	14
CHAPTER FOUR: RESEARCH FINDING .....	15
4.1 Introduction .....	15
4.2 Distribution of respondents .....	15
4.3 Bivariate analysis.....	17
4.4 Multivariate Analysis .....	19
CHAPTER FIVE: SUMMARY OF RESULTS, CONCLUSION AND RECOMMENDATIONS.....	21
5.1 Introduction .....	21
5.2 Summary of findings. ....	21
5.3 Conclusion.....	21
5.4 Recommendations .....	21
REFERENCE;.....	23
APPENDIX 1 .....	25

## LIST OF TABLES

Table 1: 3: Variable description and measurement.....	12
Table 4.2: showing frequency distribution of respondent's background characteristics.....	16
Table 4.3: Bivariate analysis showing the relationship between negotiation for safe sex and background characteristics in the study. ....	17
Table 4:4: Multivariate Analysis .....	19

## ABSTRACT

**Background:** Improving women's ability to negotiate for safer sex would have positive effects on their sexual and reproductive health such as reduction in sexually transmitted infections that could cause harm and damage to a woman. In my study I examined the relationship between safe sex negotiations among married women in rural areas of Uganda.

**Methods:** In the study I used the qualitative analysis of Uganda Demographic and Health Survey (UDHS) data of 2016. A total of weighted sample of 8,366.5 married women in rural areas aged 15–49 were included in our analyses. I examined the association between safe sex negotiation and independent variables using the bivariate and multivariate logistic regression analysis and using the univariate analysis to find out the frequency and percentages.

**Results:** The overall prevalence of safe sex negotiation among married women in rural areas of Uganda was 79.2% where age, education, wealth status, region and frequency of watching television were found out to be the predictors of SSN among married women in rural areas of Uganda. Women aged 20-24 are 90% more likely to negotiate for safe sex than women in age group of 15–19 years. Likewise, those with at least primary level of education 67.37% approximately with [OR= (0.1493205); CI = 1.167-1.758] are more likely to negotiate for safe sex compared to those with no formal education. Women in middle wealth index 44.31% [OR = 1.264689; CI = 1.032-1.549] are more likely to negotiate for safe sex than those in the poor wealth index

**Conclusions:** The finding will help in increasing male involvement in sexual and reproductive health is important to accelerate progress towards the achievement of the Sustainable Development Goal (3 & 5) and their targets on empowering all women and safeguarding their reproductive rights. The findings will also enhance women's awareness of safe sexual practices and how to achieve safe sexual relations with partners and also know the risky sexual behaviours and avoid them as early as possible.

## CHAPTER ONE: INTRODUCTION.

### 1.1 Background of the study

Safer sex negotiation refers to the means through which partners in sexual relationships agree to have intercourse that protects both partners from adverse sexual health outcomes. Women's ability to negotiate safer sex with partners refers to women's capacity to refuse sex when not desired, and to request, partners to use a condom during intercourse. Knowledge of safe sex and STIs is vitally important for adolescents who need to be imbued with a comprehensive awareness of how to avoid unsafe sex, STIs, and teenage pregnancies.

Globally, each year estimated 333 million new cases of curable STIs occur, with the highest rates among 20–24-year-old, followed by 15–19-year-old. Besides that, more than one million STIs are acquired every day. Each year, it is estimated there are 357 million new STIs. Moreover, estimated 23 million girls aged 15–19 years have unintended (Inthavong et al., n.d.)

In SSA, women's ability to negotiate for safer sex has been associated with sexual and reproductive health outcomes since men are regarded as more powerful, and sometimes autocratic, when it comes to sexual decision-making (Saul et al., 2018; Darteh, 2020). In addition, associations have been found between some socio-demographic, economic and cultural factors, such a place of residence, marital status, age and educational level, and women's ability to negotiate for safer sex (Exavery et al., 2012; Darteh et al., 2014; Ameyaw et al., 2017). The Sustainable Development Goal (SDG) 5 focuses on women's empowerment to advance their rights in reproductive health decision-making, attitudes and overall ability to negotiate for safer sex with their male partners (United Nations, 2015).

Safer sex negotiation is particularly important to promote women's sexual health in sub-Saharan Africa due to the persistence of patriarchal practices that adversely affect women's economic and reproductive lives. In most cases, these practices manifest in the domination of women by men and in the subjugation of women's sexual and reproductive health lives to male authority and preferences (Awolaye et al., 2022)

Policymakers, especially those in low- and middle-income countries (LMICs), are therefore beginning to pay particular attention to issues relating to women's sexual autonomy, including their ability to ask their partners to use condoms during sex (Chol et al., 2019; Adu et al., 2023).

In Uganda where, heterosexual intercourse is the main mode of HIV transmission among couples, HIV prevalence among men and women aged between 15 and 49 years tested between 2015 and 2016 was highest among widows (56%) and widowers (61%) (UBOS & ICF, 2018). HIV, being one of the leading causes of death among adults, it is seen to be consequently the major cause of widowhood. Therefore, this study will widen the knowledge of promoting safe sex negotiation, hence Preventing HIV infection which is now an international HIV prevention priority (Merson et al., 2008), also finding out predictors of safe sex negotiation will help in achieving SDG 3.7 (universal access to sexual and reproductive health [SRH] services) and SDG 5 focusing on a need to achieve gender equality and empower all women and girls.

Studies in Nigeria as well as in other countries have focused on safer sex negotiation with a view to improving women's sexual and reproductive health autonomy. Women's ability to negotiate safer sex with partners reflects three important development and public health concerns. One, it reflects gender norms within sexual or marital relationships. Across developing countries, marital norms and practices are tilted against women, and gender dynamics in many sub-Saharan African households undermine women's reproductive health. In many parts of Nigeria, women's sexual health and rights are not well-recognized and respected, and men have the final say on women's sexual and reproductive choices (Solanke et al., 2023).

## **1.2 Problem statement.**

Negotiation of safe sex is a formidable challenge among women yet it helps ensure the consistent use of safer sex practices, which reduces the risk of pregnancy as well as getting or spreading a sexually transmitted infection.

In SSA, AGYW's ability to negotiate for safer sex has been a major problem associated with HIV incidence since men are regarded as being more influential and domineering when it comes to sexuality decision-making (Saul et al., 2018; Darteh, 2020).

Unprotected sex is among several factors that account for new HIV infections among AGYW (Wang et al., 2012; Sathiyasusuman, 2015; Mwale & Muula, 2018). Also, lack of comprehensive knowledge on HIV has been identified as one of the critical factors contributing to the surge in the incidence of new cases of HIV among AGYW (Siziya et al., 2008; Darteh, 2020, Frimpong et al., 2022). Unsafe sex has been identified as the major cause of HIV/AIDS and other STIs as it is estimated that over 2.3 million people are newly infected with HIV per year, and most new infections occur in Sub-Saharan Africa by 70 percent per year, mainly as a result of unprotected heterosexual intercourse (Mugweni et al., 2014).

Unsafe sex is highest in the rural parts of Uganda than in urban areas. This gives an explanation to high rates of HIV/AIDS and STDs among married women residing in rural areas compared to their counterparts in urban centres. Therefore, this study, by the help of UDHS 2016 data set is intended to investigate the predictors of safe sex negotiation among married women in rural area to widen the knowledge on how to promote safe sex practices among married women in rural areas.

### **1.3 Objectives of the study**

#### **1.3.1 Main objective of the study**

To examine the determinants of safe sex negotiation among married women in rural areas

#### **1.3.2 Specific objectives.**

1. To find out the relationship between demographic factors and safe sex negotiation among married women in rural areas
2. To examine the relationship between socio-economic factors and safe sex negotiations among married women in rural areas.

#### **1.5 Significance of the study.**

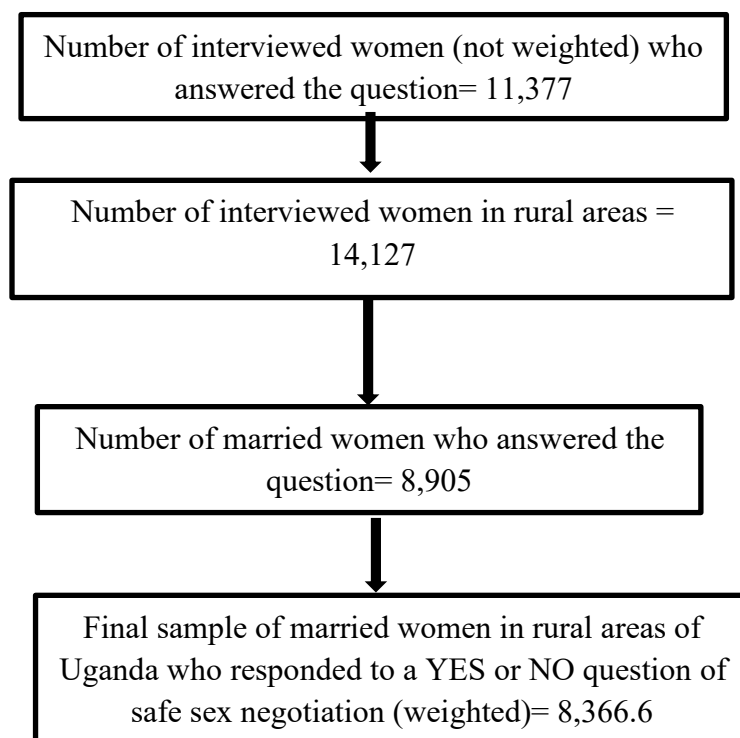
The study focused on establishing factors associated with safe sex negotiation among the married women in rural areas and this will be expected to create new knowledge on safe sex negotiation

among women especially those in rural areas. These findings can inform policies and programmes on the crucial role of comprehensive HIV/AIDS education and knowledge in increasing safer sex negotiation among adolescent girls and young women in SSA

## 1.6 Hypothesis

1. Women with higher levels of education are more likely to negotiate for safest sex with their husbands than women with primary and no education.
2. Women with richest wealth index are more likely to negotiate for safe sex with their husbands than women with poor wealth index.
3. Working women are more likely to negotiate for safe sex with their husbands than women who are not working.
4. Women with comprehensive HIV/AIDS knowledge and other STIs are more likely to negotiate for safe sex with their husbands than women with no comprehensive HIV/AIDS knowledge.

## 1.7 Scope of the Study



## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

The literature information that is pertinent to the study problem is presented in this chapter. The literature review includes sections on safe sex negotiation statistics from around the world and factors that influence them, which are divided into socioeconomic and demographic categories.

### **2.2 Global statistics**

Regarding the knowledge of STIs, 93% of the adolescents in a study from Vietnam did not know any symptoms of STIs, 50% could not identify any cause of STIs and 76% did not know that STIs could be prevented. Adolescents have been reported by WHO to not know how to avoid a pregnancy or access contraceptives, including emergency contraception (Inthavong et al., n.d.)

Globally, each year estimated 333 million new cases of curable STIs occur, with the highest rates among 20–24-year-old, followed by 15–19-year-old. Besides that, more than one million STIs are acquired every day. Each year, it is estimated there are 357 million new STIs. Moreover, estimated 23 million girls aged 15–19 years have unintended pregnancies in developing regions (Inthavong et al., n.d.)

### **2.3 Factors associated with safe sex negotiation**

#### **2.3.1 Age of the respondent**

An estimated 16 million adolescents aged 15–19 give birth each year. Complications from pregnancy and childbirth are the leading cause of death in girls aged 15-19 in Low- and Middle-Income Countries (LMIC) where almost all of the estimated 3 million unsafe abortions occur [2]. Perinatal deaths are significantly higher in babies born to adolescent mothers than in those born to mothers aged 20–29 years, as are other problems such as low birth weight. Preventing adolescent pregnancy is a key strategy in improving maternal and infant outcomes (Chandra-

Mouli et al., 2014). The result only captures married girls and women aged 15–49. The contraceptive use component includes only married girls and women who are currently using contraception.

A study in Vientiane reported 33.4% of the participants aged 15–19 years had engaged in premarital sexual intercourse and 62.7% of the adolescents had their first sexual experience before the age of 15. In the six months prior to the survey, 48.5% of the adolescents reported not using condoms during sexual intercourse. In addition, 2.9% of the male and 0.5% of the female adolescents had multiple sexual partners (Inthavong et al., n.d.)

### **2.3.2 Alcohol consumption**

Experimental studies have demonstrated that acute alcohol intoxication can increase appraisal of a situation's sexual (Norris et al., 2009) and relationship (Zawacki et al., 2009) potential and in turn lead to increased endorsement of secondary appraisals related to condom request and unprotected sex intentions. Further, in some studies, alcohol consumption has directly decreased assertive condom negotiation (Maisto, Carey, Carey, & Gordon, 2002; Maisto, Carey, Carey, Gordon, & Schum, 2004; Maisto et al., 2004) and increased unprotected sex intentions.

Alcohol can affect sexual judgments through two processes. First, through its cognitive effects, alcohol can impair one's ability to focus on cues that would inhibit risky behavior (Cooper, 2002; Steele & Josephs, 1990; Taylor & Leonard, 1983). After drinking, therefore, women may be less likely to focus on a man's sexual risk and more likely to focus on the pleasurable nature of an interaction. Because many women have sex with a partner of unknown risk status after consuming alcohol (Parks, Hsieh, Collins, Levonyan-Radloff, & King, 2009), it is important to understand how information about the partner affects their decisions after drinking.

### **2.3.3 Wealth index**

One of the main pathways promulgated for the attainment of sexual and reproductive autonomy, both in lower- and higher-income contexts, is financial autonomy (Do & Kurimoto 2012; Odutolu, et al 2003). Women who lack economic independence but rather depend on sexual

relationships for sustenance may be prone to sexually transmitted diseases (STDs) and unintended pregnancies as they have little or no influence over decisions pertaining to condom use and safe sex (Odutolu, et al 2003). One reason may be that male partners may tend to reinforce traditional gendered structures that grant them control and privilege over women's lives even when the women have some economic independence (Fox & Romero 2017). Further, in low- and middle-income contexts, household decision-making and economic autonomy may have unclear links with reproductive health outcomes, due to the overarching effects of other social determinants of health (Atiglo & Codjoe 2018; Do & Kurimoto 2012; Mumtaz & Salway 2005).

For instance, in a review of a sample of 46 quality-controlled studies on women's empowerment and family planning, about two-thirds of the papers on household decision-making and over three-quarters of the papers on financial autonomy respectively showed no relationship between these concepts and current contraceptive use (Prata, et al 2017).

The interactions of these structures are well exemplified in Nigeria. Men are dominant in the formal economic sector of the country. Men exert dominance over women's sexual and reproductive lives which may hinder Nigerian women from having total control over the circumstances in which they get pregnant and raise children. Women in Nigeria are often poorer and subordinated to men (Ajala, 2017; Bako & Syed, 2018) and often lack property rights (Aluko, 2015; Udoh et al., 2020) which further aggravate women's poverty in the country. In several parts of the country, childbearing is regarded as the key duty of women in the society (Dimka & Dein, 2013) while childlessness whether voluntary or involuntary is not accepted in most Nigerian communities (Ibisomi & Mudege, 2014).

#### **2.3.4 Religion**

In many cultures, religion is an important governing factor in the delineation and implementation of sexual norms and values (e.g. Bartelink, 2015). Many religious dogmas as well as other 'traditional' cultural values related to gender and sexuality are, in many more or less subtle ways, at odds with the idea of sexual rights for all and complicate efforts to improve sexual and

reproductive health (e.g. Altman, 2001; Bijlmakers et al., 2018; Bradley, 2010; Cornwall et al., 2008; Corrêa et al., 2008, 2014; Harcourt, 2009; Kuhar & Paternotte, 2017; Vanwesenbeeck, 2011).

We also observed from our study that women who professed Islam or no religion had lower odds of SSN. This implies that Christians are more likely to negotiate for safer sex. The result is supported by Jesmin and ready (2014) who found from their study that Muslims compared to non-Muslim women were less likely to negotiate for safer sex. This is probably because, Muslim women by virtue of the traditional and ideological perspectives may be less mobile and less vocal about their rights and participation in decision making (Naved & Persson, 2008). Consequently, it reduces their likelihood to negotiate for safer sex (Seidu et al.,2021).

Various religious and cultural traditions and beliefs restrict sexual autonomy among women and place them in subordination to men (Aboagye et al., 2021).

### **2.3.5 Education level**

Richer and more educated women in urban settings are more likely to have control over their reproductive and sexual choices than their poorer and less educated counterparts who might be living in the rural settings (Amoyaw, Kuuire, Boateng, Asare-Bediako, & Ung, 2015; Tenkorang, 2012). The reason being that those richer and more educated women who are working may not necessarily have to depend on their partners economically. A study conducted in Nigeria reported that due to women 's lower socioeconomic status, married women with lower household-decision making autonomy face barriers in negotiating safer sex with partners (Sano et al., 2018). Whereas women's autonomy in household decision-making has gained much attention as a means of enhancing their lives and that of their families (Allendorf, 2012), empirical evidence on women's autonomy in household decision-making and safer sex negotiation (SSN) in sub-Saharan Africa is limited. It is against this backdrop that our study seeks to investigate the association between women's autonomy in household decision-making and safer sex negotiation in SSA (Seidu et al., 2021). Women who had a high level of education

(high school to college) were relatively likely (4.1%) to have good knowledge of HIV (Pradnyani et al., 2019).

### **2.3.6 Mass media**

In subSaharan Africa (SSA), particularly, the normative societal organization is based on a patriarchal system where men exercise power over women. Over the past two decades, media has been considered a powerful tool for bringing women's rights issues to the attention of a wider public and has also been used as an attempt to enhance various behaviors in mass populations. The advent of the new age media has proven potential for mobilizing attention and accountability to women's rights, and challenging discrimination against them. A lack of mass media exposure has been identified as one of the critical factors that contribute to the rise in the incidence of STBBIs among women in sexual unions. Previous studies have revealed that mass media influences women's ability to negotiate for safer sex (Aboagye et al., 2021).

Evidence suggests that mass media exposure enhances one's ability to negotiate for safe sex which in turn is linked to the reduction in STBBIs such as HIV/AIDS. For instance, a woman who has knowledge on STBBIs such as HIV/AIDS and asks a partner who has contracted or been exposed to STBBIs (HIV/AIDS) to use a condom or refuse the partner sex may have a lower likelihood of being infected with the virus (Aboagye et al., 2021).

### **2.3.7 Occupation**

This could be justified by the financial and psychological independence that employed women experience, thereby increasing their potential to negotiate for safer sex. This result also corroborates our findings that women in the middle and richer wealth status have a higher likelihood of negotiating for safe sex. As women become employed, their economic/wealth status increases and that empowers them to take critical decisions about their health, including SSN (Ung et al., 2014 ; Tenkorang, 2012).

Among women who were unemployed, 0.6% had good knowledge of HIV. Unmarried women had the highest percentage of good HIV knowledge compared to other groups defined by marital status (Pradnyani et al., 2019).

### **2.3.8 Comprehensive HIV/AIDS knowledge**

Globally, HIV/AIDS remains a public health issue, especially in sub-Saharan Africa (SSA). Despite the increased advocacy and dissemination of comprehensive HIV/AIDS information in SSA, it appears that little progress has been made to reduce the incidence of HIV/AIDS in the sub-region. (Frimpong et al., 2022) Evidence suggests that HIV knowledge enhances an individual's ability to negotiate for safer sex, which in turn is linked to a reduction in HIV incidence (De Coninck et al., 2014). The respondents in the present study, as most (72.5%) had completed at least primary education. Young women who are educated are more likely to be able to negotiate for safer sex compared with their counterparts who are not educated (De Coninck et al., 2014).

In recent years, several researchers have concentrated on knowledge of safe sex and STIs, but without focusing on factors that affected levels of knowledge of safe sex and STIs among adolescents. There are few studies that have gathered data from in-school adolescents in Lao PDR on sexual knowledge and its determinants. The aim of this study was to describe the knowledge of safe sex and STIs and associated factors among high school students in Vientiane City. Understanding adolescents' knowledge of safe sex and STIs can help design appropriate educational programmes that support adolescents' sexual decision-making and findings from such research are important in planning preventive and treatment strategies (Inthavong et al., n.d.)

### **2.3.9 Place of residence**

The low prevalence of comprehensive HIV/ AIDS knowledge among AGYW in SSA found in this study is also consistent with the findings of previous studies (Idele et al., 2014; Asaolu et al., 2016). A possible reason for this finding could be the place of residence of the respondents, as the majority (68.3%) were living in rural areas where access to comprehensive sex education is sometimes a problem (Secor-Turner et al., 2017).

## CHAPTER THREE: METHODOLOGY

### 3.1 Introduction

This chapter covers the methodology used in the study. It includes the data source, study area, study population, study variables, data analysis, and ethical consideration.

### 3.2 Data source

The study used data from the 2016 Uganda Demographic and Health Survey (UDHS) that was accessed on the DHS Program website (dhsprogram.com) after formal request and was approved. The UDHS is the nationally representative Population based on household survey conducted every after every 5 years.

### 3.3 Study area

The study area was rural areas and considering married women who were asked the question of “could you ask your partner or husband to use a condom if you wanted him to”?

### 3.4 Sample size

This study used a sample of 8905 which was selected from the total number of women (11,377) interviewed during the survey. From this sample, weighe samples of 8,366.6 married women in rural areas (either married or cohabiting) were selected for the analyses. I used the women’s individual sample weight variable (v005) included in the UDHS data then I applied (v005/1000,000) to correct for over and under sampling and the survey command (svy) in Stata.

### 3.5 Variable description and measurement

**Table 3.1: Variable description and measurement.**

Variable	Variable label	Category	Data type
Dependent variable			
V850B	Safe sex negotiation	0=No 1=Yes	Binary
Independent variables			
V501	Marital status	1=married 2=living with partner	Categorical
V013	Age of the respondent	0=15-19 1=20-24 2=25-29 3=30-34 4=35-39 5=40-44 6=45-49	Numerical
V130	Religion	1=Anglican 2=catholic 3=Muslims 4=others	Categorical
V149	Education level	0=no education 1=primary 2=secondary	Categorical
V190	Wealth index	0=poor 1=middle 2=rich	Categorical
V714	Working status	0=not working 1=working	Categorical
V024	Region	0=Central 1=Eastern 2=Northern 3=Western	Categorical
D113	Husband/partner drinks alcohol	0=do not drink 1=drink	Binary
V157	Frequency of reading newspapers	0=No 1=Yes	Binary
V159	Frequency of watching television	0=No 1=Yes	Binary
V750	Ever heard of a sexually transmitted infection	0=No 1=Yes	Binary

### 3.6 Data Analysis

Data analyses were performed using STATA version 15. The analyses were carried out in three steps Univariate, Bivariate and Multivariate analysis.

#### 3.6.1 Univariate analysis

This was the first analysis; frequency tables and descriptive statistics were analyzed to establish the percentage distribution of the respondent's background characteristics selected for this study as shown in table below.

#### 3.6.2 Bivariate analysis

At bivariate analysis, association between the dependent variable and each of the independent variable was investigated. In this analysis, the chi-square test statistic was used to test for the significant association between selected independent and dependent variable. The chi square statistic takes the form of equation below,

$$\chi^2 = \sum_{i=1}^r \sum_{j=1}^c \left[ \frac{(O_{ij} - E_{ij})^2}{E_{ij}} \right] \dots\dots\dots 01$$

Where:

$X$  = chi-square value

$O_{ij}$  = observed frequencies

$E_{ij}$  = number of expected values

$r$  = number of rows

$c$  = number of columns

### 3.6.3 Multivariate Analysis

At multivariate level of analysis, binary logistic regression model was performed. In this case, the interest was in finding out the association between independent variables and dependent variable taking keen interest in the level of significance and the odds ratio. In cases where the level of significance was less than 0.05, that indicated a significant association between the independent and dependent variable. On the other hand, where the P-value was greater than 0.05 that indicated that there is no significant association between the dependent and the independent variable. The model used the equation below;

$$\ln \left[ \frac{P_i}{1 - P_i} \right] = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k + \varepsilon \dots \dots \dots \mathbf{02}$$

Where;

$P_i$  probability of women in rural areas who can negotiate for safe sex.

$1 - P_i$  probability of women in rural areas who cannot negotiate for safe sex.

$\beta_0$  intercept of the constant

$\beta_1 \dots \dots \beta_k$  Coefficients of the explanatory variables.

$X_1 \dots \dots X_k$  explanatory variables

$\varepsilon$  Error term (all other covariates which have not been accounted for in the model)

### 3.6.5 Ethical consideration

The demographic and health survey DHS website, [dhs program.com](http://dhs.program.com), was contacted for permission to view and utilize the data set. This was accomplished by signing up and submitting a request to use the dataset. The authorization letter served as the proof of ownership for granting approval.

## CHAPTER FOUR: RESEARCH FINDINGS

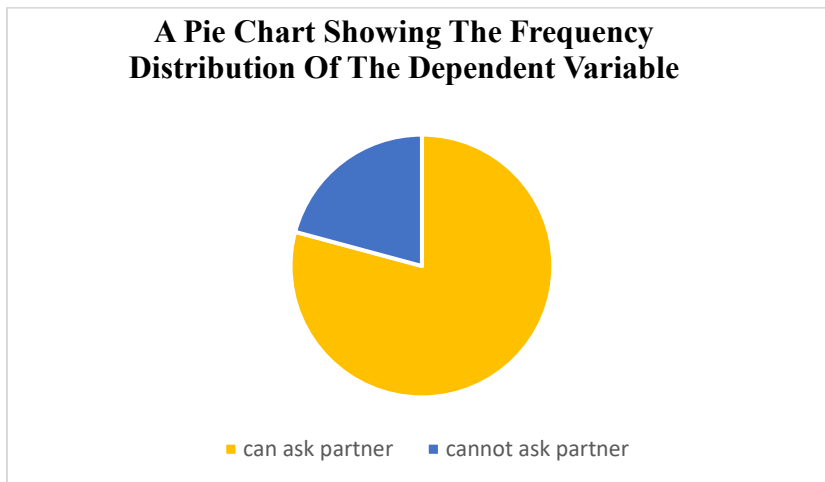
### 4.1 Introduction

This chapter presents distribution of respondents by their characteristics and the association between the independent variables and safe sex negotiation among married women. It also presents a discussion of the results.

### 4.2 Distribution of respondents

Results presented in show that out of the weighted sample of 8,366.6 women; 79.2 had the ability to negotiate for safe sex, majority of the women 30.2% were aged 20 to 24, 40.5% of the respondents were Catholics, majority of the women 65.4% had attained primary level of education, most of the women 47.6% were from the poor wealth index, most of the women are from the rural areas 76.3% and from the Eastern region with 56.3% of men reported to drink alcohol, 82.4% of the women from the working occupation, 80.7% of the women do not watch television and 86.3% do not read newspapers.

### Dependent Variable



**Table 4.2: showing frequency distribution of respondent's background characteristics**

<b>Variables</b>	<b>Frequency (N= 8905)</b>	<b>Percentage (%)</b>
<b>Independent variable</b>		
<b>Age of the respondent</b>		
15-19	680.6	8.1
20-24	1,813.8	30.2
25-29	1,633.4	19.5
30-34	1,470.1	17.6
35-39	1,179.5	14.1
40-44	923.6	11.0
45-49	665.7	7.9
<b>Place of residence</b>		
Rural	14,127	76.3
Urban	4,379	23.7
<b>Marital status</b>		
Married	4,689	52.7
Living with partner	4,216	47.3
<b>Religion of the respondent</b>		
Anglican	2,686.2	32.1
Catholic	3,392.3	40.6
Muslim	978.5	11.7
Others	1,309	15.7
<b>Education level of the respondent</b>		
No education	1,152.5	13.8
Primary	5,474.6	65.4
Secondary	1740.5	20.8
<b>Wealth index</b>		
Poor	3,980.2	47.6
Middle	3,605.7	43.1
Rich	780.6	9.3
<b>Region</b>		
Central	1,598.6	19.1
Eastern	2,634.5	31.5
Northern	1,907.9	22.8
Western	2,225.5	26.6
<b>Husband or partner drinks alcohol</b>		
Don't drink	2,075.5	43.7
Drinks alcohol	2,675.2	56.3
<b>Working status</b>		
Not working	1,469.9	17.6
Working	6,896.7	82.4

<b>Variables</b>	<b>Frequency (N= 8905)</b>	<b>Percentage (%)</b>
<b>Frequency of watching television</b>		
Do not watch	6751.1	80.7
Do watch	1,615.6	19.3
<b>Frequency of reading newspapers</b>		
Don't read	7,218.5	86.3
Do read	1,148.2	13.7

### 4.3 Bivariate analysis

**Table 4.3: Bivariate analysis showing the relationship between negotiation for safe sex and background characteristics in the study.**

<b>Variables</b>	<b>Safe Sex Negotiation</b>		<b>P-Values</b>
	<b>No (%)</b>	<b>Yes (%)</b>	
<b>Religion of the respondent</b>			
Anglican	33.9	31.6	0.0066
Catholic	40.2	40.6	
Muslim	9.1	12.4	
Others	16.8	15.4	
<b>Education level of the respondent</b>			
No education	21.8	11.6	0.0000
Primary	67.4	64.9	
Secondary	10.9	23.4	
<b>Wealth index</b>			
Poor	56.3	45.3	0.0000
Middle	38.5	44.3	
Rich	5.3	10.4	
<b>Region</b>			
Central	11.1	21.2	0.0000
Eastern	28.6	32.2	
Northern	27.3	21.6	
Western	33	24.9	
<b>Husband or partner drinks alcohol</b>			
Don't drink	50.9	57.7	

Variables	Safe Sex Negotiation		P-Values
	No (%)	Yes (%)	
Drinks	49.1	42.3	0.0002
<b>Working status</b>			
Not working	13.9	18.5	
Working	86	81.3	0.0002
<b>Frequency of watching television</b>			
Do not watch	87.6	78.8	
Do watch	12.4	21.1	0.0000
<b>Frequency of reading newspapers</b>			
Don't read	92.5	84.6	
Do read	7.5	15.4	0.0000

**Association between background characteristics and safe sex negotiation among married women.**

The table shows the percentage of safe sex negotiation among women according to the background characteristics. The findings showed that the prevalence of Safe Sex Negotiation among married women in rural was 76.3%. Results showed that all the selected background characteristics were statistically significant with the negotiation of safe sex with a p-value of (p-0.000), except religion of the respondent which had a p-value of (0.0066) and the prevalence of Safe Sex Negotiation was highest among women aged 20-24 (30.2%) from the catholic religion (40.6%) especially those who have at least attended up to primary level of education (64.9%), those women from the middle (44.3%) and rich wealth index (10.4%), those working (81.5%) compared to those not working (18.5%), those whose husbands do not drink alcohol (57.7%) compared to those whose husbands drinks alcohol (42.3%), the percentage of Safe Sex Negotiation was higher among women who watched television (87.6%).

#### 4.4 Multivariate Analysis

**Table 2:4: Multivariate Results of Background factors and Safe Sex Negotiation**

<b>Background characteristics</b>	<b>OR (std, Err)</b>	<b>95%CI</b>
<b>Age of the respondent</b>		
15-19		
20-24	0.94(0.15)	0.68-1.29
25-29	0.95(0.16)	0.67-1.33
30-34	1.08(0.19)	0.76-1.54
35-39	0.94(0.16)	0.67-1.33
40-44	0.68(0.10)	0.50-0.93
45-49	0.74(0.15)	0.49-1.12
<b>Religion of the respondent</b>		
Anglican		
Catholic	1.27(0.11)	1.06-1.53
Muslim	1.04(0.17)	0.74-1.43
Others	1.0(0.12)	0.79-1.27
<b>Education level of the respondent</b>		
No education		
Primary	1.43(0.15)	1.16-1.75
Secondary	2.86(0.44)	2.10-3.87
<b>Wealth index</b>		
Poor		
Middle	1.26(0.13)	1.03-1.54
Rich	1.55(0.34)	1.00-2.39
<b>Region</b>		
Central		
Eastern	0.80(0.15)	0.54-1.19
Northern	0.65(0.13)	0.44-0.97
Western	0.57(0.122)	0.38-0.87
<b>Husband or partner drinks alcohol</b>		
Don't drink		
Drinks	0.87(0.07)	0.74-1.03
<b>Working status</b>		
Not working		
Working	0.75(0.08)	0.60-0.95

<b>Background characteristics</b>	<b>OR (std, Err)</b>	<b>95%CI</b>
<b>Frequency of watching television</b>		
Do not watch		
Do watch	1.28(0.17)	0.98-1.67
<b>Frequency of reading newspapers</b>		
Don't read		
Do read	1.57(0.26)	1.12-2.20

## **CHAPTER FIVE: SUMMARY OF RESULTS, CONCLUSION AND RECOMMENDATIONS.**

### **5.1 Introduction**

This chapter presents the summary of results, the conclusion, the recommendations and research agenda.

### **5.2 Summary of findings.**

This study aimed at investigating the determinants of safe sex negotiation among married women of Uganda. According to the study of 8905 women, majority of the women were aged 20-24 and comprised of 30.2%. Most of the respondents were married 52.7% living in rural areas 76.3% and were working 82.4%. Results showed that most of the respondents 40.6% were Catholics, belonged to poor wealth index 47.6% and had attained at least primary level of education 65.4% from the Eastern region 31.5% who do not read newspapers and have no access to watching television who comprised of 86.3% and 80.7% respectively.

### **5.3 Conclusion**

There are different major determinants of safe sex negotiation among married women of Uganda. A woman's education level, wealth and region were significantly associated with safe sex negotiation however there was no significant relationship between occupation and religion.

The findings of the study on determinants of safe sex negotiation among married women in rural areas highlight the need to supplement women empowerment programs and interventions in order to promote greater SSN among married women rural areas of Uganda.

### **5.4 Recommendations**

The following suggestions should be adopted and put into practice by the different stakeholders to improve on the safe sex negotiation among married women in rural areas of Uganda.

Improving women's autonomy in sexual and reproductive health decision-making is central to the attainment of the sustainable development goal of gender equity and women empowerment and this would give women more power to make decisions in their sexual life.

The findings of the study could help inform policy formulation in the sub-Saharan African countries to reduce high parity and its negative consequences, such as maternal mortality. as Uganda has taken note of the problems of safe sex among partners by setting and putting it among the Sustainable Development Goals particularly, SDG 3.7 (universal access to sexual and reproductive health services), and SDG 5 (achieve gender equality and empower all women and girls) with this am sure safe sexual and reproductive health among women would be achieved.

In addition, women's health promotion programs and increasing male involvement in sexual and reproductive health services to consider the development of strategies that seek to promote sexual and reproductive health

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## APPENDIX 1

Jun 20, 2023

Nakiramba Oliver

Makerere university

Uganda

Request Date: 06/19/2023

Dear Nakiramba Oliver,

This is to confirm that you are approved to use the following Survey Datasets for your registered research paper titled: "Determinants of safe sex negotiation among married women in rural areas"

For restricted surveys, you must also request special permission from the Implementing Agencies. If approved, the restricted datasets will be provided to you by FTP.

To access the datasets, please login at:

[https://www.dhsprogram.com/data/dataset\\_admin/login\\_main.cfm](https://www.dhsprogram.com/data/dataset_admin/login_main.cfm). The user name is the registered email address, and the password is the one selected during registration.

The IRB-approved procedures for DHS public-use datasets do not in any way allow respondents, households, or sample communities to be identified. There are no names of individuals or household addresses in the data files. The geographic identifiers only go down to the regional level (where regions are typically very large geographical areas encompassing several states/provinces). Each enumeration area (Primary Sampling Unit) has a PSU number in the data file, but the PSU numbers do not have any labels to indicate their names or locations. In surveys that collect GIS coordinates in the field, the coordinates are only for the enumeration area (EA) as a whole, and not for individual households, and the measured coordinates are randomly displaced within a large geographic area so that specific enumeration areas cannot be identified.

The DHS Data may be used only for the purpose of statistical reporting and analysis, and only for your registered research. To use the data for another purpose, a new research project must be registered. All DHS data should be treated as confidential, and no effort should be made to identify any household or individual respondent interviewed in the survey. Also, be aware that re-distribution of any DHS micro-level data, either directly or within any tool/dashboard, is not permitted. Please reference the complete terms of use at: <https://dhsprogram.com/Data/terms-of-use.cfm>.

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Sincerely,

Bridgette Wellington

Data Archivist

The Demographic and Health Surveys (DHS) Program

530 Gaither Road, Suite 500, Rockville, MD 20850 USA +1.301.407.6500 +1.301.407.6501 fax  
[icf.com](http://icf.com).