‘As a man I felt small’: a qualitative study of Ugandan men’s experiences of living with a wife suffering from obstetric fistula

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ABSTRACT

The effects of obstetric fistula surpass the individual woman and affect husbands, relatives, peers and the community at large. Few studies have documented the experiences of men who live with wives suffering from fistula. In this study, our objective was to understand how fistula affects these men’s lives. We conducted 16 in-depth interviews with men in central and western Uganda. We used thematic narrative analysis and discuss our findings based on Connell’s theory of hegemonic masculinity. Findings show that the men’s experiences conflicted with Ugandan norms of hegemonic masculinity. However, men had to find other ways of explaining their identity, such as portraying themselves as small men but still be responsible, caring husbands and fathers. The few individuals who married a second wife remained married to the wife with the fistula. These men viewed marriage as a lifetime promise before God and a responsibility that should not end because of a fistula. Poverty, love, care for children and social norms in a patriarchal society compelled the men to persevere in their relationship amidst many challenges.

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Introduction

> As a man I felt small. I was a young man, just married to a young girl and my brain was excited and on fire. We left hospital, thinking she was okay but on reaching home we realised that she was actually not. She was all wet. I felt bad seeing her with that problem. She no longer lived like a woman. I felt I was not a man to sleep in the same bed with a woman leaking urine. I tried to send her back to her parents. After some time, I realised that I was not in love with any other person so I decided to go and bring her back. I went and collected her from her parents and we have remained together up to now. (Anderea[1])

Anderea, a 40-year-old man from western Uganda shared with us the above narrative. His wife’s first pregnancy had resulted in a stillbirth and thereafter she leaked urine from her birth canal uncontrollably. Despite the continuous leakage of urine for 20 years, they remained married and stayed together.

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In countries such as Uganda, childbearing is a reason for joy and gratitude that confirms the relationship of a husband and wife and secures the continuation of the family for another generation (Mbiti 1988). However, childbearing is a challenge in low-income countries, where reproductive indicators remain poor. Uganda has a large rural population, with more than 80% of its citizens living in rural areas, where most people rely on subsistence agriculture as the main source of income (CIA 2014).

Uganda has a high total fertility rate (6.2 children per woman), a high maternal mortality ratio (438/100,000 live births) and only 58% of deliveries are attended by skilled birth attendants (UBOS, and ICF International Inc 2012). Male involvement in maternal health is believed to be critical for reducing maternal mortality and morbidity (JHPIEGO 2001). Men usually control a family's socioeconomic affairs and decide on the conditions for their sexual relationship, family size and healthcare (Iliyasu et al. 2010).

In Uganda, both men and women consider large families to be a sign of success, while pregnancy and childbirth are essentially women's affairs (Kyomuhendo 2003). Mothers and other female relatives are the main source of information on pregnancy and motherhood for young women, and men rarely accompany their wives when they go into labour (UBOS, and ICF International Inc 2012). Men have little knowledge and information about the birth process, but are only called upon when complications occur, professional help is needed and funds for transportation and hospital care are requested (Kyomuhendo 2003). Often this information gap leads to delays in accessing professional obstetric care and can eventually lead to obstructed labour, maternal deaths, stillbirths and obstetric fistula if the mother survives (Lewis and De Bernis 2006).

Obstetric fistula is a serious morbidity related to childbirth and is characterised by continuous leakage of urine and/or faeces from the birth canal, restricting women's activities and impeding their roles as mothers and wives (FIGO, Partners 2011; Hancock 2005). Obstetric fistula is an international public health problem affecting over two million women, mainly from sub-Saharan Africa and Asia (Murray and Lopez 1998; Wall 2006). In Uganda, 2% of women aged 15–49 years have had fistula, mainly due to obstructed labour (UBOS, and ICF International Inc 2012). Fistula is known to affect the lives of both the woman and her social networks including relatives, especially the husband (Donnelly et al. 2015; Women's Dignity Project, Engender Health's 2006). Women with fistula experience multiple losses and are often abandoned by their husbands, who then remarry women who can fulfil marital roles (Mselle et al. 2011).

The literature shows that women with fistula are usually divorced, rejected and stigmatised due to leakage of urine and/or faeces (Bangser et al. 2011; UNFPA and Family Care International 2007; Waaldijk 2008; Women's Dignity Project, Engender Health's 2006). Much less is known about what happens to men when their wives develop fistula. A study conducted in Tanzania found consensus among husbands to marry another woman, and women with fistula were expected to understand and accept this situation (Mselle et al. 2011). Stigma surrounding fistula and ridicule by the community contributed to the husbands' decision to abandon their wives (Mselle et al. 2011). In contrast, some husbands and relatives are helpful and supportive of women with fistula, and some women remarry and deliver more children (Bangser 2006; Bangser et al. 2011; Mselle et al. 2011; Roenneburg, Genadry, and Wheeless 2006; Yeakey et al. 2009). Divorce among women with fistula varies depending on the con-text; in east and central Uganda 52% of the women with fistula were divorced (Bangser et al. 2011), while in western Uganda most of the women with fistula (66%) remained in their marriage and 16% were divorced or separated (Barageine et al. 2014).

Culture defines gender identity, gender expression and specific gender roles within a social context. Uganda is a patriarchal society in which men are seen as providers and protectors, largely in control of the economic resources (Otiso 2006). As heads of households, men make decisions for the family, including determining access to healthcare, often without consulting their wives (Dolan 2002; Greene 2000). In addition to owning the productive resources, men are traditionally considered the 'owners' of their wives and children, and of the fruits of their labour (Flood 2007). Women are responsible for domestic chores such as food production and preparation, cleaning and fetching water, caregiving and child rearing. Good standing in a clan supersedes the individual, and experienced clan members are relied on to resolve marital conflicts; thus, divorce is rare in traditional Ugandan society (Otiso 2006). Marriage provides both men and women with a high social status, and polygamy has traditionally been held in high esteem. Modernisation, increasing urbanisation and changing socioeconomic conditions have caused a decline in the traditional cultural mores and monogamous marriages are increasingly accepted as a norm (JRank 2015).

It is not clear from the existing literature how men perceive their role in reproductive health in general, or how they experience their wives' severe morbidity (Kaida et al. 2005). Very few studies specifically explain what happens to men whose wives develop fistula, including how it affects their lives and why some opt to remain with their wives. We there-fore conducted this study with the spouses living with women who have fistula. The main objective was to understand how fistula affected the men's lives, by exploring how the men described and explained their situation when living with a wife who has a fistula.

Theoretical framework

The concept of hegemonic masculinity was proposed in the early-1980s and has since then been widely used but also heavily critiqued (Connell and Messerchmidt 2005). Hegemonic masculinity describes the normative behaviours and practices that allow for male dominance over women (Connell 2012). This form of masculinity usually embodies the most honoured way of being a man in a certain cultural setting, which can be a small community or a larger society, and it differs over time (Connell and Messerchmidt 2005; Morrell et al. 2013; Schofield et al. 2000). Hegemonic masculinity is the ideal that men measure themselves against and are also measured against by other men (Connell 1987; Morrell et al. 2013). Courtenay (2000) defines masculinity as a collective gender identity with a set of behaviours that most men are encouraged to perform, which is fluid and socially constructed rather than a natural attribute. This identity includes demonstrating virility and physical and emotional strength while denying weakness. Ideals of masculinity define the means of achieving manhood and men often exaggerate elements of their masculinity to gain approval (Courtenay 2000). Men who cannot live up to the expected gender role develop alternative, non-hegemonic masculinities (Connell and Messerchmidt 2005). In Uganda, hegemonic masculinity encompasses marriage and fatherhood, being a provider for the material needs of the family, offering physical protection and exercising control over one's wife and children (Dolan 2002). In this paper, we use the concept of hegemonic masculinity and other masculinities to analyse how living with a wife who has fistula affects men's understanding of themselves as men and how they cope with the challenges and new demands placed on them.

Methods

Design

This was an exploratory qualitative study using in-depth interviews and thematic narrative analysis (Frank 1995; Riessman 2008). Qualitative, in-depth interviews are suitable when trying to explore highly sensitive topics, such as the topic of the current study (Ulin, Robinson, and Tolley 2005). In qualitative interviews, participants describe their actions in relation to what they experience (Green and Thorogood 2010). When people discuss their lives and important events that have affected them, they explain and justify their decisions in relation to the events and how their understanding was affected (Riessman 2008). The narratives people tell may change over time and vary depending on who the listener is. When listening to and systematically analysing how people describe their experiences, we can discern and illustrate how they reason, and thereby obtain a better understanding of their actions and decisions (Riessman 2008).

Research team

The research team consisted of two researchers from Uganda and two from Sweden. Team members had competence in obstetrics, midwifery and qualitative research methods, as well as both insider and outsider perspectives on the social and cultural aspects addressed in this study. The Ugandan team was more up to date on current issues and the social context. The principal investigator/first author (BJK) was a Ugandan obstetrician and gynaecologist. He is an experienced fistula surgeon and a doctoral student with substantial experience of meeting and caring for women with urine leakage and fistula. The other Ugandan -co--author (JKB), who is experienced in qualitative research and reproductive health in the local context,-further enhanced the insider perspective. The two Swedish co-authors (EF and BR), with qual-itative research expertise and wide experience from research in African countries, -provided an outsider perspective.

Study setting

The interviews were conducted from May to November 2012 at Mulago National Referral and Teaching Hospital and Hoima Regional Referral Hospital in central and western Uganda, respectively. Mulago Hospital is located in Kampala, the capital of Uganda, and provides routine treatment, rehabilitation and preventive services to women with obstetric fistula. Hoima Hospital is a regional referral hospital in western Uganda that treats patients in surgical outreach camps run by visiting surgeons from Mulago and other centres in Uganda. Patients in both hospitals are informed about the surgical treatment dates through periodical radio announcements. In each institution, fistula treatment is provided free of charge and patients' transportation, depending on the distance travelled, is reimbursed.

Participants and data collection

Women with obstetric fistula seeking treatment in Hoima or Mulago hospital were asked about their husbands and how they could be contacted for an interview about their experiences. Our target population was men who had ever lived with a wife with fistula,

irrespective of the current marital status. Women seeking treatment for leakage of urine at Mulago and Hoima Hospitals and confirmed by a fistula surgeon to have fistula, provided contacts with their spouses. We aimed to include all men who consented and agreed to be audio recorded during interviews. The only exclusion criterion was if the spouse did not agree to be interviewed. We had no predetermined sample size. We planned to stop interviews when saturation was achieved. The first author contacted the husbands either directly or by telephone to inform them about the study. Apart from those who were divorced or separated, all the men who were contacted agreed to participate. Men were informed about what participation would entail, and then a convenient time and place for the interview was agreed upon. Some interviews were conducted in the hospitals and others in the community. An interview guide was prepared to include the different aspects of interest in the study and to serve as a reminder for the interviewer. The first author conducted all of the interviews. Participants consented to participate in the study and for their voices to be recorded, with both verbal and written consent being obtained from each participant before starting the interview. The interviews were exploratory, conversational and non-judgemental, allowing for silence and reflection and using probing to ensure clarity (Kvale 1996). Interviews were conducted in the local languages (Runyakitara and Luganda), which the interviewer speaks fluently. All the inter-views were audio recorded.

Respondents were encouraged to give detailed information about their experiences and reactions from the time when their wives became pregnant, through the labour process, the time following delivery and during the time their wives had fistula. The consequences of fistula for their sexual relationships were explored in depth, as was the question of how the men's psychological and everyday involvement in the care of their wives affected their lives. The interviewer was careful to keep an open mind to emerging ideas and unexpected information from the respondents. Men were interviewed one by one as they were con-tacted until saturation was achieved when the information coming forth had already been encountered in previous interviews. All women with fistula who were still leaking received free surgical repair irrespective of whether their spouses were interviewed or not.

Data analysis

All of the interviews were transcribed and translated from the local language to English. The first author read through the transcripts and compared them with the audio files several times, identifying and revising areas that were unclear. Acting as 'narrative finders' (Kvale 1996, 201), the research team (all the authors) read the interviews, looking for common stories about the men's feelings, actions and decisions. The analytic process involved moving between the narratives within each life story and between the different life stories to search for common themes and how they were described and justified. We looked for the main characteristics in the men's own behaviour in relation to other people in their environment (wives, relatives, healthcare personnel, neighbours) and how the men justified and explained their behaviour and decisions. As 'narrative creators' (Kvale 1996, 201), we constructed one narrative using stories from all the participants to illustrate the men's struggle with handling their own values, hopes and responsibilities for the marriage, their relationship with their wives and relatives and the expectations and opinions of the family and community.

Ethical considerations

Ethical approval for this study was obtained from Makerere University College of Health Sciences, School of Medicine Research and Ethics Committee (#REC REF 2011–104), the Uganda National Council for Science and Technology (HS 1,337) and the Regional Research Ethics Committee in Stockholm (No.2012/474–31/2). Participants were provided with oral and written information explaining why the study was conducted, the data collection procedure and confidentiality. Information was also provided on voluntary participation, including the right to withdraw from the study at any time if the participants wished without their wives being denied treatment. Participants also consented to have the interviews recorded. After being fully informed about the study, each participant gave verbal consent and signed or stamped their right thumbprint on the consent form. The participants were assured that they would remain anonymous and no names would appear on the transcripts, study report or publications. Study participants were given a transport refund, which ranged from 5000 to 20,000 Uganda Shillings (US$2–8), depending on the distance they had travelled to reach the interview location.

Findings

We conducted a total of 16 in-depth interviews in total with men whose wives were confirmed by a doctor to have a genital fistula (Table 1). The men were mainly subsistence farmers, aged 26 to 45, with a primary-level education. Their wives had leaked urine for a period of 2 months to 30 years following difficult deliveries in which most of the babies died. All the women developed fistula in the process of giving birth, except for one woman who was accidently injured during treatment for a molar pregnancy. Fourteen men had continued their marriage with the wife who had a fistula, although two of them had married a second wife. Two of the men had knowingly married women who already had a fistula. The interviews were rich in men's descriptions of their experiences of living with a woman with a fistula. The men narrated how urine leakage affected their social and sexual life, their contact with health services and the economic consequences for the couple. Men told much the same story of love, compassion, responsibility, stigma, sadness and frustration, which we have moulded together into one coherent narrative to provide the fullest possible account of their life situation.

The single narrative that follows is based on consistent responses found across inter-views with all 16 men that have been moulded into a single voice. The theme 'as a man I felt small' depicts how the men described the consequences of living with a wife who leaked urine all the time. The interview conducted with Anderea, 40 years (Table 1) was used as a frame narrative, which was then condensed and enriched with accounts from the other 15 participants.

As a man, I felt small

> My name is Aruha Jam [composite pseudonym]. I studied up to primary six. I grow food for home consumption. I have been married for 21 years. We have had six pregnancies together; three children alive and three dead. My wife cannot control urine since her first delivery that resulted in the death of our first baby. She became pregnant soon after the marriage. She went for pregnancy check-ups at a local health centre and always told me that the baby was okay. I

Table 1. Demographic characteristics of participants (spouses of women with fistula).

Interview number	Pseudonym	Age	Education	Marital status	Marriage duration (years)	Spouse parity at leakage	Spouse parity at interview	Spouse leakage duration	Outcome of pregnancy that led to fistula
1	Saul	26	Primary 5	Married	2	1	1	3 months	Stillbirth
2	Jim	28	None	Married*	2	1	6	10 years	Stillbirth
3	Anderea	40	Primary 6	Married	20	1	6	19 years	Stillbirth
4	Billy	40	Primary 6	Married	22	6	8	21 years	Stillbirth
5	Simei	27	Primary 2	Married	4.5	1	3	1 year	Stillbirth
6	Guard	33	None	Married	11	6	6	2 months	Stillbirth
7	Deus	40	None	Married*	25	1	4	30 years	Stillbirth
8	Dandus	38	Senior 3	Married	20	4+1	4+1	4 months	Abortion**
9	Varitus	30	Primary 7	Married	6	2	2	1 year	Stillbirth
10	Dirisa	30	Senior 4	Married	8	3	3	3 years	Stillbirth
11	Willy	45	Primary 7	Married	19	3	3	13 years	Alive
12	Ivan	44	Primary 6	Married ***	20	6	6	5 years	Stillbirth
13	Medard	37	Primary 5	Married	10	4	4	6 years	Stillbirth
14	Agrey	36	Primary 4	Married	3	1	1	3 years	Stillbirth
15	Meritus	37	Primary 3	Married ***	7	4	4	2 months	Alive
16	Siraj	28	Primary 5	Married	2	1	1	3 months	Alive

* married his wife when she had fistula;
** during treatment or a molar pregnancy the bladder was injured leading to fistula;
*** married another wife in addition to spouse leaking urine.

> never accompanied her for these pregnancy check-ups. She started labour at 5.00 pm She spent the whole night at a local birth attendant's home, who tried to assist but failed. In total she spent 18 hours in labour. We had just migrated to a new district where the means of transport were rare. We were very poor and had nothing, not even a bicycle for transportation. We used *engozi* [a locally made stretcher carried by four men] to the nearest road. The baby was lying with the head up and the legs coming first. As she pushed, the baby's legs kept kicking her urinary bladder. Finally there came a vehicle carrying charcoal and we hired it. We travelled about 40 km on top of the charcoal to Hoima hospital where she was operated promptly but the baby had already died. I was called to collect my wife from theatre and I was also given a small box with baby's body. I then took the body for burial before she was awake only to return a day later and find her in a pool of urine that she could not control. She asked me: 'Where is my baby?' I explained that the baby had died during birth and was already taken to the village and buried. She had a turbulent recovery and she spent one month in hospital with a tube connected to a plastic-bag. She became terribly depressed, sorrowful and deeply concerned with the loss she had incurred. 'How could this happen for me to loose my first baby?' she asked. She was still unable to control her urine and was leaking all the time. The health workers told us that the baby had destroyed her bladder and hence the leakage of urine. We were told to spend one year without having sex and that she should not conceive, as it would make her condition worse. We left the hospital, thinking she was okay but on reaching home we realised that she was not. She was all wet. She could no longer live like a woman. I thought that she had been bewitched. I sent her back to her parents, but realised that I was not in love with any other person so I decided to bring her back. I had no money [bride price] to get another wife to satisfy my needs. Life was full of adjustments. Our house smells badly and when visitors come, they put their noses out. Women told me that I was stupid for refusing to divorce a smelling woman. My life turned upside down. I regretted and hated myself.

As a man I felt small. I was still a young man just married to a young girl and my brain was excited and on fire. I felt bad because of the urine that did not smell good. I wondered why I was created on this earth and I asked myself many questions. I did not feel for her as I had before. She was responsible for the daily house chores before but after she got the problem, most of the responsibility shifted to me. I had to cook, clean and also wash for her. All the time I was full of thoughts. Some people said I better leave her in her disabled state, not to waste my resources. I would look at the situation and think God is punishing me since he is above all. It is all about suffering, I look at the condition of my wife and I cannot point a finger at anybody, there is no other person to blame. Because of love for my wife, I persevered and accepted all the suffering because I cannot throw her out. She is all the time wrapping herself in rugs to stop urine leaking through her clothes. It is not pleasing because all the time we have to wash. I have to constantly buy soap. This forces me to have money all the time.

We tried our best to abstain [from sex] but managed only for six months. When she became pregnant again, I felt this was beyond me. She was going to be re-operated and I feared the leakage would be worse. My heart told me to escape from home and I did so for five months. While I was away, I thought my wife was going to die. I came to my senses and decided to go back home and see what had happened. When I reached home I found that she was ready to be taken to hospital for delivery. I knew God was going to take care of her in the theatre. She was then taken to the theatre and while I was still thinking, they brought the mother alive and the baby alongside her also alive. Then I became suddenly overjoyed and told myself finally I have also got a baby boy. I felt happy and actually sang and I said: 'even if there is this problem of leakage of urine at least we have a baby boy'. I think there is so much that changed. You know when somebody's thoughts change there is a lot that changes in the brain.

We have never fought but we have sometimes exchanged bitter words. We have not had any big problems in our sexual relationship, but I could not have sex with her the way other men have sex with their wives. There is a point you reach and you feel sad. This happened to me for a long time. When I would be in a group of other men, I would hear their description of sex with their wives and I would realise the big difference. Their wives would have real vaginal fluids but mine would only bring urine. And as we meet, I would not get the feeling and would not like the process. With my wife it is rough, coarse and occasionally I feel a lot of pain. Because she is leaking, when we have sex together, there is a lot of fluids, too much water, and I cannot understand it. The man and wife seem not to move together in that activity. It is like jumping from one place to another and maybe skipping some steps. When I feel it I almost give up the sexual act. This is actually a big problem for me, but I have to persevere. I do hate myself and say to myself: 'How will I manage? What shall I do? For how long will I continue like this?' My wife also hates herself and feels she does not fit in society. When she sits with other people, urine keeps on coming and smelling bad. It was a very big problem for me seeing her in a situation where she could not any more live a normal life of a woman. I had to take time comforting her. I would tell her that she should feel free since I am still in love with her. These comforting words have played a big role for her. My wife comes from a strong Christian family. And even us we are Christians and we believe that if God wishes it, her condition will be cured.

We definitely never achieved our dream of becoming rich. Twenty years down the road we are still poor. I have tried very much to look after her in hospital and I really care for her so much. I grew up as a young man liking to work and I thought that within six years together, we were going to be rich. My life experience has not been good. I still hate myself for my situation. What I previously planned has all turned upside down. I thought of making a cattle farm but my wife's problem hindered it. I have lived a life wandering from hospital to hospital. I do not have money for our care and I am about to fail looking after the children. They are in bad schools, where I do not want them to be. We buy a mattress and sleep on it for one year, then it is all in pieces and we need to buy a new one. Surely this is no joy. It has been perseverance and endurance. It is said: 'The one who perseveres is the one who will reap the right fruit'. I married her when she was a small girl. I have tried not to make her more worried because of the problem she has, for she never wanted it. I care for her. She is now generally a strong woman. I have been afraid my wife would die and I lose her. We have developed a spirit of perseverance and tolerance, seeking divine intervention through prayer, and ignoring what other people say. I resolved that no matter what comes in our way I will be with my wife. I neither wanted her to leave the children with another woman, nor did I think that I would be able to look after them alone. I wish God allowed her to heal. I am only interested in her being treated and healed.

Discussion

In their narratives, men described the constant conflict between trying to fulfil the expectations and norms of the hegemonic masculinity that dictates men's ambitions in Uganda and the challenges of living with a chronically ill wife who has a socially stigmatising condition. Respondents demonstrated a common strong feeling of responsibility and at the same time frustration with a life that did not become what they had hoped. Findings reveal that men's experiences and understanding of their identities were deeply affected

by their wives' illness. While striving to satisfy the cultural expectations of men to be strong, decisive, sexually active, earning a good living and having a big family, the men struggled to manage the demands their wives' condition caused. These challenges were difficult to reconcile with the expectations of hegemonic masculinity and the men thus identified themselves as 'small men', hating themselves, having bad sex, being disgusted by the smell and condition of their wives, failing their children and not achieving the economic ambitions they hoped for.

Participants offered various reasons why they chose to continue a marriage with a woman who leaked urine. They referred to love for their wives, marriage being a norm that includes responsibility for a wife and children, the feeling that they shared in the process that led to fistula, the mothers' role in parenting the children and the lack of money for the bride price to marry another wife. These reasons are mainly based in the norms of the hegemonic masculinity that the men aspired to. As expected of men in Ugandan society, the interviewees presented themselves as enablers in accessing health services once they realised that there was a problem the women in the community could not handle. They also underlined their own responsibility for the situation, which neither husband nor wife had wanted or expected. As men, they expected their wives to be responsible for childcare and household chores and knew that it would be hard to manage the children without a mother. Men did not like the idea of having another woman taking care of their children and also found it difficult to raise the funds for a second wife. Otiso (2006) discusses Ugandan traditional marriage and how marital conflicts were solved through community involvement. Men are expected to remain with their wives in order to be in good standing in the community and to adhere to cultural values. To stay in their marriage was, however, not the obvious option for all the men in the study, because it challenged their ambitions as men. Their peers sometimes advised men to leave their wives and not to spend their money on sick women. Some men followed the advice to send away their wives, but they soon had to bring them back home, despite the urine leakage.

Men's stories revolved around minimising the physical, socioeconomic and sexual challenges of fistula, which forced them to acknowledge their inability to achieve a high position in the hierarchy of masculinities (Connell and Messerchmidt 2005) and instead identify themselves as 'small men'. Interviewees described how they felt when they learned that their wives were leaking urine, using expressions such as: 'I felt small', 'I regretted why I was created', 'God's punishment', 'bad smell' and so on. Eventually, however, the men came to terms with reality and decided to persevere and stay with their wives. While acknowledging their non-hegemonic masculinity as small and failing, the men also por-trayed themselves as fulfilling the Ugandan male norm of the caring husband and father who does not shirk responsibility (JRank 2015; Otiso 2006). The men's narratives about the experiences of living with a wife who leaks urine have rarely been heard, and other studies have shown that men tend to leave their wives if they have fistula (Bangser et al. 2011; Mselle et al. 2011; Muleta, Rasmussen, and Kiserud 2010; Women's Dignity Project, Engender Health's 2006).

Men also explained how they lost some of their male identity, especially with regard to sexuality, as the following statements show: 'I had no feelings for her', 'I felt I was not a man', 'I could not have sex with her like other men', 'I almost gave up the sexual act', 'I felt I was not a man to sleep in the same bed with a woman leaking urine'. They described how sex had

changed and was not similar to what it had been before, and not like the sexual intercourse their male peers described. All of the men claimed that during sex there was too much water that felt like urine. The men persevered despite the sense of loss of their male identity in relation to sex, but when their wives conceived and delivered, the men felt like real men again. These experiences have not featured in any other studies.

Men identified themselves as providers for their wives and children – a cultural role and a male attribute. Their dreams to become rich were shattered by the money they had to spend on their wives' condition. The men saw themselves as failures because they could not buy the properties they had hoped for and could not pay for good schools for their children. They could, however, not shirk the responsibility of looking after their wives and children. Marriage in the context of their religion was important. They explained that the present situation could be God's plan for them and hence they had to accept it and hope for a cure. Aspects of religion and culture, but also love, played an important role in men's descriptions of their experiences and how they coped with the challenges of fistula. The men, however, did not express any sense of pride about bringing a new positive approach to man/husband-hood. Their experiences were more ones of doing what they were culturally expected to do if in a difficult situation than expressing any sense of pride as men.

Methodological considerations

We had initially hoped to include the spouses of women with fistula in the study, irrespective of whether they had stayed married or were separated/divorced. Unfortunately, the divorced men who were identified declined to participate because they were no longer interested in any activity involving their former spouses. This study thus elaborates on the experiences of men who live with and care for their wives with fistula, a focus that has not been studied earlier. The language and interviewing skills of the first author ensured rich data, collected with great sensitivity, which provided valuable insights into the lives of men in Uganda. We acknowledge the fact that the interviewer being one of the doctors who operated some women whose spouses were interviewed could have affected the preparedness of the men to participate in the interview and the responses the men gave. As a limitation, we cannot tell whether this relationship affected the results for good or bad. However, the interviewer took great care not to impose his thoughts and ideas on the participants, instead allowing the men to freely tell their stories. Using face-to-face in-depth interviewing enabled the interviewer and participants to build rapport. The interviews concerned very sensitive issues and the men's narratives included their choice of what to reveal and how they wanted to represent themselves to the interviewer, who was also the doctor who could treat their wives.

When telling their stories, the men constructed their identities as husbands of sick women in relation to the interviewer (Riessman 2008). The men had lived for different lengths of time with their wives and the fistula had occurred at varying times during the women's obstetric history, which influences the men's experiences and the way they described them. The stories, however, included similar experiences, which strengthens the plausibility of the analysis. Our study is context specific and illustrates the situation of Ugandan couples affected by genital fistula. Joint analysis by the research team with an insider and outsider perspective, different disciplines and qualitative research experience were important to increase the credibility of the study findings.

Conclusion

The effects of fistula surpass an individual woman's life and greatly affect the life of the spouse who must bear the physical effects such as a foul odour, unsatisfying sex, extra costs and the stigma his wife lives with. Men described how their experiences led to conflicting identities: while trying to fulfil the cultural norm to be responsible men providing for their families, they also felt small, frustrated and disappointed. Men's lives had not become what they had hoped for and their wives could not fulfil their roles as partners in work and love; instead, funds and time had to be devoted to caring for the women and seeking help. The men experienced a sense of loss of male identity and their sex lives were affected and they felt diminished as real men. To endure their situation, men reported turning to God with questions, but also accepted God's will and trusted in his mercy. Poverty, desire for children, love and faithfulness, compassion and responsibility, and fear of God were reasons why the husbands persevered in marriage.

Note

1. All names in this paper are pseudonyms to protect confidentiality and anonymity.

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