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Neglected older women and men: Exploring age and gender as structural drivers of HIV among people aged over 60 in Uganda

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This study explored how women's and men's gendered experiences from childhood to old age have shaped their vulnerability in relation to HIV both in terms of their individual risk of HIV and their access to and experiences of HIV services. It was a small scale-scale study conducted in urban and rural sites in Uganda between October 2011 and March 2012. The study used qualitative methods: in-depth interviews (with 31 participants) and focus group discussions (FGDs) with older women (2) and men (2) in urban and rural sites and 7 key informant interviews (KIIs) with stakeholders from government and non-government agencies working on HIV issues. Women's position, the cultural management of sex and gender and contextual stigma related to HIV and to old age inter-relate to produce particular areas of vulnerability to the HIV epidemic among older women and men. Women report the compounding factor of gender-based violence marking many of their sexual relationships throughout their lives, including in older age. Both women and men report extremely fragile livelihoods in their old age. Older people are exposed to HIV through multiple and intersecting drivers of risk and represent an often neglected population within health systems. Research and interventions need to go beyond only conceptualising older people as 'carers' to better address their gendered vulnerabilities to HIV in relation to all aspects of policy and programming.

Key words: older people, Uganda, HIV, gender, age, structural drivers

Background

Introduction and background

Studies on older people and HIV have highlighted the significant role of older people in caring for HIV positive family members in low income contexts. Such results have been found in Uganda (Nyanzi 2009) and in South Africa (Schatz 2007, Schatz and Ogunmefun 2007). Others have unpacked aspects of older carers' health and well-being in these contexts, such as studies in Kenya (Kyobutungi et al. 2009, Chepngeno-Langat et al. 2011) and in South Africa (Munthree and Maharaj 2010). Such studies have mainly focused on the experiences of older people as HIV-affected rather than HIV-infected. However, research from high income contexts has also recognised older people's vulnerabilities in relation to HIV transmission (Emlet 2004, Neundorfer et al. 2005, Emlet 2006). Based on data from demographic and health surveys and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Negin and Cumming (2010) calculate that in 2007, of the approximately 21 million HIV positive people in sub-Saharan Africa, 14.3% are in the 50 years or above age bracket. In the context of global ageing populations these studies highlight the importance of focusing more attention on older people's experiences of HIV beyond their caring role and taking into account their vulnerabilities to HIV. In addition, they highlight the importance of adopting a structural approach that takes gender and socio-economic factors into account as crosscutting aspects of older people's experiences of HIV.

Structural factors — social, cultural, economic, political, legal and environmental — are known to affect individual risk and vulnerability to HIV (Rao Gupta et al. 2008); amplify exclusion of people living with HIV; and limit access to services. The public health approach to HIV prevention has focused on changing individual behaviour, but increasing evidence shows that key social and structural factors such as gender, socio-economic inequalities, stigma, age, discrimination, and human rights violations drive individual behaviour and constrain change (Vincent 2009). Prevention interventions have been more successful in changing behaviour when they have better understood and addressed structural factors (Coates et al. 2008).

Gender inequities have been identified as key drivers of the epidemic because they shape and constrain individual behaviour in sexual interactions (Rao Gupta et al. 2008). However, we cannot talk generally about 'gender inequality' as a direct driver of HIV infections, but must identify the specific ways in which gender (and sexuality) dynamics operate in conjunction with other social and cultural dynamics in particular social contexts to produce vulnerability to infection, or not, and target HIV prevention efforts accordingly (Auerbach et al. 2009). In this study, in a Ugandan context 'older' refers to men and women over 60

years of age. For these older people it is important to know the meanings and importance women and men attach to their sexuality and relations to understand relationships and sexual behaviour from a cultural and gendered perspective and how these influence vulnerabilities of older men and women to HIV in different contexts.

Structural drivers are complex social phenomena which operate at several levels simultaneously, including: policy and legal frameworks; service infrastructure and access; social norms and practices; interpersonal relations, including community and household; and individual capabilities (Panos 2006). Gender norms and relations interact at all these levels with other factors such as age and socio-economic status. The interaction of inequalities generated by these factors exacerbates risk and vulnerability among older people. The research and evidence on the health of older women and men in HIV research have several major gaps, including on their experience of gender roles and relations as a key structural driver of HIV. There is also limited understanding of experiences of gender based violence (GBV) amongst older people and the impact of this on their vulnerability to HIV.

In Uganda, national HIV prevalence is 7.3% (Ministry of Health 2012). Sero-discordancy with partners is about 60% among HIV-infected individuals. Once hailed as a success story because of reduced prevalence, HIV incidence appears to be rising, particularly among married couples, maintaining the generalised epidemic (UAC/UNAIDS 2009). Unfortunately data are unavailable for people over 60 years old. The need for data collection systems to include older people was a theme throughout a recent pre-ICASA (International Conference on AIDS and STDs in Africa) workshop on HIV and ageing (held in Addis Ababa, Ethiopia, in December 2011). Much more needs to be known about the experience of older people in terms of how gender interacts with other social factors to drive GBV and influence intervention outcomes to guide responsive HIV programming. This paper begins to address the neglect of older people in the growing literature on structural drivers of HIV through a gender sensitive exploratory qualitative study which builds on ongoing work with older people in Uganda.

Study setting and design

The study was conducted in 2011 in one peri-urban and one rural area in southern Uganda. The rural site was in Kalungu district where in 1989 the Medical Research Council/Uganda Virus Research Institute (MRC/UVRI) established a general population cohort to study the epidemiology of HIV. Annual demographic and serological surveys have been conducted with this population for the past 22 years, resulting in a wealth of data on approximately 20 000 people in 6 000 households. People living in the study area are largely subsistence farmers who produce small amounts of cash crops such as beans, bananas and coffee. Most of the population (70%) is ethnically Baganda and the area has a large representation of immigrants from Rwanda (15%). About 4% of the population comprises immigrants from Tanzania. A mixture of other tribes makes up the rest of the population. The main local language is Luganda, spoken and understood by all the tribes. The community is predominantly Roman Catholic (60%) with (17%) Protestant and (23%) Muslim. Just over 50% of the population is under 15 years old. A few households in the population are landless, however, most households have less than five acres of land. The peri-urban site was in Wakiso, the district that includes Entebbe, where the MRC/UVRI headquarters is based. MRC/UVRI has conducted several studies in Entebbe and the surrounding areas over the past 20 years.

The 'peri-urban' label refers to the site of service provision, not place of residence. Many participants lived in rural areas around Entebbe and were not therefore residents of the town. The population in Wakiso district is more mixed than at the rural site in Kalungu, because people from many different tribes have settled near Entebbe. While there is a strong Roman Catholic presence in the district many other Christian denominations and Muslim groups are also represented. Many people in the rural areas near the town still practise cultivation as their main form of livelihood, but there are also people engaged in fishing and various forms of trade. Others are engaged in formal employment in teaching, health care, and cleaning services.

We worked with a cohort of older people established through studies previously undertaken by MRC/UVRI (funded by the World Health Organization, Cordaid and MRC) as our sampling frame (total of 510 people aged 50 years and over). Two-fifths of the cohort was living with HIV, half of which were on antiretroviral therapy (ART). However, HIV status was not a selection criterion for this study as we were interested in getting a broad view of the social context of older people's lives and relationships and their opinions about the challenges faced by older people (including HIV). We purposively selected female and male interviewees to ensure diversity by age, geography (rural, peri-urban and urban) and household structure (for example, including those that care for resident grandchildren and those who do not). In this sub-sample, the older people selected were all over the age of 60 years, to focus on older people who had been experiencing the effects of ageing for longer than the younger members of the broader cohort which included people in their 50s and above.

The sample size was chosen based on experience of when data saturation may be reached and to achieve a manageable number of interviews within the short time frame available for this study. Data were collected from 16 women and 15 men; 2 focus groups of women and 2 focus groups of men, and 7 key informants (including local leaders, health workers and other stakeholders). Most respondents (55%) were aged between 70 and 79 years.

We used qualitative methods because they offer the most potential for eliciting concepts and perspectives of different community groups, such as older women and men, as well as for understanding the complexity of life practices and gender relations and the opportunities for change (Welbourn 1992, Pope and Mays 1995). Initial interview checklists for both participants and key informants were developed by the team and piloted with two men and three women at the two study sites. Individual in-depth interviews (IDIs) were conducted by four experienced interviewers (one man and three women) all aged over 50 years (three

were aged over 60 years). Three additional field workers assisted with the focus group discussions (FGDs). A senior social scientist helped with the key informant interviews (KIIs) although the bulk of these interviews were conducted by the main interviewers. Interviews and FGDs were conducted in Luganda and tape recorded, with the participant's agreement. The interviewer team transcribed and translated the taped interviews. Topic guides included questions on relationship histories; influences on choices of partners; attitude and behaviour of partners to spouses and children; changing positions of women and men in society as well as in marriage and other sexual relationships; changing attitudes to relationships and sex across the life course; and perceived risk of HIV or other sexually transmitted infection (STI) infection.

The framework approach to qualitative analysis was used. This is a transparent and structured analytical approach ideally suited to analysis that involves teams and multiple analysts (Spencer et al. 2003). This involved developing a thematic structure for interpretation, under which individual codes could be grouped. Thematic headings included 'marriage practices', 'livelihoods' and 'sexual relations'. This process meant that ideas could be shared more easily between members of the team conducting analysis. In reporting the findings we used a mixture of transcript notes which included quotes written by the interviewer reporting on the transcript, as well as some quotes in the first person, where appropriate. Pseudonyms are used throughout this paper to protect the identities of the respondents. Ethical approval for the study was obtained from the Uganda Virus Research Institute Science and Ethics Committee and the Uganda National Council for Science and Technology.

Results and discussion

This section explores and discusses the data generated through IDIs, FGDs and KIIs carried out with older women and men in urban and rural areas and with local leaders, health workers and other stakeholders. Overall the analysis shows how socio-cultural aspects of older people's experiences drive HIV risk in terms of transmission and access to services. Gendered aspects of these drivers intersect with age-related stigma to produce particular challenges for older women. The findings explore first the broader aspects of HIV vulnerability among older people and then focuses on the greater burden experienced by older women, in some cases compounded by gendered violence and social isolation.

HIV and ageing: Twice stigmatised

This paper explores some of the ways in which the cultural management of gender roles, sex and sexuality drive HIV vulnerability and risk among older people. These drivers are multidimensional and are woven into the cultural fabric of men's and women's lives with consequences at each stage. A significant structural factor which exacerbates HIV vulnerability among older people entails the persistent levels of stigma attached to HIV as a disease and the intersecting stigma attached to perceptions of old age and older people's expected behaviour (Kuteesa et al. 2012). This was borne out in our study with reports from older women and men on the challenges they face in accessing information about sexual health and HIV. While some participants mentioned specific organisations, services or media outlets to access information, others suggested that they would feel uncomfortable using services due to the stigma of being recognised by other members of the community, or by being seen by a health practitioner from a younger generation:

> *'I can go there and get an interview about issues which I feel as being sensitive, e.g. how long have I spent without having sex? With whom? How often a month and others, yet the one interviewing me is the same age as my children'* (FGD with older women, rural area).

Overall, it was clear from the comments of several respondents about HIV prevention that there is a low level of knowledge among older women and men about HIV transmission and risk and some anxiety related to accessing HIV services. Beyond the need to address the information gap, there is a need to address age-related stigma about older people's sexuality which renders them invisible to service providers:

> *'The risk is there because health workers think older people are not sexually active so in most cases they are not targeted by health services. Health workers think that old people are a 'spent force'. They do not realise that they too need information on HIV'* (KII, policy maker).

Older people have sexual health needs and questions. These people have the right to receive information and education on their sexual and reproductive health, free from age discrimination. Several respondents said that few services exist for them as older people, not only in relation to HIV specifically, but more broadly in terms of their general health and well-being. Others also expressed anxiety about general health needs, highlighting the lack of state-run services available to them:

> *'When you grow [old] your sight is affected, hearing is impaired, thinking is affected, feeling is affected, and the skin becomes scaly. Problems also heighten for people as they age. With many forces of nature like lack of money, having to pay school fees and buy food, there is a lot of worry and the ability to feel in a relationship reduces and happiness goes'* (FGD with men, an urban area).

Interviews with key informants supported these findings, pointing to the lack of service focus on older people (including for HIV), especially by the Ministry of Health:

> *'Very few older people get information on HIV because most sensitisation programmes leave them out. Very few organisations have come in specifically to address issues of older people for example MRC and Uganda Reach the Aged Association. Even the Ministry of Health has not come in to help older people. Their focus is elsewhere, oblivious of the fact that many older people got HIV as adults and have progressed with the disease'* (KII, policy maker).

Key informants reflected on some of the challenges which exist when trying to address older people's sexual

and reproductive health rights. First, that 'older women and men are a forgotten group' since interventions are mainly designed for children below five and lactating mothers; second that older women and men are unlikely to access health centres because of the negative attitudes of health workers, who believe that they are simply suffering the effects of old age; third, that health centres do not stock the appropriate drugs for diseases that specifically attack older people (such as diabetes, hypertension and arthritis) since they are expensive. Finally, the data suggest that family support for older members has been eroded by the deaths, and by rural to urban migration of many younger family members. Older people have become increasingly impoverished, especially given their responsibilities as carers of grandchildren. This caring role has often led to older people being visible to policy makers solely in their capacity as 'carers' or in stark economic terms as those supporting the reproduction of the next generation of labour. However. this view of older people has overlooked the fact that older women and men are vulnerable members of society who need considerable care in their own right.[1]

Structural aspects of isolation in old age

While most interviewees had faced financial and livelihood constraints throughout their lifetimes, older men generally described a broader range of opportunities available to them and were more likely to have found wage-paying work. In contrast, women in most cases and particularly those in rural areas described fragile livelihoods mainly built around subsistence farming. Even here, inheritance laws and customs have a negative impact on women's access to farming land. Previous research in Uganda suggests that women's access to land, while not legally restricted, is difficult because most cannot afford to buy it (Karuhanga 2008: 121). Karuhanga argues that an important way for women to get land is through customary land tenure, where women's primary access to land is through marriage. Issues of land ownership arose in our study, especially in relation to women's reliance on husbands for their livelihoods. In a few cases, women had access to land through their natal families, which allowed them more freedom to leave their husbands. These factors reflect the different levels of agency that these older women and men have experienced in key areas throughout their lifetimes. While taking into account the socio-economic constraints men also experience it is clear from these life histories that cultural norms in Uganda have allowed older men more control over their education, their marriage choices and their livelihoods in comparison to older women.

Nevertheless, men described ways in which their livelihood activities might change due to their age. They referred to the necessity of handing over some responsibility for particular tasks to young family members or employing other people for certain tasks. Hiring help requires capital which may not always be possible for older people. Men also distinguished between those older people who had financial stability and those '*whose backgrounds were shaky'*, who were likely to '*have a lot of problems, are destitute, are desperate'* (FGD with men in an urban area). They pointed out that while a small minority of older people had access to pensions, most were without financial support. Both older men and women surviving through low-level subsistence farming described the challenges they faced in continuing to produce food given their lack of strength and worsening health:

> *'… As her life became weak due to many health complaints, she only does little work, like digging at her banana plantation, picking coffee when it is harvesting time'* (Transcript from interview with Noelina, woman, age 74, rural area).

In addition, respondents highlighted that lack of capital, unexpected shocks affecting crops and changes in climate presented huge challenges to their ability to continue supporting themselves. These broader factors demonstrate the precarious position of older women and men whose livelihood options have narrowed through poverty and through age-related depletion of their energy and strength.

Researching socio-cultural practices among the Baganda during the 1970s, Nahemow (1979) found that among her sample of 115 elderly Baganda, 18 lived alone, but most lived near a relative, most often adult offspring. She comments that "while dissatisfaction [with support and care] is prevalent among elderly Baganda, loneliness is not. […] their separation is a matter of personal preference and can be viewed as adaptive and consistent with societal norms" (Nahemow 1979: 182). In our study we found that several older people expressed a sense of social isolation and loneliness linked to their age.

For example, Dorice is a 71-year-old woman originally from Burundi who has lived in Wakiso most of her life. In interviews that took place over several months she expressed a strong sense of sadness about her life, mixed with anxiety about the future. She had lost two children and was the sole carer for her ailing husband and her teenage granddaughter. One of Dorice's main worries was her sense of social isolation. Although she did receive assistance in the form of food packages she felt very alone and reported only one visitor in a three-month period:

> *'Since we are poor, we do not get visitors at all. Not even people to say hello...becoming old is really a big problem; well wishers will find us dead in the house'* (Dorice, woman, age 71, rural area).

Our study found that the sense of social isolation played heavily on the minds of some older people, especially women. In an interview with Noelina, 74 years old, who was also living in a rural area, isolation was linked to her illiteracy and inability to communicate through writing with friends and family. Noelina reflected that '*lack of education hurts more when one is adult*'. These cases illustrate the complex interplay between historical narratives and contemporary realities of interviewees. The significance of gender in mediating aspects of older women's social isolation has multiple socio-historical threads which are woven into the life histories of women's and men's narratives. Structural drivers operate through time as well as through dimensions of age, sex and socio-economic status.

Older women like Dorice and Noelina experience contemporary challenges which are rooted in established forms of discrimination. For example, they and others had experienced constraints due to socio-cultural expectations by families and communities. Women described ways in which these affected their education and marriage options as young women:

> *'Most of the girls at that time were getting married at 14 years most especially those who did not go for education, but those who went for education could get married at the age of 18–20'* (transcript notes from interview with Elizabeth, woman, age 67, rural area).

Many of the women's narratives in the IDIs included references to their education being overlooked by their parents. This was mainly due to financial constraints, but in some cases explained by the fact that girls were expected to marry rather than complete their education.

> *'Mary sadly confessed that she has no education at all. This was because her parents by that time thought that girls were marriage materials not fit to study and that boys were the only ones to have an education'* (transcript notes from interview with Mary, woman, age 60, urban area)

While men also experienced constraints in their educational attainment and were often forced to curtail their schooling before completion, they most often stopped going to school at a higher level than that of the women interviewed. Furthermore, some men indicated they had done odd jobs and other work to help pay for school. While socio-economic constraints played a role in forcing both men and women to curtail their schooling, the data suggest that women's access to education was further affected by socio-cultural expectations that they should be married.

Contextual aspects of marriage practices and customs existing in Uganda are important, particularly among the Baganda, the dominant ethnic group resident in the study area. Previous studies show that marriage has a range of definitions in Uganda. These include: customary, which includes the transfer of payments and gifts by the bridegroom to the bride's father, or equivalent family member; religious, which may be based on a Christian or Islamic ceremony; civil, in which a registrar performs the ceremony; or informal, in which couples who are cohabiting, describe themselves as married (Nabaitu et al. 1994). The types of marriage most commonly referred to by the interviewees were customary, religious or informal. It is not unusual in this setting for women and men to experience unstable marital relations and to experience more than one type of marriage during their lifetimes (Nabaitu et al. 1994, Seeley 2012). Many of the interviewees described unstable marriages and may have experienced different types of marriage with different partners, or with the same partner.

The study also found significant differences between men's and women's experiences of marriage customs and practices. Women described the importance of gifts and 'payments' in negotiation processes between family members and prospective husbands. Notably, greater emphasis was laid on items for parents and other family members such as uncles and brothers. Many of the interviewees, men and women, from rural and urban settings, accept and endorse the system of bride payments, or bride-price. According to Charles, a man from a rural area, bride-price ensures that parents of a girl are thanked for their work in raising her. For Noelina, a woman from a rural area, bride-price helped to guarantee that her husband would not mistreat her and she was therefore happy that the payment had been secured. Not all participants experienced such marriage exchanges, but while more men described experiencing an element of choice, women were less likely to be involved in the negotiations for their own marriages. However, female relatives sometimes played a role, as illustrated by the following excerpt:

> *'Her aunt was the first person to identify a man for her… but Mary's father was uninterested in him and sent him away. The second man was identified by her uncle's wife and this one was also sent away as he was so ugly. The third one was identified by a certain man in the same village, but after making enquiries about him, they learnt he was related to her family and again that he had married several women. The fourth partner was identified by her aunt who was married in Masaka town. He was a good man, but he wanted a small occasion, as he didn't have money. The Mary's father said that his daughter was the first born and that he wanted her to get married in a ceremonial way. The fifth man was identified by her uncle (father's brother) and he is the one she who married her* (transcript notes from interview with Betty, woman, age 66, rural area).

The 'cultural management' of gender roles, sex and sexuality

The practice of early marriage, bride-price, and the prioritisation of boys' education over girls' are all indicative of socio-cultural power structures limiting women's physical, psychological and emotional agency. Some of the older women interviewed described ways in which their behaviour was shaped by the expectations of others throughout their lifetimes, particularly family members:

> *'[My] father had strong principles at home which we had to follow and obey otherwise we could face problems with him [when there was] failure to do what he wanted…. My mother was a good lady who was always counselling me to keep silent and avoid answering my father'* (Noelina, woman, age 74, rural area).

> *'…she got married but her marriage was unstable. She had many miscarriages which made her annoyed and thought the cause was from her husband who was so promiscuous… She told me that her stepmother refused to let her go to school. She was always pointing to her to get married and it is the reason she got married at the age of 16* (transcript notes from interview with Matilda, woman, age 70, rural area).

As highlighted older female relatives may play a key role in encouraging younger women to conform to expectations of submissiveness and to fulfil desired gender norms. These tendencies can be shaped by multiple factors, including an attempt to maintain a 'peaceful' household as in the first quote, or perhaps to ensure less competition for resources, as in the second quote.

Reporting on sexual practices revealed how gender relations and socio-cultural norms may have driven HIV transmission over time. Several men and in fewer cases women reported that they have had concurrent sexual partners during their marriages. In many cases they also

reported that their partners had had other sexual partners throughout their marriage. Nevertheless, both women and men expressed the feeling that extra-marital sexual relations by their partners constituted an abuse of their marriage relationship. Men, however, tended to justify their affairs by explaining that such behaviour is 'normal' for them and often appeared to maintain some sense of pride through their past sexual exploits as the following quotes illustrate:

> *'I was good at giving, sometimes I could be on my way and turn off to any home to get fire for my cigarette and whenever I saw there a woman I could talk to her the words of love and give her something… and I was always chanceful'* (Francis, man, age 79, rural area).

> *'He had never got another formal marriage but he had cheated with another partner which caused quarrels in the home when his wife knew about it. He said that naturally it was unavoidable for a man to live without "peeping at a woman through the window"'* (Dominic, man, age 68, rural area).

Several men and women described experiencing lower desire for sex as they aged. Women's and men's perceptions of the sexual behaviours of the opposite sex differed considerably in this area. For example, women in FGDs repeatedly complained that while their own sexual desires had diminished, men's continued sexual desire into old age was problematic and demonstrated men's 'immaturity'. Men in FGDs, however, expressed a sense of identity loss due to the fact that their sexual abilities had reduced. This was also demonstrated by men's expressed fear that women would seek younger partners for their sexual fulfilment. It was difficult to ascertain whether men's and women's narratives about their current sexual relations could be relied upon, nevertheless, it was clear that sexual desire, or lack thereof, is integral to the cultural management of gender and sexual relations. A major finding from these conflicting viewpoints is that older men and women conceptualise sex as an intrinsic aspect of male and female identities and behaviours, although they differ in their perceptions of the meaning and causes of men's sexual 'frustration' and women's sexual 'denial'.

Sex, gender and gender-based violence

The cultural expectations mediating sexual relations provide insight into constructions of sexually 'assertive' masculinities and 'submissive' femininities. The study revealed further insights into the cultural management of gender roles where women described how men took advantage of their more powerful position in marriage:

> *'Mary narrates that she stayed with her husband for 17 years and bore only 2 children, a boy and a girl. But during their marriage… her husband was adulterous and a drunkard [so] that whenever he would come back home late, he would beat and abuse her so much'* (transcript notes from interview with Mary, woman, age 60, urban area).

> *'Teddy mentioned that in her marriage to KL she had so many challenges which included the man beating her, especially after taking a lot of alcohol. The man also used so many women outside marriage which made Teddy worry'* (transcript notes from interview with Teddy, age 69, rural area).

These reports of violence and abuse were not reported in every case, but illustrate how cultural expectations about women's and men's roles may be reinforced through violent means. Several women interviewed individually reported experiencing different forms of violence including physical, sexual and psychological.

Fewer reports of violence by men were recorded. One man, Nicholas, did admit to using violence within his marriage in the context of disagreements about money. Nicholas described how, at times when he refused to give money to his wife, she would deny him sex. He demonstrated anger that his wife would deny him sex and explained that he did not always give her the money she wanted because "she was extravagant". When probed about the outcome of an ongoing disagreement between them, the man explained that sometimes he would '*give her what she had asked for*' while at other times he would '*apply force*'. This demonstrates the level of entitlement that this man experiences in relation to his finances, his wife's sexuality and his wife's autonomy.

Women who reported violence at the hands of their husbands most often related this to their husband's consumption of alcohol or to disagreements over their relationships with other women or co-wives. FGDs emphasised the likely causes and consequences of violence among older women and men. A view held by both women and men was that men's sexual desire was likely to continue into old age while women's was more likely to diminish, which could lead to sexual violence if women denied their husbands' sex. However, while women said that most violence was not reported, saying: '*You just keep silent*', men felt that women were more able to report violence now than in the past, as the following quote from an FGD participant shows:

> *'Those days you would use a woman in any way and you would not be answerable to anyone but these days women are free to report when they perceive a situation as sexual violence'* (FGD with men, urban area).

A man in the rural FGD even suggested that women's expanded legal rights may have increased violence perpetrated by women themselves, although individual men did not disclose experiences of violence by their female partners:

> *'The laws have caused violence in homes because women are given the chance to share family riches. A woman may wish her husband dead so that she can remain with all the belongings of the family… All the things in the home are split because the women are very much supported by the Uganda Association of Women Lawyers'* (FGD with men, rural area).

It is striking that men perceived that women have increased freedom to report violence successfully while women claimed that they were still unlikely to report violence. This perception is also contradicted by the cases of women interviewed for this study who had experienced

violence and yet had not reported it to any authorities, even where this had occurred in the recent past. While gender-based violence is a recognised risk factor associated with HIV, it is unlikely that older women are in a position to either report violence or access health or other services to receive appropriate care and advice. Organisations and government services working to address gender-based violence need to consider how to work with older women and men, as survivors and perpetrators of violence.

Conclusion

Others have highlighted the need for intersectional analysis to explore how gender interacts with other social factors such as age, social and economic inequalities, social norms and moralities, and legal and political frameworks, to increase vulnerability to HIV in different contexts (Rao Gupta et al. 2008, Tolhurst et al. 2012). Our analysis of older people's experiences used a socio-historical lens to explore how past experiences of structural factors shape current gendered realities highlighting the importance of considering multiple dimensions of older women's and men's experiences.

The interviews demonstrated how socio-historical gendered factors have exerted pressure on women's and men's decisions about education, marriage, employment and sexual relations over their lifetimes. In combination with cross-cutting dimensions of their status and age, these factors shape HIV risk and vulnerability for the older people we interviewed. The data showed how the ageing process has led to even greater constraints for some older people in relation to their access to HIV services. These findings concur with recent research on older people living with HIV in Uganda which highlights the 'double stigma' experienced by older people in relation to HIV (Kuteesa et al. 2012).

Women are often in a particularly precarious position due to disparities in access to resources and decision-making power. Contributing to this disparity between women's and men's position is the way in which gender roles, sex and sexuality are culturally managed. The 'cultural management' of women and men's roles is illustrated in the attitudes and perceptions about men's and women's sexuality, their sexual behaviour and their experiences of violence. These insights contribute to addressing gaps in our understanding of the sexual behaviour and practices of older people, an area highlighted in earlier research as critical to our ability to develop tailored interventions to this population (Negin and Cumming 2010).

Gender-based violence is reported mostly by women and often downplayed by men. Research has demonstrated links between this type of violence and HIV (Rao Gupta 2002, Dunkle et al. 2004), but there has been little focus on older people' experiences of violence, as survivors or as perpetrators. Older women experiencing gender-based violence are at greater risk of HIV transmission and are at a greater disadvantage in terms of their ability to negotiate access to health services.

Although we have emphasised that our interest in older people needs to move beyond a focus on their caring role, we must point out that many older people have a strong sense of responsibility about caring for other family members. Their battles with social and economic isolation present huge barriers to their role as carers. A recent paper exploring experiences of despondency among older people in the Ugandan context has also underlined the psychological burden that such care entails (Wright et al. 2012). Older carers have serious care needs which are often unmet, either by family members or by state or community support networks. Research must seek opportunities to support older people in their roles as carers and to broaden this lens to develop policies and practices sensitive to the wide range of challenges faced by older people, not least in relation to HIV prevention and services.

Notes

[1] These insights were generated through discussions and critique developed at the HIV and Ageing Workshop, one of the official pre-conference events of ICASA 2011 organised by HelpAge International where the authors participated in the early stages of this research project.

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