Addressing the links between gender-based violence and HIV in the Great Lakes region.

Country report: Tanzania
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Adressing the links between Gender-Based Violence and HIV in the Great Lakes region.


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Acknowledgments

This study was commissioned by UNESCO to provide policy-relevant research on links between gender-based violence (GBV) and HIV and AIDS in conflict and post-conflict situations in the Great Lakes Region in order to fill identified gaps in existing research and to assist governments in developing and implementing their national action plans and strategies on prevention of gender-based violence and on HIV and AIDS. Special thanks go to Dr Ester Steven, Ms Bathsheba Mahenge for their preliminary participation in preparing the zero draft. I also extend my gratitude to Dr Elizabeth Amuli for tireless efforts of reviewing number of documents that were used in this study. We would like to thank number of individuals from the government and nongovernmental organizations who were willing to provider their time and materials for this study.
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<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
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<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HINARI</td>
<td>Health InterNetwork Access to Research Initiative</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>LMA</td>
<td>Law of Marriage Act</td>
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<tr>
<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TCAIDS</td>
<td>Tanzania Commission for AIDS</td>
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<tr>
<td>TDHS</td>
<td>Tanzania Demographic and Health Survey</td>
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<tr>
<td>THMIS</td>
<td>Tanzania HIV, Malaria Indicator Survey</td>
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<td>TPFNET</td>
<td>Tanzania Police Female Network</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations AIDS</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children XXX Fund</td>
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<tr>
<td>USAID</td>
<td>United States AID</td>
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<td>WHO</td>
<td>World Health organization</td>
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Gender-based violence and HIV are both significant health and human rights concerns. The two epidemics overlap and intersect in complex ways which have not yet been fully mapped or understood. A thorough understanding of these intersections is however, vital for planning adequate policy responses to GBV and HIV. In 2010 sub-Saharan Africa accounted for 70% of new HIV infections globally\(^2\). Girls and women represent 59% of those living with HIV in sub-Saharan Africa and continue to be more vulnerable to new infection because of social, political, cultural and economic gender inequalities\(^3,4\). According to evidence from Africa, among young women gender inequality within a relationship increases the risk of infection by 13.9%. GBV involving sexual violence is closely associated with HIV transmission, particularly in high-prevalence countries. Male perpetrators of violence may engage in behaviours with a high risk of HIV transmission such as not using condoms and having sex with multiple partners. In addition, evidence from research suggests that GBV, or the fear of GBV may interfere with the ability to negotiate safer sex, or to refuse unwanted sex. GBV may also interfere with the ability to access treatment and care, and the ability to maintain adherence to ARV treatment. Evidence also exists that living with HIV may constitute a risk factor for experiencing GBV, with an increase in violence following disclosure of HIV status, or even following disclosure that HIV testing has been sought. Fears of experiencing violence may potentially delay a person’s decision to disclose her HIV status and seek treatment when necessary. Conflict and emergency situations may affect the intersections of GBV and HIV. Violence against women, particularly sexual violence, is widespread in conflict and post-conflict settings. In such situations, women and girls face increased risks of acquiring STI and HIV by: Direct transmission through rape; being placed in situations where they may be forced to exchange sex for survival; Experiencing increased levels of overall violence including intimate partner violence, which in turn, makes it difficult for them to negotiate safe sex in their relationships. In addition it may often be more difficult for girls and women in these situations to access adequate healthcare and treatment. There is an urgent need for identifying, testing and implementing effective strategies for integrating programs that address both violence against women and HIV prevention and AIDS treatment and care in conflict settings. Although there is research on the links between GBV and HIV, important gaps still remain both with regard to the conceptualization of the links between GBV and HIV and the interventions and policies designed to address them. In particular the following areas

\(^2\) UNAIDS World AIDS Day Report | 2011
\(^3\) Report of the Secretary-General on Women, the Girl Child and HIV and AIDS
\(^4\) UN Secretary General, Ban Ki-Moon, reporting to the 56th Commission on the Status of Women on women, the girl child and HIV and AIDS
remain under-researched: More research needs to be done in conflict and emergency situations and in situations of post-conflict where rape and sexual violence are often reported to be high, and interventions to address the intersections between GBV and HIV are lacking. Further investigation is needed around the potential causal or catalyst relationship between conflict settings and HIV and GBV. The “perpetuating cycle” between GBV and HIV needs to be further researched in terms of the two way causal relationships that exist between the two epidemics. Research is needed which pays greater attention to how gender is locally constructed and defined to enable a full understanding of how the epidemics are linked and can be jointly addressed. Research should provide analysis of social constructions of gender and how these can exacerbate vulnerabilities to GBV and HIV. More research needs to be done to provide recommendations on how men can be engaged as agents of change with regard to prevention of GBV and HIV.

Introduction

Human immune-deficiency virus (HIV) infection and Gender Based Violence (GBV) are two major epidemics of public health concern especially in Sub Saharan Africa. In nearly 30 years since HIV has been noted as a global crisis more women than men are shown to be affected in the Sub Saharan countries data. In the region women constitute 58 % of all people living with HIV/AIDS. Among young people aged 15-24, the HIV prevalence rate for young women is twice that of young men (UNAIDS World AIDS Day Report 2012)

Gender Based Violence in its many forms, is a serious endemic which cuts across age, class, culture and nationalities. Girls and women are the most visible group but they are not the only victims, children of both sexes, the handicapped and other minority groups are also affected (Population Council, 2008). GBV may have severe effects on a victim, literatures exposes it as a cause of ill health among the victims, seen through death and disabilities due to injuries, and through increased vulnerability to a range of physical and mental health problems (Krug et al., 2002; Mugawe & Powell, 2006). Not only that, it has been reported that female survivors are more at risk of unwanted pregnancies, reproductive tract infections having multiples partners and less use of condoms (IFPP, 2004; Campbell & Self, 2004). The World Bank’s Gender and Development Group describe violence as, although not limited to this:

- Physical violence (slapping, kicking, hitting, or use of weapons)
- Emotional violence (systematic humiliation, controlling behaviors, degrading treatment, threats)
• Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating)
• Economic violence (restricting access to financial or other resources with the purpose of controlling a person).

According to Heise (1994) Gender Based Violence may occur at any time during a person’s life span for example: violence may be in forms of prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war), in infancy violence may take place in forms of female infanticide, emotional and physical abuse, differential access to food and medical care. In childhood violence may take place as genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution. In adolescence may be in forms of dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, and forced prostitution. For those in reproductive age abuse may be by an intimate partner, through marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, and abuse of women with disabilities. In the elderly violence may take place as abuse of old men and women.

Objectives

Main Objective
The objective of this assignment is to provide policy-relevant research on links between gender-based violence (GBV) and HIV and AIDS in conflict and post-conflict situations in the Great Lakes Region in order to fill identified gaps in existing research and to assist Tanzania Governments in developing and implementing national action plans and strategies on prevention of gender-based violence and on HIV and AIDS.

Specific Objectives
- Give background information on the HIV/AIDS epidemic in Tanzania, including latest sex disaggregated data on HIV infection rates and prevalence
- Elucidate the background information and data on prevalence and form of Gender based Violence in Tanzanian
- Highlight background information on the regional or national conflicts present in Tanzania
• Highlight information on existing government policies and action plans to prevent GBV and HIV and analysis of the state of implementation / effectiveness on the policies
• Analyse the evidence links between GBV and HIV/AIDS
• Analyse the socioeconomic and socio cultural structures underlying the epidemics
• Catalogue and analyse any existing programs to engage men and boys in prevention of both GBV and HIV
• To provide recommendation on policies and strategies for prevent of GBV and HIV

1.1. Research Questions

• What’s the latest’s prevalence of HIV/AIDS in Tanzania?
• What is the infection rate of HIV in the country?
• What is the prevalence of GBV in Tanzania?
• What are the forms of GBV present in Tanzania?
• Are there regional or national conflicts in Tanzania?
• What are the legislation and policies in place in the prevention of GBV and HIV in Tanzania?
• What are the links between GBV and HIV/AIDS?
• What are the socioeconomic and socio cultural structures underlying the epidemics in Tanzania?

Methods

Description of the study

Basically this study had two major parts. The first part was to review the existing documents in Tanzania to be able to describe situation of HIV and GBV, understand the government and other stakeholder’s efforts in prevention and response GBV services at different levels, and policies and other related documents on the two epidemics. The second part was to analyze the link between GBV and HIV as well as socioeconomic and socio cultural structures underlying the epidemics. In the first descriptive part, a number of documents were reviewed and most were not in the peer reviewed articles. In the second part published data including peer reviewed articles were searched. The main focus was get studies from Tanzania but other studies were included to shed light on the underlying questions.

Study design and source of data

This study was designed to make use of the evidence using a standard systematic review methodology. A step by step review of existing secondary data mostly quantitative from different sources was employed. Data was assessed for information in any one of the
following; prevalence of HIV, prevalence of different forms of GBV, regional or national conflicts present in Tanzania, existing government policies and implementation actions on GBV and HIV prevention, the evidence of the link between HIV and GBV, social economic and social cultural structures underlying the GBV and HIV and cataloguing of existing programs of engaging men and boys in prevention of GBV and HIV. No primary research was carried out in this study.

Search strategy
Search of studies included in this analysis combined different ways from different sources including; official statistics collected by governments and their various agencies, bureaus, and departments, Technical Reports from completed or on-going research projects and conferences, Scholarly and trade journals, reference books, consultation with local experts; these included duty bearers of different sectors in the government in the areas of HIV and GBV, policy makers and implementers, some ministries focal persons, researchers, programmers, advocacy and nongovernmental organizations, Computerized databases, Internet search engines eg Cochrane Data base of systematic review, Google scholar, HINARI, PsychoINFO, Ovid MEDLINE, PubMed, CINAHL and PubMed Central for articles and abstracts. Manual searching of the reference lists of retrieved articles for potentially relevant articles and abstracts was also done. The search process will took place until 30th November, 2012.

Search terms
The following terms were entered into all computer databases: [ “HIV” OR “HIV prevalence” AND “GBV” OR “GBV prevalence” AND “Policies” OR “Policies on HIV” OR “Policies on GBV” AND “link between HIV and GBV” AND “programs engaging men and boys in HIV” OR “programs engaging men and boys in GBV” AND “social economic and social cultural structures underlying the HIV” OR “social economic and social cultural structures underlying the GBV”.

Definition and inclusion criteria
The quality of data was determined by assessing the source credentials, methods used of data collection and analysis, relevance of the reported material to this study, and if reference of the data and information are provided by the author. Two reviewers were identified to independently screen all the titles from the electronic search results. If the source of data was secondary the extractor checked if it accurately cover and report on the primary sources. The two reviewers independently assessed full articles and agreed on inclusion using a standardized form. Inclusion criteria; All studies, reports or any other relevant
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Information from Tanzania or wider aspect (regional/continental/worldwide) with some information for Tanzania. Exclusion criteria: Unmet quality criteria above.

Data extraction and analysis
Data was extracted from different sources from August 2012 through January 2013. A standardized form was developed and used specifically for this study to collect information on first author, year of publication, type of study (longitudinal or cross-sectional, quantitative or qualitative), study setting, sample size and gender composition. Additionally information was collected on any existing policies and government reports related to GBV and HIV, and any relevant actions planned or implemented in the country. The articles that will be cited will be those of quality to allow for sound conclusion. Data was extracted manually from the selected sources and coded according to pre formed themes. The data collected was then summarized into paragraphs.

Results

Background information on the HIV/AIDS epidemic in Tanzania

World and regional overview:
According to the 2011 UNAIDS report the total number of people living with HIV by the end of 2010 was estimated to be 34 million worldwide which is up by 17% from 2001. Out of the 33.4 million worldwide cases, there were 2.7 million people who were newly infected in 2008. There were also 1.8 million AIDS related deaths in 2010, a decline from a 2.2 million peak in the mid 2000s. The numbers are still high and alarming, it’s evident that AIDS remains a global epidemic (UNAIDS, 2011). Globally the proportion rate of women living with has remained stable at 50%, although more women are affected in Sub Saharan Africa and Caribbean at 58% and 53% respectively. There were 2.7 million [2.4 million–2.9 million] new HIV infections in 2010. It is further reported that in 2010 there were 2.7 million infections and 390000 among children. This figures were 15% less than in 2001 and 21% below the number of new infections at the peak of the epidemic in 1997(UNAIDS, 2011). Sub-Saharan Africa remains the hardest hit region, accounting for 68% of all people living with HIV globally. Sub-Saharan Africa also had 70% of all new HIV infections in 2010 compared to 71% in 2008(UNAIDS, 2011). The number of HIV new infections has declined by more than 26%(1.9 million) when compared to 2.6 million at the peak of the epidemic in 1997. In countries having the world’s largest prevalence like Ethiopia, Nigeria, South Africa ,Zambia and Zimbabwe, research indicates that HIV incidence has declined by more than 25% between 2001 and 2009(UNAIDS,2011)
Prevalence of HIV in Tanzania:

In Tanzania the number of people living with HIV is at 1.6 million where the prevalence for adults aged 15-49 is 5.8% of which 58.5% are women. 230,000 children are living with HIV and 1,300,000 children aged 0 – 17 were orphaned by the epidemic in Tanzania (UNAIDS 2011). Data from the third THMIS in 2011-2012 show that an overall of 5.1% of Tanzanians aged 15-49 are HIV infected, with women accounting for higher prevalence of HIV than men (6.2% versus 3.8%). However, there is a decrease in HIV prevalence amongst men and women between ages 15-49: from 5.7% in 2007-08 to 5.1% in 2011-12. HIV prevalence in women has declined from 6.6% to 6.2%; and among men there is a decline from 4.6% to 3.8%. The prevalence of HIV is higher in urban areas (7%), compared to rural areas which account for 4%, and is higher in Tanzania mainland (5%) than in Zanzibar (1%). Trend show that HIV prevalence increases by age whereby HIV prevalence is higher among women aged 45 – 49 (10%) and lowest in age 15-19 (1.3%), and in men there is an increase in 7%, whereby it is higher in age 40 – 44 (7.1%) and lowest in age 15 – 19 (0.8%). Data show that HIV prevalence is higher in divorced women (15.2%) than in divorced men (8.9%) but the prevalence is the same (5%) for both men and women who are currently married or living with a partner. HIV prevalence is higher in uncircumcised men than those who reported being circumcised (5% versus 3%), and among men aged 35-39, the prevalence is higher in uncircumcised than circumcised (5.5% versus 11.3%). Trend show that prevalence generally increases by age in both circumcised and uncircumcised men whereby in circumcised men, it is lower in age 15 – 19 than age 45-49 (1.1% versus 5.9%) and higher in (5.9%). For uncircumcised men, it is lower in age 15 – 19 than age 35-39 (0.1% versus 11.3%)5. HIV/AIDS morbidity and mortality of women and men in their prime years of productivity has had a serious social and economic impact on all sectors, and at community and individual levels. Overall, 2.0% of young women and men age 15-24 are HIV-positive.

**HIV prevalence among young women is higher than among young men, particularly for youth age 23-24 where women are more than twice as likely to be infected as men (6.6% versus 2.8%)(THMIS 2012)**

Prevalence and forms of Gender based Violence in Tanzania

**Overview**

Worldwide, the prevalence of lifetime experiences of physical and sexual intimate partner violence is estimated to range from 15 % to 71 %, with one to 28 % of women reporting intimate partner violence during pregnancy (García-Moreno, Jansen et al. 2005; Devries,

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5 Tanzania HIV and Malaria Indicator Survey 2011 – 2012 (THMIS III)
Kishor et al. 2010). The South African DHS (1998) reported that 7 % of 15-19 year-olds had been assaulted in the past 12 months by a current or ex-partner; and 10 % of 15-19 year-olds were forced or persuaded to have sex against their will. The Zambian, DHS data indicate that 27 % of ever-married women reported being beaten by their spouse/partner in the past year; this rate reaches 33 % of 15-19 year-olds and 35 % of 20-24 year-olds. 59 % of Zambian women have ever experienced any violence since the age of 15 years (Kishor & Johnson, 2004). Women in the age group of 15-49 years in Kenya, 43% reported having experienced some form of gender based violence in their lifetime, with 29% reporting an experience in the previous year; 16% of women reported having ever been sexually abused, and for 13%, this had happened in the last year prior to the particular study (Kenya DHS, 2003).

Gender based violence situation in Tanzania

There are a number of studies conducted in Tanzania informing on the magnitude of gender based violence. The human rights report on Tanzania (2006) indicates Mara is the region with highest case reports on GBV. This may indicate the inhabitants are more likely to report the incident of GBV as compared to other regions in the country. WHO multicountry study was one of its kinds in Tanzania which did shed light on the magnitude and nature of gender based violence in the country. Recently, two important national surveys were done in Tanzania. The Tanzania Demographic and Health survey for the first time included a module on gender based violence and reported on different forms of violence across different regions. The national survey on violence against children was the first to be conducted in Africa and revealed horrifying figures of different forms of child abuse in Tanzania.

WHO Multicountry study on Women Health and domestic violence

The WHO study on women’s health and domestic violence was done in number of countries and Tanzania was the 11th to be included. This study established that gender based violence and violence against women in particular are prevalent across Tanzania. This study (n=3270) found that 41% per cent and 55% of ever-partnered women in Dar es Salaam and Mbeya respectively had experienced various forms of violence. In some areas 15 to 71% of the women reported physical or sexual violence by a husband or partner. It was also found that 30.7% and 23% of ever partnered women reported to experience sexual violence in their life time in Mbeya and Dar es Salaam respectively. The same study indicated that 15% of women reported to encounter forced sex at first sexual debut. About twelve per cent of women reported being ever experience physically violence during pregnancy.
Tanzania Demographic and Health Survey:

**Overall:** Tanzania Health and Demographic survey included a survey of gender based violence for the first time. This research was conducted in all regions of both Tanzania mainland as well as Zanzibar assessing physical, sexual violence and other forms of violence. The results of this study revealed that almost half (45%) of Tanzanian women age 15-49 have experienced physical or sexual violence. The study revealed regional prevalence variations of gender based violence. While Mara (72%) and Dodoma (71%) were shown to have high level of physical and sexual violence, Unguja (7%) and Pemba (5%) were the least.

**Physical violence:** TDHS shows that thirty nine percent of women age 15-49 have ever experienced physical violence since age 15, and almost one-third of women (33 percent) age 15-49 have experienced physical violence in the previous 12 months. Most of these women who have experienced physical violence report that a husband, partner, or boyfriend committed the violence. The likelihood of experiencing physical violence increases with the woman’s age, from 13 percent for women age 15-19 to 25 percent for women age 25-29.

**Sexual violence:** TDHS found that 20 percent of women report to have ever experienced sexual violence. Over one third of women who are divorced, separated, or widowed have experienced sexual violence, compared with only 22 percent of women who are currently married and 11 percent of never-married women. Further analysis by zones indicates that the highest prevalence of sexual violence is in Southern Highlands (29 per cent). From the survey the age of sexual debut for 58% of women between the ages of 15-24 in mainland was before 18 years.

**Controlling behavior:** In TDHS reported that most commonly reported controlling behavior exhibited by husbands/partners is to be jealous or angry when the woman talks to other men (66 percent). Almost half (49 percent) report that their husbands insist on knowing where they are at all times, 16 percent say their husbands do not trust them with money, 32 percent frequently accuse them of being unfaithful, and 20 percent do not permit them to meet their female friends.

**Marital violence:** TDHS shows that one in two ever-married women age 15-49 report having experienced one or a combination of the three types of violence—
emotional, physical and sexual violence. Furthermore, 39 percent of ever-married women age 15-49 have ever experienced physical abuse perpetrated by their current or former husbands, 17 percent experienced sexual violence, and 36 percent experienced emotional violence. Almost half (44%) of ever-married women have experienced some form of physical and/or sexual violence, and 13 percent have experienced both physical and sexual violence. Frequency of spousal violence is an indication of the extent to which domestic violence is a current or recurring problem for Tanzanian women. 88 percent of women who have ever experienced emotional violence by their husbands experienced such violence in the 12 months preceding the survey; 33 percent experienced emotional abuse often and 55 percent sometimes experienced emotional abuse. Similarly, 85 percent of women who have experienced physical or sexual violence by their husbands experienced such violence in the 12 months preceding the survey; 30 percent experienced such violence often, and 56 percent experienced the abuse only sometimes.

**Female Genital Cutting/Mutilation:** In the TDHS 2010, the prevalence of female genital cutting appears to have dropped from 18% in 2006(TDHS) to 15%. GBV in forms of FGM had a prevalence of 15% 2010 TDHS with Manyara and Dodoma regions showing highest prevalence of 71% and 64% respectively.

**Violence against men:** TDHS also has indicated that women at some point may initiate violence. However it is only a fraction as when compared with violence initiated by men. Overall, 2 percent of ever-married women age 15-49 report that they have initiated physical violence against their current or most recent husband, and 2% say they committed such violence in the 12 months preceding the survey. The likelihood that a woman initiated physical violence against her husband has a direct association with her husband’s violent behavior. 5% of women who have also experienced spousal physical violence initiated violence against their spouse compared with 1% of women who did not experience physical violence. Urban women are twice as likely as rural women to initiate violent behavior against their husbands (4 and 2 percent, respectively). Disparities by zone indicate that the Eastern zone has the highest proportion of men experiencing violence at the hands of their partners.

**National Survey on Violence against children:**
The 2009 Tanzania Violence against Children Study (VACS) is the first national survey of violence against children in the United Republic of Tanzania. The study involved sample
(n=3,739) females and males, 13 to 24 years of age. Primary objective of the survey was to assess the magnitude of all forms (sexual, physical, and emotional) of violence against children (<18 years).

**Sexual violence:** The findings indicate that violence against children is a serious problem in Tanzania: nearly 3 in 10 females and approximately 1 in 7 males in Tanzania have experienced sexual violence prior to the age of 18.

**Physical violence:** Almost three-quarters of both females and males have experienced physical violence prior to 18 by an adult or intimate partner.

**Emotional Violence:** One-quarter of the respondents reported to have experienced emotional violence by an adult during childhood prior to turning 18.

Regional and National Conflicts in Tanzania

There are reports on regional conflicts in countries surrounding Tanzania. During the post-election violence in Kenya (2008), 40 percent of the women who were raped contracted HIV. GBV cases appear to have escalated during the riots: In one month, 337 women, 275 children, and 44 men were treated at the Gender Recovery Centre in Nairobi. A study to look into GBV related to post-election violence that was conducted in the Kibera slums—an area of Nairobi inhabited by about 1 million people and one of the largest slums in the world—found that the ages of rape survivors ranged from 25–68 years old—the majority in their 30s. GBV affected women of all ages. Interviews revealed that some of the survivors contracted HIV. (HDT 2011) A study done of HIV Infection Among Internally Displaced Women and Women Residing in River Populations Along the Congo River in the war torn Democratic Republic of Congo showed participants in the IDP population were more likely to report a history of sexual violence during the conflict compared to the river population (11.1 vs. 1%, P<0.01). (Andrea A. Kim et al 2009) Refugee camps set up in Tanzania due to surrounding regional conflicts show presence of GBV in such communities slightly more prevalent as compared to neighboring villages. At Lugufu, 20% of all camp respondents and 6% of those from villages had ever had transactional sex and 10% of refugees and 4% of nationals said that they had ever been forced to have sex against their will. (UNHCR 2005) Reports from law enforcement in Tabora indicate rape and murder cases are on the increase at Ulyankulu Refugees Settlements, as told to journalists during a UNHCR familiarization tour in May 2012.
Policies and action plans to prevent GBV and HIV in Tanzania

Policies and laws

Overview: The Tanzanian government has shown its commitment to address GBV issues by being a signatory to several international instruments related to GBV and gender: The Convention on the Elimination of all forms of Discrimination against Women (CEDAW, 1985), which has been instrumental in fighting the effects of discrimination, including violence; the Beijing Platform for Action (BPA, 1995), African Charter on Human and People’s Rights on the Rights of Women, and the SADC Protocol. Tanzania’s development priorities are spelled out in number of documents including the National Strategy for Growth and Poverty Reduction (NSGPR) which addresses HIV and gender as cross-cutting issues and is the first national strategy to have identified the need to address gender violence as a public policy issue. Tanzania has national policies and laws which affect women and men differently and even on certain areas contradict other existing laws. The traditions and customs that exist in our society play a role in inhibiting the freedom for those experiencing Gender Based Violence to report acts to the authorities that involve breaking the law and are liable to punishment.

While Tanzania has recently enacted the law of the child act to foster child protection, there is neither clear national law(s) on domestic violence or gender based violence.

The constitution of the United Republic of Tanzania

The Constitution of the United Republic of Tanzania, as amended in 1977 and subsequently amended in 2001, recognizes the universal rights of every human being. Article 13:6(e) stipulates that “no person shall be subjected to torture or inhuman or degrading punishment or treatment.”

The law of the marriage act:

The Law of Marriage Act Revised in 2002 places the minimum age for males to marry at 18 years but for females it is 15 years and the bride’s family are those to give consent for her marriage. This law also allows for polygamy which can further lead to maltreatment of the woman.

The law of the child act 2009:

The Law of the Child Act, 2009 does not contest the marriage age of 15 for females but clearly notes many other areas where a person under 18 years is not considered as adult.
Tanzania signed the African Charter for life and Welfare of the child in 1990 which recognises a 15 year old as a child.

**The Sexual Offenses Special Provision Act 1998:**
Other Laws such as the Sexual Offenses Special Provisions Act, 1998 does not recognise marital rape unless the couple is separated which also puts a woman at a higher risk of contracting HIV from her spouse if he were infected and having no legal support. There is limited protection for unmarried couples with many forms of GBV not included or described in the laws such as economic deprivation.

**The Anti-Human Trafficking Persons Act, 2008**
This law prohibits the solicitation of women and children for the purpose of forced labour, forced marriages and sexual exploitation yet this law is constantly overlooked due to social norms that encourage movements of women and children from rural to urban areas with promises of a better life and safe employment. The percentage of reported human trafficking increased from 5% before 2000 to 71% in a period between 2006 and 2008. Women, girls and young males were reported the main victims of HT (Kamazima, 2009)

**The HIV and AIDS Prevention and Control Act, 2008**
This law allows for voluntary testing for HIV of the pregnant woman and the partner responsible for the conception. The law also requires that the one with knowledge of being HIV infected immediately informs his or her sexual partner or spouse. Fear of rejection and cultural practices have made implementation of this difficult. Very few partners voluntarily escort their spouses. From TDHS 2010 9% of women reported physical violence during pregnancy.

**International laws**
Tanzania is a signatory to and ratified number international human rights laws and instruments related to gender and children.

**Tanzania National Health Policy 2007**
The National Health Policy aims to provide adequate health services to every Tanzanian including aspect of HIV prevention and response, but it does not adequately address GBV issues. Hence the Ministry of Health and Social Welfare took initiative to develop the National policy guidelines for health sector prevention and response to gender based violence in 2011.
Gender Development Policy of 2000: The MCDGC developed the Gender Development Policy (2000) to address gaps and inequalities between men and women.

National policy guidelines for health sector prevention and response to gender-based violence: Aims at Strengthen the MOHSW’s capacity to prevent and respond to GBV through providing a policy guideline to direct the health sector and establish effective linkages with the community and multisectoral actors.

Guidelines

National management guideline for health sector prevention and response to gender-based violence: The broad objective is to provide a framework for comprehensive medical management and referral of GBV survivors for pertinent services at all levels for both adults and children.

National Guidelines for the Integration and Operationalization of One Stop Centers for GBV and VAC (Violence Against Children) Services in Health Facility: The ultimate goal of this guideline is to spearhead the government efforts in curbing the impact of GBV and VAC in the society. Specifically, aims to Ensuring quality of care and sustainability through influencing local ownership, enhancing local partnership, collaboration and linkages in matters pertaining to GBV and VAC service provision. The guidelines provide guidance to personnel working within the OSC at health facilities and other service providers on how to assist GBV and VAC survivors in provision of medical, social and legal services in a holistic and well-coordinated manner. Number of One stop centres are about to be established in Dar es Salaam and Mwanza.


Action Plans and strategies

National Plan of Action to Prevent and Eradicate Violence against Women and Children 2001–2015: This action plan aims to eliminate related legal, social, economic, cultural, and political discrimination and exploitation targets the gaps on
existing laws by lobbying for amendments of certain laws such as LMA 1971 and changing mindsets of individuals as well as service providers.

**Gender operational plan for HIV response in Tanzania 2010-2012:** This plan that was put for a purpose of guiding TACAIDS and HIV and AIDS stakeholders at all levels in the provision of strategic information on HIV and AIDS with focus on gender issues. The decision to come up with this plan was after finding out that the main factors which fuel the spread and enhance negative impacts of HIV & AIDS in Tanzania Mainland include gender inequality, poverty, mobility, inadequate legal or policy framework, and harmful socio-cultural beliefs and practices. The priorities for Gender operational plan for HIV response in Tanzania are put on different thematic areas, and one of its thematic areas talks about Reduction of HIV infection among most vulnerable population and young girls and women are considered as the most vulnerable groups. One of the things they talk about is how men take advantage of their physical strength and in the sexual decision making to force women into sex. On another thematic area they talk about expansion of work place intervention whereby sexual harassment takes place in the formal and informal sectors where mostly women are forced into sexual intercourse in exchange for favors and employment, exposing them to the risk of HIV infection. In another sub theme the operational plan talks about continuum of care, treatment and support, Women in rural areas can and do access anti-retroviral drugs, However some of them face GBV at home and are forced to share drugs with their husbands who do not go for treatment, one of the strategy which was put was to Enhance gender sensitivity and friendliness of HIV & AIDS treatment and care which promotes men uptake.

**National strategy for gender development:** This strategy was put to enforce gender equality and equity in the country. Through this different strategies have been put down under the bases that empowering women will decrease and prevent GBV. One of the areas that were mention are in decision making and power whereby a plan to facilitate and support women in political participation and contest for election, amendment of marriage Act No. 5(1971) and law related to succession, inheritance and children’s rights and other discriminatory laws. On education, one of the strategies is to sensitize and motivate community members to participate in constructing and renovating schools for more girls and women to enroll in science subject. On training, girls and women are encouraged to take up non – traditional or male dominated trades, make information available in training opportunities. In
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National Plan of Action to Prevent and Respond to Violence against Children (2012-2015): The United Nations Secretary-General’s (UNSG) World Report on Violence against Children (2006) was the first and most comprehensive global study on all forms of violence. Among other things the report recommends that all States develop a multi-faceted and systematic framework to respond to violence against children which is integrated into national planning processes as well as develop a national research agenda on violence against children across settings where violence occurs. In responding to the recommendations, Tanzania was the second country to undertake A National Study on Violence against Children in Africa after Swaziland. A multisectoral Task Force was formed that included different MDAs, Development partners, Nongovernmental organizations (NGOs) and researcher. The task force forms a joint and collective effort which has guided the survey research, including data analysis, and the final technical report, but most importantly to steer the research into action in the form of this National Plan. It is due to strong and exemplary government leadership that it was possible to in analyze the survey data and to guide the response and build support for this comprehensive National Plan of Action to Prevent and Respond to Violence against Children. Sectoral roles were clearly outlines and framework for monitoring was set. Number of activities were already being undertaken by different actors. For example the police, over the past few years, has trained police from 94 stations and established pilot Gender and Children Desks (GCDs) to handle cases of violence against women and girls. Number of police officers across the country were trained on how to handle cases of child abuse and GBV. The enactment of the Law of the Child Act 2009 is a major milestone in creating a legal framework for the protection of children from violence. Within the existing curriculum, in-school youth are given lessons on HIV and AIDS and sexually transmitted infections (STIs), life skills, reproductive health and gender relations; As part of the overall health sector reform to improve the quality of clinical care, Gender Based Violence Policy Guidelines and GBV Medical Management Guidelines have been developed with specific protocols for the care and treatment of survivors of GBV and child abuse; number of regulations have been developed to operationalize the LCA(2009) framework for coordination of GBV and child abuse that is being formulated as well as funding mechanisms through local government authorities are under process.
Government response

The Tanzanian government has taken measures to address the subject of gender-based violence and HIV in the communities. Policies that address GBV have been included through trained ministerial gender focal points and even the Tanzanian Police Female Network (TPFNET) for reports on GBV at police stations. The government of Tanzania, particularly the Ministry of Health and Social Welfare, has played a crucial role in developing a number of guidelines and protocols to help the survivors of GBV and child abuse. On the other hand, the Ministry of Community Development, Gender, and Children has an important role in coordinating the national response to GBV and child abuse, despite the fact the speed in putting the coordination efforts has not matched with the pace of other MDAs.

According to MCDGC, a handful of promising interventions have been or are being implemented by NGOs but are limited in scope and numbers, for example in refugee settings in northwest Tanzania, the international Rescue Committee provides comprehensive GBV services including medical treatment, provision of post-exposure prophylaxis and emergency contraception, counseling and legal aid. Kivulini, an NGO in Mwanza conduct awareness raising advocacy and community mobilization with local government to help them reorganize their roles in responding to GBV and develop strategies to take action. Most of the strategies target community awareness on GBV and HIV/AIDS and on the available national wide services and laws that protect the vulnerable groups. Levels of knowledge by the vulnerable groups for both epidemics are low and existing protocols on response to especially GBV are minimal. PEPFAR launched its GBV initiative in May 2010 covering three countries, Tanzania, Mozambique, and Democratic Republic of Congo. The project in Tanzania focuses on three regions of Dar es Salaam, Iringa, and Mbeya to examine overall effectiveness and impact. The initiative aims at strengthening community based response and referral networks and provision of comprehensive services for survivors of GBV.

Evidence on links between GBV and HIV

There is a complex linkage between GBV and HIV with violence being both a risk factor for HIV acquisition as well as a consequence of being HIV infected. The first pathway from GBV to HIV is directly through the act of sexual assault. In this, genital and anal trauma that occurs in unwanted or forced sex serves as a pathway for the virus. Biologically, women are
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More vulnerable to infection and forced sex further increases the risk of HIV transmission to women due to tears and lacerations, especially in adolescent girls. Violence increases the risk of HIV infection in women as a result of physiological and psychological reasons. Uninfected women are about twice as likely to contract HIV from infected men as vice versa. On the other hand, women report fearing discrimination, physical violence, and rejection by their family if they disclose their HIV-positive status.

GBV and Risk of HIV

Four reviewed studies indicated association/risk of acquiring HIV infection and gender-based violence. None of these studies were randomized clinical trials to determine causal pathways. In Tanzania, a community-based sample of 951 men were interviewed, of whom 360 had sex in the past 6 months and were included in these analyses. Almost a third of the men (29.2%) reported that they had been physically violent at least once with an intimate partner. Men who reported more lifetime sexual partners (OR = 8.75; 95% CI = 2.65, 28.92), experienced physical violence as a child at home (OR = 1.73; 95% CI = 1.09, 2.76), and were more educated (OR = 1.91; 95% CI = 1.18, 3.11) were significantly more likely to report perpetrating violence. These associations persisted after adjusting for other variables. These data from the perspective of young men reinforce earlier findings from women that HIV risk and violence are occurring together in relationships of young adults. Second study was done in Tanzania used qualitative method to understand the role violence plays in the sexual relationships of young people. This study found that participants described complex interactions among violence, forced sex and infidelity in their sexual relationships. Men who were violent toward female partners also frequently described forced sex and sexual infidelity in these partnerships. Men with multiple concurrent sexual partners reported becoming violent when their female partners questioned their fidelity, and reported forcing regular partners to have sex when these partners resisted their sexual advances. Youth who felt that violence and forced sex could not be justified under any circumstances were often those who had not yet initiated sexual relationships or who were in monogamous partnerships. The third study: Stepping Stones - baseline data from men enrolling in a randomized controlled trial of the behavioral intervention was done to examine associations between the perpetration of intimate partner violence and HIV risk behavior among young men in rural South Africa, they found that A total of 31.8% of men reported the perpetration of physical or sexual violence against female main partners. Perpetration was correlated with higher numbers of past year and lifetime sexual partners, more recent intercourse, and a

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12 Dunkle K. et al. (2006)
greater likelihood of reporting casual sex partners, problematic substance use, sexual assault of non-partners, and transactional sex. Men who reported both physical and sexual violence against a partner, perpetration both before and within the past 12 months, and more than one episode of perpetration reported significantly higher levels of HIV risk behavior than men who reported less severe or less frequent perpetration of violence. Fourth study was done in India - cross-sectional study was to characterize similarities and differences in the relationships, psychological well-being, and sexual behaviors among Indian women (N=459). Both HIV positive (N=216) and negative (N=243) women from urban and rural areas in India were included in this study. Chi-square, analysis of variance, and logistic regression analyses revealed that in both geographic groups, HIV-positive women were significantly more likely to report marital dissatisfaction, a history of forced sex, domestic violence, depressive symptoms and husband’s extra marital sex when compared to the HIV-negative women.13.

GBV or the threat of violence may prevent women from being able to practice safer sex. Lack of negotiating skills, fear of sexual violence, partner refusal to use condoms and lack of control over their partner’s sexual behaviors were barriers for them to practice safe sex. 14

Child Sexual Abuse and the risk of Acquiring HIV

Two studies were reviewed on Child Sexual Abuse and the risk of Acquiring HIV. Child sexual abuse is an important facet of GBV with implications for HIV risk and vulnerability. Individuals who have been assaulted in childhood may later exhibit a pattern of sexual risk taking. 15 Individuals who experience a coerced sex in their childhood may have an increased risk of acquiring HIV or other STIs as adults. This study examined differential effects of forced, consensual, and no childhood sexual experiences (CSE) on health outcomes among a probability sample of adult men who have sex with men (MSM). The forced sex group had the highest levels of psychological distress, substance use, and HIV risk 16

HIV seropositivity and the risk of Experiencing GBV

HIV seropositivity may be associated with heightened risk of GBV First study was done in India17 aiming at assess the relationship between experiencing IPV and the occurrence of HIV infection in a nationally representative sample of married Indian women tested for HIV.

15 Cohen M et al. (2000)
16 Arreola S. et al. (2008)
The National Family Health Survey was conducted across all Indian states in 2005 through 2006. The nationally representative sample included 124,385 married women; analyses conducted in 2007 and 2008 were limited to 28,139 married women who provided IPV data and HIV test results via systematic selection into respective subsamples. They found that, One-third of married Indian women (35.49%) reported experiencing physical IPV with or without sexual violence from their husbands; 7.68% reported both physical and sexual IPV, and 27.80% reported experiencing physical IPV in the absence of sexual violence. Approximately 1 in 450 women (0.22%) tested positive for HIV. In adjusted models, married Indian women experiencing both physical and sexual violence from husbands demonstrated elevated HIV infection prevalence vs those not experiencing IPV (0.73% vs 0.19%; adjusted OR, 3.92; 95% CI, 1.41-10.94; P = .01). Physical IPV alone was not associated with risk of HIV infection. Women's personal sexual risk behaviors were not associated with HIV infection. Second study was done in Tanzanian including 245 HIV positive women who were found that the odds of reporting at least one violent act was significantly higher among HIV-positive women than among HIV – negative women. GBV or the fear of violence can potentially delay a woman's decision to disclose her HIV status. Barriers to disclosure identified by women in developing countries included fear of accusations of infidelity, abandonment, discrimination and violence. Between 3.5% and 14.6% of women reported experiencing a violent reaction from a partner following disclosure. GBV may negatively influence adherence because it can prevent women from accessing health services. Abusive partners are sometimes reported to sabotage women’s efforts to seek care, keep appointments or take medications.

Socio economic and socio cultural structures influencing HIV and GBV in Tanzania

The overall economic impact of HIV/AIDS is difficult to establish. The World Bank estimates a reduction of average real GDP growth rate in the period 1985-2010 from 3.9 per cent without AIDS to between 2.8 and 3.3 with AIDS. The traditional male dominated gender relations and poor economic opportunities impact negatively on the capacities of girls and women to determine their sexual relations. Thus making them more vulnerable to HIV infection. In southern Africa, gender inequalities and livelihood insecurity are two important drivers of HIV for young people, particularly if the two overlap. Hence, HIV

18 Maman et al. (2002)
20 Lichtenstein B.(2006)
22 Dworkin S. (2007)
24 Campbell C (2010)
Interventions are looking to amend these structural factors. A randomized control trial of income enhancement and gender training reduced GBV and HIV risk behaviours, and a trial of a learning program reported a non-significant reduction in HIV incidence and reduction of male risk behaviours\textsuperscript{25}.

Existing programs to engage men and boys in preventing HIV and GBV

The Government of Tanzania along with local and international organization has cited the importance of involving men and boys in the fight against gender based violence. Within the government, behavior change strategies in the health sector have shown that inequitable gender attitudes by men (and women) can be unlearned and that doing so can contribute to healthier relationships. Focusing initiatives on girls as “survivors” to be protected without addressing patriarchal attitudes and behavior among boys simply reinforces the notion that gender-based violence is acceptable. Throughout society and the community in general, men are often leaders and have the power to pave the way for change. MenEngage, a newly formed network of organizations seeking to further engage men in family health programs and policies, is a potential resource to mobilize men and boys against GBV. (USAID,2008). One good example is the CHAMPION project (Channeling Men’s Positive Involvement in the National response to HIV and AIDS ) lead by Engender Health in Tanzania which aims to promote dialogues about men’s roles in HIV and reproductive health including community GBV sensitization and prevention. The program has adapted Engender Health’s global “Men as Partners” curriculum and mended with the SASA approach on community engagement in GBV prevention.\textsuperscript{26}

\textsuperscript{25} Andersson N (2008)

\textsuperscript{26} Fleischman J.(2012)
Conclusion

Prevalence of HIV and GBV in Tanzania is high. In responding to HIV and GBV, the Government of Tanzania in collaboration with other stakeholders has taken considerable efforts to prevent and respond to both pandemics. This is evidenced by the facts that Tanzania is a signatory to a number of international documents and instruments. More importantly, there is some existing policies on GBV and HIV, enacted laws, developed guidelines, action plans and strategies to address the same. The multitude of evidence in the research reviewed demonstrates existence of links between gender-based violence and HIV. Additionally, there is paucity though consistent evidence regarding the association of Gender based violence with either HIV-positive status or HIV risk behaviors. There is no clinical trial that was found to elucidate the casual pathways. Poverty and gender inequality were found to be structural factors influencing HIV and GBV in Sub Saharan Africa. Given the urgency of the HIV and GBV pandemics and its impact on women’s health, the evidence of links between GBV and HIV merit inclusion of GBV programming in HIV prevention and response services as well as a call for further research on the topic to inform development of cultural and context appropriate interventions.

Recommendations

1. A policy shift is essential to further mainstream GBV issues and different key sectors to also include structural component.

2. HIV interventions must factor in the link between GBV and HIV and hence reduction of gender based violence should be part of HIV prevention programs.

3. More methodologically rigorous research is needed to further inform the causal pathways and other culturally relevant seropositivity and HIV risk behaviour.
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