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

Country report: Uganda
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Uganda at a Glance: Selected Key Indicators

- Success story in drastically reducing HIV prevalence from 18.5 in 1990s to 5% in 2002. But infection rates going up again to 6.5%
- Poverty fell from 60% in 2005 to 45% in 2009/10
- Gender Parity in net primary School enrolment
- Women in parliament –31.5% in 2011 up from 12% in 1990
- Share of women wage employment in non agricultural sector 39%
- 87% of the population lived in rural areas in 2010
- Life expectancy at birth 54.54 years (females), 52.4 years (males)
- Access to improved water source increased from 43% in 1990 to 72% in 2010
- Per capita income of US $ 506
- Ranked 161 out of 187 countries on 2012 Human Development Index
- Has gone through major civil wars Amin1979, NRM 1980-85 and LRA (1986-2005)
- Only 12 % of households use electricity for lighting
- Maternal mortality stands at 438 per 100,000 live births up from 435 in 2006
- Infant Mortality stood at 54 per 1,000 live births in 2011, down from 76 in 2006.
- Literacy rates: 76.8 (male) and 57.7% (females) 2002 Population census

1.0 Introduction

Uganda has braved a severe and devastating epidemic of HIV infection and AIDS since the 1980s (RoU, 2006). The virus was first discovered (Sero-behavioral Survey) in 1980 and by the 1990s, the HIV had reached all districts in Uganda, from its epicenter in Rakai district. It was soon to be classified as a generalized epidemic. In the same vein, Uganda has been hailed largely as a success story for its national response to HIV/AIDS which was termed as a multi-Sectoral Aids Control approach. This approach also took on HIV/AIDS as more than a health issue and also involved a mass education campaign to ensure that the population became aware of its spread and prevention measures. As a result HIV prevalence was seen to have declined from 18.5% in the 1980s to 5% in 2002 (Uganda Aids Commission). Further, the Uganda Demographic Health Survey (UDHS, 2011) notes increased levels of awareness about HIV/AIDS. The survey shows that virtually almost all women and men in Uganda say that they have heard of AIDS, although proportion of respondents who know both HIV prevention methods is higher in urban areas than in rural areas, with the difference being more pronounced among women (82 percent versus 72 percent) than among men (84 percent versus 78 percent) (UDHS, 2011).

Yet, the optimism around this success story is slowly waning away. Infection rates are rising once again. This reversal of the gains is not just a Ugandan phenomenon but rather connects to many other countries, especially in Sub Saharan Africa in general and the great lakes region in particular. In 2010 sub-Saharan Africa accounted for 70% of new HIV infections globally.
The discussion now is that there exists a multiplicity of factors especially within the realm of gender relations that are yet to be adequately addressed in its various manifestations. One of these factors is gender based violence (GBV) understood as any act of violence directed at groups or individuals on the basis of their gender. GBV disproportionately affects women due to the unequal gender relations although men also tend to be affected. The purpose of this paper is to highlight this GBV-HIV/AIDS nexus and draw implications for policy and programming. This paper presents an overview of the GBV/HIV/AIDS nexus, which has been largely established, the national response as well as pointers for policy and programming. The paper was derived from a review of literature and policy documents\(^2\) to establish the trends and approaches to the issue of the interconnection between GBV and HIV/AIDS.

2.0 The GBV and HIV/AIDS NEXUS

According to MGLSD (2011), gender based violence (GBV) is an umbrella term of any harmful act that is perpetrated against a person’s will and is based on socially ascribed gender differences between males and females. GBV is denial of basic human rights through social customs, roles and habits that are directed against a person because of his/her gender identity. The person often has little or no choice in refusing the options given to her or him without severe physical, social or psychological consequences. GBV therefore encompasses a variety of abuses that include; sexual threats, exploitation, forced labour, humiliation, assaults, molestation, emotional and psychological abuse, trafficking, domestic violence, incest, involuntary prostitution (sexual bartering), sexual harassment, torture, insertion of objects into genital openings and attempted rape, defilement, female genital mutilation and other harmful and discriminatory traditional practices, including forced child marriage. Such a holistic definition of GBV by MGLSD as Uganda’s national Machinery for gender mainstreaming creates a sense of optimism that the attendant response will also be equally holistic.

The links between HIV/AIDS and gender based violence are becoming increasingly apparent based on the findings of various studies conducted primarily in the United States and Sub-Saharan Africa (UNAIDS 2012; WHO, 2011; MGLSD, 2011). Findings show an increased risk of HIV/AIDS among victims of gender based violence. The World Health Organization Global Health Sector Strategy on HIV/AIDS 2011-2015, which guides the health sector’s response to HIV, clearly highlights this linkage. The strategy whose goals are consistent

\(^2\) No fieldwork was undertaken and hence this paper is only able to draw out implications that can then be direct processes of making programmatic courses of action.
with UNAIDS strategic vision (for the same period) on “Getting to Zero” rhymes with other international commitments on HIV that call for universal access to HIV prevention, diagnosis, treatment and care interventions for all in need and achieving health-related Millennium Development Goals by 2015. In its strategic direction 2, the strategy focuses on leveraging broader health outcomes through HIV responses. The strategy also requires strengthening links between HIV and other health programmes. World Health Organization (2011) indicates that HIV is closely linked with a wide range of other health issues, such as sexually transmitted infections, broader sexual and reproductive health, drug dependence, tuberculosis and blood safety. These links are also expected to be reflected in the delivery of health services in order to optimize investments in a range of health areas. Further attention is paid to key populations and people living with HIV, including particular services for:

...prevention, diagnosis and treatment of sexually transmitted infections; family planning, including condom programming for dual protection and post-abortion care; cervical cancer screening and care; and survivors of sexual assault and gender-based violence, including emergency contraception, counseling and post-exposure prophylaxis. (WHO, 2011).

The other strategic direction that brings out the link between HIV and GBV is the focus on reducing vulnerability and removing structural barriers to accessing services. In this direction, the strategy notes that People Living with HIV Stigma Index indicates high rates of physical and verbal abuse experienced by people living with HIV, among which a significant proportion (from 12% to 88%) were denied access to health services.

Studies on trends of HIV/AIDS indicate an emerging evidence connecting the rapidly expanding HIV epidemic and gender based violence particularly on the part of women (Auerbach and Byram, 2005; WHO, 2007.) For example, a growing number of studies indicate that amongst young women, the first sexual experience is often coerced and that such coercion is often viewed as a routine part of a relationship (Republic of Uganda (RoU,2006; UNAIDS 2008; Auerbach and Byram2005, Dolan, 2010). Not only can gender-based violence lead to HIV infection, but it may also be a consequence of it. The risks associated with disclosure of HIV infection deter many women as well as men from revealing their sero-status which undermines efforts around prevention and treatment. For women in particular, the risk for violence is much real and directly impacts on their life choices and decision making (Auerbach and Byram, 2005.) Indeed, the threat of GBV also impacts on adherence to antiretroviral therapy on the part of women as disclosure becomes a highly gendered process.

More than ever before, it has become clear that effective HIV/AIDS programming requires a clear conceptualisation of predisposing factors to HIV, most of which have been the cultural
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expectations and social attitudes about the roles of men and women. Gender-based violence, stigma and discrimination, and inequitable access to services remain some of the key challenges in the fight against HIV. In sub-Saharan Africa, statistics provide ample evidence that gender inequality plays a major role in the epidemic, where women are consistently and disproportionately affected by HIV/AIDS. Over 60% of the population living with HIV in this region are women (UNAIDS 2008). This trend continued to worsen even in 2010 with girls and women continuing to be more vulnerable to new infection because of social, political, cultural and economic gender inequalities. According to UNAIDS (2012; 70), women represent 58% of the people living with HIV and bear the greatest burden of care.

In Uganda, both HIV prevalence rates and estimated cases of gender based violence remain different for women and men. Among Ugandan women, HIV prevalence is 7.5% compared to 5.0% among men (UBOS, 2007). According to the 2004-5 Uganda HIV/AIDS Sero- Behavioural Survey, more women are infected at a younger age than men. The survey further indicates gender based violence as an obvious violation of human rights with serious consequences for women’s health and well-being. For example, the Uganda Bureau of statistics (2007) indicated that although both women and men experience violence in Uganda, women are more likely to suffer every form of violence with a vast majority of violence committed by an intimate partner. According to UDHS (2006), 44% of women who have experienced sexual violence say their current husband or partner was responsible, while another 22% cite a former husband or partner. Violence in intimate relationships especially for women often attains the status of what is natural and normal with women getting accustomed to it, which means that the prevalence reported could be much lower that what the situation actually is. It is also indicated that 24% of women aged 15-49 have had first sexual intercourse forced against their will (UBOS 2007). This intimate nature of violence is further pointed out by the Ministry of Gender, Labour and Social Development, in the National GBV Situational Analysis in Uganda (MoGLSD, 2011; 66).

Many acts of normalised GBV are widespread and these include domestic violence, assaults against women, child sexual abuse, and rape (NDP 2010, Gender policy 2007). All this is
commonly attributed to cultural and social norms that imbue men with power and authority over women. The 2006 UDHS widely indicated that wife beating can be justified in circumstances such as neglecting the children; going out without telling the husband; refusing to have sex; arguing with the husband; and burning the food. While the survey indicated that 7 in every 10 women agree that at least one of the latter five circumstances is sufficient justification for wife beating, 6 in 10 men also agree that at least one of these reasons justifies wife beating.

In the same vein, it has generally been established that women and girls are two to four times more susceptible to HIV infection than men and boys. This fact has given rise to what is termed as the feminization of AIDS especially in the African context, where it is noted that three young women are infected for every man. Behind this seemingly feminization of HIV/AIDS is the low status of women and girls. Poor women in particular are often denied basic human rights, including access to education, health care, safe sex, economic and physical security. Discrimination and violence, tend to render women and girls far more susceptible to HIV infection. Coerced or forced sex increases the risk of HIV infection. The injuries that go with violent and coerced sex offer a perfect conduit for HIV transmission. Because they are often so powerless, women may be unable to negotiate the conditions under which they have sex with their husbands or partners. Male partners may become violent if women refuse their sexual advances.

Vulnerability to violence and HIV also takes various forms depending on the circumstances such that there are groups that tend to be more at risk of violence than others. For instance, Uganda’s National HIV/AIDS Strategic plan (2007/8 - 2011/12), indicates that although the HIV epidemic is generalized, there are certain groups which are most at risk, such as commercial sex workers (including males), fishing communities, uniformed personnel, IDPs, women and men in conflict situations, among other categories. While cases of violence may lead to HIV infection, even those already infected with the virus face multiple forms of abuse that affect their access to treatment, care and support. According to the Ministry of gender Labor and Social Development (2011), the intersection of GBV and HIV is located within the broader context of gender inequalities in society as illustrated below;

The high incidences of defilement today in Uganda are also to some extent attributed to high prevalence of HIV among adult women, which makes some

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men seek sexual relations with underage girls on the assumption that this age cohort may be free from HIV infection. Discordance couples have also been associated with some specific forms of SGBV. In situations where the woman is HIV positive and the man is negative, the woman suffers physical battery and economic violence and is sent way from the matrimonial home. On the other hand, women who may be HIV negative when the male partners are positive, are denied the right to safer sex which consequently exposes them to HIV infection (MGLSD, 2011).

Such scenarios are also associated with inadequate disclosure of women’s Sero status, irregular uptake of ARVs or taking ARVs in hiding for fear of stigmatisation by those around them. Traditional gender roles for women often leave them with fewer options and power and therefore more vulnerable to violence and HIV/AIDS. Hence for women, the link between HIV and GBV particularly Violence against women is cyclic and self reinforcing as illustrated below:

![Diagram of the cyclic and reinforcing nature of HIV and GBV](image)

On the part of men, the fact that society more often than not places them in a position of power works to conceal their vulnerability in the GBV HIV nexus. Men and boys place themselves and their partners at risk by ignoring their health needs and shunning available prevention and health care services (ibid, 69). Furthermore notions of masculinity not only put men at risk of violence but also limit the manner in which they address the consequences of such violence.

Jungar and Oinas, (2005) note that the exclusion of women’s experiences in males circumcision as a strategy to HIV prevention, a mistake that is most likely to exacerbate
sexualized violence but also aggravate HIV infections. Male circumcision targets males since they are the main actors in male-female HIV transmission. They note that emphasis on male circumcision not only tolerate sexualized violence (reduce women’s attempts to negotiate safe sex) but also portray discourses that embrace male power in heterosexual practices (Jungar and Oinas, 2005).

2.1 The concrete Links: HIV/AIDS leads to GBV

That HIV/AIDS leads to GBV is an established fact. Several studies indicate that HIV cases have an impact on the way women relate with men in different social contexts. Government of Uganda’s Roadmap towards Universal Access to HIV Prevention (2007) identifies a number of gender-specific behaviours that impact HIV prevention efforts such as increased male involvement in extramarital relations due to gender norms that privilege male sexuality/condone male sexual conquests as validation of masculinity. The Roadmap also draws attention to gender-specific vulnerabilities including non-disclosure among females for fear of domestic violence and marital disruption.

Furthermore the status of being HIV positive drives men into several acts of violence. Dolan (2010) for example argues that there are men who believe that by having sexual intercourse with a virgin they can be cured of HIV, a myth that has only served to increase HIV infection among young girls. Young girls as young as a year old and less, have fallen victim of this myth as HIV positive men struggle to overcome their health and social predicaments.

At another level, HIV positive women are often constructed as vectors. Gender stereotypes allow women to be blamed for spreading HIV/AIDS. Often, because women are more likely to interface with the health system (Bantebya, 2010), they tend to be the first to know their HIV status and when it is positive they then become accountable for bringing the disease into the home. For example, women are the first to be tested because of pregnancy, or a sick baby. When found positive, they bear the brunt and responsibility to relay the dreadful information to their partners. And at this point men have the privileged position to blame their female partners as the cause of the problem, hence justifying violent acts such as battering and expulsion from the home.

Stigma and discrimination have long been recognized the world over as one of the main obstacles to the prevention, HIV testing and counselling, care and treatment of AIDS (Bond
et al. 2003; Parker and Aggleton 2002; 2003). Since the onset of HIV&AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic nearly world over (Fredriksson and Kanabus, 2008). From early in the AIDS epidemic a series of powerful images (HIV&AIDS as punishment for sin, as a crime, as war, as horror or as otherness) reinforced and legitimized stigmatization. This looming fear then in turn impacts on disclosure especially on the part of women. Once disclosure is curtailed, the spread of infection is likely to increase and treatment will also be limited. The fear of violence including stigmatization promotes secrecy that increases HIV vulnerability and poor uptake of HIV&AIDS prevention, care and adherence in treatment services (ACORD, 2008).

2.2 GBV leads to Vulnerability to HIV

In his publication *War is not yet over*, Dolan (2010) shows how military presence in Eastern Democratic Republic of Congo raised levels of sexual violence with increasing cases of HIV infection. The study findings indicate that although a few respondents argued that rape was preferable to being shot because the survivor could have recourse to medical treatment, the vast majority – along with the women of Kaniola in Eastern DRC – felt that;

“...it would be preferable to be shot and die rather than to have to live a slow death in which social ostracism would be aggravated by the likelihood of having been infected with HIV” (Dolan, 2010).

In this case, the stigma and the shame not only associated with rape but also being infected with HIV drives female and male victims of sexual violence to suffer in silence there by limiting their chances for treatment and/or increasing the likelihood of infecting many more people.

The Uganda National HIV&AIDS Strategic Plan (NSP) 2007/8 - 2011/12, acknowledges the gender disparities in HIV prevalence rates, where more women (7.5%) than men (5.0%) are HIV positive, as well as regional gender disparities across the country with the highest prevalence rates for women in the central region especially in urban Kampala (11.8%). Central to these disparities in infection is the gender-specific drivers of the epidemic which include gender based violence, manifesting itself through women’s inability to negotiate safer sex, economic dependence, stigma and social exclusion and discrimination of HIV positive women, early marriage, property grabbing and disinheritance.

According to HSSP II 2005/06 – 2009/2010, Gender based violence is identified as an area that has a bearing on health and HIV/AIDS. The national HIV/AIDS strategic plan 2007/8 – 2011/12also indicates that women are infected more than men across the age spectrum
from birth to age 45-49 years (P. VII). The plan further shows that **women are often unable to negotiate safe sex due to lower status, economic dependence and fear of violence** (P. 6). The plan strongly argues that drivers of the HIV epidemic in Uganda are mostly behavioural, social cultural and economic. Cited examples included individual behaviours influencing risk of sexual transmission; economic factors linked with sexual risk; social cultural and other factors influencing relationship risks; and gender factors influencing relationship risks among others.
The higher numbers of women who are infected with HIV compared to men could be a reflection of several cases of GBV meted out against them, such as early and forced marriages, limited participation in education as well as male dominance in sexually related decision making.

Many studies (e.g. UNAIDS 2004; UNESCO 1999; PSI 2006) have long shown the linkages between economic aspects especially poverty with transactional sex. Cases of sexual exploitation, mostly unprotected cross-generational sex in some cases involving male adolescents with old women (Bohmer and Kirumira 2000), and unwanted pregnancies for female youths (Kyaddondo et al. 2005; Asiimwe et al. 2005) have been reported. Further articulation on how GBV leads to HIV is reflected in the Uganda National AIDS Policy of 2008. The policy and the National HIV & AIDS Strategic Plan (NSP) 2007/8 - 2011/12, acknowledge "gender disparity" as one of the major risk factors driving HIV epidemic. It identifies poverty and women’s and girl’s lower social and economic status, and infringements on their human rights as major challenges to addressing vulnerability to HIV infection. It further highlights a number of gender-specific vulnerabilities including women's subordinate socio-economic status, culturally sanctioned practices such as female genital cutting, widow inheritance, widow cleansing, child marriages and sexual and gender based violence that put women at greater risk of HIV infection than men. The policy draws specific attention to the impact of gender-based violence on women’s vulnerability to HIV and calls for development of a strategy in which "women will especially be empowered and capacitated to safe-guard against sexual and gender based violence, exploitation and unsafe sex. For men, the policy notes that "multiple sexual relationships as a sign of masculinity" put men at risk and limit male involvement in seeking services—such as
participation in PMTCT "where men’s decisions are crucial." Some cultural practices aggravate women’s physiological risk to HIV infection. According to Appiah-Donyina\(^5\) examples of these cultural practices are men’s preference for dry sex which may lead to sores in the mucous membrane, and female genital mutilation, which could lead to extensive tearing and bleeding during sex.

**From the Press- Uganda**

**Women who suffer violence more likely to get STDs- WHO**

Physical and sexual violence affects more than one in three women worldwide according to a new report released by the World Health Organisation… some 35% of all women will experience either intimate partner or non partner violence…Gender based violence is responsible for the psychological distress, which results in acceptance more violence and consequently …a cycle of risk and consequence…psychological distress makes it much harder for women to protect themselves…It makes them more likely to accept the man’s dominance in the relationship and she is more likely to have frequent sex without a condom…sadly a common side –effect of abuse is more abuse- it is a downward spiral.

Extract from : The New Vision Newspaper, July 1 2013

### 2.3 GBV and HIV in Situations of Armed Conflict

It is well documented that conflict exacerbates sexual and gender based violence in societies the world over (Opolot, 2011). Citing the Ministry of Gender Labour and Social Development (MOGLSD) Policy Framework on Violence against Women (2008), Opolot argues that ‘military conflict, in combination with societal factors and traditional practices that have already weakened the historical position of women, creates an ideal environment for increased incidents of GBV’. As armed conflicts rage on, communities experience generalized chaos and frequent social breakdown that accompany warfare while the disincentives against engaging in SGBV are reduced, if not removed (Wood 2006). In other cases, Wood, (2006) and Dolan, (2011), cite cases where gender violence is used as a means of inflicting pain on the enemy forces. In such cases, sexual violence represents a deliberate, organized, proto-military tactic designed to kill, demoralize or remove the population in question. Aginam & Rupiya, (2012) modern-day wars in African nations and elsewhere are increasingly characterized by the use of rape as a weapon of war resulting into both untended and willful transmission of the HIV to innocent victims, women and men.

Furthermore, situations of armed conflict create conducive environment for GBV as many women flee their homes, lose their families and livelihoods, and may have little or no access to health care and education for rehabilitation thereafter (Opolot, 2011). Above all, these

factors create conditions in which women and girls’ vulnerability to STDs and HIV/AIDS is disproportionately increased (WHO, 2004).

In Uganda, the impact of armed conflict on men and women is gendered and manifests in different ways, but the most significant is SGBV (MoGLSD, 2011). Conflicts worsen existing patterns of gender-based violence especially sexual violence as communities’ breakdown during and after conflicts. The most rampant forms of SGBV in conflict are sexualized violence and domestic violence. Sexual violence manifests in different ways ranging from rape, defilement, gang rape, abduction of girl children for sexual slavery and boy children for recruitment into armed forces, forced impregnation, intentional HIV transmission, forced prostitution, male rape, forcing parents to engage in sex with their children or the vice versa or to watch forced sex against one’s parents or children and physical harm inflicted on sexual organs (MGLSD 2011, Dolan, 2009).

3.0 How is Uganda addressing the HIV/GBV nexus?

Uganda realized the gravity of the HIV epidemic right from the outset and mounted public health interventions to counter its spread. Different interventions have ranged from creating a National AIDS Control Programme, with a focus on public education, promoting safe sexual behavior, safe blood transfusion as well as care and treatment of HIV infected persons. Realizing that majority of the new infections were transmitted through heterosexual contact, the strategy to contain the spread of HIV focused on addressing sexual behavioral risk factors by promoting primary and secondary abstinence, mutual faithfulness among married or cohabiting partners and condom use. This approach to prevention was popularly known as ‘ABC’ (Abstinence, Be faithful to your partner, use a Condom) and was later expanded to ‘ABC+’ to include voluntary counseling and testing (VCT), Prevention of Mother –to-Child Transmission (PMTCT), Antiretroviral treatment (ART) and HIV/AIDS care and support services (RoU, 2006) The National HIV Prevention Strategy for Uganda: 2011-15 also emphasizes the biomedical HIV prevention services in the country currently comprising of PMTCT, treatment of STIs, HIV counseling and testing (HCT), medical infection control and post HIV exposure prophylaxis (PEP), condom promotion, and blood transfusion safety. The strategy also appreciates the additional prevention of People living with HIV (PwP) and safe medical male circumcision (SMC) as the new additions.

At the policy level, the government also exhibited commitment to establishing national frameworks but also aligning its programmes to regional and international policy measures
to contain the epidemic. HIV control was reflected as one of the developmental priorities in the 1997 Poverty eradication Action Plan. Other legal and policy interventions that prioritize the focus on HIV include the 1995 constitution, National Equal Opportunities Commission - 2006, The Uganda Gender Policy - 2007, the National Development Plan – 2010 among others.

The government recognized that the impact of HIV/AIDS transcended the sphere of public health, requiring the involvement of all spheres of public life in the country comprising public, civil society, Non Governmental Organizations, communities and individuals. Consequently a multisectoral approach to HIV prevention and control including care and support services was adopted as early as 1990 (Sero- Behavioral Survey) and currently forms one of the pillars of the national response. This multisectoral nature of addressing HIV also informed the manner in which HIV along with gender relations were appreciated as cross cutting issues, planned for across all development sectors (NDP, 2010). Under its report on Uganda’s progress on MDGs, MoFPED (2010) emphasised that men play a pivotal role in achieving gender equality, including improving women’s and children’s health, reducing HIV transmission, and eliminating child marriage and gender-based violence.

Within the National development plan, the Government of Uganda identified HIV prevention as a priority and set a target of 40% reduction of new infections by 2015. To achieve this, the GoU conceived the need for a new HIV prevention strategy to build on previous efforts including the National HIV/AIDS Strategic Plan (2007/8-11/12) and the 2006 Road Map towards Accelerated HIV Prevention, HIV/AIDS policy, National Health Policy as well as other strategic plans of action. The HIV Prevention Strategies in Uganda are also aligned with other international and regional development frameworks, conventions and commitments to which Uganda is signatory. These include the MDGs, and Universal Access targets, the Abuja Declaration of Heads of States (Kirungi & Bukuluki 2011), and now the Global Health Strategy on HIV/AIDS 2011-2015 whose mission is reducing new infections to zero.

In terms of addressing GBV, Uganda has had several interventions. Uganda is party to international and regional human rights treaties and commitments which expressly prohibit sexual and gender-based violence. These include, CEDAW, ratified in 1985, the African Charter on Human and Peoples’ Rights, the UN International Covenant on Civil and Political Rights, the UN Convention against Torture and other Cruel, inhuman and Degrading
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Treatment or Punishment, the UN Convention on the Rights of the Child and the UN security Council Resolutions UN SCR 1325 and 1820.

At the national level, Uganda has specific legal provisions in the Penal code on assault or grievous bodily harm, indecent assault, defilement, rape, attempted rape that are used. Other provisions on GBV are reflected in The 1995 Constitution of Uganda; The Penal Code Act CAP 120; The Children Act CAP 59; The Divorce Act CAP 249; The Probation Act CAP 106 of 1964; The Local Council Courts Act Acts Supplement No 5; Uganda Human Rights Commission Act CAP 24; The Hindu Marriage and Divorce Act CAP 250; among others. There is an explicit law against domestic violence - the Domestic Violence Act 2010, and the law against Trafficking in Human Persons (2010)

At the regional level Uganda is signatory to Goma Declaration of 2008. As a response to the escalation of sexual violence in the Great Lakes Region:

Because rape as a weapon of war is an alarming characteristic of armed conflict in the Great Lakes Region and because of the high prevalence of sexual violence against women and girls, coupled with a culture of impunity surrounding sexual violence, in 2008, key stakeholders in the region were compelled to confront the problem at regional level within the framework of the International Conference on the Great Lakes Region (ICGR)...the government is obliged to develop national policies and laws to undertake necessary actions... (CEWIGO, 2010:5).

What should be measured now is how far these commitments make the GBV /HIV link in the design and implementation processes.

At the programmatic level, Uganda has had several stakeholders in addressing GBV such as the ministry of Gender Labor and Social Development, Civil society organizations such as the Association of Uganda Women Lawyers (FIDA U), Action for Development (ACFODE), Isis WICCE (Women International Cross Cultural Exchange), among others. Isis-WICCE in particular engages in painstaking work on women in conflict and post conflict settings and attempts to address the impact of GBV in these settings in a full cycle manner. UNFPA has also been a critical actor in GBV and reproductive health especially in refugee situations. In one of its manuals Reproductive Health in Refugee situations: an Inter-agency field manual,(UNFPA, 1999) UNFPA clearly indicates that an increase in sexual violence in insecure situations is well recognised. Displacement, uprootedness, the loss of community
structures, the need to exchange sex for material goods or protection all lead to distinct forms of violence, particularly sexual violence against women.

Despite all these critical interventions, the challenge remains that mainstream programming continues to operate in silos and the intersection between GBV and HIV is not substantively addressed in the actual programming. The section below attempts to highlight some of these critical challenges in this nexus.

4.0 Critical challenges for GBV-HIV Planning and Implementation

Auerbach and Byram (2005) indicate, that not only can gender-based violence lead to HIV infection, but it may also be a consequence of it since the risks associated with disclosure of HIV infection deter many women from revealing their serostatus. The link appears so pronounced that addressing one without the other leaves the challenge half-addressed. The section below looks at the challenges in Uganda to address this linkage in policy terms.

4.1 Unclear frameworks HIV/AIDS and GBV

While Uganda has been heralded for its initiatives around control and prevention of HIV there exists no explicit framework for addressing the HIV/GBV nexus. What is existing, are piecemeal legal provisions that remain as isolated cases without overarching guidelines especially for addressing the HIV and GBV nexus. These legal provisions have therefore remained like lonely voices in a wider wild society largely guided by unequal gender relations within which gender based violence is embedded.

Even when HIV and gender are stipulated in Uganda’s National Development plan, there is still inadequate harmonisation, coordination and planning for HIV and GBV as common and cross cutting areas. For instance, the Ministry of Gender Labor and Social development, as a coordinating institution for gender mainstreaming, noted that mainstreaming HIV and gender (later on GBV) in the ministry and all other development sectors has remained a challenge:

*Under the multi-sectoral approach, the ministry has developed an HIV/AIDS Workplace Policy although there is no strategic plan to guide implementation of the policy. The ministry has developed guidelines for integrating HIV/AIDS interventions in the sector’s areas of focus, but there has been minimal systematic guidance on gender programming in HIV/AIDS interventions offered by the ministry to other sectors and stakeholders addressing HIV/AIDS (Bantebya, et.al 2010).*
This inadequacy has largely left the well-intended multisectoral approach to planning for HIV wanting. The implementation of structural interventions and mainstreaming of HIV prevention in most programmes has therefore remained sub-optimal, yet this would provide opportunities for mainstreaming HIV in the work place and development programmes, providing avenues for addressing the structural drivers.

Although, HIV/AIDS has been mainstreamed in the NDP 2010-15, and other sector policies, engagement of communities, cultural structures and networks to address harmful socio-cultural norms and practices is still low and often lack guidelines. Vocational and apprenticeship skills and micro-credit schemes for reducing vulnerability also have limited coverage. The policy and legal frameworks with a potential to address gender imbalances e.g., Domestic Violence Act, 2010 and the National Gender Policy, are also constrained by enforcement weaknesses.

4.2 Cross-cutting but Parallel: the Dilemma of HIV/GBV Programming

From the outset of the HIV epidemic, Uganda recognised the gravity of the problem it posed and initiated public health strategies for containment (MoH, 2006). The government also recognised that HIV/AIDS and its impact transcended the sphere of public health, requiring the involvement of all spheres of public life in the country. Consequently, a new approach known as the multisectoral approach to HIV prevention and control including care and support services was adopted as early as 1990 to inform HIV redress mechanisms (MoH, 2006). This approach focused on HIV as a cross cutting issue, in the same way that gender is recognized as a cross cutting issue since its impact was cross-sectoral. For example the National Development Plan (NDP) recognizes HIV and Gender as crosscutting issues and further identifies GBV as one of the key gender issues that need to be addressed.

However, even when there is this clear recognition that gender and HIV have negative consequences on wider community, there has not been clear programming process that articulates the link between GBV and HIV. Each of them are analyzed and planned differently and the intersection is not well articulated in policy terms. The NDP for example targets reducing gender based violence and promoting women’s rights through the following: sensitization and awareness programmes; clear reporting and administrative mechanisms for handling the cases; ratification, domestication and reporting on regional and international protocols, conventions and principles on women’s rights and gender equality; supporting survivors of gender based violence to engage in income generating activities and providing access to professional psychosocial counselling services, among others. No
attempt is made by the NDP as a national development framework to plan for addressing GBV and HIV in their interconnected nature.

At policy level therefore, there has largely been no attempt to provide a guideline on how to assess, and therefore develop programmes that jointly tackle HIV and GBV even when the link is widely recognised. The two areas have only remained defined as cross-cutting but parallel to each other, without one informing the other. Yet the moment this disconnect appears at the bigger policy level, it has implications for the lower levels of programme/project designs, implementation, evaluation as well as resource allocation.

This therefore results into an uncoordinated manner in interventions focusing on gender based violence and HIV. Even when both areas are identified as cross-cutting issues, they never cut across each other. Bantebya et al. (2010) indicate for example that Ministry of Gender Labour and Social Development, as an institution mandated to coordinate Gender related programmes has developed two sets of guidelines on mainstreaming - Guidelines for HIV/AIDS Mainstreaming in Planning and Budgeting Processes at National and District Levels, and the Guidelines for Mainstreaming gender in Sectoral Development Plans, Programmes and Projects (MGLSD) but HIV/AIDS and gender mainstreaming have remained running as parallel programmes.

4.3 Lack of clarity on HIV/GBV link

Although global, regional and national strategies in GBV and HIV programming appreciate the link between the two, there is inadequate clarity on which aspect (GBV or HIV) leads to the other. This lack of clarity ultimately has an impact on selecting the primary aspect of target, whether - HIV or GBV. Even when HIV or GBV could be independent variables making the other a dependent variable, this conceptual relationship needs to be clearly known and articulated at policy making level to be able to inform strategic actions and effective mechanisms for assessing progress made in addressing HIV and or GBV and their consequent impact on the other.

4.4 More Word, Less action, minimal Resource Allocation

The link between HIV and GBV has largely remained at the level of the word. Everybody seems to recognise the link but action is limited in a sense that the planning does not go far enough in identifying activities at the intersection of GBV and HIV/AIDs. Activities around the intersection would then demand for resources to be allocated to specifically address the needs that arise. Hence, the GBV/HIV nexus falls into pit of what is normally referred to as
‘gender evaporation’, which is largely a result of failure to carry through the gender analysis to activity level and resource allocation.

4.5 On GBV and Masculinity

Strategies to address GBV have almost exclusively looked at it from a women’s perspective. Although there is a realization that specific cultures in Uganda give more cultural leverage to men than women, there is an entirely inadequate focus on what this power means for men, how they exercise it between and among themselves, as well as its impact on their health and the health of those around them. This kind of discussion indicates not only an inadequate focus on what GBV is but also what its victims are likely to be. The understanding that GBV goes beyond violence against women is not adequately translated in policy terms. The influence of constructions and practices of masculinity in situations of armed conflict as well as in normal situations also predispose men to acts of violence either as perpetrators or as victims, thereby increasing their vulnerability in ways that are different from women’s.

5.0 Implications for Policy and Programming

There is a clear link between HIV/AIDS and gender-based violence. Both GBV and HIV are embedded in the social cultural relations that define women and men’s roles and entitlements differently. As a result, GBV and HIV cannot be limited to the Health and epidemiological issues but rather should also be seen in the context social issues that require social interventions. The findings of this study indicate that although gender and consequently GBV and HIV are identified as cross-sectoral and cross cutting issues, there has not been a conscious and systematic effort to link these two areas. Hence the intersection of GBV and HIV/AIDs has not been properly translated in policy terms. The result has therefore been parallel programming rather than intricately linked spheres of GBV and HIV programming. To address this lacuna there is need to do the following, among others:

5.1 The need for a 360 degrees approach to the GBV/HIV nexus

The GBV/HIV nexus cannot be addressed by approaches structured in conventional silos. There is need for a full cycle approach that takes all key aspects as part of an holistic response. Some lessons can be learn from existing responses. A good example is the response by Isis-WICCE to the needs and aspirations of women in conflict and post conflict settings.
In dealing with women survivors of ghastly effects of sexual violence, torture and psycho social displacement, Isis-WICCE consciously aims at achieving a delicate balance of the mind, body, heart, soul and spirit as a two way process. A two way process that flows from the Isis-WICCE work as well as from the communities in question. Isis-WICCE deploys the mind to innovate the holistic feminist response to a specific conflict, gathers evidence around it goes ahead to address issues that relate to the women’s body, mind and spirit. And much more importantly restores the spirit to push on. As a result, the participating communities and women in particular graft into this delicate balance where they have to deploy their mind, heart hands and soul to be the agents prime movers of peace building reconstruction (Isis-WICCE 2013).

5.2 Integrate Peace building into HIV programming in conflict and post conflict situations

The Great Lakes Region and Uganda in particular, has gone through a series of armed conflict with devastating effects. One of these effects is the perpetration of Sexual and gender based violence as a weapon of war and the spread of HIV among the victims of violence. Armed conflicts are therefore highlighted as a major scenario that aggravates GBV and HIV. Planning for GBV and HIV therefore requires integrated strategies for peace building as well as the fight for gender equality.

5.3 A Clear structural framework within which to address the intricate interconnectedness of GBV/HIV

The link between GBV and HIV is well appreciated. This appreciation needs to be elevated to the level where there exists an explicit structural framework through which the different activities by government and civil society are coordinated and monitored. Benchmarks for success should be developed in terms of how far the intersection of GBV/HIV is being addressed.

5.4 Embed a feminist approach within HIV/GBV programming

Government of Uganda acknowledges gender as a cross cutting issue and the overall policy framework is committed to gender mainstreaming. However, these commitments do not translate into actual deliverables because gender is largely constructed in neutral and apolitical terms. Violence has increased so much that it is fast becoming the norm rather than the exception and could be one of the factors rolling back the gains that Uganda as a country had made in terms of combating the HIV scourge/ infection. A feminist approach requires a re-centering of the woman subject in a full cycle manner looking at all her needs be they physical, economic, political and psychological. In this way the question of power will be central and hence enabling women to be active agents as opposed to being eternal victims.
5.5 **Integrate Masculinity in HIV/GBV programming**

Bantebya et al. (2010), and Fox (2003) indicate that information on GBV and HIV tends to focus solely on women knowing their rights and not enough on men’s understanding of women’s rights. Dolan also asserts that if we are ever to successfully engage men and boys in gender equality and the reduction of violence against women, we need to first understand (and show that we understand!) that gender often works against men too, notably in conflict and post-conflict settings (Dolan, 2010). Therefore there is need to blend into the GBV and HIV nexus a more nuanced and holistic gender aware framework which explores and influences the mutual interactions between masculinities and femininities. The aspect of maleness and how masculine constrictions place men as perpetrators but also as victims need to be appreciated and used to inform programming to break the viscous cycle of GBV and HIV/AIDS.

5.6 **Continuous citizen Awareness on HIV/GBV as part of Civic education**

Addressing the challenge of deep seated socialisation that breeds inequality remains a priority. Through consistent sensitisation, Government, development partners, civil society need to engage men and women at the community level to enable them to appreciate gender differences, identify negative practices and possible ways of ending them. It is an all round task that requires focusing on women and men in their different contexts to help them appreciate the impact of gender inequalities on their lives. On the part of men specifically more effort needs to be channelled towards creating positive masculinities and positive male models. Knowledge creation (research) on cases of positive deviance can help in forming these positive role models and specifically making it attractive for men not to be violent.

5.7 **Beyond the individual: Comprehensive programme for HIV Testing and feedback**

It has been noted that women often bear the burden of relaying their HIV status to their partners due to their maternal roles. As already noted, women are often the first to know their status as compelled by the needs of antenatal and child care. There is need for a comprehensive programme to lift the burden of information relay from the individual to the health system. In this way the issue is moved from the private to the public realm. Furthermore the discourse in HIV programming that looks only at mothers needs to change to look at parental roles.
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References


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National HIV & AIDS Strategic Plan (NSP) 2007/8 - 2011/12

Health Sector Strategic Plan (HSSP) II, 2005/06 – 2009/2010, Volume I.


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Kyaddondo D, Nakkazi, P and Siu G (2005), Causes and perceptions about child marriages in Maddu sub county Mpigi District, Kampala: Child Health and Development Center, Makerere University.


