Interventions to Mitigate Gender-based Violence: Experiences from Uganda

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The Uganda Program for Human and Holistic Development (UPHOLD) is a five-year program designed to assist Ugandans to offer and use quality social services in three sectors: education, health and HIV/AIDS.

Financial support for this publication was provided by the United States Agency for International Development (USAID), Cooperative Agreement number 617-A-00-02-00012-00. The views expressed in this document do not necessarily reflect those of USAID.

UPHOLD is implemented by JSI Research & Training Institute, Inc., in collaboration with Education Development Center, Inc. (EDC), The Constella Futures Group, The Malaria Consortium, The Manoff Group, Inc., and World Education, Inc.

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Abstract

Gender-based violence (GBV) has been identified as a major set back to the implementation of PMTCT programs. Sero-prevalence studies report HIV prevalence lower in men than women in Uganda. JSI/UPHOLD, a USAID-funded program, provided technical support to civil society organizations and local drama groups on GBV prevention including training in music dance and drama performances and conducting community dialogue. HIV-positive pregnant women and their spouses were supported to form family support groups (FSGs) and facilitated to engage in peer counseling. An increase from 222 to 1,837 of women being tested and counseled together was reported in areas where local MDD troupes had conducted community mobilization. FGDs revealed that inclusion of males in FSGs improved male involvement in PMTCT services and spousal disclosure of sero-status. Addressing GBV through MDD at community level contributes to improving couple counseling as a proxy indicator for positive behavioral change in the fight against HIV transmission.

Introduction

HIV and Issues of gender have been highlighted as having a very close relationship. The relationship between these two topics is in community practices, norms and values that finally impact on the areas of Prevention of Infection and utilization of health services. This is further worsened by disparities both biological and socio-cultural that put women at a greater risk of acquiring infection than men [1,2, 7] Therefore we are experiencing higher prevalence of HIV among females (7.5%) than men (5%) [3] that if some of these practices are left unattended to there will continue to be challenges in controlling the HIV/AIDS epidemic particularly in the developing world. This paper shares experiences from the implementation of GBV prevention interventions and its effect on uptake of PMTCT Services in Uganda.

Background

Gender-based violence (GBV) has continuously been raised as one of the factors further increasing the risk of women to HIV infection, yet at the same time is hindering their utilization of health services[2,4,5,6]. GBV can be described as a complex of negative practices, customs and practices such as assault, intimate violence including forced sex against a person based on their gender. This has been officially defined by The United Nations Declaration on Violence against Women as *".... violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family, or within the general community)" (UNFPA Gender Theme Group, 1998)* [7]

These practices are often fuelled by underlying factors such cultural practices (norms), communication breakdown between the couple, low socio- economic status particularly of the woman as well as alcohol and substance abuse.

Social norms and Male dominance in society causes men to wield the power of whether women can freely seek med-care or have access to vital necessities like money, or transport if at all the women can make the choice to seek medical attention.

GBV has been recognized as one of the major set backs to successful implementation of Prevention of Mother-to-Child Transmission (PMTCT) of HIV [8,9]. This is highlighted by evidence of reduced willingness of women to take up HIV tests, despite this being the care entry point into PMTCT, widely available and even routine Antenatal care service[10]. For those that go ahead and take the test, some may choose not to pick up their results or even disclose their HIV test results [11]. Worse still the success of PMTCT in pregnant mothers also relies on the mother's ability to adhere to a safe Infant feeding option for the child; this is grossly affected by the socio- cultural expectations or the availability of finances as mentioned above.

The problem of GBV and women's exposure/ risk for HIV has been addressed by both National and international bodies such as the World Health Organization and UNAIDS mainly calling for action to ensure that the perpetration of violence among women if unattended to will continue to fuel the HIV/AIDS epidemic[8,12] A clear and direct link has been implied in Uganda between gender-based violence and HIV/AIDS. In addition to a relationship between violence and positive status, fear of gender-based violence can keep a girl or woman from negotiating safer sex, seeking HCT, PMTCT, and even use of antiretroviral drugs (ARVs) [6,7]

Therefore, The Uganda Program for Human and Holistic Development (UPHOLD), - a USAID–funded Bi-lateral program has supported GBV prevention initiatives through CSO partners as one way of increasing Uptake of PMTCT services.

Approach

The report is derived from 6 UPHOLD supported districts in Uganda which is located in Sub-Saharan Africa experiencing a mature generalised HIV epidemic with the prevalence being estimated at 7% [3]. During 2005, UPHOLD provided support –training- to Civil Society Organizations (CSOs) in refocusing community dialogue towards prevention of GBV this was further strengthened by training local drama groups in utilising this channel to convey messages related to GBV prevention. This was done in partnership with a country agency specialized in Gender Based Violence prevention training called Raising voices together with Ndere Troupe *(a performing arts troupe)*which assisted the partners to realize the role of Music, Dance and drama in community sensitization and how to conduct community dialogue and awareness sessions on GBV. The focus of the training for the CSO representatives was on –

- Approaches to preventing gender-based violence
- Skills in integrating gender-based violence prevention into their program activities
- The intersection between violence and HIV/AIDS prevention,
- How to promote key behaviours related to social sector services using MDD, using scripts that emphasize overcoming barriers and supporting positive practices.
- How to use materials, including posters and modules, during community outreach visits

In addition, that of the drama groups dwelt on-

- How to adapt the scripts to local situations
- Methods of incorporating performance techniques such as large audience management, use of megaphones, and interactive dialogue.

At the end of the training, participants developed action plans that would be monitored and supported by Raising Voices through follow-up visits. They were also provided with resource packs containing relevant literature, posters, and monitoring forms for implementation.

Once this was done, the various trained CSOs which included -

- Rural Welfare for Development (RWIDE) in Kyenjojo district.
- Maturity Audio Visual (MAV) in Mbarara district.

- Environmental Community Health Outreach Foundation (ECHO) and World Vision Luwero in Luwero district
- World Vision Kitgum in Kitgum District.
- Uganda reproductive Health Bureau (URHB) in Bugiri district
- Rakai Health sciences in Rakai district, Implemented the interventions with in the community. Implemented the interventions with in the community. This involved the training of community and opinion leaders such as the police, Local council chairmen, and religious leaders on the role of GBV in HIV transmission and the benefits of interventions to end this tendency. This was followed by actual implementation with-in the communities of activities such as community dialogue meetings, Radio talk shows/Programs, music , dance and drama performances making the case of GBV and uptake of HIV/AIDS services, disclosure of HIV test results and stigma and discrimination

Overall, 32 representatives from seven CSOs were trained in GBV prevention promotion at community level. This was followed by a cascade of trainings at community level. In addition, 220 local groups from 20 districts were trained and supported on MDD content and methods.

Coverage/Community level out puts

53,000 people in all are estimated to have attended the various drama and community dialogue sessions. (NB: there are no statistics of those reached through the radio programs as this was difficult to quantify)

Further, UPHOLD provided support supervision to the CSOs in the implementation of GBV prevention and utilization of PMTCT services. In addition to these initiatives, UPHOLD supported HIV positive pregnant women and their spouses to form Family Support Groups (FSGs), trained them and equipped them with skills in peer counselling, and community mobilization on PMTCT services and referrals.

Data Sources

For this paper program reports and data were retrospectively analyzed with relation to the subject. The major source of data for the foregoing discussion however, are two Lot Quality Assurance Sampling (LQAS) surveys conducted by UPHOLD in 2005 and 2006 with in the program's Monitoring and Evaluation plan. In both surveys, more than 15000 adults were interviewed on various reproductive health behaviour. Data drawn from the surveys covers 6 intervention districts (n=2850) where GBV and PMTCT interventions were implemented concurrently. In the 6 districts-Kyenjojo, Kitgum, Luweero, Rakai, Bugiri and Mbarara, the program took a two pronged approach, where GBV interventions combined community dialogue and Music, Dance and Drama. It is therefore expected that the impact of GBV interventions was greater in the six districts than in the rest of the 14 districts.

Program Outcomes

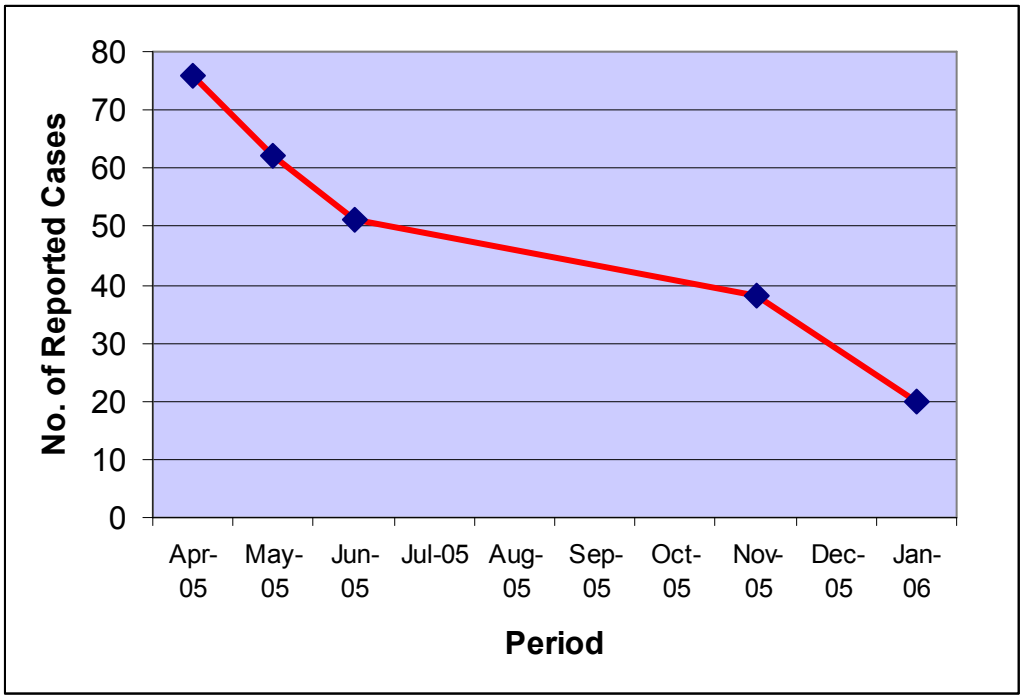
In assessing the benefits of GBV reduction within the communities, and its application to the utilization of HIV services particularly PMTCT services, this discussion considers four markers/ proxy indicators of behaviour change. These are

a) Reported reduction in GBV in communities
b) The number of couples agreeing to be counselled, take an HIV test and receive their results as a couple
c) Percent of pregnant women who were counselled for HIV, took and HIV test and received their results
d) Percentage of women attending Antenatal care at-least four times during their previous pregnancy (B to D above are used as indirect/proxy indicators. Hence, while the data reflects changes in these indicators with in program areas, more research need to be done to establish the magnitude by which changes in uptake of HIV/AIDS services can be attributed to the GBV intervention)

Reported reduction in GBV in communities

Overall, program reports form the six districts indicate that there has been a reduction in GBV cases reported to religious leaders, Police and Local Councils. A case in point is Mbarara district, where Maturity Audio Visual conducted active monitoring of GBV cases reported to Police, Local Council and religious leaders. As shown in figure 1 below, there is a declining trend in the number of GBV cases-from 76 in April 2005 to 20 in January 2006.

Figure 1. Number of GBV cases reported in Mbarara District (April 2005-January 2006).



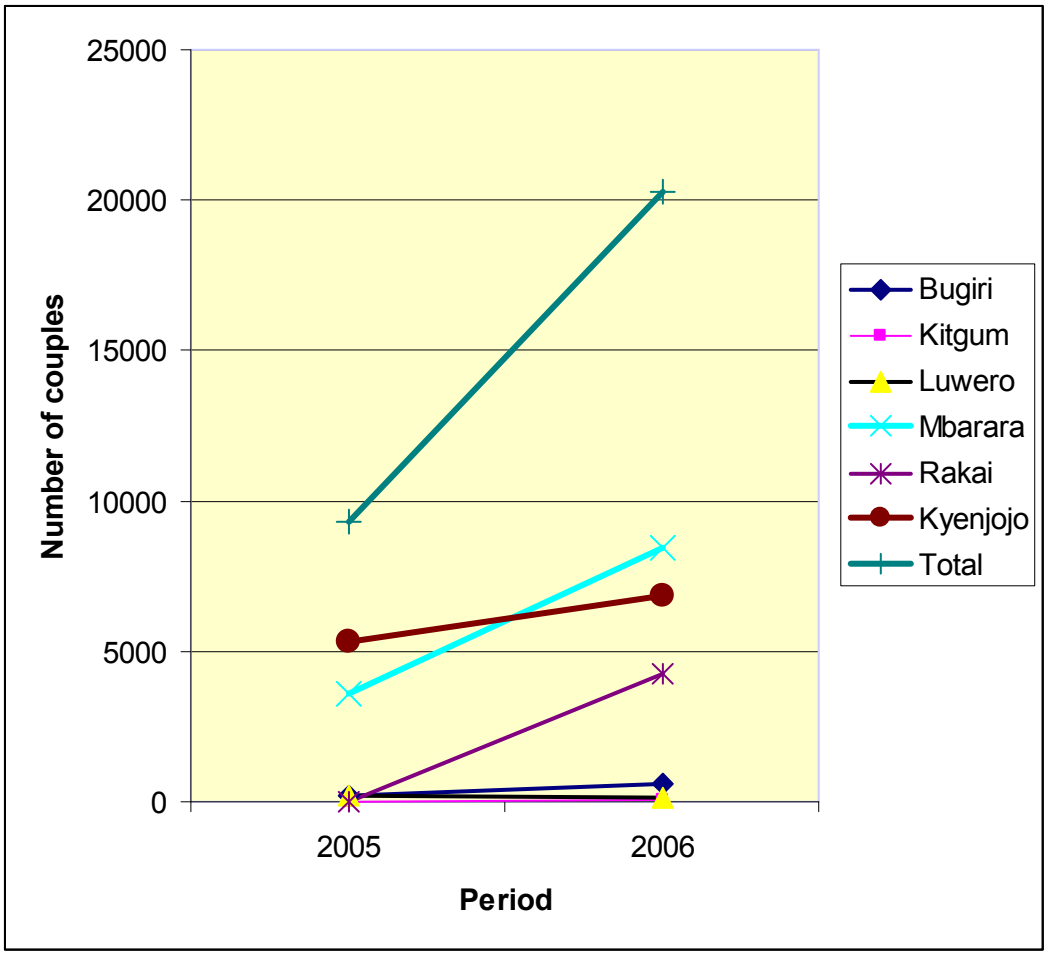
Source: UPHOLD Program Reports, 2006

Another example of successful GBV intervention implementation is that of Kyenjoj district, where implementation was conducted by RWIDE. RWIDE collaborated with Kyenjojo police to train some of the community members in crime prevention and community policing. These community members established local GBV courts to address the family conflicts, they also established a community neighborhood scheme to ensure that there is peace in the neighborhood and people access VCT / PMTCT without causing conflict.

The number of couples agreeing to be counselled take an HIV test and receive their results as a couple

An indirect but plausible measure of the relationship between GBV and uptake of PMTCT services is the number of couples agreeing to be counselled; take an HIV test and receive their results as a couple. This is because decisions for couple counselling are less likely in relationships where GBV is prevalent than where it is not [6]. Program reports from the intervention districts between 2005 and 2006 indicate that there has been an increase in the number of couples receiving counselling, testing and results for HIV as a couple as shown in figure 2 below. This is an indication that GBV reduction is increasing p take of HIV services.

Figure 2: Number of Couples that were counseled, tested and received results for HIV (2005-2006)



Source: UPHOLD Program reports, 2005-2006

Percent of pregnant women who were counselled for HIV, took and HIV test and received their results

Another indication of reduced GBV and increased uptake of HIV/PMTCT services is the Percent of pregnant women who were counseled for HIV, took a test and received results during ANC in the last two years. This is because GBV is often a major hindrance for HCT uptake for pregnant women [[11]]. Results of the 2005 and 2006 UPHOLD LQAS surveys indicate statistically significant increases in HCT uptake for pregnant women during Ante Natal care with in the 6 intervention districts.

Figure 3: Percent of pregnant women who were counseled for HIV, took a test and received results during ANC in the last two years

District	% for 2005	% for 2006	
Bugiri	4.9	12.5	*P< .001*
Kitgum	30.9	52.9	*P< .001*
Kyenjojo	9.0	21.2	*P< .001*
Luweero	18.1	27.0	*P< .001*
Rakai	24.1	29.2	*P< .001*
Mbarara	21.5	50.0	*P< .001*

Source: UPHOLD LQAS reports 2005-2006

Percent of pregnant women attending ANC at least 4 times during the last pregnancy

Another indication of reduced GBV and increased uptake of HIV/PMTCT services is the Percent of pregnant women who attended ANC at least four times during the last pregnancy. This is because GBV is often a major hindrance for women to access resources to enable them attend ANC which is the major entry point for PMTCT [[8]]. Results of the 2005 and 2006 UPHOLD LQAS surveys as shown in figure 4 below, indicate statistically significant increases in ANC attendance for four out of the six focus districts. The decline in the two districts may be attributed to redistricting causing the loss of trained Human Resources as well as the worsening civil strife in the North heavily affecting Health services Utilization in Kitgum district.

Figure 4: Percent of pregnant women who attended antenatal care at least 4 times during the last pregnancy

District	% for 2005	% for 2006	
Bugiri	44.6	41.7	*P< .005*
Kitgum	62.2	57.8	*P< .001*
Kyenjojo	47.2	50	*P< .001*
Luweero	47.6	61.3	*P< .001*
Rakai	52.4	62.6	*P< .001*
Mbarara	50.8	64.5	*P< .001*

Source: UPHOLD LQAS reports 2005-2006

In light of the reducing prevalence of GBV in the focus districts we notice a significant increment in the uptake of HIV/AIDS services that are critical for the PMTCT program. The limitation of this paper is that we cannot attribute 100% all the benefits observed here to GBV reduction as there were other interventions to encourage the uptake of these services in these districts. However this combined with Qualitative information within the program reports we are certain that the GBV reduction interventions played a key role in this observed positive trend.

Challenges

There were a couple of challenges encountered during the implementation that heavily affected the implementation of GBV within the communities. These included

a) The redistricting process that took place between end 2005 and early 2007. This translated into loss of critical trained Human Resources for the provision of the key HIV/AIDS packages. This coupled with the Ministry of Health guidelines of restricting the cadre of personnel that can provide PMTCT services meant that we had lesser gains in the core PMTCT interventions as opposed to HCT.
b) The civil strife in Northern Uganda, led to a lot of internal displacement of the communities as well as closure of some health units. This means that even though the Anti-GBV campaigns continued within the communities, there were no facilities like ANC for the mothers.
c) Limited facilitation - much as the intervention needed countrywide implementation, we could only limit ourselves to a few districts within the country.

d) The absence of a legal framework to address GBV, this meant that in some cases where continuous perpetrators were identified, there was little that could be done beside counselling and reconciliation and occasional reprimand from the police.

Key Recommendations

GBV prevention should be an integral part of all HIV programs to improve couple counselling and Uptake of PMTCT services.

Provide more support to CSOs in GBV prevention since they work directly with communities and have the capacity to increase male support and participation in PMTCT activities.

Put in place a legal frame work that will address and apprehend the perpetrators of GBV

A more detailed study into the link between GBV reduction and utilization of PMTCT services needs to be done to further strengthen the experiences shared in this paper.

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