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CONSEQUENCE OF GENDER-BASED VIOLENCE ON THE PREVALENCE OF HIV AND AIDS AMONG WOMEN IN UGANDA

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ABSTRACT

The study of HIV and AIDS is a consequence of Gender-Based Violence (GBV) is thought about as a result of new cases of HIV and AIDS infections being reported in different health facilities in Uganda. This literature survey focuses on Uganda with an attempt to establish if GBV could be a factor to the incidence. The key findings indicate that GBV is a contributory factor to the HIV AND AIDS prevalence not only in Uganda. It is noted that a number of studies do not consider this element and instead cite other factors like alcoholism, poverty, limited supplies of HIV AND AIDS preventive methods namely abstinence, faithfulness, use of condoms and male circumcision as factors for the prevalence of HIV AND AIDS in the country. It is inferred that one of the key consequences of GBV is HIV and AIDS among households. It is recommended that key stakeholders should put more energies to preventing GBV and hence the incidence of HIV AND AIDS through accelerated sensitization of the masses on GBV and HIV AND AIDS as well as ensuring that the existing legislation against GBV are fully implemented so that the potential abusers are reprimanded.

INTRODUCTION

Human Immunodeficiency Virus and Acquired immune deficiency syndrome (HIV and AIDS) and AIDS have continued to remain a serious public health issue globally. According to Global Health Policy (2019), the world statistics on HIV and AIDS prevalence state that 37.9 million people of the population worldwide are at present living with HIV AND AIDS. This epidemic is disproportionately spread as Sub-Saharan Africa (SSA) bears the heaviest burden (McDonald, 2019). South Africa remains the epicentre of HIV and AIDS pandemic as the highest prevalence of AIDS in the world. This is because 20percent of all people living with HIV AND AIDS are in South Africa and 20percent of new HIV AND AIDS infections occur in the same nation as well (Allinder, 2019). In the Ugandan context, the UNAIDS Report (2018) shows that 1.4 million people aged between 15 and 49 are living with HIV and AIDS. This figure represents 5.7percent of the total population of Uganda suffering from HIV and AIDS; of which 8.8percent are female and 4.3percent are male. In comparative terms,

this suggests that the prevalence of HIV and AIDS is higher amongst women than men. According to the same report, 53,000 people had newly acquired HIV and AIDS in the gap of one year and 23,000 people died in the year 2017 from HIV and AIDS-associated infections. As a consequence, the PEPFAR Country Operational Plan (COP19) for Uganda (2019) reflects a bold move towards controlling the epidemic in line with both the UNAIDS 90-90-90 and the national 95-95-95 goals across sexes and age bands.

The HIV and AIDS epidemic remains a major setback in the development priorities of Uganda given its effects on the different sectors. Uganda has made key progress in fighting HIV and AIDS with positive results in the area of elimination of Mother-to-Child Transmission (eMTCT) and enrolment into care and treatment. That notwithstanding, Uganda has seen a rise in the epidemic especially among adolescents and young adults. This brings about a major setback in the achievements hitherto made and calls for refocusing in the priority areas. According to the World health organization (2019), sexual violence is more common amongst women, and approximately one-third of all women have experienced some form of violence. The Report further states that women who have experienced physical or sexual intimate partner violence are 1.5 times more likely to acquire HIV and AIDS those who have not experienced violence.

The phenomenon of GBV is deeply rooted in gender inequality; it is directed against a person simply because of their gender. GBV is an umbrella term used to describe any harmful act that is perpetrated against a person's will on the basis of unequal relationships between women and men as well as through abuse of power. While both women and men experience GBV, majority of the victims are women and girls. GBV remains one of the most notable violations to Human Rights, a public health challenge and a barrier to social, political and economic participation within every society across the world. GBV is a global challenge that affects 1 in 3 women in their lifetime. Approximately, 35percent of the women worldwide have experienced either physical or sexual intimate partner violence or non- partner sexual violence. Worldwide, 7percent of women have been sexually assaulted by someone other than their partner; 38percent of murders of the women in the world are committed by an intimate partner; and 200 million women have experienced genital mutilation (World Bank, 2019). The highest prevalence of intimate partner violence (65.64percent) was reported in the SSA (WHO, 2013). The overall prevalence of GBV ranges from 42.3percent in Nigeria to 67.7percent in Ethiopia; the lifetime prevalence of sexual violence ranges from 43percent to 76.4percent; physical violence ranges from 7.4percent to 66.1percent, and emotional violence ranges from 26.1 to 50.8percent.

In Uganda, the Demographic Health Survey (2016) reveals that up to 22percent of the women aged 15 to 49 have experienced some form of sexual violence. The Report reveals that every year, 13percent of women aged 15 to 49 experience sexual violence. This translates to more than 1 million women exposed to sexual violence every year in Uganda. Much of this violence occurs within the family, school, place of work and in the community. However, most of the cases of GBV are never reported and of those that have been reported, only few are investigated and perpetrators tried in the Courts of Law. According to The Uganda Police Force Annual crime Report, GBV cases that are reported and investigated have increased by 4percent (from 38,651 to 40,238 cases) between 2015 and 2016. The Justice Law and Order Sector (JLOS) Report (2019) demonstrates that 7 out of every 10 women in Uganda have at one time gone through sexual violence; this is an alarming statistic and the Police Annual Report findings of 2014 indicate that there is a rising trend of Gender-Based sexual violence.

The WHO identifies a number of causes and risk factors of GBV; traditional gender norms that support male superiority and entitlement against perpetrators, excessive use of alcohol, weak legal sanctions, drug abuse, poverty and high levels of crime and conflict in the society. As a result, GBV is precarious, its scale is tremendous and it has devastating effects on the prevalence of social problems such as social exclusion, psychological distress, mental and anxiety disorders, the spread of HIV and AIDS and STD infections, unwanted pregnancies and the trauma experienced by victims, it has a direct impact on the dignity of the victims and productivity in general.

Problem statement

Uganda has a vision to reduce the HIV and AIDS infection to zero using the 90:90:90 strategy. The 90:90:90 strategy is an ambitious treatment target that was launched by UNAIDS and other HIV and AIDS programming partners. The strategy aims to diagnose 90percent of all people living with HIV and AIDS, provide antiretroviral therapy for 90percent of those diagnosed and achieve viral load suppression of 90percent for those treated by 2020 (PEPFAR/COP, 2019). However, there is slow progress towards realizing this goal since cases of new infections and poor viral load suppression have remained a challenge (Wandawa, 2020). Despite a number of interventions made against HIV and AIDS in Uganda, statistics indicate that there is a very high prevalence among women with cases of new infections reported at 8.8percent among women against 4.3percent for men (The UNAIDS Report, 2018). Accordingly, women of age bracket 15 to 49 are the most affected with GBV and yet that same age bracket are the most affected by HIV and AIDS. This trend suggests a correspondence between GBV and the prevalence of HIV and AIDS in Uganda. This study therefore, aims to establish the consequence of GBV on the prevalence of HIV and AIDS in Uganda.

Purpose of the study

This study investigates the consequence of GBV on the prevalence of HIV and AIDS in Uganda. Consequently, three questions are asked and answered, namely: (a) how does GBV contribute to the transmission of HIV AND AIDS among Women in Uganda? (b) What effect does GBV have on women under Care, Support and Treatment of HIV AND AIDS in Uganda? And (c) what possible remedies can be adopted to reduce GBV and hence HIV and AIDS among women in Uganda?

Study area

The study covers Uganda which is located in the Eastern part of Africa. The current population of Uganda is 45,221,410; this is equivalent to 0.59percent of the total world population. The population density in Uganda is 229 per square Kilometre. The total land area is 199,810 square Kilometres. 25.7 percent of the population is urban and the median age is 16.7 years (World meter elaboration of the latest United Nations data, 2020).

METHODOLOGY

This study is a desk-based research that involves reviewing available literature on GBV and HIV and AIDS, clustered group files and thematic review of secondary data. The study utilizes across sectional data from the Uganda demographic health surveys (UDHS) and Baseline surveys conducted in the Country.

RESULTS AND DISCUSSIONS

A consequence of GBV on HIV and AIDS transmission among women in Uganda

According to the Report on Violence against Children Survey (2016), a high level of physical, sexual, and emotional violence against women is present in Uganda. Looking at females and males aged 18 to 24, 59 percent and 68 percent respectively report experiencing physical violence before the age of eighteen. Twice as many girls (35 percent) than boys (17 percent) have experienced sexual violence and one-third of both girls and boys have experienced emotional violence. Among young people aged 18 to 24, 10 percent of girls and 2 percent of boys are victims of forced sex before age eighteen. Un-negotiable early sexual encounters can force children out of homes and expose them to the risk of HIV and AIDS. Data from the Uganda Population-Based HIV and AIDS Impact Assessment (2017) reveals that boys and girls have similar prevalence of HIV AND AIDS up until the age of ten. At that point, the prevalence of HIV and AIDS increases in females so by the age of 15 to 24, the prevalence of HIV and AIDS among females is up to four times that of males (0.8 percent in males aged 15 to 24 versus 3.3 percent in females aged 15 to 24).

According to the Ministry of Health (2017), the prevalence of HIV and AIDS is almost four times higher among young women aged 15 to 24 than young men of the same age. The issues faced by this age group are GBV (including sexual abuse) and a lack of access to education, health services, social protection and information about how they can cope with these inequities and injustices. Nevertheless, the Uganda Demographic and Health Survey (2011) reveals that 50.5percent of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months (UBOS, 2012). Women aged 20 to 24 are worst affected, with 40percent experiencing recent intimate partner violence, compared to 31percent of women aged 15 to 19 and 30percent of women aged 25 to 49 (UNAIDS, 2017). Certainly, young women in Uganda who have experienced intimate partner violence are 50percent more likely to have acquired HIV and AIDS than women who have not experienced violence (Uganda AIDS Commission, 2015).

The Global and regional estimates of violence against women (2018) reveal that intimate partner violence (IPV) and HIV and AIDS infection are key interrelated public health problems worldwide. Sexual IPV may directly lead to HIV and AIDS acquisition by forced condom-less sex or inability to negotiate the use of condom with an infected or violent partner. Both Campbell et al (2008) and Mumtaz et al (2014) agree that men who apply violence against their partners are more likely to engage in a range of high-risk sexual behaviours (e.g., multiple partners and condom-less sex) and/or drug use (e.g., hazardous alcohol use and injection drug use behaviours relative to men who are non-violent. According to the Rakai Health Sciences Program substantial evidence has been generated on the relationship between IPV and HIV and AIDS infection in agricultural settings of Uganda. Data collected over a period of 10 years from 15,080 adult women found 59 percent and 29percent experienced lifetime, and past year IPV (including physical, sexual and verbal) respectively (Koenig et al 2004). In analysing data on Rakai, 14.4percent of adolescent females (15 to 19 years) experienced forced first sex (Koenig et al 2004). Many adverse reproductive and relationship-level outcomes have been associated with partner-level violence, including unintended pregnancy, higher rates of genital tract symptom, attempted abortion, and union dissolution through divorce or separation (Wagman JA et al 2016; Kouyoumdjian et al 2013). Significant associations are found between IPV and the incident HIV and AIDS. The estimated adjusted population fraction of HIV and AIDS attributable to IPV in Rakai district is 22percent (95percent CI 12.5–30.4) (Kouyoumdjian et al 2013). As a consequence, longitudinal data collected from Rakai, Uganda, has demonstrated that

IPV is a risk factor for HIV and AIDS.

Partner's use of alcohol before sex is a significant risk factor for IPV victimization among women in fishing and trading communities, and IPV perpetration among men in agricultural communities. Problematic use of alcohol is associated with IPV perpetration as well as HIV and AIDS infection in studies beyond Uganda (Iyoke et al 2014). In our review, we found that women's use of alcohol before sex in fishing communities and partner's use of alcohol before sex in agricultural communities are related to HIV and AIDS infection among women. Thus, the use of alcohol can put individuals at risk for both IPV and HIV and AIDS. Hence, efforts aimed to prevent IPV and HIV and AIDS in Uganda need to address use of alcohol among women as well as their partners.

A recent study among young people in slum areas in Kampala, indicates that 34.3percent agreed that it was okay for a boy to force a girl to have sex if he has feelings for her and 73.3percent affirmed that it is common for strangers and relatives to force young females to have sexual intercourse with them without consent. AGYW are at risk of sexual coercion "an act of forcing or attempting to force another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against his or her will; all these practices expose the AGYW to risk of HIV and AIDS infections. Available evidence demonstrates a complex relationship between GBV and HIV and AIDS among women (Dunkle & Decker, 2013). For example, women who experience GBV are more likely to engage in HIV and AIDS risk behaviours such as condom-less sex and are more likely to be living with HIV and AIDS (Li et al 2014). Likewise, obtainable evidence suggests that women living with HIV and AIDS are at higher risk of experiencing violence (Olwookere et al 2015).

According to the Uganda Police Crime Report (2016), cases of defilement shot by 34 percent, from 13,118 in 2015 to 17,567 in 2016. Defilement is the act of having sex with girls under 18 and it is a form of GBV. The Report further indicates that rape cases reported according to, also increased, from 1,419 to 1,572. The same report indicated that, in Lira, the number of defilement cases increased from 79 in 2015 to 101 new cases in 2016. This figure puts Lira district among the top 10 districts in the country with the highest cases of defilement. All these expose the adolescent girls and young women to the risk of HIV and AIDS.

There is a very strong interrelationship between HIV and AIDS infection and SGBV. A cross-sectional study conducted on 334 people above 18 years old in Lira district to assess the prevalence of HIV and AIDS as influenced by SGBV and in particular to determine the prevalence of HIV and AIDS established that the prevalence of SGBV among these people was 47.3percent. More women are affected (77.6percent) than men (22.4percent). The various types of GBV occurring are; emotional violence (62percent), physical violence (55.5percent) and sexual violence (8.6percent). The Report showed that 44.3percent of SGBV cases are reported to clan leaders, relatives, elders and the Police. This increase in GBV suggests an increase in HIV and AIDS prevalence by 1.7percent in Lira mainly among women aged 15 to49 (Achar et al 2010).

Effect of GBV on care, support and treatment among HIV and AIDS positive women in Uganda

In 2015, WHO published guidelines to promote the use of antiretroviral treatment (ART) by anyone diagnosed with HIV and AIDS, given the protective effects of early treatment initiation (Cohen et al 2016). In 2017, UNAIDS adopted the 'epidemic control' model in which the global HIV and AIDS response are now working towards 90percent awareness of HIV and AIDS status, 90percent of those with HIV and AIDS on treatment, and 90percent of those on treatment viral load suppressed (Glion, 2017). Also in the same year, WHO finalized guidelines promoting pre-exposure prophylaxis - a

formulation of ARVs which prevents HIV and AIDS acquisition even if exposed for all those at substantial risk including members of key populations (McCormack et al 2016; WHO, 2016). Over the past several years, limited evidence has been documented on GBV as an obstacle to women's engagement in the HIV and AIDS care continuum. For example, a methodical analysis by Hatcher et al (2015) conducted before the guidelines was established discovered the effects of IPV on use of ART, adherence to ART and retention in HIV and AIDS care among WLHIV and AIDS. IPV is associated with lower use of ART, adherence to lower self-reported ART, and lower odds of viral suppression (Hatcher et al 2015).

The study suggests that the issue of GBV are related with reduced linkage to HIV and AIDS care among WLHIV and AIDS (Watt et al 2017; Maeri et al 2016) including FSW. A cross-sectional study among WLHIV and AIDS conducted in Kenya found that women are less likely to link to HIV and AIDS care if they anticipate a violent reaction from their partner upon learning the HIV and AIDS-positive sero status of a woman (Hatcher et al 2012). This is reinforced by qualitative research from Uganda and Kenya, which established that women evade revealing their HIV and AIDS-positive status to their partner as they fear a violent reaction (Maeri et al 2016). Further, women reveal that non-disclosure is a key obstacle to uptake of HIV and AIDS care since they do not want to reveal their status to their partner by seeking care (Maeri et al 2016).

There is evidence to advocate that GBV prevents WLHIV and AIDS from staying engaged in HIV and AIDS care, once they have already enrolled (Watt et al 2017). A cross-sectional study among WLHIV and AIDS in Canada found that experiences of IPV are connected with increased disruptions in HIV and AIDS care longer than one year (Siemieniuk et al 1999). Qualitative evidence proposes that women miss their HIV and AIDS care schedules due to fear that attending to such appointments will accidentally alert their husband to their HIV and AIDS-positive status and cause violence (Lichtenstein et al 2006). Having spouses who bully women with violence or prevent them from attending their HIV and AIDS care appointments may also prevent WLHIV and AIDS from remaining engaged in HIV and AIDS care (Kosia et al 2016). Also, women who experience violence miss their appointments due to misery, physical ailment, or injury caused by violence, and or shame of being abused (Lichtenstein et al 2006).

Taken together, evidence suggests that WLHIV and AIDS who experience violence are less likely to initiate adhere to ART (Hatcher et al 2014; Sullivan et al 2015; Trimble et al 2013; Mendoza et al 2017; Conroy et al 2017; Kidman et al 2018) and achieve viral suppression (Sullivan et al 2015; Espino et al 2015). In terms of ART initiation, a longitudinal study among WLHIV and AIDS in the US found that women who experienced physical or sexual violence were likely to be non-ART users after a three-month follow-up period (Mendoza et al 2017). In a cross-sectional study, Espino et al. (2015) found that African American women in the US with a history of violence were less likely to be virally suppressed than women without a history of violence (Espino et al 2015). A study by Hampanda et al (2016) found that, in Zambia, violence from a partner is associated with reduced adherence to PMTCT during and after pregnancy among pregnant and post-partum WLHIV and AIDS.

Qualitative studies shed light on potential mechanisms through which GBV can lead to poor ART adherence. They suggest that women choose to keep their HIV and AIDS-positive status a secret from their partner because they fear their partner may become violent upon learning their status (Hatcher et al 2014; Ayadi et al 2016). As a consequence, women hide their pills and have to take their medication in secret (Hatcher et al 2014). This leads to missed doses of ART (Maeri et al 2016). Additional qualitative research reveals that some partners throw away the ART medication, or otherwise prevent

women from taking their medication, which limits their adherence (Kakoko et al 2016). Other research demonstrates that WLHIV and AIDS who experience violence from their partners can miss treatment due to depression (Hatcher et al 2016). While much of the literature suggests a negative association between violence and ART use and adherence, there are studies among WLHIV and AIDS that do not follow this trend (Wilson et al 2016). For example, a cross-sectional study on WLHIV and AIDS attending an HIV and AIDS clinic in Baltimore, Maryland does not find any association between GBV and current ART use. The authors note that this finding is due to the fact that women in the sample were recruited from an HIV and AIDS clinic and, all participants were engaged in HIV and AIDS care and treatment (Illangasekare et al 2012). Additionally, a cross-sectional study among FSW in Cote D'Ivoire does not find a significant relationship between experiences of violence and ART adherence (Lyons et al 2017).

Three other studies find no significant relationship between experiences of violence and engagement in HIV and AIDS care among WLHIV and AIDS (Blank et al 2015; Blackstock et al 2015). All three studies are cross-sectional and from the US. Additionally, a mixed methods study among FSW in Kenya found that GBV does not limit women's engagement in HIV and AIDS care (Wilson et al 2016). Findings from this study suggest that women utilize a number of different strategies to stay engaged in HIV and AIDS care including not disclosing their HIV and AIDS status to their partner and seeking support from their friends.

It is a known detail that Viral load suppression is a problem among the HIV and AIDS clients which impacts on the third 90 of the UNAIDS/Uganda HIV and AIDS fight strategy. This fact can be attributed to poor adherence caused by GBV related issues, poor nutrition, stigma and non-disclosure of HIV and AIDS + status, especially to intimate partners and relatives. The issue of non-disclosure can be related to GBV since a number of partners in particular women fear to share their conditions with their partners for fear of violence. Hence low ART uptake and poor adherence lead to a low viral load suppression.

Remedies to GBV among women in Uganda

Expand efforts to target harmful gender norms and educate young people, women, and men through comprehensive sexuality education, behaviour change initiatives, and community-based programming. Numerous programs can be enhanced to address harmful gender norms in society that perpetuate discrimination against girls and women and give rise to violence (Jewkes et al 2004). The programs seek not only to question harmful gender norms, but to develop gender-equitable behaviours as well as effective mechanisms for protection. Such programs have effectively addressed stigma around gender-based violence (GBV), intimate partner violence, school-related GBV, female genital mutilation (FGM), and child, early, and forced marriage. Many of the programs incorporate sexuality education and take a rights-based approach (Arango et al 2016).

Comprehensive sexuality education (CSE) is an important aspect of preventing GBV because it aims to provide young people with the knowledge necessary to engage in safe, consensual sexual behaviour. CSE not only covers all aspects of reproductive and sexual health, inclusive of all gender identities and sexual orientations, but it also normalizes sexuality and reduces stigma. Furthermore, CSE contributes to gender equality by increasing awareness of the diversity and impact of gender in people's lives. By embracing CSE, governments can promote healthy, inclusive, and consensual sex that discourages violence and coercion (UNESCO, 2018).

Ensure and enforce legal protections and justice for survivors of gender-based violence. Preventing violence against girls and women is only possible through the implementation of strong legal and policy frameworks that recognize all forms of gender-based violence and inequality among genders, address harmful attitudes, and respect human rights, regardless of sexual orientation or gender identity (UN Women, 2012). Government of Uganda ought to account for their responsiveness to and investment in reducing GBV and their protection of women survivors in the justice system, which includes deterring perpetrators order to increase women survivors' access to justice, governments should create, strengthen, and ensure the implementation of laws that provide thorough protection from GBV (World Bank Group, 2017). Furthermore, governments must ensure effective prosecution of perpetrators and justice for survivors, which includes funding a range of rehabilitation and treatment programs. This can be accomplished through the establishment of mobile courts, specialized police units such as women's police stations and trained prosecution teams. Survivors should have access to legal support and services, especially doubly-disenfranchised survivors, including migrants, refugees, people with diverse sexual orientations and gender identities, and people in humanitarian and conflict-affected regions. (Gender Equality Advisory Council, 2018).

Engage men and boys in the prevention of violence and the promotion of gender equality. Gender equality and gender-based violence will never be eliminated without the full participation of men and boys. Because men generally have more power than women, they often are the decision-makers in families, communities, the private sector, and governments. Men tend to control women's access to sexual and reproductive health services, finance, and transportation, and men's violence against women around the world is pervasive. (Peacock, et al 2014). However, some men are interested in moving toward more equal societies. Many men recognize the existing gender imbalance in home and child care and want to work toward a more balanced dynamic and research has shown that male leaders are important allies in the prevention of violence against women (Heilman, 2017). Interventions that include men and boys should take a multi-level approach, recognizing the importance of impacting at the individual, family, community, society, and governmental levels, and including boys, young men, and adult men. These programs aim to foster non-violent masculinities and strengthen partnerships with women's rights organizations (Men engage alliance, 2018.) Any solution involving men and boys should aim to improve the lives of men and boys as well as women and girls, and it should be inclusive of diversity among men in terms of sexual orientation, gender identity, and masculinity (Gender equality advisory council, 2018).

Increase equitable access to economic assets. Building girls' and women's economic empowerment is key to transforming relations between men and women and integral to changing attitudes, behaviours, and ultimately ending gender-based violence (UN Women, 2015). There are multiple approaches to designing programs that make access to economic assets more equitable for girls and women. Examples of effective programs include those that increase girls' access to education; provide marketable skills training for women as well as financial opportunities; and work to secure land, inheritance, and property rights impacting women. The relationship between women's economic empowerment and intimate partner violence is a complicated one that changes over time and context. Introducing economic empowerment into communities may lead to a temporary increase in intimate partner violence, pointing to a need to address harmful and restrictive gender norms along with economic empowerment in such situations (Schuler et al. 2013). In many contexts, when women do have access to economic assets, a pervasive gender wage gap persists, contributing to gender

inequality and intimate partner violence. (Gender equality and women's rights in the post-2015) A study conducted across the United States showed that a decrease in the wage gap reduced violence against women (Aizer, 2010). It is also important to note that increasing equitable access to economic assets does not refer only to initiatives that aim to improve women's abilities to enter the workforce and earn a salary or wage. Increasing access to economic assets also includes increasing access to land. Securing land rights for women is an integral step toward breaking cycles of poverty and supporting the economic empowerment of women (UN Women. 2017). When women are empowered to build a life outside the home and outside the informal economy, they are better able to access legal and supportive services in response to violence. Reducing women's economic dependence on their partners also enables women to leave environments where there are incidences of domestic violence (Women's economic empowerment and domestic violence, 2015).

Invest in local women's movements and women-led civil society. A global comparative analysis of policies on violence against women (VAW) over four decades found that strong, feminist movements were the original catalysts for government action. Feminist civil society affects policy change by influencing global treaties, influencing regional agreements on VAW, and exerting pressure at national and regional levels to conform to new norms. While Millennium Development Goal 3 led to considerable progress in empowering girls and women, its focus on education and health was not enough to secure their equality. Without a corresponding emphasis on the rights of girls and women, Sustainable Development Goal (SDG) 5 (Achieve gender equality and empower all women and girls) will fall into the same trap. Gender equality requires the consistent engagement of gender-equality activists and experts, which in turn requires institutional and financial support.

CONCLUSION

Following the literature review made, it is indeed a fact that GBV has a significant consequence in the prevalence of HIV and AIDS and it is one of the key drivers of HIV and AIDS prevalence in Uganda. There are however other factors as well that are contributing to the prevalence of HIV and AIDS in Uganda example, alcohol abuse, prostitution, drug abuse, exposure to multiple sexual partners. A combined effort is required by all stakeholders if this trend is to change.

Recommendations

Engagement of Key stakeholders like police, Health workers, CDOs and other Opinion leaders in the sensitization and education of the community people on GBV and HIV and AIDS-associated risks.
Implementation of laws against Gender-based violence so that it works as a warning to the potential abusers.

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