service providers and often mobile HIV-positive populations
■ acknowledge the reality that state-provided ART programmes are under-resourced
■ decentralise treatment and fund community-based support to help ensure continuity of treatment
■ recognise the burdens placed on community-based ART adherence monitors, especially those who are themselves HIV-positive
■ target support to HIV-positive patients so that while they are struggling with transition they are also helped with treatment adherence
■ use community workers to help patients overcome anxiety over the return period through providing information about treatment options
■ ensure that data collection in post-conflict situations focuses not just on adherence but also on patient attrition.

In addition, data from well-resourced non-governmental programmes cannot be viewed as representative of all programmes; there is a need in northern Uganda, and elsewhere, for an assessment of more poorly resourced state antiretroviral programmes. While treatment provision can be successful to conflict-affected communities, the transitional phase poses a new set of challenges which have affected patients and may have increased the chances of drug resistance developing.

Those living with HIV in northern Uganda – as in other post-conflict contexts – show a remarkable capacity to adapt to the difficulties of return by forming new support groups. However, they remain vulnerable and live in fragile circumstances. The long-term sustainability of ART relies on the fostering of strong communication and support between donors, civil society, national health authorities, patients and local providers.


5. Interview with Dr Elizabeth Namagala (July 2009). National ART Coordinator, Ministry of Health. Interview with Dr Solomon Woldetsadik (August 2008), Head of World Health Organisation, Gulu Sub-office.

Gendered violence and HIV in Burundi

Hakan Seckinelgin, Joseph Bigirumwami and Jill Morris

Pre-existing gender relations changed for the worse during the conflict and interventions to promote disarmament, demobilisation and reintegration (DDR) failed to address the dynamics which shape the spread of HIV.

Conflict has scarred Burundian society since independence in 1962, although in recent years a still fragile peace has emerged from a series of ceasefire agreements signed by armed groups.

A series of interviews with men, women, youth, ex-combatants, IDPs and sex workers highlighted the extent of conflict-related changes in Burundian society and how HIV prevention efforts must take these changes into account. Each interview aimed to elicit a narrative of experiences before, during and after the conflict in order to understand gender relations and perceptions of HIV/AIDS. They explored the traditional role of women as household care-givers and agricultural producers; the gendered hierarchy of decision-making which disempowers women; and legal restrictions on women’s ownership of land. These structural gender norms and vulnerabilities, remaining as constraints on women’s role in society, have facilitated the spread of HIV/AIDS.

In the literature on HIV/AIDS and conflict, it is often stated that conflict increases the likelihood of spreading HIV. However, the possible links between conflict and HIV/AIDS are complex. The literature largely focuses on the military, often simplistically relying on a single causal link between men and women. ‘Military’ implies a male gender position while the use of ‘general population’ suggests a female gender position.

This is a limited way of thinking about gender and conflict. Groups in conflict are linked in many other ways and these linkages do not necessarily allow a sharp distinction between protagonists in a protracted conflict as in Burundi.

Rather than attempting to prove or disprove the existence of a clear link between conflict and the spread of HIV/AIDS, it is more productive to think about how both processes create gendered vulnerabilities.

Gender context

The interviews produced evidence to suggest that while it is possible to argue that the conflict intensified and worsened gender disparities by exposing women to more violence, the particular forms of violence and deprivation during the conflict were shaped by pre-existing gender disparities. One of the things that has changed as a result of conflict is people’s sexual behaviour; for
example, extra-marital relations were formerly regarded as shameful and an acute embarrassment to the family if publicly known but have now become commonplace.

HIV has further exacerbated the vulnerability of women. Even when women are responsive to HIV/AIDS training and prevention messages, their capacity to deal with them in their everyday lives at present seems to be constrained. Many interviewees stated that men always blame women for their HIV status. Although most women stated that they were sexually active only with their husbands, men generally terminate relationships on learning of their positive status. This leaves women without husbands and unable to access land and other resources.

**Gender and conflict**

After 1993, conflict occurred between the government and multiple armed groups. As the conflict became prolonged, women became increasingly impoverished and exposed, left to defend themselves and to look after their families. The interviews indicated that when women joined armed groups to increase their chances for survival they were ill-treated. Those who went into IDP camps were also exposed to violence. General militarisation meant that many households lost adult males, while the situation for those women who did not have a formal marriage was particularly precarious. The relationship between wives who had been left behind and their in-laws and male relatives changed as the conflict continued. Often male in-laws sought to get rid of sisters-in-law in order to absorb women are responsive to HIV/AIDS training and prevention messages, their capacity to deal with them in their everyday lives at present seems to be constrained. Many interviewees stated that men always blame women for their HIV status. Although most women stated that they were sexually active only with their husbands, men generally terminate relationships on learning of their positive status. This leaves women without husbands and unable to access land and other resources.

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**DDR insensitive to gender vulnerabilities**

Demobilisation camps are integral to DDR, the first point at which ex-combatants have an opportunity to receive information on HIV/AIDS. Informants stated that while sensitisation and testing were important there was insufficient time for many ex-combatants to digest information and reflect on the personal implications for their behaviour as they prepared to return to communities from which many had been absent for many years. HIV programmes did not reach either the few women in demobilisation camps or the greater number of female ex-combatants who reportedly demobilised themselves. During DDR, female combatants were tested, but testing in general took place in environments that did not cater for their particular needs as women and as female combatants. If found to be positive they were generally condemned by men upon their return, and forced to fend for themselves while men were taken care of by families and relatives.

In Burundi, the DDR process was located within traditional gender structures that made women vulnerable during the conflict. Women coming out of the bush, or who were pushed out of their communities, were not integrated in a way that allowed them to become functioning members of society and they remain vulnerable to sexual violence.

**Conclusions**

In Burundi and elsewhere, the relationship between conflict and HIV/AIDS is complex and mediated by gender norms and values that pre-date the conflict. Prolonged conflict, displacement and restrictions on movement damaged social relations and traditional livelihood options, creating increased vulnerability to HIV. In this prolonged conflict, both within the household and outside, women were the most vulnerable, while pre-conflict gender relations had also created expectations among females from early childhood that they should be voiceless and submissive.

All interventions dealing with the spread HIV/AIDS, before and after conflict, need to take account of the sociological context of a particular conflict as well as structural gender characteristics – and must acknowledge how the various actors are interlinked.

DDR processes should not focus solely on military and armed groups. Given the nature of the conflict and the extent of violence experienced by so many people, DDR initiatives must address the underlying causes of violence, especially gendered violence. If they do not, they can become part of the HIV/AIDS problem, rather than assist the response.

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