Deprivation, HIV and AIDS in Northern Uganda

Peter Rwagara Atekyereza
Department of Sociology and Anthropology, School of Social Sciences, Makerere University, Kampala, Uganda
E-mail: atekyereza@chuss.mak.ac.ug

Abstract

This study focuses on HIV infection within the context of poverty and deprivation. The study used both quantitative and qualitative methods from a stratified random sample of 98 respondents, Key Informant Interviews and six Focus Group discussions, to investigate risk of HIV infection in Paimol Internally Displaced People's camp in Pader district, Uganda between 2008 and 2009. This district in Northern Uganda was characterised by war and insecurity physical aggression, deprivation, hunger and family separation, among others, for over twenty years. The Study shows that in spite of the relatively high levels of HIV/AIDS awareness, some people are at risk to HIV infection as a result of these. Significantly, with resettlement after the war, most people are still deprived of basic source of livelihood, which still continues as a factor in the spread of HIV infection.

Key Words: *HIV & AIDS, Deprivation, Susceptibility, Vulnerability, Deaths, IDP camps, Northern Uganda, Paimol, Pader*

Résumé

Cette étude se concentre infection par le VIH est dans le contexte de la pauvreté et de la privation. L'étude a utilisé des méthodes quantitatives et qualitatives bothans partir d'un échantillon aléatoire stratifié de 98 répondants, Entrevues avec des informateurs clés et des groupes de discussions de six, pour évaluer le risque d'infection à VIH dans Paimol déplacées à l'intérieur du camp de personnes dans le district de Pader, en Ouganda entre 2008 et 2009, ce quartier dans le nord de l'Ouganda a été marquée par la guerre et l'insécurité agression physique, la privation, de la faim et de la séparation de la famille, entre autres, depuis plus de vingt ans. L'étude montre que, en dépit des niveaux relativement élevés de sensibilisation au VIH / SIDA, certaines personnes sont plus à risque d'infection par le VIH à la suite de ceux-ci. De manière significative, à la réinstallation après la guerre, la plupart des gens sont encore privés de la source de base des moyens de subsistance, qui continue encore comme un facteur dans la propagation de l'infection à VIH.

Mots-clés: *VIH et le SIDA, la privation, la sensibilité, la vulnérabilité, Décès, camps de personnes déplacées, dans le nord de l'Ouganda*

Introduction

There seems to be a consensus that HIV infection has stabilized since 2006 following a UNAIDS report of global infection of the virus (UNAIDS 2006). While this might probably be the case, Sub-Sahara Africa still accounts for almost 69% of HIV/AIDS despite having 10% of the world population. As for those dying from the AIDS disease and AIDS-related illnesses, there is also a reported decline. Death from the latter is said to have dropped by 32% between 2005 and 2011. This has been attributed to the scaling-up of antiretroviral therapy, the robust focus on saving lives and preventing new infections through various programmes and strategies (UNAIDS 2012:4). In Uganda, which is the focus of this paper, the reverse seems to be the case: there is an increase in HIV/AIDS. Figures from the Uganda AIDS Indicator Survey show a rise in prevalence of HIV from 6.4% in 2005 to 7.3% in 2011. This rise shows regional and gender differences: there is a rise in prevalence of HIV among women from 7.5% in 2005 to 8.3% in 2011 compared to the rise in prevalence among men. High HIV prevalence remains concentrated more in mid-northern and central Uganda compared to other regions. This rising trend was first reported in 2008 (Shefer et. al. 2008). What accounts for the reported reversal and increase in the prevalence of HIV/AIDS in Uganda? This is the key question in this paper. The paper focuses on one noted district in Northern Uganda to examine the rise in the prevalence of HIV/AIDS. The paper is structured as follows: it starts with the general explanation for the spread of HIV followed by a brief discussion of HIV/AIDS in Northern Uganda. This is then followed by the examination of the rise in prevalence in this part of the country. A district chosen for this purpose and the rationale and method for the examination are provided before the discussion of the findings.

Established reasons for the spread of HIV/AIDS

The literature provides many reasons for HIV infection and prevalence. Poverty, civil strife and family disintegration are among these reasons and in addition to these factors, there are attitudinal and perception factors that further fuel the increase in HIV infections among various age groups in different societies. These factors include having multiple-sexual partners especially in relation to the attitude to and type of partners (Ntozi 1995; RoU/UAC 2006; UAC 2006). This seems to have strong cultural base. Infidelity and inability to negotiate safe sex by most female partners also contribute to the rate of HIV infection. Several studies of poverty and HIV point to survival strategies which particularly make women and girls vulnerable to unsafe sex and hence have higher exposure to HIV infection than men and boys (UAC 2005). There is also peer pressure coupled with sexual curiosity among young people that make them engage in risky sexual behaviour without due regard for the consequences. These are further aggravated

by various types of sexual crimes of rape (including marital rape), defilement and child abuse, prostitution and/or survival sex (Swart-Kruger and Richter 1997).

A highly significant factor in the prevalence of HIV in most conservative societies in Africa is sexual regulation. According to Atekyereza (2011), sexual regulation among various cultures traces its origin from sex education. Traditionally, boys and girls received sex education from their parents and/or relatives. No pre-marital sexual relations were entertained. There was strict law in form of mores and their enforcement. Sexual crimes like incest, defilement or indecent assault were very abominable. Sex education derived its primacy from the rationale of sex in family life. The traditional safeguards against improper sex were many and were part and parcel of the socialisation process and each person knew the consequences of sexual deviation. Parents never entertained lone visits by girls and showed exemplary behaviour. Young boys and girls did not freely mix with each other. Today, however, the context and rules that define social and sexual interaction have changed. With more urbanisation, formal education, migration, globalisation (in all its forms) and permissiveness, sexual regulation has become very low. Regulating institutions are weakening due to prolonged absence or separation of family members from resident authorities. There is less and declining value for virginity that used to be the cornerstone for regulation of sexuality. Most young men and women are sexually active at a very young age and outside marriage. Sexual regulation and respect is not any much better in marital relations (Atekyereza and Kirumira 2004). This becomes even more serious a problem in conditions of insecurity or lawlessness and poverty or deprivation. It is against this background that the study was conducted seeking to probe further why and how people may be forced to choose between *deaths* and not between *life* and *death,* i.e. choosing *death* (by exposure to HIV infection) in order to live.

Vulnerability and HIV/AIDS in Northern Uganda

To understand vulnerability in the context of HIV and AIDS, it is important to have a clear understanding of other related concepts of susceptibility, resistance and resilience. According to Loevinsohn & Gillespie (2003) and Gillespie (2006), susceptibility refers to the chances of an individual becoming infected by HIV. It has two components, first, the chance of being exposed to the virus, which in turn relates to the risky environment and specific situations of risk that the person confronts, and the riskiness of behaviours (both of which may be related), and, second, the chance of being infected with the virus once exposed. Resistance, on the other hand, is the ability of an individual to avoid infection by HIV, either by escaping exposure or, if exposed, by escaping infection. To avoid susceptibility to HIV infection, the individual must be knowledgeable and in position to resist the risks of exposure to HIV infection. Unlike susceptibility, vulnerability refers to the likelihood of significant impacts occurring at a certain level (e.g. individual, household, community level etc). These impacts are not one-time events, they are processes, often

hidden, slow-moving, but destructive. These processes are often triggered by events, such as the sale of assets, some of which are irreversible, leaving the household, if it survives, significantly impoverished (Savage *et. al.* 2008). These impoverishments affect capacity for resilience. Resilience refers to the active responses that enable people to avoid the worst impacts of AIDS at different levels or to recover much faster to a level accepted as normal. AIDS is just one of the many disasters with which the rural people of Africa are learning to live. However, the diverse ways in which AIDS can affect rural people, societies, livelihoods and economies are not always obvious, and less so are the sources of strength that would enable people to be resilient to those impacts.

The significance of the environment in disease transmission was first highlighted by Louis Pasteur who stated *the microbe is nothing, the terrain everything* (quoted by Stillwaggon, 2002). A number of factors combine to influence behaviour and shape risky environments and situations. These include asymmetrical sexual relations, movement of people move into and out of, or between situations of risk and inequalities of several sorts which are central to the risks of exposure that people face. Asymmetrical sexual relations increase exposure to HIV infection especially where a small number of women have unprotected sex with a larger number of men, or vice versa. Epidemiological models show that such asymmetrical relationships hasten the spread of infection in a population (Garnett & Anderson 1996). The people of northern Uganda lived in internally displaced people's (IDP) camps for over 20 years due to the war between the Uganda government and the rebel soldiers led by Joseph Kony. The camp life presented a more complex nature of such asymmetrical sexual relations for different needs and purposes. The movement of people move into and out of, or between situations of risk contributes to widening the epidemic and raising infection rates in areas or among groups previously little touched by it. In the displaced people's camps in northern Uganda, movements by the displaced people, armed security forces i.e. Uganda Peoples Defence Forces (UPDF), the Police and Local Defense Units (LDUs), the rebel forces (the Lord's Resistance Army (LRA)), wrong elements taking advantage of the fragile security situation as well as service providers complicate the serious nature of the sexual risk and nature of sexual networks that evolve. Different types of inequality expose people to risks (Farmer 1999). Social, economic and gender inequalities shape the sexual relationships people enter and geographic disparities affect their decisions on movement. The camp life vividly shows these inequalities particularly between service seekers and providers, displaced and security providers across age and gender.

Northern Uganda

Traditionally, north-central Uganda was predominantly Acholi and Langi. The Pader district, in particular, is predominantly Acholi, who are a collection of small ethnic groups that came together with Luo migration in the mid nineteenth century. Their main

livelihood was traditionally based on mixed farming of cattle keeping and crop cultivation occasionally supplemented with hunting (Nzita and Mbaga, 1997). This livelihood pattern survived for a long time through the pre-colonial and post-colonial time under traditional leadership (the *Rwot*) who had spiritual, judicial, executive and legislative powers. However, in 1986 the National Resistance Movement/Army (NRM/A) took power and thereafter insecurity and civil strife raged in northern Uganda mainly between the government forces and the Lord's Resistance Army (LRA) of Joseph Kony. Consequently, the lives and livelihoods of many people in this part of the country started deteriorating and gradually became susceptible to all forms of socio-economic and security vulnerabilities resulting in widespread poverty. It is, for example, only northern and Eastern regions of Uganda that are highly dependent on free government health units for medicine (UBOS 2010:175) and yet these units either have very few inadequate and poorly remunerated health workers or are hit by drug stock-outs repeatedly. Table 1 shows variations in other socio-economic indicators between national averages and the region of northern Uganda.

Table 1: Basic Indicators: Comparison of Northern Uganda the entire Country

Socio-Economic Indicator	2005/2006		2009-2010	
	Northern Uganda	Nationwide	Northern Uganda	Nationwide
Poverty: Poor persons[3]	3,250,000	8,440,000	2,840,000	7,510,000
Consumption Expenditure per Household (Ugx)[3]	111,700	205,250	150,200	210,250
Literacy rate of persons aged 10 years and above (percent)[3]	59	64	64	73
Education Status of Persons aged 15+ - %[3]	26.7	20.1	22.8	17.3
Moderate malnutrition among children -% (MoH 2003)	25	23		
Vulnerable Children (Percent)[3]	80	65	43	38
Distribution of Orphans (percent)[3]			3.7	2.4
HIV prevalence rate - %[2], 4	8.2	6.4	8.2	7.3
Population without Access to safe water -% (UNDP 2005)	29.7	37.4		
Community access to improved sources of drinking water (%)[3]			65.7	68.9
No Latrine/Bush (Percent)[3]	21.2	10.6	24.9	8.7
Telephone Service (Percent)[3]	12.1	48.5	19.7	70.8
Bank Branch office[3]	0.3	0.4	0.5	4.8
Loan Applicants by region (percent)[3]	4.1	10.4	15.0	17.4

***Sources**:*

[1]United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2006

[2]MoH and ORC Macro, 2006, Uganda HIV/AIDS Sero-Behavioural Survey 2004/05

[3]Uganda Bureau of Statistics (2010) Uganda National Household Survey 2009/10. Kampala: UBOS

4*Uganda Ministry of Health and ICF International 2012. 2011 Uganda AIDS Indicator Survey: Key Findings. Calverton, Maryland, USA: MOH and ICF International.*

In Table 1, indicators show that in spite of the efforts by the Ugandan government and its development partners to improve the well being of Ugandans, northern Uganda has continued to be a region with high poverty incidence. As a result there are higher rates of illiteracy, malnutrition, lack of access to safe water and HIV infection. By 2006 over 1.8 million people were displaced in Acholi region and parts of Teso and Lango regions and Adjumani district (UN-OCHA 2006) and more people lived in inhumane conditions despite the increased intervention of the humanitarian community (36 Non-Governmental Organisations and United Nations agencies). The over-crowded camps were susceptible to recurrent disease outbreaks, wildfires during the dry season and human rights abuses from the LRA, the Uganda Peoples Defence Forces (UPDF) or Local Defence Units (LDU) including sexual and gender-based violence. The July 2005 mortality survey carried out in Gulu, Kitgum and Pader districts by the Ministry of Health, World Health Organisation, UNICEF, UNFPA, WFP and IRC estimated crude and under 5 mortality rates at 1.54/10,000 and 3.18/10,000 per day, respectively. These rates are far above the emergence threshold of 1/10,000/day and the leading causes of this mortality are malaria, diarrhoea, violence, malnutrition,HIV and AIDS and limited access to quality health services compound the problem.

Furthermore, vulnerability in northern Uganda has been compounded by cattle rustling by the Karimojong and ethnic tensions in the Karamoja region which is hampering durable return of displaced persons. Fear of the Karimojong warriors grips everybody and security escort from local militia or LDU is necessary to graze cattle or collect firewood. Furthermore, hosting of refugees coming from Sudan and the Democratic Republic of Congo in an area already characterised by population displacement overstretches the hosting capacity of the border areas in terms of water, sanitation, shelter and food. Ultimately, the entire population becomes vulnerable and has to make hard choices for survival. Whereas other areas in the country have received programme interventions for poverty alleviation, HIV prevention, AIDS treatment and care and support, insecurity and instability in northern has negatively affected nature of programmes and organisations that provide support. Insecurity further affects the timing and timeliness of the interventions compared to the rest of the country. In the area of poverty alleviation, for example, out of six IFAD operations completed in Uganda between 1982 and 2006, only 2 focused on northern and eastern Uganda and these projects were the Agricultural Development Project (1986-1992) and Agricultural Reconstruction programme in northern and eastern Uganda (1982-1986). This implies that IFAD's key poverty programmes stopped in 1992. In addition, out of the 4 projects on-going, northern Uganda is only included in the Rural Finance Service programme which is countrywide (IFAD 2007).

Even by 2010 with removal of IDP camps, the northern region remained vulnerable to poverty and its effects. According to the Uganda National Household Baseline Survey 2009/2010, of the population aged 15 years and above, the majority live in northern

Uganda; northern Uganda has the least working population, is the worst in terms of dwelling structures (i.e. characterised by 68.9 percent living in huts compared to 21.5 percent nationally (UBOS 2010:110)); least accessible to electricity by only 1.7 percent compared to 12.1 percent nationally; is the region with highest number of people depending on firewood for fuel by 87.6 percent compared to 73 percent nationally. Furthermore, the region has the highest levels of unemployment and is also the area where expenditure on food, beverage and tobacco increased from 52 percent in 2005/06 to 55 percent in 2009/10 and yet stagnated for health and education. It is the region with a higher proportion of poor people who escaped out of poverty (45 percent compared to 60 percent nationally) and also with highest proportion of non-poor who fell back i.e. 26 percent compared to 15 percent nationally (MFPED 2012:25) and so most people may not be out of poverty for long or sustainably. In addition, after resettlement, HIV prevalence in Northern Uganda stagnated at 8.2 percent (i.e. dropping from 7.1 percent to 6.3 percent for men and rising from 9.0 percent to 10.1 percent for women) compared to the national rate that has risen from 6.4 percent to 7.3 percent (Uganda Ministry of Health and ICF International 2012). With resettlement, more women continue to be more susceptible to HIV infection than men. It is therefore within this context that we need to understand the research findings on people's hard choices in the context of HIV and AIDS.

Methodology

This article is based on the secondary data review and findings from an exploratory study that was conducted in the camp of internally displaced people in Paimol, Pader district. Pader is found in North Central region of Uganda. There were 31 camps in Pader District before the decongestion exercise and they became 82 camps after decongestion. Data from personal interviews was collected from a stratified random sample of 98 respondents according to Blocks in the camp. Six Focus Group discussions (FGDs) were held with married men, married, unmarried men and unmarried women, widowed men and widowed women. In order to guard the respondents against trauma, the interviews and discussions were done and guided, respectively, by a graduate student from the area of study. This promoted freer interaction and willingness to participate in the study. The primary data from personal interviews was analysed using SPSS (version 11.0) for quantitative data while qualitative data analysis of open-ended questions and data from FGDs involved the thematic and content analysis of how respondents socially constructed their perceived risk to HIV infection and ultimately responded to this risk. Qualitative data provides a deeper understanding and interpretation of the findings. Key verbatim responses have been included to provide explanatory context for the quantitative data and also provide explanation in their own right.

Findings

In order to prevent HIV infection, seek treatment and support as well as mitigate the likely impacts of AIDS, people need to know HIV & AIDS especially in terms of its context, causes and effects. It is important to understand how the primary study findings relate to the context in Pader district (*described in the background*). Primary findings are presented in the order of the demographic characteristics of the respondents, level of awareness of HIV and AIDS, nature of sexual patterns and their rationale and implications as well as prevention efforts against HIV and mitigation against the impacts of AIDS amidst vulnerability.

Demographic Characteristics of Respondents

It is important to understand the nature of the sample which generated the findings that are presented and discussed. Demographic characteristics have been presented according to ethnic tribe, place of birth, sex, age, marital status, type of marriage, duration of marriage education, occupation and working status.

Table 2: Demographic Characteristics of Respondents

Demographic Characteristic	Frequency	Percent
Sex (n=98)		
Male	45	45.9
Female	53	54.1
Age (n=98)		
17 Years and Below	3	3.1
18-20 Years	4	4.1
21-20 Years	20	20.4
31-40 Years	18	18.4
41-50 Years	18	18.4
51-60 Years	15	15.3
Over 60 Years	20	20.4
Marital Status (n=98)		
Never married but ever had sex	8	8.2
Currently married	57	58.2
Separated or Divorced	4	4.1
Widowed	27	27.6
Abandoned	2	2.0

Duration of Marriage (n=88)		
5 Years or Less	20	22.7
6-10 Years	10	11.4
11-15 Years	10	11.4
16-20 Years	12	13.6
21-25 Years	3	3.4
26-30 Years	6	6.8
Over 30 Years	27	30.7
Religious Affiliation (n=95)		
Catholic	57	60.0
Protestant	34	35.8
Pentecostal	4	4.2
Highest level of Education (n=92)		
No formal education	30	32.6
Primary incomplete	25	27.2
Completed Primary or Junior	13	14.1
Lower secondary – incomplete	6	6.5
Completed Lower secondary	7	7.6
Upper secondary – incomplete	5	5.4
Completed upper secondary	3	3.3
Tertiary institution	3	3.3
Occupation (n=95)		
Not able to work	4	4.2
Housewife	2	2.1
Self-employed	5	5.3
Farmer	70	73.7
Professional / Civil servants	10	10.2
Local leader / Politician	2	2.1
Other	2	2.1

The findings indicate that all the respondents, except one Karimojong, are Acholi and 88 of them were born in Pader except for the 7 who were born in the neighboring districts of Kitgum and Gulu and Kotido. Since the HIV epidemic has a gender face, there were 45 males (45.9 percent) and 53 women (54.1 percent) in the sample and a majority of these were married on in union (57 respondents) followed by those who were previously married but were now widowed (27 respondents). The other categories included 8 respondents who were never married but ever had sex, the four who were formerly married but now divorced and lastly two who were formerly married but abandoned. This pattern of marital statuses shows that most respondents come out of marital union not only due to death but also abandonment and separation which may further be linked

to the threat of HIV. Separation increases risky behaviour as one woman said *when there is a misunderstanding and man leaves his wife, then each of them is free to do what he or she want with their bodies because they are no longer together* (FGD Young women, Muttu IDP camp). Findings further show that 70.5 percent of the married were living together with their partners compared to 29.5 percent that lived separate from their partners. In addition, of respondents who were or had ever been married, 39 (48.1 percent) were in polygynous marriage and 42 (51.9 percent) in monogamous marriages and 59.1 percent of these marriages have lasted between 1 to 20 years which corresponds to time that insurgency in northern Uganda has taken. Table 2 further demonstrates that majority of the respondents are Catholics; about 80 percent are aged 30 years or less; about 74 percent either have no formal education or only went up to primary seven or junior level. This level of education further explains the occupational pattern, which shows that most respondents are engaged in farming with only a few being formally employed. However, farmer respondents were not practising farming after living in the camps for more than 20 years. In fact, the working status indicated that 76.1 percent were working while 23.9 percent were not.

Awareness of HIV and AIDS

In Uganda, awareness of AIDS is reported to be over 99% and more than three in five Ugandans can cite two or more preventive practices (MoH and ORC Macro 2006) though comprehensive HIV & AIDS knowledge slightly lower ranging from 63 percent to 95 percent varying with gender and specific issues (Uganda Ministry of Health and ICF International 2012:4-5). The study findings also show that there is a high level of awareness of the epidemic. Of the respondents interviewed, 79.6 percent reported that they have heard about HIV/AIDS compared to the 20.4 percent who had not. However, hearing about HIV & AIDS is different from having correct information on what the two concepts mean. There are, for example, only 27.3 percent of those who have ever heard about HIV/AIDS that understand that HIV is the virus that causes AIDS and only 32.5 percent that know that AIDS refers to the sickness caused by HIV. Further analysis of FGD findings indicates that awareness among men is higher compared to women. In the FGD for unmarried women in Paimol Muttu IDP camp, a participant said, *"AIDS gets transmitted like this. When you go the bathroom and you find that the AIDS patient has just finished bathing, you can step on it"*. The findings from the FGDs show that separated and widowed women have far much less adequate information on HIV & AIDS compared to the married and singles. This may be attributed to different sources of information and stigma that might isolate the widows particularly those whose husbands are believed to have died of AIDS. Hence, though the population may generally be aware that HIV and AIDS exist, the nature of understanding may

not be adequate to enable them make informed prevention decisions. In terms of the understanding of HIV, for example, 46.8 percent of the respondents said that it is a sexually transmitted virus and 23.4 percent called it just an infection while 2.6 percent did not know. The findings further showed varied but high level of knowledge of the modes of HIV infection as Table 3 shows.

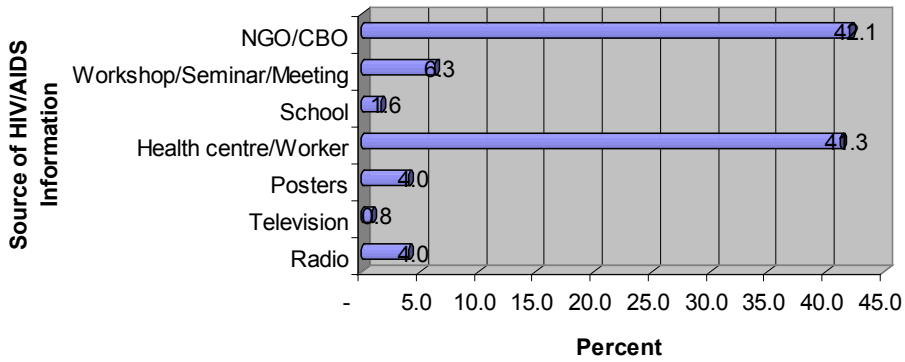
Table 3: Known Modes of HIV Infection (n=98)

Known Modes of HIV transmission	Tally	Percent
Sexual intercourse	92	93.9
Injectables	62	63.3
Blood substances	64	65.3
Mother to child	56	57.1
Infected fluids	52	53.1
Sharing of sharp objects	12	12.2

**Multiple responses were possible*

The commonly known mode of HIV transmission is through sexual intercourse with an infected partner and this finding is further supported by the findings from FGDs. The variations in the awareness and understanding could be attributed to the different sources of information about HIV & AIDS and also the emphases by these sources of information. As noted earlier, the highest levels of HIV infection in developing countries including SSA and Uganda is through heterosexual sexual intercourse. However, while the rate Mother-to-child transmission of HIV was 22 percent by 2008 (UNAIDS 2008), there was low level of awareness (57 percent) on the mother-to-child transmission of HIV in Pader compared to 82.5 percent nationally (Uganda Ministry of Health and ICF International 2012:4). This has serious implications for HIV control. The findings show that though the people in Pader IDP camps received information from different sources, one source i.e. the Non-governmental Organisation (GOAL) dominated all of them (see Figure 1). According to UAC (2007), most organisations were by then concentrated in neighbouring districts of Gulu and Lira and very little attention has gone to Pader district (Savage *et. al.* 2008). It was also established in the study that the GOAL NGO also doubled as a health provider.

Figure 1: Source of Information about HIV & AIDS



Whereas the MoH and ORC Macro (2006:43) say that the radio was the most important source of information about HIV/AIDS, the study findings show that only 4.0 percent of the respondents had got information from this source and only one person had got the information from the Television. A majority of respondents received information from GOAL. GOAL was a Non-Governmental Organisation which provided the internally displaced persons with medical and health services. According to Fountain Publishers (2007), there were only two NGOs operating in Pader district by 2005 (i.e. African Medical Research Foundation (AMREF) Uganda and World Vision Uganda). In spite of the proliferation of NGOs in Uganda, especially in response to HIV & AIDS, very few appear to be committed to operate in areas affected by insecurity like Pader. This implies that there was a very serious problem of information flow or access to information on HIV/AIDS among the IDPs which ultimately affected their sexual decisions and behaviour. Uganda AIDS Commission (UAC) noted that the problem of limited or total lack of timely, correct and adequate information heightens the risk of HIV infection for all categories of people and most particularly for women, girls and boys who are deemed more prone to the risk (UAC, 2005).Young women in camps, for example, associated HIV with men who have more than one wife, are adulterous and marrying without establishing one's HIV status and that of the partner. The nature of HIV & AIDS awareness has implications on how people in the internally displaced camps constructed and responded to the perceived risks to HIV infection. Lack of or inadequate or late information about HIV and AIDS to the people living in the camps cannot help people to make informed decisions for effective HIV prevention.

HIV & AIDS Awareness and Sexual Behaviour among IDPs in Paimol Camp

Whereas there is high level of knowledge that HIV is transmitted through sexual intercourse with an infected person, the sexual relations among the IDPs indicates that a number of people do not translate this knowledge into practice. There are a number of people who continue to have unprotected sexual intercourse with non-regular or casual partners as Table 4 demonstrates.

Table 4: Sexual Patterns among Internally Displaced Persons in the previous1 year.

Sexual Patterns among IDPs Have you had:	Last 1 year		Last 6 months		Last 1 month		Last 2 weeks	
	Yes	No	Yes	No	Yes	No	Yes	No
sex with more than one partner	33.0	67.0	20.3	79.7	16.2	83.8	12.7	87.3
protected sex with a casual partner	10.5	89.5	8.8	91.2	6.3	93.7	5.3	94.7
unprotected sex with a casual partner	50.0	50.0	48.7	51.3	44.6	55.4	42.3	57.7
protected sex with a regular partner	8.9	91.1	5.4	94.6	4.2	95.8	2.9	97.1
unprotected sex with a regular partner	63.7	36.3	63.3	36.7	58.4	41.6	57.1	42.9
protected sex with a prostitute	7.9	92.1	2.8	97.2	1.5	98.5	1.5	98.5
unprotected sex with a prostitute	13.3	86.7	13.1	86.9	8.2	91.8	8.2	91.8
An sexually transmitted infections (STIs)	18.9	81.1	2.9	97.1	1.4	98.6	1.5	98.5

High levels of unprotected sex among regular (often married) partners are understandable. However, the rate of 50 percent of the respondents reporting to have had unprotected sexual intercourse with a casual partner in the previous one year had serious implications for the risk of exposure to HIV infection in the camps. The findings from FGDs show that unsafe sex is not voluntary. Most young girls and women would be raped by unmarried young men and rebels when they go to fetch water or firewood away from the camps. This has also been reported in Karamoja (Yiga 2012) and was further aggravated by alcoholism and inheritance of widows. One male FGD for the married reported, *In Acholi, flood follows the same path. How can a man whose wife has died inherit a woman whose husband has died?*

The study established a statistically significant relationship between marital statuses, whether couple are living together and religion and having unprotected sex with casual partners. These findings show that most persons who have protected sex are those in marital or conjugal relationships. Table 5 indicates the correlations with unprotected casual sex.

Table 5: Correlations with Unprotected Casual Sex

Respondents Characteristic	**Unprotected Casual sex**
Marital Status of Respondent	0.008** (n=92)
Is the couple living together	0.023* (n=83)
Religious affiliation of Respondent	0.043* (n=89)

*p<0.05, **p<0.01

The not married but had ever had sex and those who were married had a higher likelihood of engaging in unprotected sex with a casual partner compared to respondents who had lost their partners or had separated or divorced or been abandoned. Respondents reported a high level of unfaithfulness among the married mainly attributed to the influence of alcohol. It was also reported that there are women who go out with young men to look for sexual satisfaction especially if their husbands failed to meet their

conjugal and other family obligations. Furthermore, couples living together are the ones likely to unprotected sex with casual partners. This has grave implications for HIV prevention since it is not couples living apart but those living together that were not only engaged in extra-marital sex but unsafe sex. It was reported that there are women who are poor and become vulnerable to men who have some money as one FGD reported *A man can come with 10,000/= and say, Madam, I can see that you have problems. This will make me believe that this man can help me in many ways if I get his money but this also means accepting to have sex with him. As I result, I may get infected with HIV* (Young women FGD, Muttu IDP camp). The contradictory behaviour confirms sexual permissiveness that had engulfed the social ecology in and around the IDP camps. It also explains why marriage continues to become a high risk environment for HIV infection (MOH and ORC Macro, 2006; MOH and ICF International 2012). Extra-marital sexual relations are not due to normal lack of sexual partners but also other factors that affect sexual lives of the partners in marital unions. Akello, for example, reported of the Camp Commandant in Pabbo camp in Gulu district, who said *Adultery and infidelity are high. Men and women are stealing each other's wives and husbands. There is no shame and respect anymore. Grandmothers now steal young boys from their wives and hide them in their huts* (Akello 2006:52).

In terms of religion, more Catholics were likely to have unprotected casual sex compared to other religions. The findings need to be contextualised in terms of the proportion of Catholics in Pader district. According to the 2002 Uganda Population and Housing Census, there are 231,450 Catholics in Pader. This is 71 percent of the total population of 326,320 (UBOS 2005). However, the findings could also be attributed to Catholic ideological teachings on HIV & AIDS which promote faithfulness for the married and abstinence of the non-married and against use of condoms as a preventive measure against both contraception and sexually transmitted infections. The implication of these findings is that Catholics in Northern Uganda may not only be highly susceptible to HIV infection but they could also be a sexual risk group that if no appropriate and effective interventions are planned during the post-camp resettlement and rehabilitation. The Catholic Church needs to identify alternative practical interventions among these people to guard them against susceptibility to HIV infection and severe AIDS impacts.

Respondents were asked whether they would have sex with a person they know to be infected with HIV in order to further explain sexual patterns. Out of the total sample, 43.3 percent said they would while 56.7 percent said that they would not. Since it

takes only one HIV+ person in a sexual network to spread the virus, this risky sexual behaviour was bound to spread HIV infection further. Table 6 show the correlations for unprotected sex with a person known to have HIV.

Table 6: Correlations with Unprotected Sex with HIV+ Person

Respondent's Characteristic	Unprotected sex with HIV+ person
Age of Respondent	p=0.004** (n=97)
Marital Status	p=0.023* (n=97)
Duration of marriage	p=0.002** (n=97)

*p<0.05, **p<0.01

The relationship between age and the likelihood of having sex with an infected person shows that people aged below 50 years are likely to have sex with an HIV+ person compared to those aged above 50. The social pressures and sexual networks in the IDP camp's social ecology appeared to more affect on younger people compared to the older ones. Secondly, in terms of marital status, respondents who are either separated or divorced or widowed or abandoned are more likely to agree to have sex with an HIV+ person compared to those who are single but ever had sex and the married. The most likely explanation for such behaviour could be that most of such respondents could have been widowed, separated or divorced and abandoned due to HIV and hence see no difference in protected and unprotected sex. Thirdly, it was respondents who had stayed together in marriage for twenty years or less, who were most likely to have sex with a person known to be HIV+. The twenty years correspond with the time that camps have been in northern Uganda implying that Camp life is a significant factor in shaping perceptions of HIV risks and how they respond to them.

Most respondents reported that people are likely to have sex with a person infected with HIV mainly because they were unable to physically determine which person has HIV (58.3 percent). This could be further related to the constrained flow of HIV/AIDS information. Other reasons mainly reported by women relate to their socio-economic susceptibility. The women reported that they would have sex with an infected person when they are in desperate need for financial or material assistance (16.7 percent) or to out compete rival women by getting pregnant (16.7 percent) while one woman reported that it is up to the man to decide whether to use a condom or not. It was further established that there are persons who are willing to have unprotected sex with persons believed to be HIV+. The findings indicate that of the 42 respondents who said they would have sex with an infected person, only one male said that he would use a condom. Table 10 gives the explanatory reasons for why people in the camps still continue with their risky sexual behaviour even when they know that there is no cure for AIDS.

Table 7: Reasons for not using a Condom during sex with an HIV+ person (n=24)

Reason Why one would not use a condom	Frequency	Percent
If it is my marriage partner	4	16.7
It is up to the man to decide	6	25.0
AIDS is not the only source death	5	20.8
I need to produce many children	2	8.3
Real men do not fear death	2	8.3
Inheritance of Widow(er)s	1	4.2
Sex with a condom is not nice	1	4.2
If I am raped or have forced sex	1	4.2
If the woman is beautiful	2	8.3
Total	**24**	**100.0**

The reasons given in Table 7 are critical. Though some of them were reported by a small number, the findings from Key informants and Focus Groups Discussions indicate that they are very grave and their consequences graver for spread of HIV. Insecurity in the IDP camps, for example, exposed many women and girls to rape. Most Focus Group Discussions reported that internally displaced persons had to be escorted by the army to go to fetch water or firewood and that most of the women and girls were defiled during that time. According to Kasasira (2007) and Karugaba (2007), girls in northern Uganda preferred to give in to sex just to get some money for survival. Both authors quote "*I prefer death by HIV/AIDS than hunger. Through sex, I can at least get 500-2000 shillings. With this, I can buy basic commodities like salt, soap, clothes and sanitary pads*" a 17 year old girl in Aleptong Camp in Lira District was reported to have said. All these findings on sexual patterns in the IDP camps could explain the persistent high HIV prevalence rates of 8.2 percent in the North central region (MoH and ORC Macro 2006, MOH and ICF International 2012). Therefore, the critical nature of the HIV pandemic needs to be seen from the perspective of people's livelihoods and social environs and how they affect sexuality and sexual regulation or control.

Conclusion

HIV & AIDS have debilitating effects on the health of human beings, their livelihoods and ultimately the life sustenance of infected persons and those dependent on them. These impacts are systemic in nature. Despite the breakthrough in the manufacture and distribution of Anti-retroviral drugs (ARVs), the rates of HIV infection that continue to increase. Effective prevention of HIV infection requires high level perception of risk of the modes of HIV transmission. However, the findings from Paimol camps in Pader District indicate that political strife and/or security are critical factors in the prevention efforts. Areas experiencing instability are characterised by

inhuman conditions which make people emotionally numb and strategically plan for today. Like the ActionAid study (2005) in northern Uganda found, people look at life as if it is ending today and that AIDS is something for the future hence no need to think about it. It indicates that people are already hardened and can never think of using a condom because, first of all, their supply is limited and they are too poor to afford them. Abducted girls and women are forced into sexual intercourse with rebels or soldiers over whom they have no control and whose sero-status they do not know. These women then later come back to their spouses or community after rescue or escape. The political and security situation in Northern Uganda both during camp life and after resettlement, has distorted people's normal social construction of risk to die. The perceived social risk now overrides the medical risk and as a result, people continue with risky sexual behaviour patterns in spite the levels of HIV/AIDS awareness. So this explains why people choose between types of deaths and not between life and death. It is, therefore, important to note that as the resettlement and peace building processes go on, plans should be made to recover people's prioritisation of medical risk over the social risk through psychosocial and poverty or deprivation alleviation support in order to reverse HIV prevalence in the region.

There are challenges to the early philosophy which have to be addressed in order to maintain the prevention successes and strengthen the treatment and care and support in the fight against HIV & AIDS. In particular, security and support of people's livelihoods are very important for the strategic efforts in the prevention, treatment and care and support for people infected and affected by HIV and AIDS. Socio-economically secure livelihoods, for example, form the basis for food and nutrition security, decent living and life sustenance. In spite of the critical value of good nutrition in helping to reduce weight loss and wasting, delaying the progression of HIV infection into AIDS disease, improving the effectiveness of medications like Antiretroviral Treatment/Therapy (ART), enhancing the body's ability to fight opportunistic infections and improving quality of life (Gillespie & Kadiyala 2005; Avert 2005; WFP 2004a), most households in many areas of Uganda are food insecure (USAID FEWSNET-Uganda & UN World Food Programme Uganda 2005, MFPED 2012, Loevinsohn *et. al.* 2012) and the level of poverty is still high (Uganda Bureau of Statistics (UBOS) & International Livestock Research Institute (ILRI) 2004, UBOS 2012). This aggravates the problem of hunger and malnutrition (UDHS 2011) which further increase temptations for survival sexual behaviour that make individuals more susceptible to HIV infection. The dynamic nature of people's livelihoods immensely influences their decisions related to defining and responding to the risks to HIV infection.

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