



# Gender Assessment of Rwanda's National HIV Response



# Executive Summary

Gender inequality is recognized globally as a driving factor in the HIV epidemic. In sub-Saharan Africa women are disproportionately burdened by the epidemic and account for 59% of adults living with the virus.<sup>1</sup> An effective and gendered HIV response that helps to address gender inequalities is based on sound investment in evidence-informed, high impact approaches, and framed within a human rights framework. A sound HIV response is based on reliable information on the HIV epidemic and context. Understanding the gender dimensions of the epidemic requires investigating the impact of gender inequality on HIV prevention, care, treatment and support. A gender assessment of the HIV response is a process that determines the current status of the HIV response from a gender perspective, in order to strengthen the consideration of gender equality as a goal of the response.

## Background and Rationale

A Gender Assessment of the National HIV Response was conducted in Rwanda from November 2012-March 2013. The assessment was led by the Rwanda Biomedical Center, Institute of HIV/AIDS, Disease Prevention and Control, in collaboration with the Ministry of Gender and Family Promotion and with the financial and technical support of UNAIDS. The purpose of the Gender Assessment was to strengthen the capacity of Rwanda and its partners to implement a sound, gendered HIV response. The assessment involves understanding and analyzing the practices and behaviors that contribute to HIV transmission and the conditions in which these occur. Through this process, the specific needs of different populations emerge, enabling the country to tailor interventions, modalities and services based on these needs.

The Gender Assessment in Rwanda was designed with three specific objectives: i) to collect, consolidate and analyse existing qualitative and quantitative data, national plans and policies related to gender and HIV; ii) to develop key recommendations to provide strategic guidance and support to national partners to 'Know their epidemic, context and response' from a gender perspective and enable a stronger and more effective gender-related response to HIV; and iii) to advocate for evidence-informed and gender responsive HIV planning and programming that reflects, promotes, and respects the needs and rights of women, girls, men, boys and key populations. The findings of the gender assessment will be used to help re-orient existing initiatives and to inform future HIV planning, programming, monitoring and evaluation and budgeting.

## Methodology

The Gender Assessment was facilitated by a Country Research Team (CRT) composed of nine representatives of government institutions, United Nations, and civil society partners working in gender and HIV. The assessment methodology was guided by the draft Gender Assessment Tool for National HIV Responses (hereafter 'Gender Assessment Tool'), developed by UNAIDS in 2012 and currently being piloted in several countries in Asia, Africa and South America. The Gender Assessment Tool is a structured set of guidelines and questions that can be used to analyse the extent to which national HIV responses take into account the critical goal of gender equality.



The pilot version of the tool encompasses a set of systematic and deliberate steps and processes to examine the status of the HIV response with specific reference to its gender dimensions, including four stages and 27 individual steps.

The Gender Assessment in Rwanda utilized all four stages of the Gender Assessment Tool: 1) Preparing for the Gender Assessment; 2) Knowing your HIV epidemic and context; 3) Knowing your HIV Response; and 4): Analysing and using the findings of the Gender Assessment. In order to compile the relevant information needed to respond to the tool and adequately assess the gender-responsiveness of Rwanda's HIV response, the CRT conducted a desk review of existing HIV and gender strategies, policies, and research. A national consultation workshop was then conducted with key Government institutions, development partners, and civil society organizations working in the fields of HIV, gender and/or gender-based violence (GBV) in order to validate the information collected and provide key recommendations for strengthening a gender and HIV response.

## Summary of Findings

The Gender Assessment report presents the consolidated findings of the Gender Assessment tool, including the desk review and the findings and recommendations of the national stakeholder workshop. The report focuses on the two overarching areas of i) Knowing your HIV Epidemic and Context, and ii) Knowing your HIV Response. 'Knowing your HIV Epidemic and Context' from a gender perspective refers to gathering data on who is becoming infected, how, and where (epidemic) and analyzing the biomedical, behavioral, socioeconomic and political factors that contribute to the spread of HIV (context). 'Knowing Your HIV Response' from a gender perspective involves assessing how well the country HIV response is addressing gender equality in both policy and practice. This involves examining the country's national HIV strategies, policies and programmes against the information that we know about the nature of the HIV epidemic as it applies to women and girls, men and boys, and key and vulnerable populations.

### Knowing Your HIV Epidemic and Context

In Rwanda, HIV prevalence is 3.0% in the general population aged 15-49, but is higher among women (3.7%) than among men (2.3%). The Gender Assessment shows that women and girls are disproportionately affected, representing nearly 60% of adults living with HIV. Women and girls have a higher HIV prevalence than their male peers in nearly every age group. The gender differentiation is particularly pronounced among young people, where young women aged 18-19 are ten times more likely to acquire HIV than young men of the same age. In the 20-24 age category, young women have a five times greater risk of HIV infection than their male peers. Girls become infected at a younger age than boys, although men report higher rates of early sexual debut. HIV prevalence is higher among women living in urban areas, those who are widowed, divorced or separated, women with a secondary education or higher, and among those living in the highest wealth quintile.

Among men, HIV prevalence is higher among older men, although men have a lower HIV prevalence than women in all age groups except those aged 40-44. HIV prevalence is higher in men living in urban areas, in those who are divorced or

separated, those with no education, and among those living in the highest wealth quintile. Key populations at higher risk of HIV infection include female sex workers, clients of sex workers, men who have sex with men, truck drivers, prisoners and HIV sero discordant couples. HIV prevalence among female sex workers is especially high at 51% nationally. In 2010, 2% of cohabiting couples in Rwanda were sero discordant, with relatively equal distribution between couples where the female partner is HIV positive and those where the male partner is HIV positive. There is currently limited data on HIV prevalence for the remaining key populations.

The primary mode of HIV transmission in Rwanda is unprotected sexual intercourse. Modes of Transmission (MOT) modeling (2013) suggests that stable heterosexual couples (sex in union) will account for 64% of new HIV infections, while clients of sex workers will contribute to 19%, and sex out of union (youth) is estimated to account for approximately 10% of new infections. The new MOT indicates that men who have sex with men and female sex workers will account for fewer new infections than estimated in previous years, at 5% and 1% respectively. While there has been an increase in HIV knowledge and an improvement in delaying sexual debut, condom use remains low among women and girls, men and boys, and many key populations, thereby contributing to HIV transmission.

Contextual factors contributing to the epidemic include poverty, gender inequality, and stigma and discrimination of marginalized groups. Key factors increasing HIV risk and vulnerability for women and girls include, among others: strict gender norms that promote unequal power relations; traditional attitudes towards sex and sexuality that limit access to information and services; limited educational attainment; economic vulnerability and dependence on men; and limited decision-making power in relationships. Cross-generational relationships and gender-based violence are two additional factors driving HIV transmission. Strict gender norms also impact men and boy's HIV risk and vulnerability. Traditional norms of masculinity that promote a strong, powerful man also encourage men's risk-taking behaviors, discourage health-seeking and perpetuate violence against women and girls. Men's higher educational attainment and economic earning power further establish their decision-making power in relationships, limiting women and girls' ability to negotiate sex and condom use.

At the community level, stigma and discrimination facing key populations, such as female sex workers and men who have sex with men (MSM), continues to hinder their access to HIV information and services and to commodities to prevent HIV infection. Punitive laws criminalizing sex work further isolate female sex workers and increase their risk of violence, discrimination and HIV. Discrimination and social isolation also contribute to increased vulnerability among marginalized groups such as people living with disabilities and orphans and other vulnerable children (OVC).

## Knowing Your HIV Response

Rwanda is committed to promoting gender equality and has established a strong legal and policy framework for promoting and protecting the equal rights of women, girls, men and boys. The commitment to mainstream gender equality encompasses the national HIV response. The country's current guiding HIV strategy, the National Strategic Plan on HIV and AIDS 2009-2012 (NSP) recognizes the role of gender



inequality, including gender-based violence, as a driver of the epidemic. 'Respect for equity and human rights' is one of three overarching principles of the NSP, which incorporates the promotion of equal access to health services, equity for marginalized groups, Greater Involvement of People living with HIV and AIDS (GIPA), and gender equality. In 2010 the country adopted the National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010-2014, a strategy to further address the specific needs and rights of women and girls within the context of HIV.

Rwanda has made significant achievements towards Universal Access to HIV prevention, treatment, care and support services. The country has scaled-up the availability and accessibility of services for voluntary HIV testing and counseling, prevention of mother-to-child transmission of (PMTCT), and antiretroviral therapy (ART). ART is provided free of charge to all eligible individuals. Condom distribution and promotion has improved through social marketing and community-based distribution mechanisms. HIV prevention outreach and information has increased, resulting in an increase in comprehensive knowledge of HIV among young people, although knowledge remains low. HIV prevention minimum packages have been developed for all key populations at higher risk of HIV infection, although dissemination has been limited.

Gaps and areas for improvement remain in order to ensure an effective, gendered HIV response. Although the response has promoted meaningful participation, more can be done to ensure that women, girls, women living with HIV, key populations and marginalized groups are empowered and facilitated to participate in HIV decision-making. The root causes of gender inequality and individual's increased HIV risk and vulnerability need to be further addressed by promoting attitudinal and behavior change at the community level. This includes strengthening the engagement of men and boys in promoting gender equality and preventing HIV and GBV. The capacity of civil society organizations and other implementing partners must also be strengthened. The capacity of Government institutions and implementing partners can be strengthened to more effectively coordinate, monitor and evaluate the promotion of gender equality within the response, including tracking gender-related expenditure.

## Key Recommendations

The Gender Assessment identified seven key recommendations for strengthening a gendered HIV response and number of targeted recommendations aimed at addressing specific gaps or barriers. The key recommendations are summarized below. The entire list of targeted recommendations is contained within the full Gender Assessment Report. The recommendations are aimed at all partners working in the HIV response, including Government institutions, United Nations, development partners, international and local civil society organizations, and the private sector. The recommendations should be used to guide planning, programming, monitoring and evaluation of HIV programmes and activities, as well as interventions addressing gender equality and/or gender-based violence.

**Promoting gender equality in HIV programmes:** The national HIV strategy should incorporate gender equality as a core goal and provide specific strategies to reduce HIV risk and vulnerability for women and girls, key and marginalized populations. This includes advocating for policy and social changes to address the contributing social, cultural, economic and political factors and structural determinants of HIV transmission for women and girls, men and boys, and key and marginalized groups.

**Advocating for an enabling environment:** The national HIV response should continue to advocate for an enabling environment for the provision of HIV prevention, care, treatment and support services and the removal of all punitive laws and policies that form barriers to universal access to HIV services and commodities. The sociocultural environment must also be safe and empowering to enable women and girls living with and affected by HIV, sex workers, MSM and people living with disabilities to securely access services without fear of stigma, discrimination or violence. The response should also ensure that HIV programmes, plans and policies promote an enabling environment for gender equality.

**Ensuring meaningful participation in the response:** The national HIV strategy should include clear strategies for strengthening the meaningful involvement of women, girls, marginalized and key populations in national HIV decision-making, planning, programming, research, monitoring and evaluation. This includes the establishment of mechanisms to institutionalize their meaningful involvement and the provision of technical and financial support to enable them to participate in processes that affect their lives and wellbeing.

**Integrating HIV within an SRHR approach:** The national HIV strategy should incorporate strategies to promote and ensure the full sexual and reproductive health and rights of women, girls, men, boys, key and marginalized populations, including linkages/integration of sexual and reproductive health, management of gender-based violence and HIV services. This includes engaging men and boys in sexual and reproductive health services.

**Eliminating gender-based violence and discrimination:** The national HIV strategy should recognize gender-based violence as both a cause and consequence of HIV transmission and include strategies for responding to and promoting



primary prevention of gender-based violence, including activities to engage men and boys in HIV and violence prevention. Attention should be paid to gender inequality as a driver of violence and to addressing violence in all its forms.

**Addressing stigma and discrimination of marginalized groups:** The national HIV response should define clear strategies to address stigma and discrimination of people living with HIV and marginalized groups such as men who have sex with men, female sex workers, and people with disabilities at both the community and health facility level. HIV programmes should incorporate strategies to halt and respond to all forms of discrimination in order to reduce vulnerability to HIV and ensure universal access to HIV prevention, care and treatment and support services.

**Ensuring accountability for gender equality:** Ensure accountability for commitments to promote gender equality in the HIV response by strengthening the capacity to coordinate, monitor and evaluate interventions designed to advance gender equality among government institutions, and between development partners and civil society organizations. Ensure that gender specific actions and interventions are fully costed and budgeted within the NSP, and that mechanisms are in place to monitor expenditure on gender-related activities.



## Preface

This report presents the findings of the Gender Assessment of the National HIV Response conducted by RBC/IHDPC in collaboration with the Ministry of Gender and Family Promotion and other key partners supporting the national response between November 2012 and February 2013. An effective and gendered HIV response is one that helps to address gender inequality and is based on sound investment in evidence-informed, high impact approaches that are framed within a human rights framework. A sound HIV response is based on reliable information on the HIV epidemic – who is becoming infected, where, and under what conditions. Understanding the gender dimensions of the epidemic requires investigating the impact of gender inequality on HIV prevention, care, treatment and support for women and girls, men and boys, and marginalized and key populations.

The Gender Assessment of the National HIV Response was conducted in Rwanda with the aim of providing information to strengthen the country's capacity to implement a sound, gendered HIV response. The Gender Assessment engaged a number of key stakeholders involved in gender, GBV and HIV to first, identify the gender dimensions of the epidemic, including key social, cultural, economic or political factors influencing HIV transmission, and second, to assess how the current national response is utilizing this information in its programmes to address gender-related barriers and to promote gender equality.

We encourage all of our partners to utilize the findings and recommendations contained within this report to inform the planning and implementation of programmes designed to address HIV and AIDS, gender inequality, and/or gender-based violence. The Government of Rwanda remains committed to promoting gender equality within the HIV response and ensuring that all individuals – women and girls, men and boys, key populations and vulnerable groups – are afforded equal access to HIV prevention, care and treatment and support services.

I would like to take this opportunity to thank all of our partners who contributed their time and expertise to this endeavor, especially UNAIDS, which provided both financial and technical assistance to carry out the assessment. I would also like to acknowledge the role of the individuals in the Country Research Team, who committed their time and energy to conduct the assessment. We are grateful to their respective organizations for enabling them to participate, including the Ministry of Gender and Family Promotion, the Network of People Living with HIV (RRP+), CARE International, the Rwanda Men's Resource Center, UNFPA, and UNAIDS. I would also like to thank GESTOS for its role in supporting the piloting the Gender Assessment Tool in Rwanda.

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# Acronyms



<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Antenatal Consultation
<b>ART</b>	Anti-retroviral Therapy
<b>ARV</b>	Anti-retroviral
<b>BCC</b>	Behavior Change Communication
<b>BSS</b>	Behavioral Surveillance Survey
<b>CCM</b>	Country Coordinating Mechanism
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CDLS</b>	District AIDS Control Committee
<b>CNLS</b>	National AIDS Control Commission
<b>CSO</b>	Civil Society Organization
<b>CVCT</b>	Couples' voluntary testing and counseling
<b>DDP</b>	District Development Plan
<b>DHS</b>	Demographic and Health Survey
<b>EDPRS</b>	Economic Development and Poverty Reduction Strategy
<b>FBO</b>	Faith-based Organization
<b>FHH</b>	Female-Headed Household
<b>FP</b>	Family Planning
<b>GBV</b>	Gender-based Violence
<b>GIPA</b>	Greater Involvement of People living with HIV and AIDS
<b>GMO</b>	Gender Monitoring Office
<b>GOR</b>	Government of Rwanda
<b>HIV</b>	Human Immunodeficiency Virus
<b>HSSP</b>	Health Sector Strategic Plan
<b>IEC</b>	Information Education Communication
<b>IHDPC</b>	Institute of HIV/AIDS, Disease Prevention and Control
<b>IPV</b>	Intimate Partner Violence
<b>IUD</b>	Intrauterine Devices
<b>LGBTI</b>	Lesbian, Gay, Bisexual, Transsexual and Intersex

<b>M&amp;E</b>	Monitoring and Evaluation
<b>MIGEPROF</b>	Ministry of Gender and Family Promotion
<b>MOT</b>	Modes of Transmission
<b>MSM</b>	Men who have Sex with Men
<b>NAP</b>	National Accelerated Plan
<b>NSP</b>	National Strategic Plan
<b>OSC</b>	One Stop Center
<b>OVC</b>	Orphans and other Vulnerable Children
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>RBC</b>	Rwanda Biomedical Center
<b>RRP+</b>	Rwanda Network of Associations of People Living with HIV
<b>RWAMREC</b>	Rwanda Men's Resource Center
<b>SRH(R)</b>	Sexual and Reproductive Health (and Rights)
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>TWG</b>	Technical Working Group
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UNWOMEN</b>	United Nations Entity for Gender Equality and Women's Empowerment
<b>VCT</b>	Voluntary Counseling and Testing
<b>YFC</b>	Youth-Friendly Center
<b>YHH</b>	Youth-Headed Household



# Glossary of Terms

The following are key terms and definitions that are essential to the Gender Assessment of the HIV Response and informed the assessment process and the final report. All of the definitions are from the Revised UNAIDS Terminology Guidelines (October 2011) unless otherwise noted.

## **Concentrated epidemic**

In a concentrated epidemic, HIV has spread rapidly in one or more populations, but is not well established in the general population. Typically, the prevalence is over 5% in subpopulations while remaining under 1% in the general population, although these thresholds must be interpreted with caution. In a concentrated HIV epidemic there is still the opportunity to focus HIV prevention, treatment, care and support efforts on the most affected subpopulations, while recognizing that no subpopulation is fully self-contained.

## **Concurrent sexual partnerships**

Persons who have concurrent sexual partnerships are those who report at least two partners for which first sex was reported six months or longer ago, and the most recent sex is reported as less than or equal to six months ago. The phrases 'concurrent sexual partnerships', 'concurrent partnerships', or simply 'concurrency' may be used, but expressions such as 'multiple concurrent partnerships' or 'MCP' should not be used to identify or describe concurrency.

## **Discrimination**

Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group, irrespective of whether or not there is any justification for these measures.

## **Empowerment**

Empowerment is action taken by people to overcome the obstacles of structural inequality that have previously placed them in a disadvantaged position. Social and economic empowerment is a goal and a process aimed at mobilizing people to respond to discrimination and achieve equality of welfare and equal access to resources and become involved in decision-making at the domestic, local and national level.

## **Enabling environment**

There are different kinds of enabling environments in the context of HIV. An enabling legal environment is one in which laws and policies against discrimination on the basis of HIV status, risk behavior, occupation, and gender are in place and are monitored



and enforced. An enabling social environment is one in which social norms support healthy behavior choices.

**Gender based violence**

Gender based violence refers to violence perpetrated against any individual because of their gender identity or sexuality. This includes violence against women and girls. The term is often used to make a distinction between violence against women and violence against an individual who does not conform to a society's gender norms. [Source: Gender Assessment Tool for National HIV Responses, UNAIDS]

**Gender equality**

Gender equality, or equality between men and women, entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviors, aspirations, and needs of women and men are considered, valued and favored equally. It signifies that there is no discrimination on the ground's of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.

**Gender-sensitive**

Gender-sensitive policies, programmes or training modules recognize that both women and men are actors within a society, that they are constrained in different and often unequal ways and that consequently they may have differing and sometimes conflicting perceptions, needs, interests and priorities.

**Gender-transformative**

A gender-transformative HIV response seeks not only to address the gender-specific aspects of HIV but also to change existing structures, institutions and gender relations into ones based on gender equality. Gender-transformative programmes not only recognize and address gender differences, but go a step further by creating the conditions whereby women and men can examine the damaging aspects of gender norms and experiment with new behaviors to create more equitable roles and relationships.

**Generalized epidemic**

A generalized HIV epidemic is an epidemic that is self-sustaining through heterosexual transmission. In a generalized epidemic, HIV prevalence usually exceeds 1% among pregnant women attending antenatal clinics.

**Harmful masculinities**

Social and cultural norms of masculinity that cause direct or indirect harm to women



and men, for example, norms of masculinity that contribute to women's risk and vulnerability to HIV, and that hinder men from seeking information, treatment and support or assuming their share of the burden of care. [Source: Gender Assessment Tool for National HIV Responses, UNAIDS]

### **Incidence**

HIV incidence is the number of new cases arising in a given period in a specified population. UNAIDS normally refers to the number of adults aged 15-49 years or children (aged 0-14 years) who have become infected during the past year. Whereas, HIV prevalence refers to the number of infections at a particular point in time, no matter when infection occurred, and is expressed as a percentage of the population (like a camera snapshot).

### **Key populations at higher risk of HIV**

The term 'key populations' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and sero-negative partners in sero-discordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. Don't use the term 'high-risk group.'

### **Marginalized populations**

Marginalization refers to social exclusion, and the inability of certain individuals or groups to participate fully in the economic, social and political life of a particular society. Populations may also be marginalized in terms of access to healthcare services and resources, making a person more susceptible to HIV infection and to developing AIDS. This can include groups marginalized because of their gender and/or sexuality (e.g. men who have sex with men, sex workers). [Source: Gender Assessment Tool for National HIV Responses, UNAIDS]

### **Meaningful participation**

Going beyond the inclusion of relevant populations in relevant debates, discussion and decision-making processes, to ensure their active participation and voice in these events. [Source: Gender Assessment Tool for National HIV Responses, UNAIDS]

**Men who have sex with men**

The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men. However, abbreviations should be avoided whenever possible. Writing out the term is preferred.

**Prevalence**

Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who are living with HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults aged 15–49 years.

**Risk**

Risk is defined as the risk of exposure to HIV or the likelihood that a person may become infected with HIV. Certain behaviors create, increase, or perpetuate risk. Behaviors, not membership of a group, place individuals in situations in which they may be exposed to HIV. Avoid using the expressions 'groups at risk' or 'risk groups'. People with behaviors that may place them at higher risk of HIV exposure do not necessarily identify themselves with any particular group.

**Stigma**

'Stigma' is derived from the Greek meaning a mark or a stain. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions.

**Vulnerability**

Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. These factors may include: lack of the knowledge and skills required to protect oneself and others; accessibility, quality, and coverage of services; and societal factors such as human rights violations or social and cultural norms. These norms can include practices, beliefs, and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.



# I. Introduction



Gender inequality is recognized globally as a driving factor in the HIV epidemic. Since the 1980s, women have steadily become more infected, reaching half of the adults (15 and above) living with HIV worldwide in 2010.<sup>2</sup> In sub-Saharan Africa (where 68% of people living with HIV reside) women are disproportionately burdened by the epidemic and account for 59% of adults living with the virus.<sup>3</sup> That means that 1.4 times more adult women are living with HIV than men. In addition, young women ages 15-24 account for 31% of new infections in the region.<sup>4</sup> Although the epidemic varies from country to country, it is clear that gender inequality is contributing to the spread of HIV among women and girls.

In 2011, Rwanda signed the 2011 Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS, recommitting the country to address the epidemic. The declaration highlights the need to address gender inequity and harmful gender norms as a central component of the global HIV response. The declaration pledges to eliminate gender inequalities and gender-based abuse and violence, and to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection. It also calls on countries to ensure that women and girls can exercise their sexual and reproductive rights free of coercion and discrimination; to create an enabling environment for the empowerment of women; and to strengthen women's economic independence.<sup>5</sup>

Gender inequality, or unequal power relations between men and women, is well recognized as putting women and girls at greater risk and hampering progress made in HIV prevention, treatment, care and support. However, men, boys and key and marginalized populations are also impacted by strict gender norms and unequal power relations, and social, cultural, economic and political factors that increase HIV risk and vulnerability. It is crucial that countries assess how gender inequality contributes to the spread of HIV in their own country, and how gender norms and unequal power relations impact women and girls, men and boys, marginalized and key populations. Only then will countries be able to adequately address the underlying factors that contribute to the epidemic, and ensure a gender-transformative HIV response in which gender equality is a core goal.

## 1.1 Rationale and Purpose of the Gender Assessment

An effective and gendered HIV response that helps to address gender inequality is based on sound investment in evidence-informed, high impact approaches, and framed within a human rights framework. A sound HIV response is based on reliable information on the HIV epidemic and context – who is becoming infected, where, under what conditions and why. Understanding the gender dimensions of the epidemic requires investigating the impact of gender inequality on HIV prevention, care, treatment and support for women and girls, men and boys, and marginalized



and key populations. The evidence about the epidemic and its context, as well as the gaps in the HIV response, should increasingly become the basis for designing gendered HIV responses at the country level.

A gender assessment of the HIV response is a process that determines the status of the HIV epidemic and response from a gender perspective, in order to strengthen the consideration of gender equality as a goal of the response.<sup>6</sup> A gender assessment also aims to make the HIV response gender-sensitive and to enable it to be more effective in addressing the HIV-specific and gender-related needs of women and girls. It is an exercise that requires more than simply disaggregating data by sex or gender identity. It involves understanding and analyzing the practices and behaviors that contribute to HIV transmission and the conditions in which these occur. Through this process, the specific needs of different populations emerge, enabling the country to tailor interventions, modalities and services based on these needs. The findings can indicate whether a national response requires re-orientation or re-prioritizing, and how and what to scale-up in order to ensure that gender dimensions are appropriately addressed.

A Gender Assessment of the HIV Response in Rwanda was undertaken to strengthen the capacity to implement a sound, gendered HIV response, and in light of the Government's strong commitment to promote gender equality. The gender assessment focused on applying the touchstone of effective HIV planning and programming – 'Know your epidemic and context; Know your response' – from a gender perspective. This was accomplished by first examining how gender inequality contributes to the spread of HIV in the country, and then by assessing the extent to which gender equality is a priority of the current response and how well it is addressing the gendered realities of the epidemic. In order to fulfil these broader goals, the gender assessment was designed with three specific objectives:

- Collect, consolidate and analyse existing qualitative and quantitative data, national plans and policies related to gender and HIV.
- Develop key recommendations to provide strategic guidance and support to national partners to 'know their epidemic and response' from a gender perspective and enable a stronger and more effective gender-related response to HIV.
- Advocate for evidence-informed and gender responsive HIV planning and programming that reflects, promotes, and respects the needs and rights of women, girls, men, boys and key populations.

## 1.2 Guiding Principles

The Gender Assessment was informed by a set of guiding principles adapted from Rwanda's existing national HIV policies and strategies. The guiding principles, listed below, were designed in part to ensure that the process and results of the Gender Assessment would be comprehensive enough to help guide the future of the national HIV response.

- **Human Rights & Equity:** The assessment is grounded in a rights-based approach, recognizing that a successful HIV response must be founded upon a full respect for human rights, including sexual and reproductive rights, and on the principle of equity.
- **Gender Equality:** The assessment is grounded in the belief that gender equality, or equality between men and women is an inherent human right and that gender equality is integral to an effective HIV response. The assessment further recognizes that gender equality applies equally to women and girls, men and boys, and marginalized and vulnerable groups.
- **Male Engagement:** The engagement of men and boys is critical to addressing gender inequalities in the context of HIV. Men and women must work together for gender equality, to question harmful definitions of masculinity, challenge attitudes and behaviours that perpetuate unequal power relations and violence.
- **Participation:** The assessment will promote the meaningful and equal participation of women and girls, including women living with HIV, and key populations in the overall HIV response.
- **Strong Leadership:** The gender assessment is supported by strong institutional leadership and will require bold leadership from both men and women to advocate for gender equality as a central element of the HIV response.
- **Evidence-informed:** An effective HIV response must reflect the different needs and contexts of women and girls, men and boys, and key populations. The HIV response must therefore be driven by reliable evidence on the epidemiological, economic, social, cultural and political context and acknowledge the need to obtain further evidence where necessary.
- **Partnership:** Promoting gender equality in the HIV response requires partnership among all stakeholders including government, civil society organizations, including women's organizations, networks of women living with HIV, organizations of men and boys, community leaders, private sector and development partners and donors.
- **Action-oriented:** An effective HIV response must be action-oriented and provide clear, logical steps and recommendations to address specific gaps and barriers. The gender assessment will aim to provide action-oriented recommendations to strengthen the effectiveness of the gendered HIV response.

## 1.3 Management of the Gender Assessment

The Gender Assessment of the National HIV Response was led by the Rwanda Biomedical Center, Institute of HIV/AIDS, Disease Prevention and Control (RBC/IHDPC), the government institution responsible for coordinating Rwanda's HIV response. In August 2012, the UNAIDS Country Office in Rwanda approached RBC/



IHDPC about piloting a new Gender Assessment Tool for National HIV Responses, which was developed by UNAIDS to provide countries with a standardized tool to analyse their HIV response from a gender perspective. RBC/IHDPC quickly committed to the process and engaged the Ministry of Gender and Family Promotion, in charge of promoting gender equality, and other partners such as civil society organizations, as key partners in the assessment. UNAIDS provided technical and financial support to the process of piloting the Gender Assessment Tool.

In November 2012, a Country Research Team (CRT) was assembled by RBC/IHPDC to oversee the Gender Assessment. The CRT was composed of nine representatives from Government institutions, United Nations, and civil society organizations. The team members were identified and recruited based on their knowledge and experience working in the HIV, gender, and GBV sub-sectors in Rwanda. The full list of members of the CRT can be found in Annex I. GESTOS, a Brazilian non-governmental organization working in the fields of gender, HIV and communication, was engaged by UNAIDS to support the piloting of the Gender Assessment Tool and supported RBC/IHPDC and the CRT to undertake the assessment.

## **1.4 Gender Assessment Methodology**

The Gender Assessment was undertaken in Rwanda between November 2012 and March 2013. The methodology adopted for the gender assessment was guided by the draft Gender Assessment Tool for National HIV Responses developed by UNAIDS. The Gender Assessment in Rwanda was part of a global process of piloting the draft assessment tool in several countries in Africa, Asia and South America. The purpose of the pilot was twofold: first, to support countries to conduct a Gender Assessment of the national HIV response; and second, to systematically evaluate the draft tool and provide recommendations and feedback for improvement. The methodology of the gender assessment is outlined on the following pages.

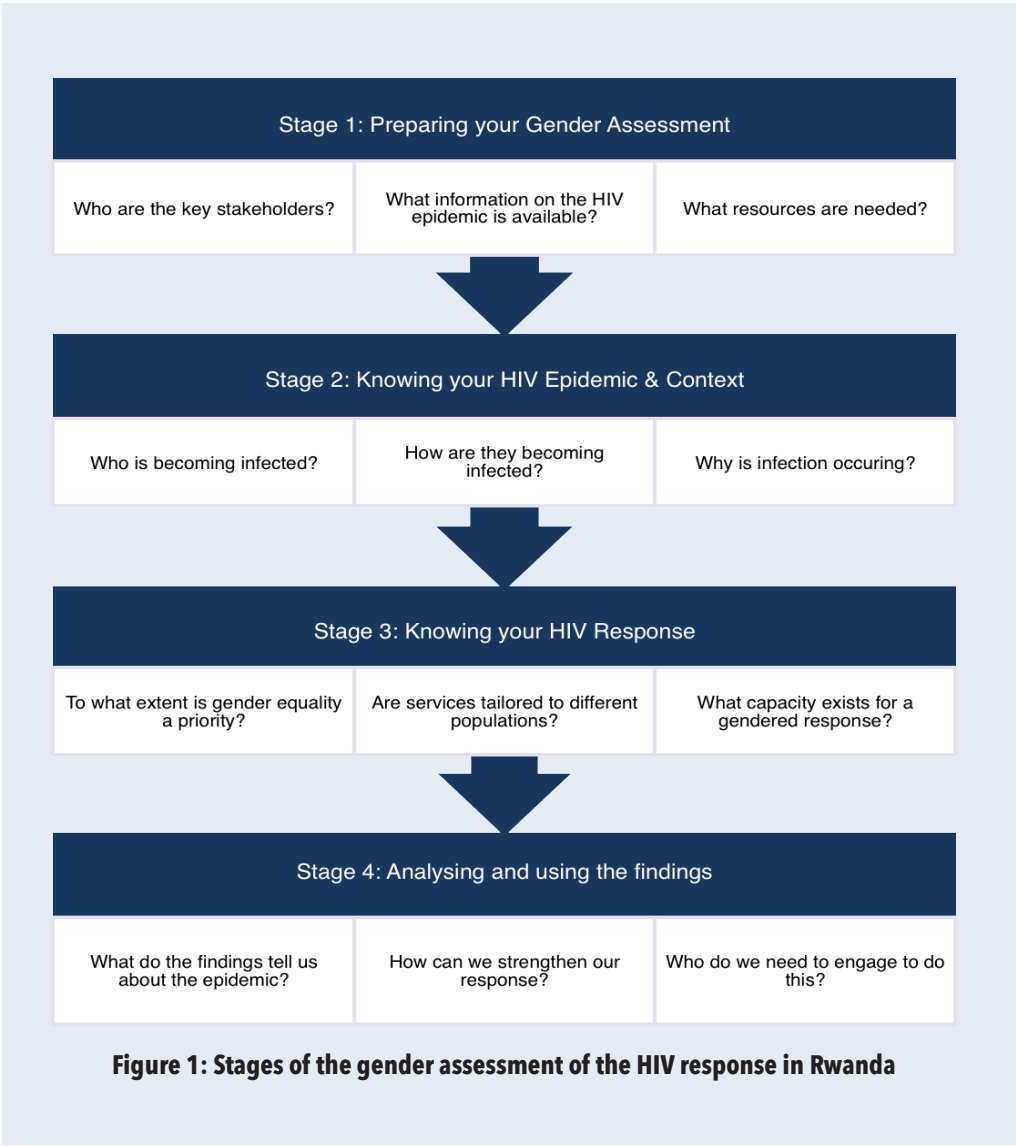
### **1.4.1 Gender Assessment Tool**

The Gender Assessment Tool is a structured set of guidelines and questions that can be used to analyse the extent to which national HIV responses take into account the critical goal of gender equality. The tool was designed to support countries to assess whether their national HIV response recognises gender equality as a key determinant of HIV transmission and whether it incorporates this recognition in its planning and programming. The tool was developed by UNAIDS in collaboration with an expert Reference Group, which included members from governments, UN agencies and civil society organizations from all continents. The tool is intended for use at both the local and national levels, in both generalized and concentrated epidemics, and can be used by individuals and partners in government, civil society, the United Nations and other multilateral agencies. The tool was piloted in a small number of countries in 2013.

The tool encompasses a set of systematic and deliberate steps and processes to examine the status of the HIV response with specific reference to its gender dimensions.



The tool is comprised of four stages, 27 steps and a total of 241 questions to elicit information on the epidemic and the ensuing response. The four stages of the tool include: 1) Preparing for the Gender Assessment; 2) Knowing your HIV epidemic and context; 3) Knowing your HIV response; and 4): Analysing and using the findings of the Gender Assessment. In Rwanda, all four stages of the tool were utilized, although the tool was adapted to the specific needs and context of the country. Figure 1 outlines the stages of the gender assessment undertaken in Rwanda.





## 1.4.2 Desk Review of Key Data Sources

The Gender Assessment Tool requires an extensive desk review of existing information available on the national HIV epidemic, context and response. The first step in undertaking the assessment was to collect all of the varied documents currently available on gender and HIV in Rwanda. This included national strategies and policies specific to gender and HIV, as well as relevant strategies from other sectors (e.g. education). It also included any epidemiological and demographic information regarding the epidemic, and contextual information on social, cultural, political or economic factors that shape the epidemic. The country research team undertook the desk review between December 2012 and February 2013. An overview of the types of documents and data sources utilized is provided below and the full list of references can be found in Annex III.

- **National HIV strategies and policies**, including reports, assessments, reviews and evaluations of the country HIV response by government, civil society or donors
- **Gender-specific frameworks or action plans**, including gender assessments, reviews or analyses of the HIV response by government, civil society or donors
- **Gender assessments, reviews or analyses** from other related sectors (e.g. gender based violence, education, sexual and reproductive health) by government, civil society or donors
- **National gender strategies and policies** for other relevant sectors (e.g. gender based violence, education, sexual and reproductive health)
- **National development policies and strategies** (e.g. poverty reduction strategies)
- **Epidemiological data** from all relevant sectors (e.g. HIV and AIDS, GBV, education, and sexual and reproductive health)
- **Legal and policy frameworks** (national constitution, laws and regulations)
- **International, Regional and domesticated human rights instruments** (e.g. CEDAW, UDHR, Maputo Protocol)
- **Political, social and economic contextual analysis** in the country and sub region by government, civil society or donors (e.g. demographic and other population-based surveys, shadow reports).

## 1.4.3 National Stakeholder Workshop

In January 2013, RBC/IHDPC and the UNAIDS Country Office in Rwanda held a three-day national stakeholder workshop to support data collection and validation of the findings of the gender assessment tool. Two international consultants from GESTOS contributed to the facilitation of the national workshop in collaboration with RBC/IHDPC, UNAIDS and the Country Research Team. The workshop was conducted to

collect and validate information on the HIV epidemic, context and response, and to provide in-depth feedback on the ease and usefulness of the pilot Gender Assessment Tool. The workshop brought together more than 30 representatives of government institutions, United Nations, development partners and civil society organizations working in the fields of HIV, gender and GBV. A full list of the participants in the workshop can be found in Annex II.

## 1.5 Gender Assessment Report

The Gender Assessment report presents the consolidated findings of the Gender Assessment Tool, including the findings and recommendations from the desk review and the national stakeholder workshop. The report focuses on the findings and then provides key recommendations to strengthen a gendered HIV response based on the findings. Chapter two presents the findings of 'Knowing Your Epidemic and Context,' which analyzes the nature of the epidemic and the contextual factors (social, cultural, political and economic) that contribute to the spread of HIV within the country. Chapter three focuses on 'Knowing Your HIV Response,' which analyzes the extent to which the current response is addressing gender inequities and the underlying factors that increase HIV risk and vulnerability. Chapter four outlines key and targeted recommendations for strengthening the gendered HIV response in Rwanda.

The report presents the findings according to the different populations: women and girls; men and boys; key populations; and marginalized or vulnerable groups. Within the scope of this report, attention is paid to the populations and groups identified as key or marginalized populations within the current national HIV response. There may be additional marginalized or vulnerable groups in Rwanda that could benefit from greater attention in the future.

**Figure 2: Participants at the national Gender Assessment workshop (Photo: Claudio Fernandez)**





## II. Knowing Your HIV Epidemic & Context



Sound and effective HIV responses are based on reliable information on the HIV epidemic and context. Understanding the nature of the epidemic relies on having data on who is becoming infected, where, why and under which conditions. It is also essential to know how social, cultural, political and economic factors within a given context shape HIV risk and vulnerability for different populations. For a gendered HIV response, it is imperative to know the epidemic in gendered terms in order to be able address the specific ways that gender inequalities increase HIV vulnerability and risk for both women and girls, and men and boys. This chapter examines the findings of Knowing your Epidemic, which outlines who is becoming infected, how, and where, and Knowing your Context, which includes biomedical, behavioral, socioeconomic and political factors that contribute to the spread of HIV.

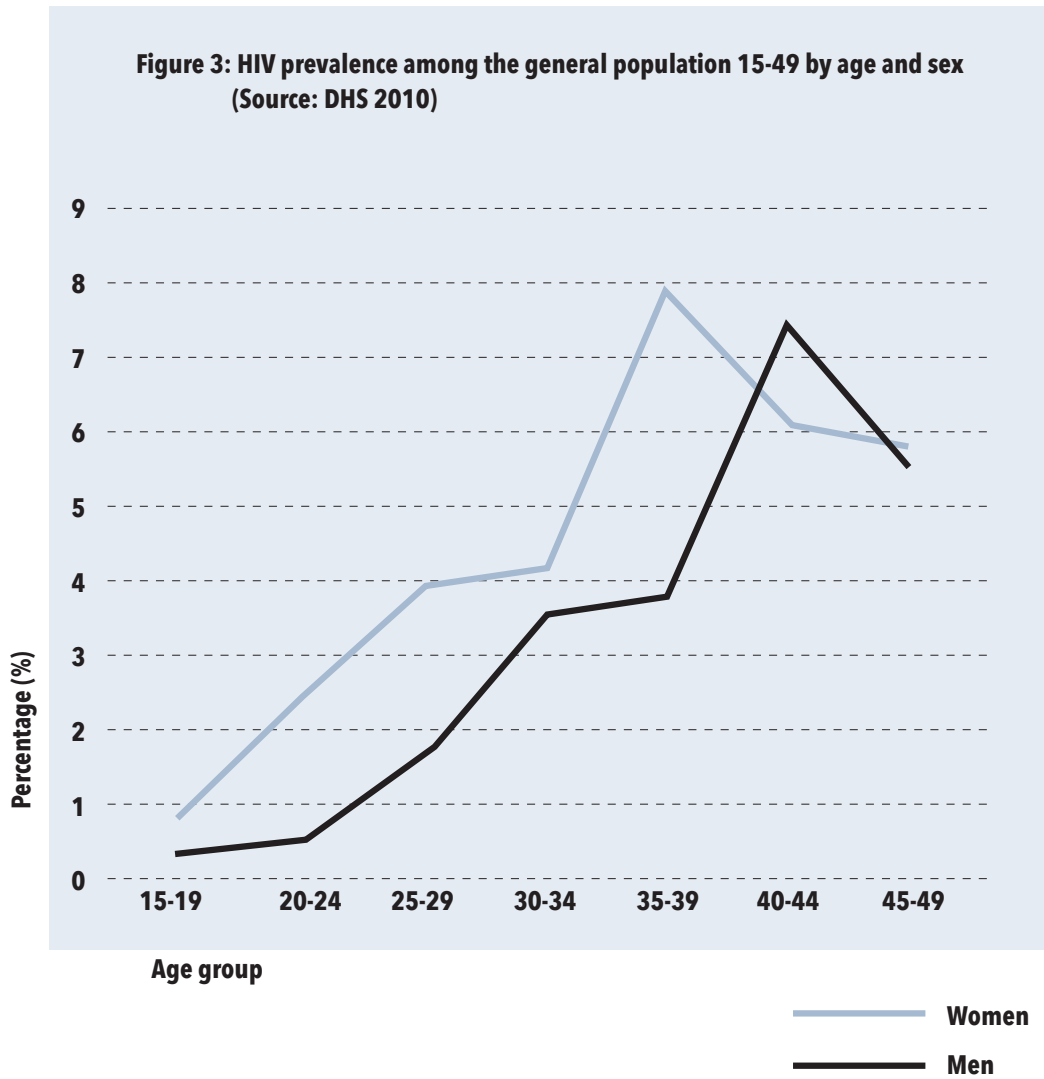
### 2.1 Overview of the Epidemic

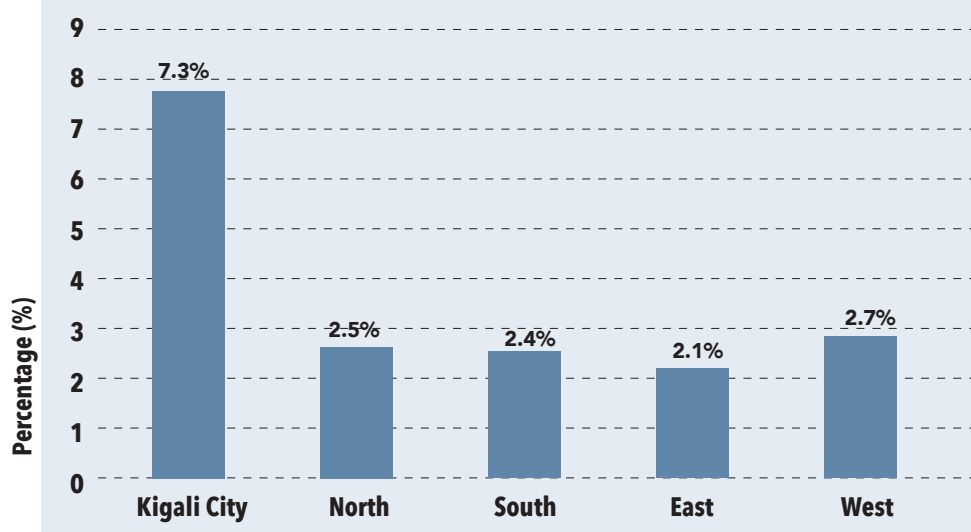
The Republic of Rwanda is a small, landlocked country facing rapid population growth. The country is divided into five administrative regions (North, South, East and West provinces, and Kigali City) and 30 districts. In 2012, the country had an estimated population of 10.5 million people and an average annual growth rate of 2.6%.<sup>7</sup> The total fertility rate dropped significantly from 6.1 children per woman in 2005 to 4.2 in 2010.<sup>8</sup> The country is one of the most densely populated in Africa and globally, with 416 people per square kilometer.<sup>9</sup> The population is predominantly female (52% women compared to 48% men)<sup>10</sup> and is essentially young, with 54% of all Rwandans aged below 19.<sup>11</sup>

Rwanda saw its first reported case of HIV in 1983, and only three years later was one of the countries most affected by the virus. The first national survey on HIV prevalence in 1986 indicated an HIV prevalence of 17.8% in urban areas and 1.3% in rural areas.<sup>12</sup> The 1994 Rwandan genocide further exacerbated the spread of HIV through widespread systematic sexual violence against women and girls. Data collected from ten sentinel sites in 1996 indicated that HIV prevalence had risen sharply after the genocide, to 27% among urban residents, 13% among semi-urban residents, and 6.9% among rural residents.<sup>13</sup>

Today, there are an estimated 208,108 people living with HIV in Rwanda, including approximately 26,000 children below the age of 15.<sup>14</sup> The country is experiencing a mixed HIV epidemic, with aspects of a generalized epidemic among the general population and a concentrated epidemic among certain key populations at higher risk of HIV infection. Since the nineties, the country has made great progress in stemming the spread of HIV. According to the 2010 Demographic and Health Survey (DHS), HIV prevalence is estimated at 3.0% among the general population aged 15-49, and has remained relatively stable since 2005.<sup>15</sup>

HIV prevalence is considerably higher among women (3.7%) compared to men (2.2%).<sup>16</sup> Figure 3 illustrates HIV prevalence among the general population 15-49 by age and sex. HIV prevalence is also higher in urban areas (7.1%) compared to rural ones (2.3%), and is highest in Kigali City (7.3%), followed by the Western (2.7%), Northern (2.5%) and Southern provinces (2.4%), and is lowest in the Eastern Province (2.1%)<sup>17</sup> Figure 4 illustrates the distribution of HIV prevalence by province.



**Figure 4: HIV prevalence in the general population by province (Source: DHS 2010)**

Although HIV prevalence data among the general population would indicate a generalized epidemic (with prevalence between 1%-5%), data on HIV prevalence among some key populations at higher risk of HIV infection also suggest a concentrated epidemic.<sup>18</sup> Rwanda's current National Strategic Plan on HIV and AIDS 2009-2012 identifies several groups as 'most-at-risk'<sup>1</sup> or key populations: female sex workers and sex work client groups (including mobile populations, truck drivers, people in uniform); men who have sex with men (MSM); HIV sero discordant couples; prisoners; and truck drivers. According to the integrated Bio-Behavioral Surveillance Survey (BSS) conducted among sex workers in 2010, HIV prevalence among female sex workers in Rwanda is estimated at 51% (95% CIs: 48%-54%).<sup>19</sup> The NSP further recognizes people with disabilities (PWD), prisoners and refugees as vulnerable populations at greater risk of HIV infection.<sup>20</sup>

The most prominent mode of HIV transmission is unprotected sexual intercourse. 2013 Modes of Transmission (MOT) modeling conducted by UNAIDS and validated by RBC/IHDPC suggests that stable heterosexual couples (sex in union) will account for 64% of new HIV infections, while sex out of union (youth) is estimated to account for approximately 10% of new infections.<sup>21</sup> The new MOT data suggests that sex workers will account for fewer new infections (1%) than in previous estimates, but that the clients of sex workers will contribute to approximately 19% of new infections. Men who have sex with men are estimated to account for 5% of new infections. Blood transfusion and injecting drug use are not significant contributing factors to HIV transmission in Rwanda. No data is available on the rate of new HIV infections (incidence), although RBC/IHDPC plans to undertake the AIDS Indicator Survey in 2013. The survey will provide data on HIV incidence for the first time.

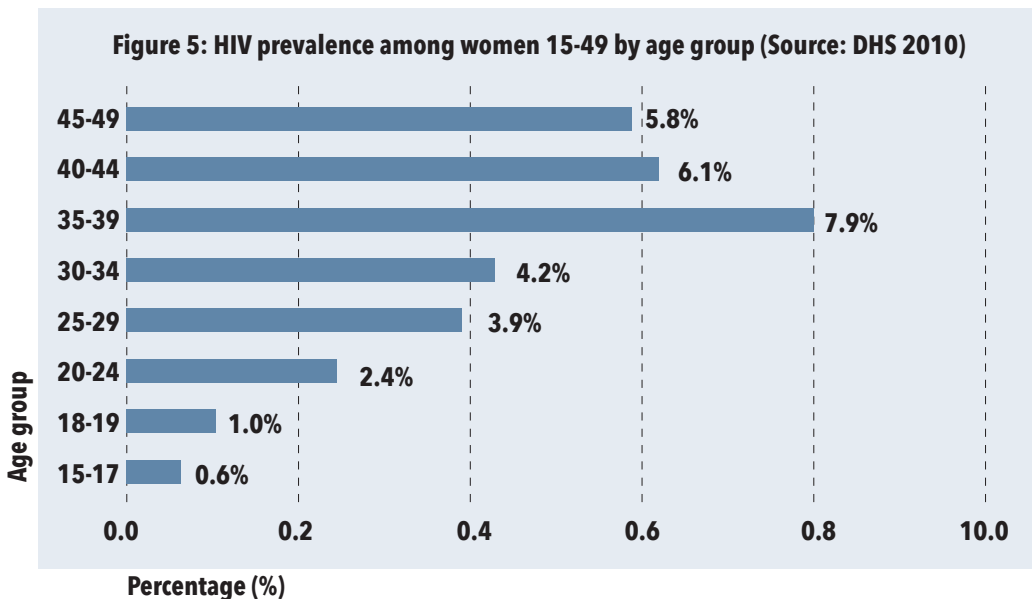
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The term 'most-at-risk populations' should be avoided. It is more appropriate to describe the behavior that places individuals at risk of HIV exposure, e.g. unprotected sex among stable sero discordant couples, sex work with low condom use, etc.

## 2.1.1 Women and Girls

HIV prevalence among women in the general population aged 15-49 is 3.7%,<sup>22</sup> although prevalence is considerably higher among female sex workers. The specificities of female sex workers will be discussed in a later section. While there is currently no data on HIV prevalence for girls aged 0-14 years, recent Spectrum estimates suggest that HIV prevalence among children is approximately 0.5%.<sup>23</sup> The data indicates that women are disproportionately infected in Rwanda – in 2008, women comprised approximately 59% of adults infected with HIV in the country.<sup>24</sup> Today, women are almost two times more likely to be living with HIV than men (3.7% prevalence versus 2.3%).<sup>25</sup> Women have a higher HIV prevalence than their male peers in every age group except those aged 40-44.<sup>26</sup> HIV prevalence is lowest among women aged 15-19 (0.8%) and highest among women 35-39 (7.9%).<sup>27</sup> Figure 5 illustrates HIV prevalence among women 15-49 by age group.

HIV prevalence among women varies depending on residence, marital status, education and wealth. Prevalence is higher among those living in urban areas (8.7%) compared to rural ones (2.8%), and is highest in Kigali City (9.4%) and the Western Province (3.2%). At the district level, prevalence for women is highest in the three districts of Kigali City, reaching as high as 10.1% in Kicukiro.<sup>28</sup> In contrast to the general population, HIV prevalence is highest among women with a secondary education or higher (5%), followed by women with no education (4%), and women with a primary education (3%).<sup>29</sup> The reason for the higher prevalence among women with higher levels of education is not currently known, however, for young women aged 15-24, HIV prevalence is actually highest among those with no education.



HIV prevalence is highest among women in the highest wealth quintile (7% compared to 3% or less in the lower wealth quintiles).<sup>30</sup> However, the relationship between HIV prevalence and wealth is not linear. Among both women and men, those in the middle wealth quintile have slightly lower HIV prevalence than those in the lowest and second wealth quintiles. HIV prevalence among women also varies according



to marital status. Prevalence reaches as high as 17% among widows, compared to 6.8% among those who are divorced or separated, 3.6% among those who are married or living with a male partner, and 1.7% for those who are never married.<sup>31</sup> The high prevalence among widows may reflect the legacy of sexual violence during the genocide, or to increased exposure to HIV from a deceased husband or partner, as well as survival-related risk taking behavior and vulnerability. The 2009 Stigma Index suggests that there are three times as many widows living with HIV than widowers.

### Modes of Transmission

Most new HIV infections among women and girls are likely to result from unprotected intercourse due to low condom use among steady sero discordant couples, especially among long-term partners.<sup>32</sup> In 2010, 2% of cohabiting couples were sero discordant, with nearly equal distribution between couples with an HIV-positive female and couples with an HIV-positive male.<sup>33</sup> Additional contributors to HIV infection among women and girls include cross-generational relationships, multiple and/or concurrent sexual partnerships, and having male partners who have multiple and/or concurrent partners.

Multiple sexual partnerships increase the risk of HIV transmission. In Rwanda, less than 1% of women aged 15-49 report more than one sexual partner in the last twelve months, but there is evidence of increased risk as only 29% of those with more than one sexual partner reported using a condom during their last sexual intercourse.<sup>34</sup> On average, women in Rwanda report 1.4 lifetime sexual partners and HIV prevalence rises significantly in relation to the number of lifetime sexual partners, from 3.1% among those with one sexual partner and rising to 31% among those reporting 5-9 partners.<sup>35</sup> Concurrent sexual partnerships, which are distinctive from multiple partnerships, may also increase risk of HIV transmission by allowing the virus to pass quickly through multiple individuals.

A concurrent partnership is defined as 'overlapping sexual partnerships where intercourse with one partner occurs between two acts of intercourse with another partner.'<sup>36</sup> For individuals reporting multiple partnerships it is important to know whether these partnerships were serial or concurrent, because overlapping partnerships can create large interconnected sexual networks whose members are at heightened risk of infection. According to the 2010 DHS, less than 1% of women had concurrent sexual partnerships, however, 63% of those women who did have multiple partners (more than one sexual partner in the past 12 months) had sexual partnerships that were *concurrent* (overlapping). Men report more lifetime sexual partners than women and higher rates of concurrent sexual partnerships, which may place their female partners at increased risk, especially where condom use is low.

Cross-generational relationships also contribute to the spread of HIV in Rwanda.<sup>37</sup> Across sub-Saharan Africa, young women are disproportionately infected with HIV compared to young men. Age mixing in sexual relationships (i.e. age disparate (5+ year age difference) and cross-generational relationships (10+ age difference)) has been offered as a probable explanation since older men often have higher HIV infection rates than young men (as is the case in Rwanda).<sup>38</sup> In Rwanda, women become infected at an earlier age than men. While HIV prevalence is similar among young women and men aged 15-19 (0.8% vs. 0.3%), a significant change occurs among those aged 20-24, where women are nearly five times as infected as their male peers (2.4% vs. 0.5%).<sup>39</sup>

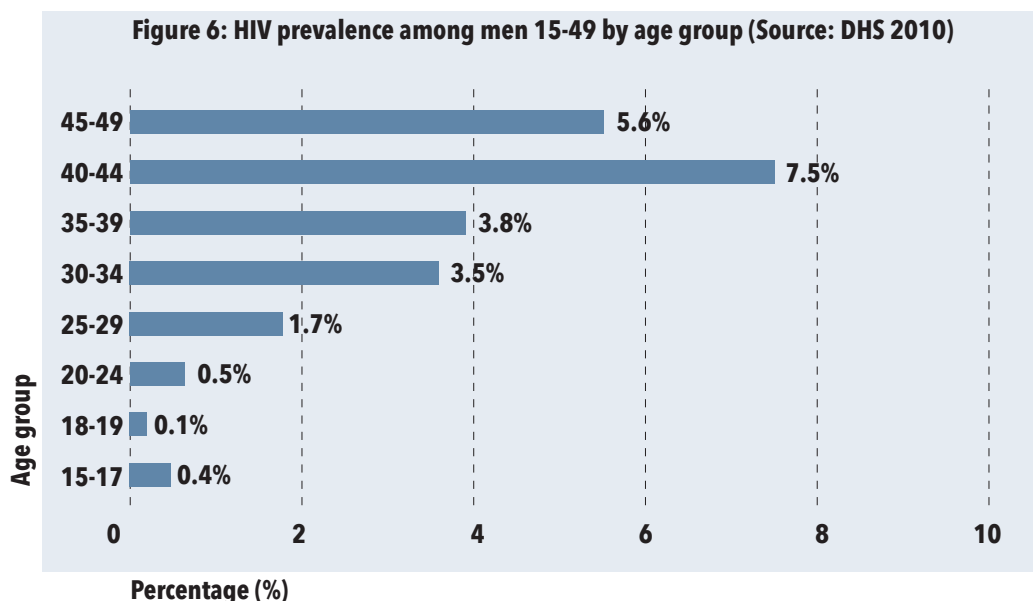


If we look more specifically at young people aged 18-19, we can see a vast gender difference – with young women of this age ten times more likely to be infected than young men of the same age (1.0% compared to 0.1%).<sup>40</sup> This data indicates that young women aged 15-24 are at increased risk of HIV infection. It also suggests that HIV transmission among young women is most likely occurring in the context of relationships with older men and not with their male peers, who exhibit much lower rates of infection. Girls and young women in cross-generational relationships (where there is an age difference of more than ten years between partners) are particularly vulnerable, given the high rates of infection among older men in Rwanda (peaking at 7.5%).

Gender based violence is also recognized as contributing to the spread of HIV among women and girls in Rwanda.<sup>41</sup> Levels of gender based violence, including rape, are quite high. Sex in the context of violence is almost always unsafe and a condom is rarely used. Forced sex often results in tears and other trauma that increase the risk of HIV transmission. According to the 2010 DHS, 22% of women aged 15-49 have ever experienced sexual violence. Intimate partner violence (IPV) is particularly high, with 56% of ever-married women having ever experienced physical or sexual violence from an intimate partner.<sup>42</sup> The link between intimate partner violence and HIV infection among women has been identified by a number of studies,<sup>43, 44</sup> including several studies examining the correlation of IPV and HIV among women in Rwanda.<sup>45, 46, 47</sup>

## 2.1.2 Men and Boys

HIV prevalence is 2.3% among men in the general population aged 15-49. As noted, HIV prevalence among men is lower than that of their female counterparts in nearly every age group except those aged 40-44. However, evidence suggests that HIV prevalence may also be higher among men who have sex with men (MSM), who are identified as a key population at higher risk of HIV infection. MSM will be discussed section 2.1.3.2. There is currently no data on HIV prevalence for boys aged 0-14 years, although recent Spectrum estimates suggest that HIV prevalence among children is approximately 0.5%.<sup>48</sup> HIV prevalence is lowest among young men aged 15-19 (0.3%) and highest among men aged 40-44 (7.5%).<sup>49</sup> Prevalence rises steadily through each age category until age 40-44, but then declines slightly among those aged 45-49 (5.6%). Figure 6 illustrates HIV prevalence among men aged 15-49 by age group.




HIV prevalence among men and boys varies depending on residence, marital status, education and wealth. HIV prevalence is higher among men living in urban areas (5.4%) compared to those in rural areas (1.6%).<sup>50</sup> Similar to women, HIV prevalence is highest in Kigali City (5.1%) and the Western Province (2.0%). In contrast to women, HIV prevalence among men is highest in the districts of Nyarugenge (6.8%), Kicukiro (5.5%) and Rwamagana (4.2%).<sup>51</sup> As in the general population, but in contrast to the female population, men with no education are more likely to be infected (3%), followed by men with primary education or higher (2%).<sup>52</sup> Men who are divorced or separated have higher rates of HIV (7.5%), followed by those who are married or living together with a partner (3.6%), and those who are never married (0.6%).<sup>53</sup> Men in the highest wealth quintile have the highest prevalence (5% compared to 3% or less in the lower wealth quintiles).<sup>54</sup> However, the DHS notes that the relationship between wealth and HIV prevalence is not linear.

### Modes of Transmission

Most new HIV infections among men and boys are likely to result from unprotected heterosexual intercourse, although 5% of predicted new HIV infections are estimated to result from homosexual intercourse (MSM will be discussed in section 2.1.3.2).<sup>55</sup> Within the context of unprotected heterosexual intercourse, HIV transmission among men is likely to occur in relation to low condom use among steady sero discordant couples, among those who are clients of sex workers, and among those with multiple and/or concurrent sexual partnerships. As previously mentioned, 2% of cohabiting couples are sero discordant, with relatively equal distribution between couples where the female partner is HIV positive and couples where the male partner is HIV positive. The number of sero discordant couples is higher in urban areas and in the City of Kigali.<sup>56</sup>

Multiple sexual partnerships are likely a contributing factor for HIV transmission among



men. On average, men in Rwanda are more likely than women to have multiple sexual partnerships, with an average of 2.9 sexual partners in their lifetime compared to 1.4 for women.<sup>57</sup> Men's higher rate of sexual partners is linked in part to sociocultural norms, which will be discussed in a later section. In 2010, 4.1% of men reported having more than one sexual partner in the past 12 months (compared to 0.6% of women). Older men are more likely to report multiple partners in the last 12 months – 6.3% of men 30-39 and 5.5% of men 40-49.<sup>58</sup> Men who reported the highest rates of multiple partnerships include divorced, separated or widowed men (10.6%), men living in urban areas (5.6%) and in the City of Kigali (5.6%).<sup>59</sup> Only 25% of men who had more than one sexual partner in the past 12 months reported using a condom at last sexual intercourse. This indicates a significant risk of HIV transmission for men and for their female partners.

As noted, concurrent sexual partnerships, which are distinctive from multiple sexual partnerships, are a risk factor for HIV transmission. Among the 4.1% of men aged 15-49 who reported having more than one sexual partner in the past 12 months, 79% had partnerships that were *concurrent* (overlapping). However, overall only 2-3% of Rwandan men report concurrent sexual partnerships, although this is slightly higher than the rate for women (less than 1%).<sup>60</sup> Men who are currently married (3%), divorced, separated or widowed (4%) are more likely than men who have never been married (less than 1%) to report concurrent sexual partnerships.<sup>61</sup> Concurrent sexual partnerships were also more reported by men living in rural areas. Multiple and concurrent partnerships are particularly risky in cases where condom is low or inconsistent.

Clients of sex workers are estimated to contribute to approximately 19% of new HIV infections.<sup>62</sup> According to the 2010 DHS, 3.9% of men aged 15-49 reported ever having paid for sexual intercourse, with less than 1% having done so in the last 12 months. HIV prevalence is 8.9% among men reporting having paid for sexual intercourse in the last 12 months.<sup>63</sup> The men most likely to report ever having paid for sexual intercourse included men age 30 and older (6%), divorced, separated or widowed men (6%), men living in urban areas (7%) and in the City of Kigali (8%), and those in the highest wealth quintile (6%).<sup>64</sup> In 2010, female sex workers reported that the majority of their clients are married men (66%), followed by widowers (21%) and single men (13%).<sup>65</sup> The district of Nyarugenge has the highest rates of men reporting having paid for sexual intercourse (14%), and is located in the City of Kigali, where HIV prevalence among female sex workers is 56%.

Truck drivers, mobile populations and people in uniform have traditionally been identified as clients of sex workers in Rwanda,<sup>66</sup> however evidence suggests there is need to broaden the understanding of the types of men that are paying for sex. Research indicates that a wide array of men are clients, including business men, students, and local authorities.<sup>67, 68</sup> Estimates of the size of the population of men who are clients of sex workers vary depending on the methodology used, with figures ranging from 15,000 to over 150,000.<sup>69</sup> A recent sex worker size estimation survey conducted by RBC/IHDPC and UNFPA suggests that there could be approximately 85,000 clients of sex workers.<sup>70</sup> Despite being a relatively small population, clients are a particular concern for HIV prevention considering the low levels of condom use reported and the fact that many are married or have other sexual partners, increasing the risk of transmission to a wider network of individuals.

## 2.1.3 Key Populations at Higher Risk of HIV

The term 'key populations at higher risk of HIV' refers to those populations most likely to be exposed to HIV or to transmit it, for example, female sex workers, injecting drug users, men who have sex with men, etc. Key populations vary depending on the country context and each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. In Rwanda, key populations at higher risk of HIV infection include: female sex workers; MSM; prisoners; truck drivers; clients of sex workers (refer to section 2.1.2); and sero discordant couples. This section examines HIV prevalence and transmission among female sex workers, MSM, prisoners, truck drivers and sero discordant couples.

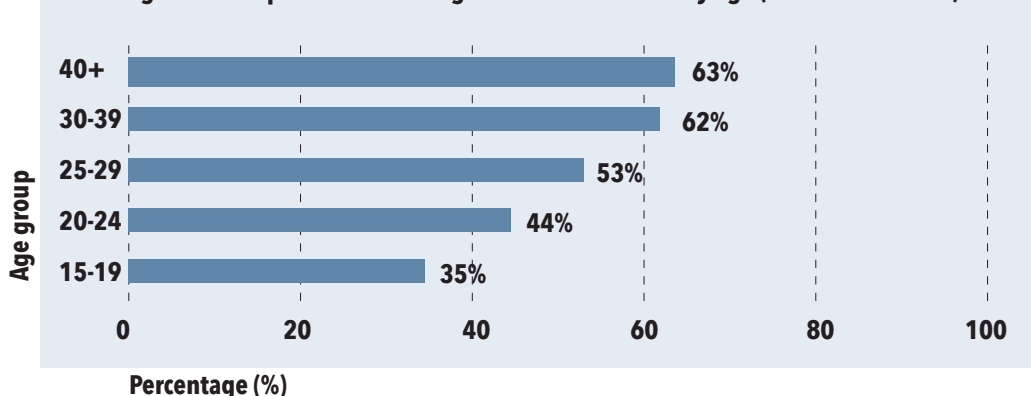
### 2.1.3.1 Female sex workers

There are an estimated 12,278 female sex workers in Rwanda, according to the most recent (2012) size estimation survey.<sup>71</sup> Modes of transmission modeling conducted by UNAIDS and RBC/IHDPC in 2013 suggests female sex workers will contribute to 1% of new HIV infections. The estimate is significantly lower than previous estimates (2008), which suggested that female sex workers could contribute to between 9-46% of new infections.<sup>72</sup> However, the new estimate is likely a stronger estimate based on the larger amount of data that is now available to inform the model. Data from 2010 indicates that HIV prevalence is 51% among female sex workers.<sup>73</sup>

There is considerable variation in HIV prevalence among sex workers depending on location, with the highest prevalence observed in the three districts of Kigali City (56%) (Gasabo, Kicukiro, and Nyarugenge), followed by the Western and Southern Provinces (55%), Northern Province (47%) and the Eastern Province (33%).<sup>74</sup> HIV prevalence is highest in the areas where the largest numbers of sex workers are concentrated – Kigali City and the Western Province – and specifically in the districts of Kicukiro and Nyarugenge (Kigali) and Rubavu and Rusizi (Western Province).<sup>75</sup>

Prevalence among female sex workers also varies depending on age, the number of years engaged in sex work, whether sex work is the only source of employment, and marital status. HIV prevalence among sex workers is already strikingly high among younger sex workers aged 15-19 (35%) and is highest among those aged 40 and above (63%).<sup>76</sup> Figure 7 illustrates HIV prevalence among female sex workers by age. Prevalence is lowest among sex workers with less than one year of experience as a sex worker (34%) and highest among those with more than eight years of experience (57%), although it should be noted that prevalence among new sex workers is already exceedingly high.<sup>77</sup> HIV prevalence is highest among sex workers who report that sex work is their only source of income (53%), compared to those who report having another type of employment or source of income (47%).<sup>78</sup> Prevalence is considerably lower among sex workers who are married and living with their husband (33%) compared to those who are never married and not cohabiting with a sexual partner (49%), and those who are separated and not cohabiting (59%).<sup>79</sup>

**Figure 7: HIV prevalence among female sex workers by age (Source: BSS 2010)**



Unprotected sexual intercourse with multiple and concurrent partners is the primary mode of HIV transmission for female sex workers. Sex workers have large sexual networks, with both paying and non-paying sexual partners. Sex workers in Rwanda report an average of seven clients per week, ranging from between one and 37 clients, while the majority of sex workers (40%) report less than five clients in a week.<sup>80</sup> Condom use among female sex workers is disturbingly low given the high rates of HIV and large number of sexual partners. Only 67% of female sex workers reported using a condom at their last sexual intercourse, and only 33% report having consistently used condoms with a paying sexual partner in the last month.<sup>81</sup> A number of sociocultural and economic factors reduce sex workers' ability to access condoms and to negotiate their use, which will be explored in section 2.2.3.1.

Male sex workers do exist in Rwanda, although this group is neither as large nor as visible as female sex workers. The existing evidence indicates that male sex workers are a much smaller population and likely contribute to a much smaller proportion of HIV infections. However, more information on this group is needed to ensure that they are being reached by HIV prevention messages and are accessing HIV treatment, care and support services.

### **2.1.3.2 Men who have sex with men (MSM)**

'Men who have sex with men' describes males who have sex with males, regardless of sexual orientation or gender identity (e.g. a personal or social gay or bisexual identity) or whether or not they also have sex with women.<sup>82</sup> This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men. Unprotected receptive anal sex is recognized as the sexual behavior with the highest risk for HIV acquisition, placing MSM at increased risk of HIV infection. In Rwanda, MSM are identified as a 'most-at-risk' population in the national HIV strategy. Although there is currently no generalizable data on HIV prevalence among MSM, 2013 MOT estimates suggest that MSM may contribute to 5% of predicted new HIV infections.<sup>83</sup> This figure is significantly lower than previous estimates (2008), which suggested MSM would contribute to up to 15% of new infections,<sup>84</sup> however the new figure is likely stronger given the significant availability of new data to inform the model. In 2013, RBC/IHDPC plans to undertake a study to obtain data on HIV prevalence among MSM, with support from the Centers for Disease Control and Prevention (CDC).

An Exploratory Study on HIV Risk Among MSM in Kigali conducted in 2008-2009 found that MSM may have a heightened risk of HIV infection as a result of low condom use and large sexual networks. MSM in Kigali reported large sexual networks, including both male and female partners. Men reported an average of two male sexual partners in the 12 months prior to survey. Only one-third of men reporting sex with another man in the past 12 months reported consistent condom use with all male partners, and nearly one-third reported that they had never previously used a condom with a male or female sexual partner.<sup>85</sup> It was also found that a high proportion of men who have sex with men in Kigali also engage in commercial and/or transactional sex.

Due to the hidden and stigmatized nature of homosexuality in Rwanda, it is difficult to estimate the number of men who have sex with men in Rwanda. A 2011 study to estimate the size of populations using a household survey utilized two methods to estimate the number of MSM (Network Scale-up and Proxy Respondent methods). The highest estimate suggests a possible 6,100 men who have sex with men in Rwanda.<sup>86</sup>

### **2.1.3.3 Truck drivers**


Truck drivers in Rwanda are identified as a key population due to their mobile nature and because they are recognized as a client group of female sex workers. The link between mobility and HIV has been well documented, with higher HIV prevalence being seen in mobile populations and in communities surrounding major transport corridors. Although there are currently no estimates of HIV prevalence among truck drivers in Rwanda, prevalence appears to be higher than in the general population.<sup>87</sup> The 2010 Behavioral Surveillance Survey among truck drivers (BSS) attempted to measure HIV prevalence among truck drivers, but was not able to obtain a sufficient sample size because an insufficient number of respondents agreed to be tested.

Truck drivers in Rwanda are put at elevated risk of HIV due to several risk behaviors, including having unprotected sex with multiple partners and purchasing sex. Truck drivers often spend long amounts of time in transit, including a significant amount of time at stopover sites and border stops along the major transport corridors waiting for authorization.<sup>88</sup> At these sites, female sex workers and other potential sexual partners often approach truck drivers. The 2006 Behavioral Surveillance Survey among truck drivers indicates that 18.5% of truck drivers had engaged in sex with sex workers, although this does represent a significant decline from 47% in 2000.<sup>89</sup> According to a 2010 study, only 10% of truck drivers reported consistent condom use in the last 12 months.<sup>90</sup> This is particularly concerning as 67% of truck drivers reported being married in 2006, indicating increased risk of transmission to their female partners and a possible sero discordance within couples.<sup>91</sup>

### **2.1.3.4 Prisoners**

In 2011, there were almost 60,000 prisoners incarcerated in Rwanda, the majority of them male (93%).<sup>92</sup> As in many other countries, data on HIV in prisons is limited, although HIV prevalence among prisoners appears to have reduced in recent years. Data from mobile VCT indicates that HIV prevalence in prisons declined from 10% in 2006 to 4% in 2007 and remained static as of July 2008.<sup>93</sup> However, no data on HIV prevalence is available since 2009. The NSP notes that HIV prevalence in prisons does not appear to be significantly higher than outside, but there is evidence of sexual





activity within the prisons, where condoms are prohibited and rarely used.<sup>94</sup> Although HIV prevention, treatment, care and support services are provided to prisoners, little information is available on HIV transmission in prisons.

### **2.1.3.5 Sero discordant couples**

HIV sero discordant couples are identified as a key population at higher risk of HIV infection in Rwanda. The NSP notes that it is likely that most heterosexual transmission of HIV will be due to low condom use among sero discordant couples. As previously noted, 2% of cohabiting couples in Rwanda are sero discordant, with relatively equal distribution between couples where the female partner is HIV positive (0.9%) and couples where the male partner is HIV positive (1.3%).<sup>95</sup> The number of sero discordant couples is higher in urban areas and in the City of Kigali.<sup>96</sup> More details on sero discordant couples can be found in section 2.1.1 on 'Women and Girls' and 2.1.2 on 'Men and Boys'.

## **2.1.4 Marginalized and Vulnerable Groups**

In addition to key populations, there are often specific groups that are particularly vulnerable to HIV infection, due to unequal opportunities, social exclusion, and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. In Rwanda, several groups are identified by the HIV response as vulnerable to HIV infection, including: people with disabilities; refugees; and orphans and other vulnerable children (OVC). These groups are considered especially vulnerable due to factors that lead to social exclusion and marginalization.

The national HIV strategy acknowledges that people with disabilities are often marginalized because of their disability, which makes them more prone to be victims of abuse and less easy to reach through regular information campaigns and general services.<sup>97</sup> There is currently no reliable data on HIV prevalence among people with disabilities in Rwanda. Refugees are also viewed as vulnerable, although evidence indicates that HIV prevalence and risk behaviors are very low in the refugee camps, possibly because they are well covered by programs.<sup>98</sup> In 2012, there were nearly 60,000 refugees and asylum seekers residing in refugee camps in Rwanda, with more than 15,000 new refugees arriving from the Democratic Republic of Congo within the year.<sup>99</sup> Rwanda plans to undertake a Behavioral Surveillance Survey among refugees in 2013 to obtain additional information on HIV risk behaviors.

Orphans and other vulnerable children are also viewed as particularly vulnerable to HIV. According to the national classification system, an orphan is a child who has lost one or both parents. A vulnerable child is a person younger than 18 years of age, exposed to conditions that limit the fulfillment of his or her fundamental right to development. The application of these categories has been problematic, with no reliable estimate of the number of OVC available based on the different categorizations. Approximately 13% of the Rwandan population under 18 and 20% of the population under 21 has lost one or more parents.<sup>100</sup> Three percent of people under age 21 have lost both



parents. The proportion of orphans is particularly high among children aged 10-14 (21%) and 15-17 (35%), largely due to the effects of the 1994 genocide.<sup>101</sup> In 2008, it was estimated that there were more than 230,000 orphans due to AIDS alone.<sup>102</sup> The highest proportion of orphans resides in Kigali City. There is currently no data on HIV prevalence among OVC.

## 2.2. Contributing Factors to HIV Transmission

A gender analysis of the HIV epidemic requires examining how social constructs affect women and girls' and men and boys' susceptibility to HIV and how cultural and economic differences and gender roles affect the responsibility of women and girls, and men and boys. Gender roles and norms interact with other factors to produce particular manifestations of attitudes and behaviors that contribute to the spread of HIV. Behaviors and practices are shaped by social, cultural, political and economic factors, some of which can make individuals more vulnerable to HIV or contribute to behaviors that place individuals at greater risk of infection. It is important to understand how and why these different factors influence HIV transmission. This chapter outlines contributing factors to HIV risk and vulnerability for women and girls (section 2.2.1), men and boys (2.2.2), key populations (2.2.3) and marginalized and other vulnerable groups (2.2.4) in Rwanda.

### 2.2.1 Women and Girls

In addition to women and girls' increased biological susceptibility to HIV, there are social, cultural, economic and political factors that significantly increase their vulnerability to and risk of HIV infection. In Rwanda, some of these contributing factors include poverty and economic vulnerability, traditional gender norms that limit women's autonomy, cross-generational sex, gender-based violence, and traditional attitudes towards sex and sexuality. These factors also influence who is more affected by the HIV epidemic, including family members and dependents that may be involved in caregiving or otherwise affected by a person's HIV status.

#### 2.2.1.1 Social and Cultural Factors

Gender inequalities, abuse, and physiological susceptibility to the virus make women more vulnerable to HIV than men. Social determinants that impact HIV risk and vulnerability for women and girls include the power to select sexual partners, to choose the timing of sexual encounters, and to insist on safer sex practices.<sup>103</sup> When women and girls lack the ability to determine these decisions, they are unable to protect themselves from HIV infection. This section examines social and cultural factors contributing to HIV risk and vulnerability for women and girls in Rwanda.

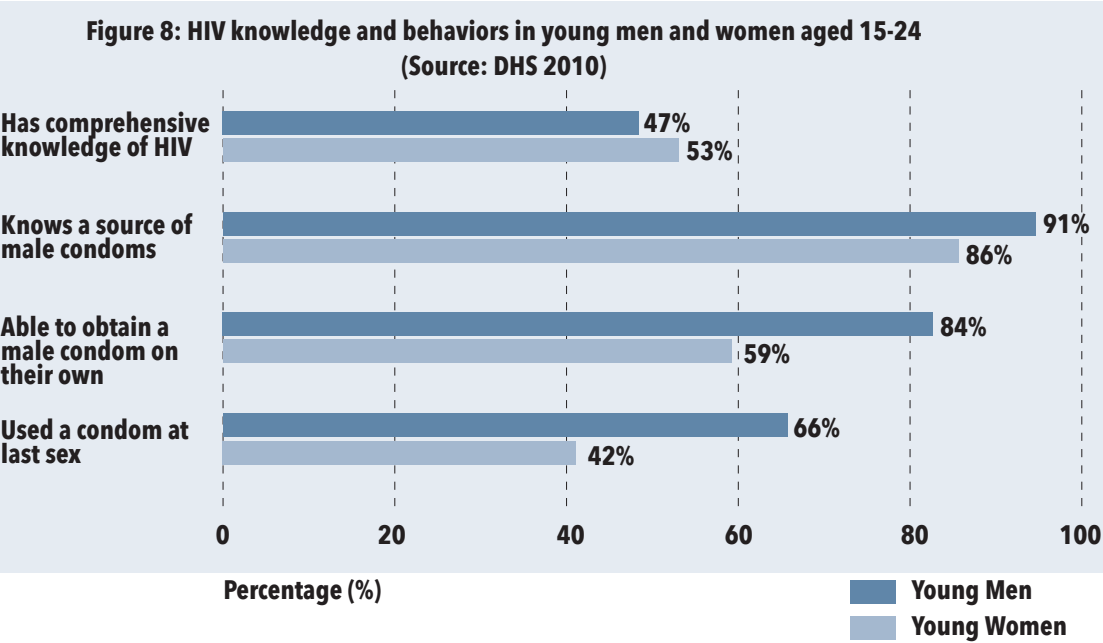
#### **Gender norms and sociocultural constructions of sex and sexuality**

Conservative attitudes to sex and sexuality are common in Rwanda, especially for young people. Discussion about sexuality is taboo between parents and children, at school between teachers and students, and also between partners.<sup>104</sup> Sex is viewed as

something that happens between a husband and a wife and sex outside of marriage is particularly discouraged. Condom use is also discouraged due to a longstanding association between condoms and promiscuity. A study among youth living with HIV found that more than half believed using a condom is a sign of not trusting your partner and up to 78% felt their partner would think they engage in sex with multiple partners if they asked to use a condom.<sup>105</sup> Such attitudes can significantly deter women from negotiating condom use.

Gender paradigms and inequities linked to conservative attitudes also impact women and girls' ability to access information and services to help protect them from HIV. For example, traditional gender roles that value virginity can discourage young women from accessing sexual and reproductive health information, services or commodities for fear of being seen as sexually active or promiscuous.<sup>106</sup> Cultural norms are particularly restrictive for girls, with sex outside of marriage and unintended pregnancy viewed as especially shameful. For this reason, girls often report having a greater fear of becoming pregnant than of acquiring HIV.<sup>107</sup> Pregnancy outside of marriage can lead to dire consequences for young women, including rejection from the family, dropping out of school, early marriage, engagement in risky behaviors such as sex work, and unsafe abortion.<sup>108</sup> These actions can significantly increase young women's risk of acquiring HIV and their vulnerability to developing AIDS.

When we examine young women's knowledge, access to and use of condoms, we see that young women are disproportionately disadvantaged compared to young men (refer to Figure 8). Although young women have higher rates of comprehensive knowledge of HIV and only slightly less knowledge of a source of (male) condoms than their male peers, they have substantially lower rates of access to (59% vs. 84%) and use of condoms than young men (42% vs. 66%).<sup>109</sup> This suggests that sociocultural norms play a substantial role in limiting young women's ability to practice safer sex, including accessing condoms and negotiating their use.



## Sexual debut and risk taking behavior

Evidence suggests that individuals who initiate sexual activity early are more likely to engage in risky behaviors, including an increased number of lifetime sexual partners and lower rates of condom use, and have a higher likelihood of acquiring HIV.<sup>110</sup> Although rates of early sexual debut have decreased in Rwanda, 17% of young women 15-24 report having had sexual intercourse before age 18, and 4% before age 15.<sup>111</sup> Research indicates that poverty and low levels of education are linked to higher levels of adolescent sexual activity among young women.<sup>112</sup> This holds true in Rwanda, where early sexual onset is higher among young women with no education (31% before age 18) than those with primary education (17%), or secondary or higher education (10%).<sup>113</sup> HIV prevalence is higher among women who report early sexual debut (6% among those whose sexual debut was before age 18) than those who delay sexual initiation.<sup>114</sup>

A significant amount of research on sub-Saharan Africa links the gender-related socialization of young people and power within relationships to risky sexual behavior.<sup>115</sup> Traditional gender norms and paradigms can lead to inequities in economic, social and personal power for women and girls, which result in male-dominated power imbalances that place women and girls at higher risk of infection.<sup>116</sup> In Rwanda, traditional gender norms promote the idea that women are subordinate to men, with the man seen as the head of the family, and women expected to be submissive to their husbands.<sup>117</sup> Rwanda women report high levels of inequality in their personal relationships with men,<sup>118</sup> and the majority of women (75%) view sexual relations as male-dominated.<sup>119</sup> A woman's subordinate status can reinforce her role as a passive partner, and can undermine or preclude her from denying sex or negotiating safer sex.<sup>120</sup> Women's own acceptance of these traditional values can be a factor in discouraging them from accessing information or services or negotiating safe sex, in part due to fear of abandonment or reprisal by a male partner.<sup>121</sup>

## Women's lower levels of educational attainment

Lower levels of training and educational attainment disadvantage women and girls from job opportunities and reduce their economic competitiveness, perpetuating women's economic vulnerability and dependence and increasing HIV risk and vulnerability. In Rwanda, 78% of women have attended or completed primary school or higher, compared to 84% of men and more than 20% of women have report having no education compared to 15% of men.<sup>122</sup> Rural women are the most disadvantaged. Rwanda has made a concerted effort to promote gender parity in education and to increase girls' enrollment in primary school, including a Nine Year Basic Education program, which removed tuition fees for students through grade six. By 2011, girls' enrollment in primary and secondary school actually outnumbered boys'.<sup>123</sup> However, boys continue to outperform girls in most subjects and there are still fewer women completing secondary and tertiary levels of education than men.<sup>124</sup> Some contributing factors to girls' underperformance include absenteeism or late enrolment due to girls' household duties and caregiving responsibilities, and menstruation,<sup>125</sup> as well as the lesser value placed on girls' education and sociocultural and institutional biases towards boys.<sup>126</sup>

Girls' recognize that opportunities for them to attend and succeed in school are improving, although they do report feeling that they have fewer opportunities to



succeed in life than boys in terms of education and job opportunities.<sup>127</sup> Girls note that parents still value and are willing to invest in boys' education more, because they believe that girls are less likely to complete school due to pregnancy or marriage.<sup>128</sup> In addition, girls cite a number of factors that precipitate dropping out of school, including unintended pregnancy, parental pressures (e.g. domestic work and caregiving), and early marriage.<sup>129</sup> Pregnancy has been recognized by the Ministry of Education as a barrier to girls' educational attainment and strategies to enable the re-entry of girls (and boys) who dropout, including girls who dropout due to pregnancy during their education, were incorporated into the 2008 Girls' Education Policy.<sup>130</sup> The level to which the re-entry policy is known or implemented is unknown.

In addition to preparing girls for future economic opportunities, schools are an important source of sexual and reproductive health information for young people. Rwandan adolescents and young adults view schools as the second most important source of reproductive health information after their friends.<sup>131</sup> Women and girls' school attendance is therefore critical to their knowledge of HIV prevention, with

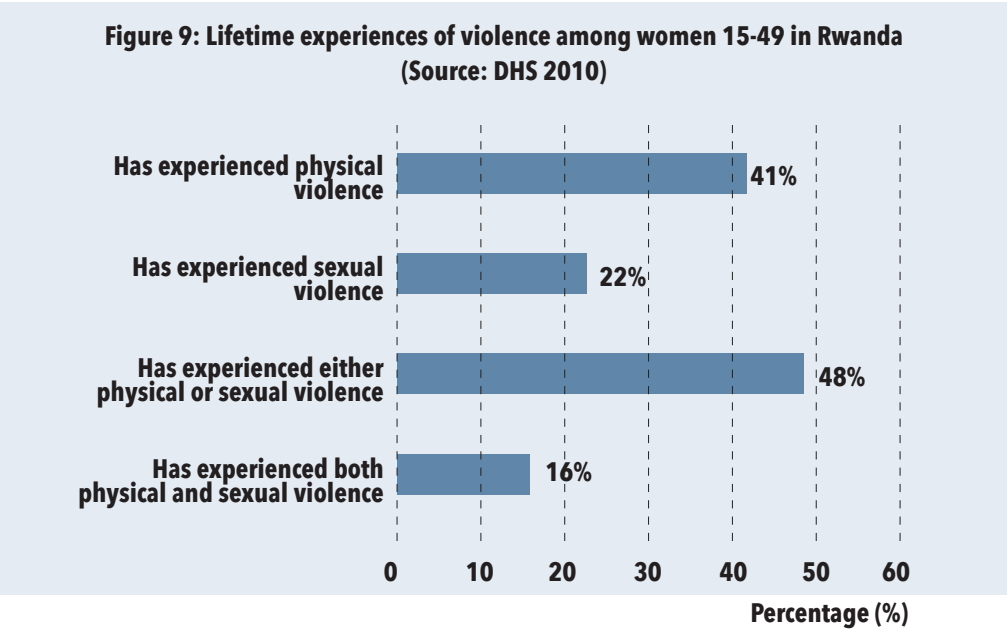
those who dropout being significantly disadvantaged in accessing such information. According to the 2010 DHS, 55% percent of women (15-49) have a comprehensive knowledge of HIV. Comprehensive knowledge of HIV is positively correlated with higher levels of education. Women with secondary or higher education have the highest rates of comprehensive knowledge of HIV (68%), compared to those with primary education (48%) and those with no education (40%).<sup>132</sup> However, as previously noted, HIV prevalence among women 15-49 is highest among those with a secondary or higher education, although this does not hold true for young women aged 15-24.

## Gender-based violence

Research indicates that women who have experienced physical or sexual violence from male intimate partners are more likely to be living with HIV.<sup>133</sup> Gender-based violence contributes to HIV transmission in a number of ways, with rape/sexual assault being the most obvious and direct route of transmission. Forced and unwanted sex is strongly linked with vaginal or anal trauma that facilitates transmission of HIV.<sup>134, 135</sup> Research indicates that the link between violence and HIV is not limited to or even primarily driven by sexual violence. A number of studies have shown that women and girls who experience physical or sexual violence are less able to influence the timing and conditions in which they have sex, including condom use.<sup>136, 137</sup> A landmark study from South Africa calculated that if gender inequalities were improved so that no women were in relationships with low power, 13.9% of new HIV infections could be prevented.<sup>138</sup> Past experiences of violence are also linked with high-risk sexual behaviors later on, including multiple and concurrent partners, lower levels of condom use, and increased participation in transactional sex or sex work.<sup>139</sup>

Levels of physical and sexual violence in Rwanda remain high. According to the 2010 DHS, 48% of women have ever experienced either physical or sexual violence, and 16% have experienced both forms of violence. Figure 9 illustrates women's lifetime experiences of physical and sexual violence in Rwanda. Rates of both sexual and physical violence are higher among those with no education, compared to those with a primary or secondary education.<sup>140</sup> More than 20% of women aged 15-49 have ever experienced sexual violence, and for the majority of women (53%) the first experience of sexual violence occurred before age 19.<sup>141</sup> In addition, 41% of women report having

experienced physical violence since age 15.<sup>142</sup> Experiences of physical violence are higher in rural areas, while rates of experiencing sexual violence are higher in urban areas.



There is a strong link between intimate partner violence – physical and/or sexual assault or threats between married or romantically involved partners or former partners – and HIV. In addition to forced sex, intimate partner violence (IPV) impairs communication between partners regarding safer sex practice, and women with abusive partners are more likely to fear negotiating condom use.<sup>143</sup> In Rwanda, 27% of women experiencing sexual violence report that their first experience of sexual violence occurred at the hands of their current husband or partner and 13% from a former husband or partner.<sup>144</sup> In addition, 17% of ever-married women report having been forced to have sexual intercourse with their husband against their will, and 95% of currently married women who have experienced physical violence did so at the hands of their husband or partner.<sup>145</sup> Spousal violence in Rwanda is lower in relationships where women have greater decision-making power.<sup>146</sup> It is important to note that women living with HIV are at increased risk of violence, especially in the period immediately after disclosing their HIV status to their partner.<sup>147</sup>

Despite a strong legal and policy framework to protect women and girls from violence, relatively high levels of acceptance of violence against women persist, particularly among women. More than half of women 15-49 (56%) believe that a husband is justified in beating his wife for at least one specified reason, compared to only 25% of men.<sup>2</sup> Acceptance of wife beating is higher among women who are or have ever been married, and among women living in rural areas. Another study found that 70%

<sup>2</sup> In the DHS 2010, the potential responses for justifying a man beat his wife include that she: burns food; argues with her husband; goes out without telling her husband; neglects the children; or refuses to have sexual intercourse with her husband.



of women and men agree with statements on tolerance and acceptance of partner violence.<sup>148</sup> Entrenched gender roles are associated with high levels of violence and sexual abuse towards women and girls.<sup>149</sup> Participants in the national Gender Assessment workshop noted that there are often times when women report partner violence to the police, but later withdraw their complaints due to: a) fear of shame and embarrassment within the community for reporting her husband; and 2) economic dependence on the male partner for the family's well-being.

## **Gender-based discrimination and sexual harassment**

Gender discrimination and violence are also present in the workplace, contributing to a culture of gender inequality that perpetuates violence. A 2008 study on workplace violence and gender discrimination in the health system found that 39% of health workers (male and female) had experienced some form of workplace violence in the year prior to the study.<sup>150</sup> Sexual harassment was mostly experienced by women, with women being less likely to disclose the experience of violence and more likely to leave a job because of bullying and sexual harassment. Gender inequality and the lack of a culture of mutual respect were identified as the two main contributing factors to the experience of violence in the workplace in Rwanda. The findings of the study contributed to recent revisions of the Rwandan Labor Law to protect against workplace discrimination.

In 2011, a Transparency Rwanda study found that 15% of respondents acknowledged the existence of gender based corruption in workplace in the form of sexual favors in order to access various opportunities such as promotions and trainings.<sup>151</sup> Participants reported cases where individuals who resisted the sexual proposals of managers or colleagues were denied various professional advantages.<sup>152</sup> Respondents also noted that the female job seekers were likely to be the most vulnerable to such violence, particularly in the relation to fears about unemployment and survival. A workplace environment in which sexual harassment and abuse contributes to unequal power relations and can lead to exploitation that places women at risk of HIV infection. The International Labor Organization (ILO) recommends that an effective workplace HIV and AIDS policy must promote gender equality and address all forms of discrimination, including sexual harassment.<sup>153</sup>

Schools can also be source of sexual harassment or violence for girls and young women. Evidence indicates that girls may be susceptible to violence within schools. A school children's survey indicates that both girls and boys (12-16) report experiencing violence in schools, including sexual harassment and violence from both teachers and students.<sup>154</sup> In these circumstances, girls are vulnerable to coercion, exploitation and violence that place them at significant risk for HIV infection. Girls may also be at risk of violence when they travel to and from school alone. Other research documents how girls have become involved in transactional sex as a means of obtaining transportation to travel the long distance to school.<sup>155</sup>

### 2.2.1.2 Economic and Political Factors

Poverty can be a significant contributing factor to HIV risk and vulnerability for women and girls'. In Rwanda, women living with HIV are more likely to live below the poverty line than men living with HIV (50% vs. 39%),<sup>156</sup> although the DHS indicates that HIV prevalence is highest among women in the highest wealth quintile. Limited economic opportunities, under- and unemployment, and limited access to credit increase women and girls' HIV risk and vulnerability.<sup>157</sup> When women are less economically independent, they are more likely to be dependent upon male relatives and partners, which creates a social dependency that often reduces women and girls' decision-making power.<sup>158</sup> Economic vulnerability and dependence can reduce women's ability to negotiate sex and safe sex, and can increase risk of exploitation or violence. Those living in poverty are also most intensely affected by HIV and vulnerable to the socioeconomic impacts of the epidemic.

#### Women's access to income and credit


Women in Rwanda are disproportionately impacted by poverty. While more women are engaged in economic activities than men, women are most often engaged in unpaid work or employed in fields where they receive less remuneration.<sup>159</sup> More than 66% of married women who earn cash report earning less than their husbands.<sup>160</sup> The poorest individuals in Rwanda are most likely to list agriculture as their main job, a field in which women far outnumber men (80% of women work in agriculture compared to 61% of men).<sup>161</sup> In recent years there has been an increase in the number of individuals moving out of agriculture and taking up professions in commerce, sales, or semi-skilled occupations, however, men have been able to make this move more effectively than women.<sup>162</sup>

Women also have less access to credit and savings than men. Women have traditionally been disadvantaged in accessing credit from commercial banks, comprising only 26% of the beneficiaries of credit from commercial banks and receiving only 14% of the total amount of funds distributed between 2005-2007.<sup>163</sup> Women aged above 18 years are also less likely than men to report having a savings account (29% of men vs. 14% of women).<sup>164</sup> Access to credit and savings is a particular concern for female heads of household. Women are the (permanent) heads of approximately 28% of households in Rwanda, 70% of which are headed by widows.<sup>165</sup> Another 6% of households are 'de facto' female headed, where the male heads have spent more than three out of the last 12 months away (e.g. in detention, in military service or working away from home).<sup>166</sup> In recent years, the poverty levels of female-headed households have declined and such households are now only slightly more likely to be poor than male headed households (47.0% vs. 44.9%), while de facto female-headed households are much more likely to be extremely poor.<sup>167</sup>

#### Women's autonomy and decision-making power

Women's autonomy and decision-making power in their relationships are often linked to their earning power and educational attainment. The majority of women who are married and earned cash for their work in the last 12 months report that they decided jointly with their husbands on how to spend their earnings (66%), with the majority also deciding jointly on how their husband's earnings are spent.<sup>168</sup> Another 18% of women report deciding how to spend their own earnings, however, 15% of women report that her husband usually decides how *her* earnings are spent.<sup>169</sup> Women with no





education were the least likely to decide jointly how to spend their earnings (60%), while women with a secondary education or higher are more likely to decide jointly (70%).<sup>170</sup> Women who earn more than their husbands are more likely to make their own decisions on how to spend their earnings (37%). Similarly, those who earn less than their husbands are more likely to report that their husbands decide on how to spend their earnings (17%).<sup>171</sup>

A woman's financial independence and earning power is also tied to her participation in decisions regarding her own health care, major household purchases, and whether she visits family or relatives. Around 74% of women report that they participate in decisions about their own health care, 71% about major purchases and over 80% participate in their own decisions to visit their families or relatives.<sup>172</sup> Urban women have higher levels of decision-making power regarding their own health care, as do those with higher levels of education and those living in the higher wealth quintiles. Working and older women show slightly higher levels of participation. Approximately 11% of women report not participating in these decisions, and these women tend to be young, unemployed and living outside Kigali. Women's participation in decision-making in all three areas is highest for women who report being employed and earning cash (61%), compared to those who are not employed (53%) and those who are employed but not earning cash (56%). The highest percentage of women reporting that they participate in none of these decisions is among those who are not employed (23%).<sup>173</sup>

### **Cross-generational relationships and transactional sex**

Poverty and economic vulnerability also contribute to the proliferation of cross-generational relationships and transactional sex. Cross-generational relationships are broadly considered as relationships that exist within and across generational configurations, which may be free, transactional, exploitative, coercive or unlawful.<sup>174</sup> Evidence suggests that in many countries young people are exploited or attempt to engage in cross-generational relationships in order to meet their basic needs, or to scale-up their standard of living and outlook among peers, and/or to obtain money, clothes, school fees, gifts and favors in return for sexual relationships.<sup>175</sup> These relationships are often considered within the realm of transactional sex. Cross-generational relationships and the existence of 'sugar daddies' (older men in relationships with young girls) are well recognized in Rwanda.

Rwanda's HIV strategies acknowledge that women and girls can be exploited or encouraged to engage in transactional sex in order to access financial resources to support themselves and their families.<sup>176</sup> The general perception of transactional sex is that it is a practice specific to girls, used as a means of securing basic needs (e.g. food, shelter, clothing and education) and as a survival strategy.<sup>177</sup> Girls view sugar daddies as a source of money and report that sugar daddies tempt them into sexual relationships by offering gifts such as clothes or jewelry, and providing money for school fees and family necessities.<sup>178</sup> Although school fees have been eliminated, it appears that there are still structural barriers and costs associated with education that may make girls susceptible to cross-generational and transactional sex.<sup>179, 180</sup> Research also indicates that it is not just poor women who are at risk of such relationships, but also relatively well-off women.<sup>181, 182</sup> Some scholars suggest that as developing country economies improve, transactional sex is also likely to increase, as young people struggle to achieve new levels of status and meet new material expectations.




Cross-generational relationships are associated with unsafe sexual behaviors, low condom use and increased HIV risk.<sup>183</sup> The age and economic asymmetries between young women and their male partners creates a power imbalance, and disparities in power reduce girls and young women's ability and confidence to negotiate sex, safer sex and condom use.<sup>184, 185, 186</sup> Young women exhibit different levels of self-determination and agency in cross-generational relationships, with coercion and exploitation more likely where sex is exchanged for basic survival needs. Such relationships often include the presence of force or coercion, which enables the man to dictate the conditions under which sexual relations occur. In Rwanda, girls have expressed that because they need the items provided by sugar daddies, they feel they cannot say 'no' to demands for sex and cannot ask to use condoms.<sup>187</sup> A number of studies indicate that the greater the degree of financial dependence in such relationships, the less likely young people are able to protect themselves.<sup>188</sup> Research also indicates that young women's risk perception in such relationships may be low, or they may perceive that the benefits of the relationship (e.g. school fees) outweigh the risks.<sup>189</sup> In addition, young women have stated being more concerned about the risk of becoming pregnant than of HIV.<sup>190</sup>

### **Women's marriage, inheritance and property rights**

In many parts of the world, women's exclusion from owning and controlling property, as well as their differential access to and use of land has been acknowledged as reducing women's chances of preventing HIV and mitigating its impact.<sup>191</sup> Rwanda has a strong legal and policy framework for protecting women and girls' rights to own, inherit and claim property and inheritance, including the 1999 Inheritance and Marital Property Law (N° 22/99) and the 2005 Organic Land Law (N° 08/05). Women have equal legal rights in marriage under the law (Civil Code, Book I, Articles 169 and 170) and under the 1999 Inheritance and Marital Property Law, couples have the option of choosing from three different marital property regimes. Regardless of the regime, both spouses must contribute to supporting the household<sup>192</sup> and in most cases, the land registration system allows for joint and family registration.

Despite a strong policy and legal framework, women and girls face barriers to claim their rights. Enforcement barriers are mainly related to a lack of awareness of the law or to women's hesitancy to claim their rights. A 2011 assessment of the 1999 Inheritance and Marital Property Law found that 26% of women had no knowledge of the law and that men had greater knowledge of the law than women.<sup>193</sup> Knowledge of the law was higher among women with greater levels of education. Even for women with knowledge of the law, traditional beliefs and values may discourage them from claiming their rights because of fear or judgment by the community, as noted by participants in the Gender Assessment workshop.

Some challenges exist with regard to the inheritance and marriage rights. The law requires gender equality in the partition of property (after death of a parent), but inequalities in the allocation of property to male and female children still occur while the parents are alive.<sup>194</sup> Respondents noted that allocation often favors the male child in line with traditional gender norms, with for example, male children being given larger and more fertile plots of land. Another challenge is that women who are unmarried but cohabiting with a male partner have fewer legal rights.<sup>195, 196</sup> Consensual unions do not create the same legal obligations or protections as civil marriages. While



cohabitation is traditionally not well respected in Rwanda, it is not that uncommon. The government encourages all couples to be legally married and not to cohabit in order to protect property rights. In recent years, some mechanisms have been developed to support individuals in consensual unions to claim their property rights, but these are limited.

### **Women's unequal burden of domestic roles and caregiving**

Traditional gender norms in Rwanda promote the perception that domestic work and caring for children are predominantly women's tasks and place the burden of domestic work and caregiving on women and girls. A 2010 study on masculinity found that 73% of men and 82% of women totally agree that a woman's most important role is to take care of her home, whereas 44% of men and 78% of women agree that changing diapers, giving kids a bath, feeding the kids are mother's responsibilities.<sup>197</sup> It is important to note that women appear to more strongly agree with these traditional gender norms than men. Overall, women spend more time on work and domestic duties (combined) than men (51 hours per week vs. 40).<sup>198</sup>

In addition to cooking and domestic chores, more than half of all women spend time on other domestic work such as foraging firewood, searching for animal fodder or fetching water, and spend an average of 11 hours per week on such tasks.<sup>199</sup> A clear trend in gender roles is visible among children and young people. While boys and girls under age 10 tend to do equal amounts of domestic work, girls do more hours than boys as children grow older, with girls age 15 doing almost six more hours of domestic work than boys.<sup>200</sup> The amount of time women and girls spend on domestic chores significantly reduces the amount of time in which they are free to take up economic and educational opportunities, further sustaining gender inequalities. As above noted, girls cite the burden of domestic chores as one factor in dropping out of school.<sup>201</sup>

In addition to domestic work, women and girls are often responsible to care for ill family members. It is well recognized that women and girls bear a disproportionate burden of caregiving, a role that most often goes unrecognized and unremunerated.<sup>202</sup> In Africa, women account for two thirds of all caregivers for people living with HIV.<sup>203</sup> Older and married women are especially affected, particularly as men would rather rely on their wives for caregiving and are often less likely to disclose their status and seek outside sources of support. Although there is very limited data on caregiving in Rwanda, women and girls appear to be disproportionately burdened with caring for ill relatives due to their traditional role as caregivers. The National Accelerated Plan acknowledges that the cost, time and emotional burden of HIV takes a significant toll on women and that at times caregiving prevents girls and young women from completing school by forcing them to drop out and care for a sick family member.<sup>204</sup>

## **2.2.2 Men and Boys**

Men and boys are also impacted by social, cultural, economic and political factors that may increase their risk of HIV or promote behaviors that put them at risk. This includes social and cultural norms of masculinity, which may promote multiple partnerships, violence or risk-taking behavior, and discourage men from accessing health services.

These contributing factors have an impact on men and their female partners, who may be made vulnerable to HIV due to certain behaviors. More recently, the global HIV response has recognized the need to question harmful definitions of masculinity and strict gender norms that may increase men's risk taking and reduce their access to HIV services.<sup>205</sup> In Rwanda, strict gender norms have been identified as contributing to the epidemic in such ways. This section examines how sociocultural, economic and/or political factors contribute to the spread of HIV in Rwanda.

### **2.2.2.1 Social and Cultural Factors**

Sociocultural factors contributing to HIV transmission for men and boys include traditional gender norms that promote strict norms of masculinity and men's risk taking behaviours. They also include gender norms that discourage men's health-seeking behaviours, and limit their access to and involvement in HIV services. In addition, men and boys are also susceptible to conservative attitudes towards sex and sexuality that reduce young men's access to information and prevention materials, and discourage condom use.


#### **Norms of masculinity**

Rwandan society has traditionally been characterized by a patriarchal social structure in which boys are attributed greater value than girls, which has often translated into unequal power relations defined by men's dominance and women's subordination.<sup>206</sup> Norms of masculinity consider the man as the head of the family and defender of country and family honor, and the majority of Rwandans believe that the man should have the final decision-making power within the home.<sup>207</sup> These norms are reinforced by social and legal customs that institutionalize these roles for men. Manhood or masculinity is also associated with taking risks and acting tough.<sup>208</sup> These gender norms translate into greater decision-making power, education and economic opportunities for men, but also define sexual relations between men and women. Sociocultural expectations of men confirm perceptions that men have to dominate and control women and that sexual relations should be controlled and dominated by the needs of men.<sup>209</sup>

The male-dominated nature of sexual relations in Rwanda limits the ability of women to negotiate sex and safer sex by placing control and power in the hands of men. As a result, women and girls are less likely to initiate sex or condom use, and are more likely to defer to men. For example, research indicates that many Rwandan girls do not openly consent to sexual intercourse, which presents a major obstacle to condom use.<sup>210</sup> In addition, 37% of women believe that a man is justified in beating his wife if she refuses to have sex with him, indicating that some women may consent to sex in order to avoid violence.<sup>211</sup> It is important to note that young men are particularly susceptible to the pressure to adhere to strict norms of masculinity that define manhood through power and dominance. For example, boys admit to coercing and pressuring girls to have sex in order to conform to such expectations in the eyes of their peers.<sup>212</sup>

#### **Masculinity and men's risk-taking**

Men and boys' behavior is strongly influenced by socially constructed gender roles



that prescribe particular norms of masculinity and masculine behavior. Around the world, sociocultural constructions of masculinity are strongly associated with men's risk-taking behaviors, including alcohol and drug use, pleasure seeking, and an alleged lack of interest in their own health.<sup>213</sup> In some instances, norms of masculinity promote certain risk-taking behaviors that men in society are expected to demonstrate, which put both men and their female partners at risk of acquiring HIV. For example, gender roles often promote acceptance of the idea that men 'naturally need' or are drawn to having multiple sexual partners.<sup>214</sup> This is likely linked to socially accepted views that men naturally need more sex than women, which can be used to justify or validate the need to seek additional sexual partners.

Gender norms in Rwanda are recognized as contributing to high rates of partner exchange and sexual risk taking among men.<sup>215, 216</sup> Research indicates that the majority of both men (83%) and women (96%) believe that men are 'always ready to have sex.'<sup>217</sup> On average, men in Rwanda have about twice the number of lifetime sexual partners than women.<sup>218</sup> Although prevalence of multiple sexual partners has decreased in recent years, men still have higher rates of multiple partnerships than women (4% compared to 0.6%), and only 28% of men with multiple sexual partners reported using a condom during their last sexual intercourse.<sup>219</sup> In addition, eight out of 10 men who had two or more partners in the past 12 months had concurrent sexual partnerships.<sup>220</sup> As noted in section 2.1.2, concurrent partnerships facilitate HIV transmission because they involve wider, overlapping sexual networks.

Men also have significantly higher rates of early sexual debut than young women, with 11% of men 15-24 reporting that they had had sex before age 15, and 27% before age 18.<sup>221</sup> Norms of masculinity value sexual activity among men in Rwanda. Research indicates that young men in school perceive having sex and impregnating a girl as important demonstrations of manhood and fertility in front of their peers.<sup>222</sup> Significantly, one out of three men in one study reported that they had ever forced a girl to have sex when they were teenagers.<sup>223</sup> These messages of masculinity are likely to encourage early sexual debut among men, while discouraging condom use.

### **Conservative attitudes towards sex and sexuality**

Men and boys are also subject to the influence of conservative attitudes towards sex and sexuality, which discourage sex before marriage and condom use. These attitudes and their prescribed norms of behavior can reduce access to sexual and reproductive health information and services, especially for young people. In Rwanda, men have slightly lower rates of comprehensive knowledge of HIV (51%) than women (56%), and knowledge is even lower among young men aged 15-24 (43%).<sup>224</sup> This trend may be a result of the fact that women and girls usually access and attend SRH services more than men, and that more women may be targeted with messages on how to prevent HIV and unintended pregnancy.

Traditional attitudes about sex also discourage condom use among men, with condoms seen as an indication of sexual promiscuity or a lack of trust between sexual partners. These attitudes and beliefs about condoms not only discourage condom use, but may also limit access for young men. While more than 80% of young men 15-24 report being able to obtain (male) condoms on their own, only 66% actually reported using a condom at their last sexual intercourse.<sup>225</sup> In addition, many young

people believe that sex without a condom is less pleasurable, and they have a lot of other misconceptions and fears about condoms.<sup>226</sup>

### **Paying for sex**


Men and boys who pay for sexual intercourse are at increased risk of acquiring HIV as well as transmitting it to their female partners, particularly given the high HIV prevalence among sex workers in Rwanda. In 2010, 3% of men aged 15-49 reported ever having paid for sexual intercourse, and 0.4% stated that they had paid for sexual intercourse in the last 12 months.<sup>227</sup> While a relatively small proportion of the general population, clients of sex workers are likely to link with larger sexual networks, increasing the risk of transmission. The new Modes of Transmission modeling suggests that clients of sex workers will account for up to 19% of new HIV infections. As noted in the NSP, certain groups have traditionally been identified as clients of sex workers, such as truck drivers, other mobile populations and men in uniform. However, as the DHS and different size estimation surveys indicate, there is a need to re-conceptualize which groups are perceived as clients of sex workers and therefore targeted with HIV prevention, treatment and care services.

Information indicates that clients of sex workers are often married and include businessmen, students, as well as local authorities. Older men and men living in urban areas are more likely to report having paid for sexual intercourse. The likelihood of having paid for sex is highest in Kigali City (8%),<sup>228</sup> where HIV prevalence among sex workers is 56%.<sup>229</sup> HIV prevalence is significantly higher among men who paid for sex in the past 12 months compared to those who either did not have sex or did not pay for sex in the past 12 months (9% versus 3%).<sup>230</sup> To date, clients have not been well reached with HIV prevention information due to the hidden nature of paying for sex, which is illegal. However, these men are particularly in need of information on HIV and violence prevention.

### **Attitudes and perpetration of violence**

Strict gender norms also contribute to gender-based violence and the acceptance of violence against women and girls. Research has shown that men's perpetration of violence is supported by dominant social norms about masculinity, femininity, and sexuality, and by patriarchal structures that define masculinity by a man's strength and control over women.<sup>231</sup> Gender norms that define a 'real' man as someone who controls and dominates his wife can also easily lead to violence between partners.<sup>232</sup> In Rwanda, norms of masculinity support the idea that violence against women is a justifiable part of male-female relations. This results in violence such as beatings and physical injury being perceived as 'normal' in the family.<sup>233</sup>

Research on gender based violence and masculinity in Rwanda found that 38% of men self-reported ever having used partner violence and 4% reported ever having forced their partner to have sex.<sup>234</sup> The researchers noted that this figure is lower compared to the proportion of women who reported experiencing partner violence. The same study found that while the majority of women and men agreed that violence against women is morally reprehensible, 70% believed that it is justified in certain circumstances. The 2010 DHS also indicates that a substantial number of men believe a man is justified in beating his wife if for example, she refuses to have sex with him.



This is likely tied to the belief that sex is a man's conjugal right and that men can demand sex from their wives at any time (despite being illegal under Rwandan law).<sup>235</sup>

### **Men's health-seeking behaviors**

Narrow definitions of masculinity also lead to vulnerabilities for men and boys. Gender norms that promote an image of a strong and powerful man are likely to restrict men and boys' health-seeking behavior, as these norms are at odds with care seeking. In Rwanda, men are much more likely than women *not* to seek care from health facilities. For example, only 35% of men with sexually transmitted infections reported seeking care from a health care professional (compared to 54% of women).<sup>236</sup> When men are encouraged to be strong and act tough, they are less likely to be able to admit weakness and seek out care and support. This has a significant impact on ensuring that men and boys are reached with HIV prevention information, and access HIV voluntary testing and counseling, treatment and care services. In addition, men are often viewed as transmitters of HIV, but not as active agents in HIV prevention, which may discourage men from participating in HIV prevention efforts.<sup>237</sup>

## **2.2.2.2 Economic and Political Factors**

Sociocultural factors that contribute to gender inequalities, violence and HIV are reinforced by economic and political factors that institutionalize men's dominance and control over sexual relations. These are namely related to men's greater access to and control over financial resources, which often translates into greater decision-making power within the household, community and in intimate partner relations.

### **Economic disparities and men's decision-making power**

Sociocultural norms about masculinity and men's dominance are reinforced by patriarchal structures that institutionalize gender inequalities. These structures precipitate economic and political realities that contribute to HIV transmission. As previously noted, men in Rwanda are more often gainfully employed, earn more, and are more likely to be employed in fields outside of agriculture, such as semi-skilled occupations, than their female counterparts.<sup>238</sup> Men have also traditionally benefited from greater access to education than women. These factors contribute to men's greater access to financial resources and decision-making power in their relationships. The social norms that establish a man as the head of the family and responsible for economic decisions are further reinforced and institutionalized by national laws that enshrine the man as the head of the household (refer to section 2.2.1.2).<sup>239</sup>

Men's financial independence and role as the head of the household grant him decision-making powers in relationships with women. Men's higher earning power creates economic asymmetries in relationships, which lead women to become financially dependent on their male partners. Women who are financially dependent on their male partners are less likely to deny sex or to demand condom use. The significant power imbalance in relationships therefore reduces the pressure on men to negotiate sex, and can lead to greater levels of coercion and increased risk of HIV transmission. Men's financial control in relationships also means that some men have the financial means to procure sex and to even pay more for unprotected sex. This may be one reason why HIV prevalence is highest among older and wealthier men,

who have the surplus income to afford to have extramarital affairs or purchase sex.

Men's (often) higher economic status also enables them to engage in cross-generational relationships that are characterized by transactional sexual relations. Financial resources enable a man to take on the role of a sugar daddy and provide basic needs, material goods, or school fees to young women that will entice them into sexual relationships. The economic disparity between an older, wealthier man and a young woman is coupled by age asymmetries, which creates significant power imbalances that undermine women's ability to negotiate sex and condom use. These imbalances place young women at significant risk of coercion, exploitation and violence. In Rwanda, we can see that young women are particularly vulnerable to and at risk of HIV in such relationships, given the higher HIV prevalence seen among older, wealthier men.

## 2.2.3 Key Populations at higher risk of HIV

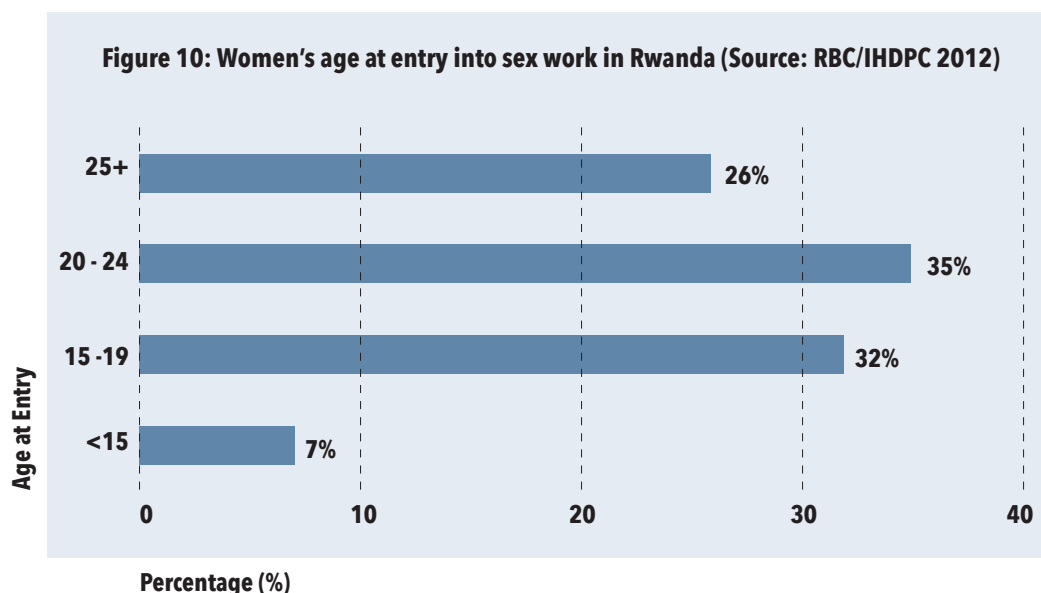
Key populations and vulnerable groups face many of the same contributing factors as the general population, but they may also face additional social, cultural, economic and political realities that further increase HIV risk and vulnerability. For example, in many parts of the world there are legal and policy barriers (e.g. criminalization) specific to these populations (e.g. sex workers or MSM) that hamper HIV prevention efforts and limit access to health services. This section examines the contributing factors to HIV transmission among key populations in Rwanda including female sex workers, MSM, prisoners, truck drivers, and sero discordant couples.

### 2.2.3.1 Female Sex Workers

Poverty and lack of economic opportunities can lead women to engage in sex work as a means of providing for themselves and their families. In Rwanda, sex work often comprises small-scale operations that are not connected with organized sex trade or international sex trafficking.<sup>240</sup> However, of recent there are reports of cases of sex trafficking out of Rwanda. Poverty and 'survival' are the prime reasons cited by sex workers for entering sex work, and the majority state that they rely on sex work as their only source of income.<sup>241, 242, 243</sup> More than half of female sex workers are heads of household.<sup>244</sup> The majority of sex workers agree that they are willing to stop sex work if they are empowered economically.

In Rwanda, women enter into sex work at a very young age, with 40% reporting beginning before age 19, and girls as young as 11 are engaged in sex work.<sup>245</sup> Figure 10 illustrates the age of women's entry into sex work in Rwanda. A number of underlying factors contribute to social exclusion and vulnerability for young women that may precipitate entry into sex work. All sex workers interviewed in one study noted that a lack of social or family support led to increased financial pressures that caused them to engage in sex work.<sup>246</sup> Women commonly cited orphan-hood, teenage pregnancy and family responsibilities as reasons they engage in sex work for survival.<sup>247, 248</sup> Teenage pregnancy was noted as a significant factor. As noted in section 2.2.1.1, adolescent pregnancy brings shame on the family, and can lead to dropping out of school and social exclusion.<sup>249</sup> More than 35% of sex workers in one study reported being adolescent mothers and 26% reported being orphans.<sup>250</sup>

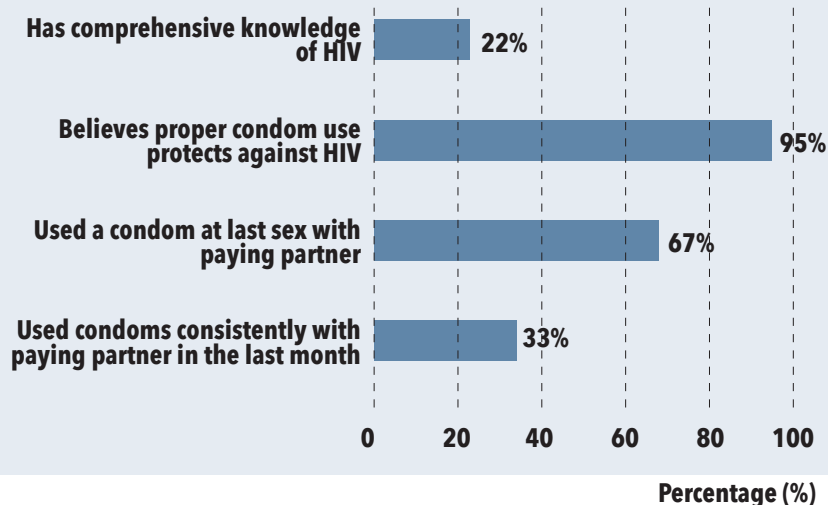




Limited educational opportunities and a gender bias in formal education are also noted as contributing factors for women's engagement in sex work, with many female sex workers stating that constraints in education played a role in their decision to enter sex work.<sup>251</sup> Limited educational attainment further reinforces social marginalization for young women and reduces their potential opportunities within the formal economy. More than 30% of sex workers in Rwanda have no education (compared to 22% of women in the general population), while 60% have completed primary school and 9% have attended school beyond primary level.<sup>252</sup> Low levels of education are also reflected in very low levels of comprehensive knowledge of HIV (only 22%).<sup>253</sup> The implementation of the Nine Years Basic Education program may have a long-term impact on reducing girls and young women's social and economic vulnerability, thereby reducing the number of women engaging in sex work.<sup>254</sup>

The same economic and social pressures that push women into sex work also make it hard for them to leave, and contribute to engagement in risky sexual behaviors. Condom use is especially important to prevent HIV among sex workers, the majority of whom have more than three sexual partners per week.<sup>255</sup> However, only 67% of sex workers report using a condom at their last sexual intercourse and only 33% report consistent condom use with paying sexual partners in the last month, despite 95% being aware that HIV can be prevented through proper condom use.<sup>256</sup> Figure 11 illustrates HIV prevention knowledge and condom use among female sex workers. In addition, HIV prevalence is highest among sex workers who report working on the roadside or another public space (52%), compared to those working in a bar or restaurant (47%), and those working in a hotel or nightclub (40%).<sup>257</sup> This may reflect the greater availability of condoms at 'hotspots' such as bars and hotels, compared to the roadside. It may also be linked with greater vulnerability of sex workers operating from the roadside due to social and economic reasons.



**Figure 11: Knowledge and condom use among female sex workers (Source: BSS 2010)**

A number of factors may limit condom use by female sex workers, including limited ability to negotiate safer sex with clients. The power and economic imbalance between a sex worker and her male client substantially reduces her ability to demand condom use, particularly in light of criminalization and threats of violence. Sex workers report that some male clients are unwilling to use condoms because they feel less pleasure and are willing to pay extra for unprotected sex.<sup>258</sup> The financial dependence which sex workers have on their clients makes condom negotiation difficult. In general, sex workers report that clients are willing to pay more for risky sexual behaviors such as unprotected or anal sex.<sup>259, 260</sup> Some sex workers believe that the short-term benefits (greater economic gain) of unprotected sex outweigh the long-term risk and impact of HIV infection. For example, they worry more about the short-term impact of losing income and not being able to care for their children than the long-term risk of dying from AIDS.<sup>261</sup>

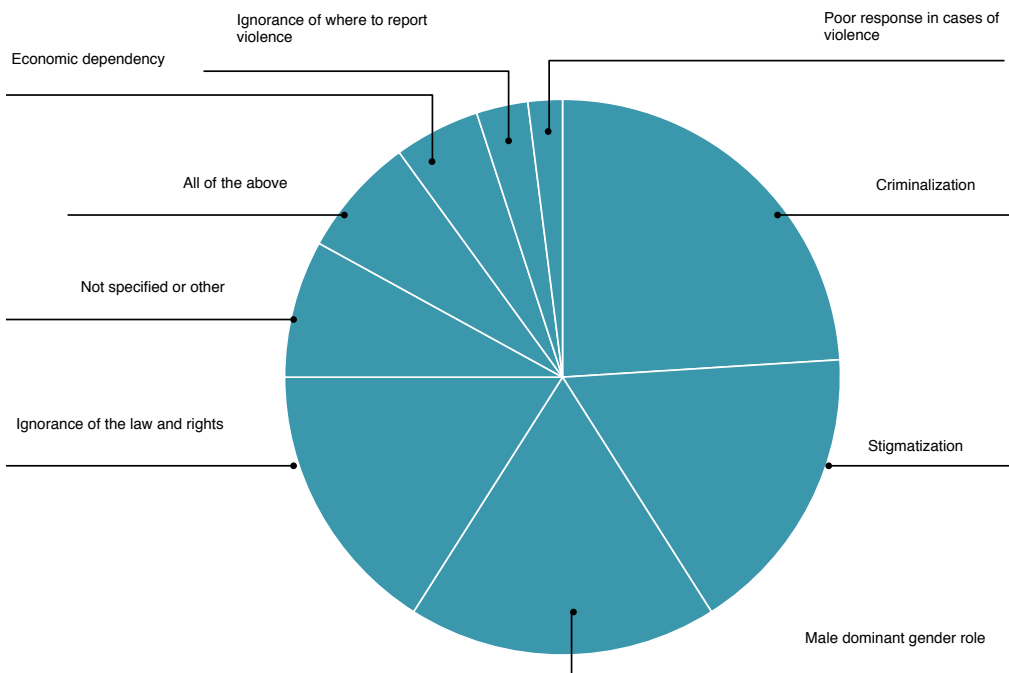
Sex work is currently illegal in Rwanda, although recent revisions in the law have led to slight reductions in the penalties facing sex workers. Criminalization reinforces and intensifies stigma and discrimination against sex workers. As a result, the power imbalance between female sex workers and their male clients is heightened as disparities in social standing compound existing economic ones. Criminalization also places sex workers at risk of violence from clients and law enforcement agents. Researchers argue that the resulting isolation and disempowerment of sex workers, enforced by the threat of violence, may significantly reduce their ability to negotiate condom use.<sup>262</sup> In addition, they may face difficulty in accessing legal services and post-exposure prophylaxis (PEP) in cases of rape.

Sex workers in Rwanda report violence, which they view as a result of criminalization, stigmatization and entrenched gender norms, among other reasons.<sup>263</sup> Figure 12 illustrates sex workers' perceptions of the different causes of violence against them. Sex workers report verbal, physical and sexual abuse from clients, which is often linked to a client's refusal to pay.<sup>264, 265</sup> More than half of sex workers have experienced

rape, and 70% identify HIV as the major consequence of violence in this context.<sup>266</sup> However, when sex work is criminalized, sex workers that suffer violence or abuse are often too fearful to report such abuses to the police, who may be perpetrators of violence themselves.<sup>267</sup> Many sex workers in Rwanda state that they fear reporting violence to the police and instead view violence as a normal part of the job.<sup>268</sup> Only 18% of sex workers who reported experiencing rape reported it to the police.<sup>269</sup>

Several studies have documented sex workers' experiences of harassment, including verbal and physical abuse, from community members, as well as local authorities, police and local defense forces.<sup>270, 271, 272, 273</sup> These studies note that female sex workers report discrimination from the police, including when attempting to obtain police or legal support to confront a violent client. A 2012 study found that there is a shared feeling among sex workers that their claims are not treated fairly by law enforcement authorities.<sup>274</sup> This includes non-registration of sex workers' complaints, which leads to the appearance of impunity for perpetrators of violence against sex workers.

**Figure 12: Sex workers' perceptions of the causes of violence against them (Source: FVA 2012)**



The children of sex workers are also particularly vulnerable and likely to be caught in a cycle of poverty, discrimination and social exclusion. Sex workers report that their children face high levels of stigma and discrimination at school and in the community.<sup>275</sup> The overwhelming lack of parental recognition by the fathers of sex workers' children is a significant barrier to their children's rights.<sup>276</sup> The children of sex workers are at risk of intergenerational transmission – as they face the same contributing factors that led their mothers to enter sex work, only at a younger age. For example, only 33% of sex

workers' children reportedly attend school, in part due to financial constraints and due to lack of knowledge of the Nine Year Basic Education program.<sup>277</sup>


### **2.2.3.2 Men who have sex with men**

Globally, men who have sex with men have significantly higher risk of HIV infection due to biological, behavioral, and structural factors, including unprotected anal intercourse, multiple sexual partners, social marginalization and discrimination. MSM in Rwanda appear to have low levels of condom use and large sexual networks, including both male and female partners. Other risk behaviors include high rates of domestic and international mobility, and selling or exchanging sex for money or goods.<sup>278</sup> Recent research indicates that there is an association between trust and condom use in the MSM community, with the perception that condoms are for commercial and transactional partners, and not for regular, romantic partners.<sup>279</sup> However, MSM are more likely to report condom use at last sex with a female partner than a male partner, and have higher rates of condom use with non-cohabiting female partners than men in the general population (64% vs. 41%).<sup>280</sup>

Although homosexuality is not criminalized, MSM and other members of the lesbian, gay, bisexual, transgender and intersex community (LGBTI) continue to face stigma and discrimination at the community level. Traditional gender norms promote heterosexual relationships and do not condone homosexuality. However, not all MSM in Rwanda identify as homosexual. A 2009 study among MSM in Kigali found that while the majority identify as homosexual (49%) or bisexual (33%), 4% self identify as heterosexual, and the remaining respondents were unsure of how to categorize their sexuality.<sup>281</sup> Issues of stigma likely prevent the majority of MSM from disclosing their sexual orientation to family members. Only nine out of 98 men reported that their families were aware of their homo- or bi-sexuality, and only two reported that their families were supportive of their sexual orientation.<sup>282</sup> Respondents who had not discussed their sexuality with their families said that it was due to fear that their families would not understand.

Strict gender norms of masculinity, which view the only acceptable romantic or sexual partnerships as between a man and a woman, are the basis of stigmatizing attitudes towards MSM. Social exclusion and marginalization can occur when men do not identify with or are perceived by society as not conforming to these norms. This can often lead to discrimination and abuse of sexual minorities. In Rwanda, MSM and other LGBTI individuals report rights violations including discrimination, verbal and physical abuse, acts of violence including beatings and rape, and arbitrary arrest based on their gender identity.<sup>283, 284</sup> One in five MSM in Kigali report being mistreated due to their sexuality or sexual behavior.<sup>285</sup> MSM also report sexual violence, with 17 out of 98 respondents reporting a history of forced sex, eight of whom reported being forced to have sex in the last 12 months.<sup>286</sup>

Stigma and discrimination keep MSM hidden and as a result they are less likely to be reached by HIV prevention services or have access to the necessary HIV prevention tools (i.e. condoms and water-based lubricants). MSM report facing discrimination from health care providers and 28% state that they would not disclose their sexuality to a health care provider if explicitly asked during a medical consultation.<sup>287</sup> Since the degree of felt stigma is high, there are implications for health service delivery. If



MSM are not comfortable disclosing their sexual history out of fear of being judged or humiliated, they will not be able to access HIV prevention services tailored to their specific needs.

### **2.2.3.3 Truck Drivers**

Evidence indicates that due to the mobile nature of truck drivers, they are more likely to have multiple sexual partners and at times purchase sex while on the road. During their time in transit, truck drivers are known to spend long spans of time at border and stopover sites while awaiting travel authorization, sometimes spending as long as 45 days in some stopover sites.<sup>288</sup> As previously noted, data indicates that approximately 19% of truck drivers admit to purchasing sex on the road.<sup>289</sup> In addition, truck drivers note that they sometimes exchange contacts with a particular sex worker, who regularly joins him when he is at a particular stopover site.<sup>290</sup>

This creates a large sexual network with the truck driver, his wife (as the majority are married), other female partners and their sexual partners. This presents a significant challenge to HIV prevention and points to a strong indication of sero discordance within couples. These challenges are further compounded by the fact that truck drivers working in Rwanda comprise a diverse group of men from across the East African region and the Democratic Republic of Congo. Truck drivers transiting through Rwanda have different languages, social customs, and preferences for sexual behaviors, posing a challenge to reaching them with HIV prevention information and services.

### **2.2.3.4 Prisoners**

Research on HIV risk among prisoners in Africa suggests that some of the common high-risk behaviors in prison settings include unprotected sex (mostly anal and between males), rape, and sex bartering.<sup>291</sup> In Rwanda, male and female prisoners are kept in separate prisons and monitored by guards of the same sex. However, sexual activity has been reported between male prisoners, with the opposite sex and with non-prisoners while prisoners are outside of the prison itself (e.g. on work duty). Evidence indicates that in the gender exclusive environment of prisons, male-to-male sexual activity is frequent, including prisoner-to-prisoner and guard-to-prisoner, but is likely underreported due to denial and fear of exposure. In Rwanda, male prisoners have reported having sex with other male prisoners in exchange for food, power, security or because no alternative partners could be found.<sup>292</sup> While much of the sex among men in prisons is likely to be consensual, there is also a high risk of rape and sexual violence.<sup>293</sup>

In Rwanda, sexual activity is outlawed in prisons and condoms are unofficially prohibited from being distributed within prisons. This situation exists despite recognition that HIV prevention is a priority for prisoners in the country's guiding development and HIV strategies (i.e. EDPRS and NSP). However, it has been stated that acknowledging sex in prisons and enabling condom distribution would amount to condoning not just sex among inmates, but also homosexuality, which is contrary to traditional Rwandan norms and culture.<sup>294</sup>

### 2.2.3.5 Sero discordant couples

Sero discordant couples are identified as a source of new HIV infections in Rwanda, with transmission likely to occur due to low levels of condom use among long-term partners. A number of social, cultural, and economic factors may facilitate transmission among sero discordant couples, including high levels of stigma and discrimination against people living with HIV, stigma surrounding condom use, and economic vulnerability. As previously noted, discussing sex and sexuality remains taboo in Rwanda and condom use is closely linked with perceptions of promiscuity. This is likely to present a significant barrier to condom use among sero discordant couples, particularly those who are married or in long-term partnerships. In 2009, 76% men living with HIV and 30% of women living with HIV were currently married or cohabiting, although men were two times more likely to be sexually active.<sup>295</sup>

Fear of disclosing one's HIV status due to stigma and discrimination is likely to compound this issue. According to the 2010 DHS, only 53% of women and 64% of men express accepting attitudes toward people living with HIV on four indicators designed to measure acceptance. However, this does represent an increase in acceptance compared to 2005 (46% of women and 51% of men).<sup>296</sup> Accepting attitudes towards people living with HIV are highest among those living in urban areas, those with more education, and those living in the higher wealth quintiles. Of particular concern is the fact that more than 66% of women and 78% of men said they would not be willing to keep a family member's HIV status secret (non-disclosure).<sup>297</sup> This type of stigma is highly likely to discourage a person living with HIV from disclosing their status to family members and partners or to lead to social exclusion.

Young people living with HIV are especially vulnerable to the social, cultural and economic pressures that may precipitate risky sexual behaviors. Less than half of young people living with HIV reported consistent condom use in the last six months and nearly 60% reported having been asked by a partner to have sex without a condom.<sup>298</sup> The most common reasons for not practicing consistent condom use was a refusal by the sexual partner (73%) and feeling safe without a condom (40%).<sup>299</sup> Condom use was also cited as a sign of promiscuity and lack of trust in their partner. Young women living with HIV also report a high prevalence of transactional sex and high rates of forced sex.<sup>300</sup> Both young men and women living with HIV reported having sex in exchange for material goods or money. These practices increase the risk of HIV transmission to sero negative partners, and the risk of STIs and HIV super-infection for the sero positive partner. Young people living with HIV are in particular need of information on prevention with positives, including skills for negotiating condom use, and psychosocial support services.



## 2.2.4 Marginalized and Vulnerable Groups

The social exclusion of marginalized and vulnerable groups compounds the existing social, cultural, economic and political factors that contribute to the spread of HIV in other populations. Marginalized and vulnerable groups are more likely to lack the knowledge and skills required to protect themselves and others, have less accessibility to services, especially services that are adapted to their specific needs, and face societal factors such as human rights violations. They may be further excluded from accessing HIV prevention information and services by norms, practices, beliefs, and laws that stigmatize and disempower them. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

### ***2.2.4.1 People with disabilities***

People with disabilities account for approximately 4.5% of the Rwandan population (about one in every 22 people) and 18% of households have at least one family member with a disability.<sup>301</sup> People living with disabilities are relatively evenly spread through the different wealth groups and are not found to be more likely to live in poverty.<sup>302</sup> However, households headed by a person with a disability are more likely to be poor. People with disabilities are however more at risk of HIV infection for several reasons: many persons with disabilities engage in behaviors which place them at risk of HIV infection and they may also belong to groups that may be socially marginalized and may face compounded stigma and discrimination; a large proportion of people with disabilities will experience sexual assault or abuse during their lifetime; and because they may have limited access to HIV information and services, particularly services that are tailored to their specific needs.<sup>303</sup>

### ***2.2.4.2 Orphans and other vulnerable children***

Orphans and other vulnerable children may face increased HIV risk and vulnerability. In Rwanda, the status of being an orphan is not an indicator that a child or young person is living in consumption poverty.<sup>304</sup> In actuality, the proportion of non-orphans living below the poverty line (49%) is higher than orphans (34%). Evidence indicates that in recent years, households headed by the very young are less prone to consumption poverty than other households, on average.<sup>305</sup> This may be a reflection of the concerted effort of the Government and its partners to provide OVC with a comprehensive package of support services. However, orphans and child heads of household may be impacted by other structural factors that place them at risk. A 2006 study found that youth heads of household face difficult living conditions, problems in accessing education, and psychological distress suffered by many orphans and vulnerable children.<sup>306</sup>

Another study among youth heads of household (YHH) aged 12-24 in the Southern Province indicates higher sexual activity and lower levels of condom use lower among YHH compared to the general population. High rates of early sexual onset were found, with 41% having had sex before age 15 (50% of males vs. 27% of females).<sup>307</sup> The mean age of first sex among YHHs was 14 for males and 16 for females.<sup>308</sup> The study also found that female YHH were more likely to report first sex with older partners than males, with 58% of female YHH having their first intercourse with a partner four years older or more.<sup>309</sup> Rates of condom use at first sexual intercourse were extremely

low (8%), with the majority citing lack of knowledge (38%) or a belief that there was no HIV risk (26%) as the main reasons. YHH who indicated having a close friend they can rely on were less likely to report having had sex, as were those who were in school, whereas youth who had moved more than two times during the last five years were more likely to be sexually experienced.<sup>310</sup>

This data indicates that the existence of social support networks may be an important protection mechanism for youth heads of household and other vulnerable children. Similar research in Rwanda indicates that the absence of an adult caregiver, being an orphan or abandoned child and/or a child-head of household are viewed as particular drivers of sexual exploitation.<sup>311</sup> Survival and transactional sex were cited as a means of overcoming poverty, obtaining basic needs such as food, shelter or clothing, as well as accessing funds for school, particularly among girls.<sup>312</sup> Similarly, the study among YHH found that a small number of female YHH reported ever having exchanged sex for protection (10%) or for money or gifts (7%).<sup>313</sup>





# III. Knowing Your HIV Response



Knowing Your HIV Response from a gender perspective requires assessing how well the country HIV response addresses gender equality in both policy and practice. This involves examining national HIV strategies, policies and programmes against the information that we know about the nature of the HIV epidemic as it applies to women, girls, men, boys, key and vulnerable populations. It also means assessing how well HIV programmes and policies address the underlying social, cultural, political and economic factors that contribute to HIV risk and vulnerability and to what extent gender equality is a priority and goal of the HIV response and its programmes.

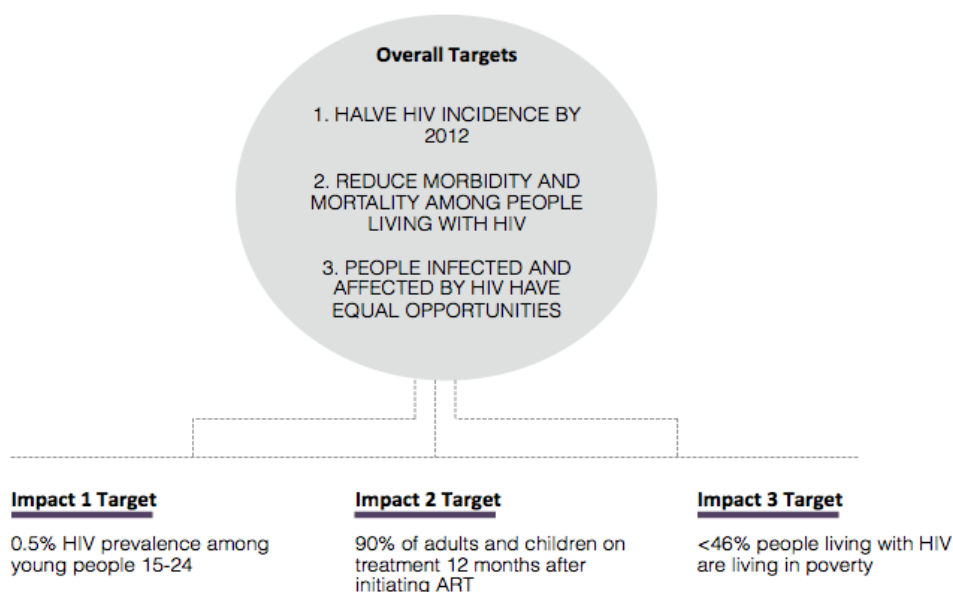
## 3.1 Overview of the Response

The Rwanda Biomedical Center is the government institution responsible for leading and coordinating the national HIV response through its Institute of HIV/AIDS, Disease Prevention and Control (RBC/IHDPC). The Ministry of Health created the RBC in 2010 to consolidate 14 different institutions involved in the health sector, including the former National AIDS Control Commission. RBC/IHDPC is supported at the decentralized level by district level AIDS control committees (CDLS), which coordinate the partners working in all 30 districts. Despite the recent restructuring, Rwanda still adheres to the 'Three Ones' principles – one national coordinating body (RBC/IHDPC), one national HIV strategy, and one national monitoring and evaluation plan.

The National Strategic Plan on HIV and AIDS 2009-2012 (NSP) and its accompanying operational and M&E plan guide the current national response. The NSP aims to achieve three main impacts: to halve the incidence of HIV in the general population by 2012; to significantly reduce the morbidity and mortality of people living with HIV; and to ensure people infected and affected by HIV have equal opportunities to the rest of the population. Figure 13 illustrates the three impacts of the NSP and their related targets. In 2012 the country conducted a mid-term review of the NSP and extended the current strategy through July 2013. Development of the next NSP began in early 2013.



**Figure 13: Overarching impacts and targets of the NSP 2009-2012**



Gender equality is a key priority of the national HIV response, reflected in the overarching principle of 'respect for equity and human rights.' This principle (one of three) incorporates equal access to health services, equity for marginalized groups, Greater Involvement of People living with HIV and AIDS (GIPA), and gender equality. The NSP acknowledges that gender inequality and unequal power relations contribute to the spread of HIV and notes that gender equality is integral to the response.<sup>314</sup> The NSP also recognizes that strict gender norms and unequal power relations also impact men and boys and key populations such as female sex workers and MSM.

In 2010, Rwanda adopted its first gender and HIV strategy, the National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010-2014. The four-year strategy was designed to address gender inequality and the underlying factors that contribute to women and girls' increased HIV risk and vulnerability. The plan has three overarching impacts that focus on: 1) knowing your epidemic and response from a gender perspective; 2) scaling up political commitment into concrete actions; and 3) creating an enabling environment for the fulfillment of women's rights. Although separate from the NSP, the National Accelerated Plan complements the guiding HIV strategy and aims to contribute to its overall targets. The creation of the plan reflects the commitment to mainstream gender across all sectors and to promote gender equality at all levels.

RBC/IHDPC has many key partners in the national HIV response, including the One UN Family, US Government (PEPFAR/CDC), development partners, international and civil society organizations. Many local and international non-governmental organizations

and associations work at both the central and decentralized levels to support the response. Civil society organizations are gathered under a number of CSO umbrella organizations, which have the mandate of coordinating the civil society response. Within the HIV response there are five CSO umbrella organizations, as well as a public sector and a private sector umbrella organization:

- Rwanda Network of People Living with HIV (RRP+)
- Rwanda NGO Forum on HIV and Health Promotion
- Network of Faith based organizations against AIDS (RCLS)
- Umbrella of People with Disabilities in the fight against AIDS (UPHLS)
- Network of Journalists in the HIV Response (Abasirwa)
- Umbrella of the Public Sector Response, under the Ministry of Trade (MIFOTRA)
- Private Sector Federation

### 3.1.1 Promoting gender equality in Rwanda

The Government of Rwanda has taken great steps to advance gender equality and protect the rights of women and girls. Today, Rwanda boasts the largest percentage of female parliamentarians in the world (at 56%), and has implemented a considerable number of laws and policies to promote gender equality across all sectors. The 2003 Rwandan Constitution establishes equal rights for all citizens and prohibits discrimination of any kind based on “ethnic origin, tribe, clan, colour, sex, region, social origin, religion or faith, opinion, economic status, culture, language, social status, physical or mental disability or any other form of discrimination” (Article 11).<sup>315</sup> The Constitution further promotes equality between women and men, establishing that women are granted at least thirty percent of posts in the country’s decision-making organs at all levels (Article 9).

Significant effort has been made to mainstream gender equity as a crosscutting component in national development policies and strategies, including Vision 2020 and the first Economic Development and Poverty Reduction Strategy 2008-2012 (EDPRS I). The government is guided by a National Gender Policy (2010) and has established a Gender Monitoring Office to ensure that its commitment to gender equality and non-discrimination is achieved. A number of national bodies and institutions promote women and girls’ engagement in economic and political life, including: the Ministry of Gender and Family Promotion; the National Women’s Council; the National Youth Council; the National Human Rights Commission; and the Forum for Women Parliamentarians. Women and girls’ active participation in these bodies has led to the adoption of new laws and policies to protect and support women’s rights.

Rwanda has signed or ratified a number of international and regional instruments designed to promote and protect the rights of women and girls, including but not limited to: the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); the Beijing Platform for Action; the Protocol to the African Charter of Human and People’s Rights on the Rights of Women in Africa (Maputo Protocol); and the International Convention on the Rights of the Child. Under Rwandan law, ratified international human rights commitments automatically become enshrined in domestic law and take precedence over existing domestic laws.



### 3.1.2 Promoting universal access to HIV services

In 2006, Rwanda made the historic commitment to work towards providing Universal Access to HIV prevention, treatment care and support services to all those in need by 2010 at the second United Nations General Assembly High Level Meeting on HIV/AIDS.<sup>316</sup> The 2006 Political Declaration established Universal Access as a guiding framework for country HIV responses and set time-bound commitments for countries to expand their HIV responses. The Political Declaration, together with the Millennium Development Goals (MDGs), established a framework for Rwanda's HIV response that continues to this day. In 2011, the country reaffirmed its commitment to addressing the epidemic by signing the new Political Declaration on HIV and AIDS: Intensifying efforts to eliminate HIV and AIDS and in recent years has made significant achievement in scaling-up the availability of HIV prevention, care, treatment and support services.

#### 3.1.2.1 HIV Prevention

Rwanda has prioritized HIV prevention and has scaled-up outreach efforts targeting the general population, youth and key populations. The country has developed comprehensive HIV behaviour change communication (BCC) and information education communication (IEC) materials that include information on condom use, sexual and reproductive health, gender based violence, and family planning. HIV prevention outreach activities take place at both national and local level, with specific interventions reaching key populations including MSM, female sex workers, truck drivers and prisoners, and marginalized populations including people with disabilities and refugees. In addition, specific minimum packages for HIV prevention have been developed for key populations. Voluntary male circumcision has also been promoted for newborn, adolescent and adult men.

There has also been a significant increase in the availability and promotion of condoms nationwide. Condoms are distributed freely in health facilities and through community-based distribution mechanisms, and can be purchased in shops and hot spots. In 2011, more than 40 million male condoms were distributed through the public sector or social marketing.<sup>317</sup> A marked improvement in access to condoms can be seen for young people, with 59% of young women and 84% of young men reporting being able to access (male) condoms on their own in 2010,<sup>318</sup> compared to 37% and 73% in 2005, respectively.<sup>319</sup> The female condom has also been made freely available in health facilities and condom vending machines, although acceptability remains a barrier to its use.

Rwanda has made the prevention of mother-to-child transmission of HIV (PMTCT) a key prevention priority. The country is currently implementing the new WHO recommendations for providing ARV triple therapy to HIV-infected pregnant women, starting at 14 weeks of pregnancy.<sup>320</sup> By December 2011, 86% of health facilities were offering the full PMTCT package (all four items) and more than 8,000 pregnant women and 7,500 babies born to HIV-positive mothers received ART prophylaxis in 2011.<sup>321</sup> The country's National Strategy for the Elimination of Mother-to-Child Transmission aims to reduce mother-to-child transmission to less than 2% by 2015.

### 3.1.2.2 HIV Treatment

Rwanda has achieved significant coverage for HIV treatment. A comprehensive treatment package is in place that includes VCT, consent and confidentiality, and access to free ART for adults and children, including provision of ART to women and girls outside of PMTCT/ANC settings. Guidelines for HIV treatment are updated and disseminated on a regular basis, and continuous training is provided to service providers. ARV treatment is provided freely and in general, the treatment package has been made accessible to those who need it. Some gaps do exist with regard to specific marginalized populations and in certain remote areas. To improve accessibility and support adherence, there has been a strong push for HIV service integration within PMTCT, sexual and reproductive health and family planning, and opportunistic infections (OI) services.

By December 2011, 75% of hospitals and health centers were offering the full package of HIV services (VCT, PMTCT, ART), compared to only 43% in 2009.<sup>322</sup> HIV testing and counselling (both voluntary and provider-initiated) is available at health facilities and through mobile services. By 2011, 448 health facilities were able to offer VCT services. The increase in service availability and promotion of HIV testing has resulted in greater rates of testing among men and women. In 2010, 39% of women and 37% of men reported that they had been tested for HIV and received their results in the past 12 months,<sup>323</sup> compared to only 12% of women and 11% of men in 2005.<sup>324</sup> Overall, 76% of women and 69% of men have ever been tested for HIV and received their results.<sup>325</sup>

Rwanda has adopted the WHO guidelines for the early initiation of antiretroviral therapy for people with CD4 counts below 200 and has increased the number of health facilities providing ARVs. By the end of June 2011, 336 health facilities were offering care and treatment services to people living with HIV, and 96,123 individuals were receiving ART, including 7,597 infants and children aged 0-14 (51% female) and 88,526 adults aged 15 years and older (62% female).<sup>326</sup> According to recent Spectrum estimates, this indicates that approximately 92% of adults eligible for ART were receiving it.<sup>327</sup> Rwanda has also prioritized intensified TB case finding among people living with HIV in order to address TB/HIV co-infection. In 2011, 67% of HIV positive individuals were screened for TB in HIV care or treatment settings and 93% of people enrolled in HIV care and treatment received Cotrimoxazole prophylaxis.<sup>328</sup>

### 3.1.2.3 HIV Care and Support

Rwanda has prioritized the provision of psychosocial, nutritional, and socioeconomic support for people living with and affected by HIV. Since 2009, there has been a steady increase in service provision for therapeutic care and support services.<sup>329</sup> There has been a strong push to ensure that health facilities providing HIV care and treatment are affiliated to local community-based organizations (CBOs) to help ensure adherence and address the social support needs of people living with HIV. By 2011, 67% of ART sites were affiliated to a CBO supporting people living with HIV.<sup>330</sup> In 2011, Rwanda adopted a new national Palliative Care Strategy which aims to make palliative care available to people living with HIV and other life-limiting illnesses at the community level. Although still in the early stages of being rolled out, a few NGOs and health facilities are providing hospice and palliative care services to those in need. Income-generating activities and participation in community-based cooperatives have been encouraged for the economic empowerment of people living with and affected by HIV.



## 3.2 Key issues of concern for gender equality

A gendered HIV response requires that laws and policies are gender responsive and rights based, and that these principles are employed in practice (implementation and enforcement) as well. The Gender Assessment Tool outlines a number of key areas to assess gender equality in the HIV response, some of which will be examined on the following pages, including: meaningful participation of women, girls and marginalized populations at all levels and stages of decision-making in the HIV response; addressing the sexual and reproductive health and rights of women and girls; addressing gender equality in HIV programmes; and accountability for addressing gender equality in the HIV response (coordination, M&E, budgeting).

### 3.2.1 Enabling Environment

An enabling environment for HIV prevention, treatment, care and support includes a legal environment where laws and policies against discrimination on the basis of HIV status, risk behavior, occupation, and gender are in place and are monitored and enforced. An enabling environment for HIV prevention also requires that there are supportive legal and policy frameworks in place to support women's rights and autonomy, including women's economic empowerment<sup>331</sup> and a social and economic environment in which women and girls are enabled to exercise those rights. Advocacy is required where laws and policies hinder universal access to HIV prevention, treatment, care and support, or where they promote discrimination against people living with HIV and other marginalized groups, especially those at high risk of HIV infection (e.g. sex workers, men who have sex with men, injecting drug users).

#### 3.2.1.1 *Elimination of discrimination based on HIV status*

The Rwandan Constitution states that all people are born free and equal in rights and duties and prohibits discrimination of any kind, including that based on ethnic origin, tribe, clan, colour, sex, region, social origin, religion or faith, opinion, economic status, culture, language, social status, physical or mental disability or any other form. The Constitution provides the foundation for prohibiting discrimination based on HIV status. The revised penal code adopted in 2012 includes a new provision for prohibiting 'stigmatization against a person suffering from an incurable disease,' with monetary fines and imprisonment as punishments for such actions.<sup>332</sup> The 2009 Rwandan Labor Code also prohibits any discrimination of disabled people in the workplace (Article 97).<sup>333</sup> However, the law does not outline who is defined as 'disabled,' and it is likely that people living with HIV on treatment do not define themselves as such. No laws currently restrict the movement of people living with HIV or criminalize HIV transmission (except in the context of rape).<sup>334</sup>

Despite these laws and policies, stigma and discrimination persist in the community and in the workplace, suggesting the need for promoting greater awareness and attitudinal change at the community level. It is also likely that people living with HIV are not fully aware or understanding of their rights, especially newer laws. In 2009, only 28% of men and women living with HIV reported knowing at least one Rwandan law that protects the rights of people living with HIV.<sup>335</sup> Where people are aware of their rights, it is likely hard to collect sufficient evidence to prove discrimination and

therefore enforce the law (e.g. when being denied bank loans). Anecdotally, people living with HIV do report being denied access to credit as a result of their status. The network of people living with HIV is currently sensitizing banks and credit providers on the rights of people living with HIV, as well as the progress made in HIV treatment, which allows people living with HIV to live long and healthy lives.

### **3.2.1.2 Criminalization of key populations**

Laws and policies do currently exist that criminalize the actions of key populations and hinder the provision of HIV prevention, treatment, care and support services. While MSM are not criminalized (largely due to advocacy conducted in 2010), female sex workers are criminalized under the current Penal Code. The current law prohibits "prostitution", which it defines as 'involvement by either a man or a woman in sex work as an occupation in exchange for consideration.'<sup>336</sup> First time offenders found to be engaged in sex work are subject to the following punishments for a period not exceeding one year: restriction of movement; being subject to surveillance; mandatory medical treatment; and mandatory reporting to the authorities.<sup>337</sup> Anyone who violates these obligations is subject to between three and six months of imprisonment, and anyone who subsequently engages in sex work is liable to imprisonment between six months and two years, in addition to monetary fines. The same penalties also apply to anyone caught having sex with a sex worker.

Criminalization leads to fear of prosecution and stigmatization and discrimination that can impede sex workers from accessing appropriate health care. These circumstances exacerbate the susceptibility of sex workers to HIV and may undermine prevention efforts that would reduce transmission among sex workers and their clients.<sup>338</sup> The NSP acknowledges that criminalization of sex work hinders HIV prevention among sex workers and outlines strategies to improve the legal environment for HIV programming by advocating with local authorities and law enforcement agents. The former National AIDS Control Commission, key ministries, the network of Parliamentarians on Population and Development, development partners and civil society organizations were active in advocating for the decriminalization of sex work during the recent review of the penal code, which took place from 2009-2012. Although unsuccessful, advocacy did result in alleviation of the penalties for engaging in sex work.

### **3.2.1.3 Additional laws and policies impeding HIV prevention**

Young people and prisoners continue to be constrained from accessing essential HIV prevention commodities by national laws and policies, despite being identified by the National Condom Policy as key target groups at high risk.<sup>339</sup> As previously noted, prisoners are unable to obtain condoms while incarcerated due to unofficial policy that prohibits their distribution.<sup>340</sup> The NSP notes that the availability of condoms in prisons is limited because prison authorities deny the existence of sexual intercourse between inmates. A 2010 Legal Review conducted by CNLS noted that prison authorities view distributing condoms to prisoners as tantamount to condoning sex among inmates, as well as homosexuality.<sup>341</sup> This significantly restricts the effectiveness of HIV prevention outreach in prisons, which has an impact not only on HIV transmission within prisons, but also with individuals in the larger community.





Access to condoms is also restricted for youth in secondary schools due to an unofficial policy that prohibits their distribution on school grounds. This is a concern especially for students in boarding schools who are restricted to school grounds for periods of up to three months. Despite a significant amount of advocacy, in 2012 the Ministry of Health announced that condom distribution in secondary schools would continue to be prohibited. The mid-term review of the NSP found that urban youth expressed a desire that condoms should be available in schools, while rural youth felt they should not be available and requested more abstinence-based education.<sup>342</sup> Prohibition of access to condoms for secondary school students persists despite the fact that approximately 90% of men and women agree that young people (12-14) should be taught about condom use.<sup>343</sup>

#### **3.2.1.4 Women and girls' enjoyment of equal rights**

Rwanda has a strong legal and policy framework for promoting and protecting the rights of women and girls in the context of HIV. Women have equal rights in marriage and protection of rights with respect to separation, divorce and child custody. In addition, women and girls have rights to inheritance and property under the law, although as noted, women who are cohabiting do not have equal rights. There is also a strong legal and policy framework for addressing all forms of discrimination against women, including laws addressing gender-based violence. As noted in other sections, although these laws and policies do exist, barriers to their enforcement include lack of knowledge and acceptance at the community level.

In 2010, the National Accelerated Plan identified Article 206 of the Civil Code as a challenge to promoting gender equality and respecting the rights of women in the context of HIV. The law, which identifies the man as the legal head of the household, ignores the lived realities of women as heads of household and supports the institutionalization of traditional gender roles, which assume that men are the highest authorities in the family and often translates into men taking unilateral decisions including financial expenditures.<sup>344</sup> The law is of specific concern for female-headed households, some of which are likely headed by women living with HIV. The Accelerated Plan calls for women's rights organizations to advocate for the removal of the law, although it is unknown if any such advocacy has been undertaken.

#### **3.2.2 Asexual and reproductive health and rights approach**

Over the last decade, the global HIV response was criticized for being too narrow, precipitating a push towards a broader sexual and reproductive health and rights (SRHR) approach that locates HIV as one component within a wider sexual and reproductive health agenda.<sup>345</sup> The SRHR approach encompasses: recognition of the SRHR of women and girls, including women living with HIV (i.e. the right to decide *whether, when, how many and the spacing* of children); the implementation of all national, regional, and international legislation and commitments that promote women and girls' sexual and reproductive rights; a focus on addressing HIV, maternal health and infant health as interlinked concerns; linking SRHR and HIV services; and promoting men and boys' access to SRH services.<sup>346</sup>



### **3.2.2.1 SRHR approach in Rwanda**

Rwanda embraces a comprehensive concept of reproductive health as defined by the 1994 International Conference on Population and Development (ICPD) in Cairo: 'a stage of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.'<sup>347</sup> Explicit in this concept of reproductive health is the recognition that women and men have the right 'to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility.'<sup>348</sup>

Together with other international and regional human rights documents such as CEDAW and the Beijing Platform for Action, the ICPD establishes a core set of reproductive rights. These rights include the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so; the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction free of discrimination, coercion and violence. Rwanda has integrated the ICPD concept of reproductive health in its key health policies including the National Reproductive Health Policy (2003) and the National Family Planning Policy (2008), and the Adolescent Sexual and Reproductive Health and Rights Policy (2011), as well as its national HIV strategies and policies.

### **3.2.2.2 Linking SRH and HIV services**

The linkage or integration of SRH and HIV services is integral to an SRHR approach. The Women, Girls, and Gender Equality Framework for NSPs<sup>349</sup> identifies seven key aspects necessary for successful linkage of SRH and HIV services in national HIV strategies: 1) access to youth-friendly services; 2) access to services that are responsive to the SRH needs of women and girls in all their diversities, free of coercion, discrimination, and violence; 3) access to cervical prevention, screening, treatment and palliative care; 4) access to a full range of contraceptive options and attention to dual protection, free of coercion, discrimination and violence; 5) access to services to support safe conception, pregnancy, childbirth and breastfeeding; 6) access to emergency contraception and post-exposure prophylaxis; and 7) access to safe and comprehensive termination of pregnancy care and services.<sup>350</sup>

In 2012, a review of national HIV strategic plans in Eastern and Southern Africa found that Rwanda was one of only a handful of countries whose NSP adequately adopted an SRHR approach (Figure 14).<sup>351</sup> The application of the seven key aspects of SRH and HIV linkages in Rwanda are explored on the following pages.

**Figure 14: Utilization of an SRHR approach in NSPs in Eastern and Southern Africa (Source: Gibbs 2012)**

NSPs should advance a sexual and reproductive health and rights based approach to HIV. Specific interventions should include:	Recognition of the SRHR of women and girls in all their diversity	Affirmation of the SRHR of women living with HIV	Implementation of all national, regional, and international legislation and commitments that promote women's and girls' sexual and reproductive rights	Recognition of and attention to addressing HIV, maternal health and infant health as interlinked concerns	Linkage of sexual and reproductive health and HIV services, with particular attention to access for marginalized communities.	Interventions to promote men and boys' access to sexual and reproductive health services in order to ensure shared responsibility with women and girls.
Angola						
Botswana				✓		
Comoros					✓	
Eritrea						
Ethiopia						
Kenya						
Lesotho						
Madagascar						
Malawi						✓
Mauritius	✓		✓			✓
Mozambique				✓		
Namibia				✓		
Rwanda	✓	✓	✓	✓	✓	✓
Seychelles				✓		
South Africa	✓	✓	✓	✓	✓	✓
Swaziland	✓		✓			✓
Tanzania						
Uganda	✓	✓				✓
Zambia			✓	✓		✓
Zimbabwe			✓	✓		✓

### Access to youth-friendly services


Scaling-up youth-friendly SRH services is a key priority for the HIV response in Rwanda, as outlined in the NSP and the new Adolescent Sexual and Reproductive Health and Rights (ASRHR) Policy. The new policy (2012) aims to scale-up 'youth friendly' SRH services that are based on three overall principles: good customer care; greater integration of related services within existing health services to suit adolescents' needs; and confidentiality. In recent years, the country has been successful in improving young people's (15-24) access to SRH information, services and commodities by integrating HIV and SRH education into the school curricula, scaling up youth friendly centers (YFCs) and conducting outreach activities through student 'anti-AIDS' clubs.<sup>352</sup> School-going youth have praised the integration of HIV into the curricula and the support given to anti-AIDS clubs, but have requested more time be allotted for HIV in the reproductive health component and an increase in financial and technical support for the clubs.<sup>353</sup>

Young women and service providers have expressed a need to strengthen girls' participation in youth SRH activities as it appears that boys are more likely to attend activities at the YFCs, with out-of-school girls being particularly underserved.<sup>354</sup> One reason cited for girls' low participation was the low proportion of female staff working in the YFCs and in youth interventions more generally. Another reason is that the services may not be well adapted to girls' needs, indicating the need to engage girls, including women and girls living with and affected by HIV, more in the design of such interventions.<sup>355</sup> These reasons were identified as likely to impact service utilization and uptake. Girls have also expressed that some community health workers are unapproachable, because they may be family friends or neighbors who 'might tell your parents,' or pass judgment.<sup>356</sup> Female peer educators and role models, abiding by strict rules of confidentiality, may therefore be a more effective way of reaching young women.

### Access to a full range of contraception options

Rwanda promotes dual protection for preventing unintended pregnancies and HIV transmission and has made a full range of modern contraceptive methods available, including pills, condoms, intrauterine devices (IUDs), implants, and injectables. The government has launched an ambitious program aimed at reducing women's unmet need for family planning through health facilities and community health workers. As a result, there has been a considerable increase in the number of women using contraceptive methods from only 17% of currently married women in 2005 to 52% in 2010 (45% of which are using modern methods).<sup>357</sup> In addition, 41% of sexually active unmarried women report using contraception. The most common modern methods of contraception among married women are injectables and pills.

Some challenges do remain in scaling up family planning. A significant number of married women report an unmet need for family planning (19%),<sup>358</sup> although this is lower than the regional average for East Africa (25%).<sup>359</sup> Unmet need is highest among the poorest women and those with no education. Contributing factors to unmet need, as highlighted in the national Elimination of Mother-to-Child Transmission strategy, include: limited access to family planning; reticence of faith-based organizations to provide modern contraceptives; and limited capacity of some health workers to provide long lasting methods.



Rwanda's NSP has ambitious targets for improving the accessibility and use of condoms for the prevention of HIV. High-level national campaigns and condom distribution has improved condom availability and use. Condoms are distributed for free from health facilities and some community-based distribution mechanisms, and are also available for purchase at shops. Condom vending machines have been installed in hot spots such as bars, hotels and truck stops. These strategies have resulted in a substantial increase in the availability, accessibility and affordability of condoms. In 2012, the majority of beneficiaries agreed that male condoms are now more accessible and affordable.<sup>360</sup> It is estimated that in 2011 there were 5 (male) condoms available per sexually active adult.<sup>361</sup> The female condom has also been promoted and is provided in some places free of charge. However, program beneficiaries feel that female condoms are neither accessible nor available,<sup>362</sup> and acceptance remains low.

A recent review of the condom supply chain found that many health care providers distribute condoms mainly for family planning and not for means of dual protection, which has led to lower accessibility, especially for young people who unmarried.<sup>363</sup> Rural and out-of-school youth have reported that male condoms are still expensive and difficult to procure.<sup>364</sup> Young people also cite social and cultural norms as barriers to condom use. Rural youth in particular identified stigma surrounding condom use as a barrier to access, while urban youth felt that stigma has decreased and is no longer a significant barrier.<sup>365</sup> Young people suggested that more be done to involve parents in condom promotion.<sup>366</sup>

### **SRH services are responsive to all women and girls**

Rwanda is committed to ensuring that all women and girls have access to SRH services that are responsive to their needs and free of coercion or discrimination, as reflected in its national reproductive health, condom, and HIV policies. The NSP aims to ensure that women living with HIV are 'empowered to take informed reproductive health decisions.' The national strategy recognizes that women in Rwanda have a high unmet need for family planning and that inequalities may limit women's ability to decide on family planning methods, particularly for women living with HIV who may face stigma and judgmental attitudes when pregnant.<sup>367</sup>

In 2009, 18% of women of reproductive age attending HIV care and treatment services had unmet need for family planning (FP).<sup>368</sup> As noted in the NSP, health care providers' attitudes can be a significant barrier to ensuring women living with HIV access FP services. In 2009, 81% of women living with HIV reported ever having been advised not to have children since learning of their HIV status and 87% reported having ever been denied FP services in the last 12 months.<sup>369</sup> These circumstances exist despite only 13% reporting that they had experienced discrimination in accessing reproductive health services.<sup>370</sup> In the same year, only 64% of family planning providers interviewed by FHI agreed that an HIV positive woman should be allowed to have children.<sup>371</sup> The NSP also notes that some people living with HIV may be coerced into using FP, with 13% of women reporting that ART was provided conditional on the use of certain forms of contraception.<sup>372</sup>

The national HIV response aims to improve family planning use among women living with HIV through greater integration of HIV and Family Planning services, including improving the quality and coverage of integrated services, and by promoting male

involvement to ensure that women have autonomy and are supported in reproductive health decisions.<sup>373</sup> The integration of services is essential for women living with HIV to make informed choices (free of coercion or discrimination), prevent unintended pregnancies and have access to PMTCT services if they do become pregnant. In just a few years, there has been a considerable increase in the coverage of integrated HIV/FP services. By 2011, 85% of health facilities provided integrated ART and family planning services,<sup>374</sup> compared to only 30% in 2009.<sup>375</sup>

Integration of services was initially slow, due in part to the absence of a clear strategy and guidelines for integrating HIV and family planning services within PMTCT and HIV care and treatment.<sup>376</sup> In 2012, a protocol on HIV and Family Planning integration was developed by RBC/IHDPC and the Ministry of Health in order to address some of these constraints and provide clearer guidance on what integrated services should look like. However, another barrier to increasing the coverage of integrated services is that some health facilities run by faith-based organizations do not provide modern family planning methods, requiring that women be referred to other public facilities to receive these services.<sup>377, 378</sup> The time and cost necessary to reach another health facility may discourage or prohibit women from accessing essential SRH services.

### **Access to services to support safe conception, pregnancy, childbirth and breastfeeding**

Rwanda has strongly promoted access to services to support safe conception, pregnancy, childbirth and breastfeeding, including scaling-up the availability of antenatal care (ANC) services and nationwide campaigns to promote safe motherhood by having all women give birth in health facilities. Rwanda has fully integrated the prevention of mother-to-child transmission of HIV (PMTCT) services into Maternal, Neonatal and Child Health (MNCH) settings, and has made it a priority to make PMTCT services available to all women of reproductive age. In 2011, 86% of all health facilities were offering the full PMTCT package and 85% of pregnant women received ARVs to prevent mother-to-child transmission.<sup>379</sup>


In 2012, the country adopted a new National Strategy for the Elimination of Mother-to-Child Transmission of HIV, which aims to reduce mother-to-child transmission to less than 2%. The new plan is a rights based strategy that addresses all four PMTCT prongs and aims to: i) reduce new HIV infections among women aged 15-49 years by 50%; ii) reduce unmet need for family planning among women living with HIV to zero; iii) reduce transmission of HIV from mother-to-child to 2% at 18 months; and iv) reduce HIV attributable deaths among women and children (less than 5 years) by 90% by 2015. The plan outlines a comprehensive package of services including safe delivery, ARVs, infant feeding counseling and nutritional support, and long-term follow-up of adults and children living with HIV. Rwanda's national infant feeding initiatives promote breastfeeding for all women regardless of their HIV status, and Option B+ (exclusive breastfeeding up to six months protected by ARVs) for mothers living with HIV.

### **Access to emergency contraception and post-exposure prophylaxis**

Rwanda's HIV NSP and national GBV policies prioritize the timely provision of post-exposure prophylaxis (PEP) to victims<sup>3</sup> of sexual violence to prevent HIV infection,

<sup>3</sup>

In Rwanda, the term 'victims' rather than the globally promoted term 'survivors', in order to differentiate GBV victims from Genocide survivors.



and to those who have been exposed to HIV through blood-borne transmission (e.g. health care providers). PEP services have been expanded to all ART and PMTCT health facilities where prophylactic ARVs are provided to those who need them free of charge. By 2011, 75% of health facilities were offering PEP,<sup>380</sup> compared to only 28% in 2007.<sup>381</sup> From July 2010 to June 2011, 77% of people who went to a health facility and reported being exposed to HIV (in all forms) received ART as prophylaxis.<sup>382</sup> Emergency contraception (EC) is also available at health facilities and pharmacies. Victims of GBV are provided EC free of charge at GBV one stop centers, and it is available to purchase at pharmacies for around 10,000 Rwandan francs (approximately USD 15). However, this costs is likely prohibitive for many, especially for young women.

While there has been a great expansion in the availability and provision of PEP to victims of GBV, there is concern about follow-up and adherence for those receiving PEP. Evidence indicates that not all victims receiving PEP return for follow-up visits and/or adhere to or receive the full course of treatment. Low adherence to PEP among victims of sexual assault has been documented in many settings, and has been noted due to stigma, trauma, lack of support, and treatment side effects.<sup>383</sup> Low adherence is of particular concern because it carries a risk of low treatment efficacy and increased risk of resistance to antiretroviral therapy in the future. There is a need to examine the causes of low adherence (e.g. need for greater psychosocial support) and to strengthen follow-up mechanisms to ensure victims of sexual assault receive the full course of treatment. Although some healthcare providers are trained to provide psychosocial support to victims of violence, the number is not sufficient.

### **Access to safe and comprehensive termination of pregnancy care and services**

In Rwanda, access to safe and comprehensive termination of pregnancy care and services is limited under the law to a few exceptional cases. In 2012, Rwanda removed its reservations to Article 14 of the Maputo Protocol, relating to women's reproductive rights and abortion. In the same year, the country amended its national abortion law to extend abortion to four exceptional cases: when a woman has become pregnant as a result of rape; when a woman has been subjected to forced marriage; when a woman has become pregnant due to incest in the second degree; or when the continuation of the pregnancy seriously jeopardizes the health of the unborn baby or that of the pregnant woman.<sup>384</sup> In cases that are outside of these exceptions, strict penalties apply for the woman and the person providing the abortion.

The recent changes in the law are a significant improvement in addressing the SRH rights of women and girls, especially for those who have suffered rape, incest or forced marriage. Prior to 2011, the procedure was only permitted to save a woman's life or to protect her physical health under the penal code enacted in 1977.<sup>385</sup> Ensuring access to safe abortion services for those who are guaranteed the right under the new law is still a challenge. For the first three exceptions listed above, a court approval is required before a doctor can perform the abortion, and the consent of two doctors is required in cases where the life of the mother or fetus is threatened. In addition, access is constrained due to stigma, lack of clarity of the law (among women and health care providers), and the limited number of medical doctors prepared to do the procedure, especially in rural areas.

A large number of illegal, unsafe abortions occur in Rwanda, placing women and

girls at significant risk of post abortion complications. Approximately 60,000 induced abortions are estimated to have occurred in Rwanda in 2009 and the induced abortion incidence is estimated at 25 abortions annually per 1,000 women aged 15–44.<sup>386</sup> The WHO estimates that unsafe abortions account for one out of every six maternal deaths in East Africa.<sup>387</sup> Access to post abortion care is a significant priority for women who undergo unsafe abortion procedures as it can lead to serious health consequences including hemorrhage, infection and even death. In 2009, more than 25,000 women in Rwanda received medical care at health facilities for complications arising from abortion, which does not include the number of women who suffered complications but did not seek care.<sup>388</sup> It is estimated that one third of women experiencing complications did not obtain treatment.

Rwanda's current HIV NSP does not refer to access to abortion or safe post abortion services. However, the new Adolescent SRHR Policy includes a package for post abortion care, including emergency treatment of abortion complications, counseling and provision of services, and advocacy and community mobilization for post abortion care.<sup>389</sup>

### **Access to cervical cancer prevention, screening and treatment and palliative care**

East Africa has the highest cervical cancer incidence and mortality rates in the world.<sup>390</sup> Cervical cancer is the most common cancer for women in Rwanda,<sup>391</sup> but it is also one of the few cancers that can be fully prevented through vaccination, screening and treatment in its early stages. There is a complex relationship between HIV and human papillomavirus (HPV), the sexually transmitted virus that is responsible for causing cervical cancer. Women living with HIV are at a higher risk of being infected with HPV, and are 4-5 times more likely to develop cervical cancer than women who are HIV-negative.<sup>392</sup> Integrating HIV and cervical cancer screening and treatment services is therefore recommended as an effective and efficient method of responding to the diseases.

In 2010 the Ministry of Health developed a National Strategic Plan for Prevention, Control, and Management of Cervical Lesions and Cancer, which includes: i) HPV vaccination of girls aged 11 to 15; ii) early detection of cervical cancer in women aged between 35 to 45 years; and iii) building country capacity to treat any stages of cervical cancer. The country aims to be free from cervical cancer by 2050 as a result of consistent vaccination, regular screening and timely treatment. In April 2011, the First Lady (who negotiated a three year donation of the HPV vaccine from QIAGEN and Merck) launched a nationwide HPV vaccination campaign for girls aged 12-15. The country reached 93% coverage in the first three-dose course of vaccination.<sup>393</sup>

Prior to 2011, cervical cancer screening and HPV vaccination were not available in public health facilities, although a few private clinics and NGOs offered screening services.<sup>394</sup> The national cervical cancer prevention effort came after the development of the current NSP, but the third national Health Sector Strategic Plan (HSSP 3) developed in 2012 prioritizes the integration of HIV testing with other routine service and screening programs, including cancer. In 2013, RBC/IHDPC, the Network of People living with HIV and UNAIDS conducted the first cervical cancer sensitization workshop for women living with HIV. The ongoing development of the new NSP in 2013 provides a further opportunity for promoting HIV and cervical cancer service integration.





Palliative care is still in the early stages of development in Rwanda. In 2011, the country adopted a National Palliative Care Policy, which outlines a strategy for developing and scaling-up community-based palliative care to provide support to individuals living with HIV and other life-limiting illnesses. A number of initiatives led by government and NGOs are currently providing palliative care, but are limited in size and scope. The government is training health care providers in palliative care and aims to scale-up the provision of services through health facilities, NGOs, and community health workers. The current NSP recognizes the right of people living with HIV to palliative care services, but it does not have clearly defined roles and responsibilities for caregivers, and does not outline financial compensation for caregivers.

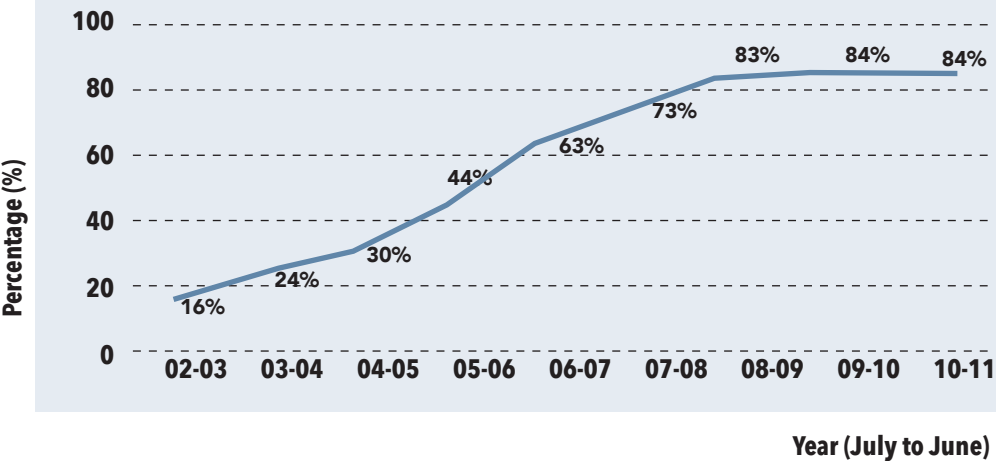
### ***3.2.2.3 Men and boys' access to sexual and reproductive health services***

Promoting men and boys' access to SRH services is an important aspect of addressing the SRH needs and rights of women and girls, in order to ensure mutual support and shared responsibility. Rwanda's HIV strategy acknowledges the role of male partners in ensuring that women have autonomy in reproductive health decisions. The NSP outlines strategies for increasing male partner involvement in HIV services through community level promotion, outreach to women living with HIV and their families, and the introduction of couples testing as a criterion for performance-based financing of health services.<sup>395</sup> As a result of these strategies, the country has seen a significant increase in male involvement in HIV testing and counselling and PMTCT services.

The national HIV program has been advocating male involvement in voluntary testing and counselling (VCT) and prevention of mother-to-child transmission (PMTCT) programs since 2003. Particular focus has been paid to increasing the number of men accompanying their partners to the PMTCT program and undergoing couples voluntary testing and counselling (CVCT) as part of a family package approach. As a result, Rwanda has seen an uptake in male partners testing for HIV from 16% in 2002 to 84% in 2011 (Figure 15).<sup>396</sup> This has been achieved through high-level national campaigns led by the President and First Lady of the Republic of Rwanda, male championship programs at the district level, and incorporation of CVCT into local authorities' performance-based contracts. The challenge is to build upon these successes to improve male participation in other SRH services, especially family planning.



**Figure 15: Male partners testing for HIV in PMTCT settings 2002-2011 (Source: 2011 Annual HIV Report)**



### 3.2.3 Meaningful Participation

Meaningful participation refers to going beyond the mere inclusion of relevant populations in debates, discussion and decision-making processes, to ensuring their active participation and voice in these events. The global HIV response has recognized the critical importance of deliberately engaging and respecting the views and opinions of women and girls, women living with HIV, women's organizations, and key populations in HIV and sexual and reproductive health and rights decision-making processes at all stages of the response. Around the world, these groups have traditionally been underrepresented in processes that make policies and decisions that directly affect their lives. This section examines the extent to which the national HIV response in Rwanda deliberately and meaningfully engages these groups in HIV planning and decision-making processes.

#### 3.2.3.1 Women's organizations

Women's organizations do participate in the HIV response in Rwanda, and the Government has recognized the need to more deliberately engage them in national HIV decision-making forums. In 2010, Rwanda's National Accelerated Plan highlighted the underrepresentation of women and girls living with and affected by HIV in the national response as a contributing factor to the epidemic.<sup>397</sup> The plan noted that opportunities for women to fully participate in decision-making processes are often limited, and called for increased representation and active participation of women living with HIV and women's rights organizations in HIV decision-making forums, including the various HIV technical working groups (TWGs) and the Global Fund Country Coordinating Mechanism (CCM).

The 2012 mid-term review of the NSP found that women's organizations were not well



represented in the key national HIV coordination forums and TWGs. While women's organizations are represented on the CCM by the umbrella organization Profemmes Twese Hamwe, they are still underrepresented in HIV TWGs. Women's organizations comprised approximately 3-14% of HIV TWG members between July 2009 and December 2011.<sup>398</sup> The low representation is partly reflective of the small number of existing organizations with a clear mandate to promote women's empowerment and gender equity and/or composed exclusively of female members, and the relatively low capacity and consequent lack of influence these organizations exert in national fora.<sup>399</sup> Low institutional capacity and limited funding of women's organizations further reduces their ability to take part in national-level meetings.

In recent years, the Government has made a concerted effort to engage women's organizations within the HIV response, with a strong precedent set by the participatory development of the National Accelerated Plan. During the mid-term review of the NSP 2009-2012, a special sub-working group on women and girls was established. In 2013, RBC/IHDPC plans to launch a Gender and HIV Technical Working Group to further increase the representation of women and girls, and women's organizations. At the district level, some women's organizations are active in committees and working groups that support HIV planning, monitoring and evaluation. The National Women's Council (NWC) also works at the decentralized level, with representatives in all 30 districts. Although the NWC is currently involved in HIV to varying degrees in different districts, there has been a call to strengthen its capacity to more effectively advocate at the district level.<sup>400</sup>

### **3.2.3.2 Women and girls living with and affected by HIV**

Rwanda is committed to ensuring that women and girls are involved in the formulation, implementation and monitoring of HIV policies and programs, as well as resource allocation and budgeting.<sup>401</sup> As noted above, the National Accelerated Plan aims to increase women and girls participation in key national HIV decision-making forums by 50%. The mid-term review of the NSP found that between July 2009 and December 2011, the proportion of women attending key HIV technical working groups ranged from 31% in the HIV M&E TWG to 97% in the GBV TWG organized by the Ministry of Health.<sup>402</sup> Women's participation is still low in the more technical sectors, while women may be overrepresented in the gender-specific working groups.

In Rwanda, many women living with HIV are represented by the National Rwandan Network of People living with HIV (RRP+), through their participation in local associations and cooperatives that have membership in the national umbrella. RRP+ is a key partner of the government active in national HIV decision-making and a member of the CCM. A number of additional associations and non-governmental organizations have been founded specifically to represent the interests of women living with HIV (e.g. Femmes Rwandaïses Seropositives dans la lutte contre le VIH/SIDA, Women Alive Foundation, Vivre Femme Plus) or young people living with HIV (e.g. Kigali Hope Association). Rwandan women living with HIV are also active members in regional and international forums including the International Community of Women living with HIV (ICW) and the Pan-African Positive Women's Coalition (PAPWC).

In 2010, the National Accelerated Plan highlighted the need to more meaningfully engage women living with HIV and empower them to transform the national agenda to

protect and promote the needs and rights of women and girls.<sup>403</sup> The mid-term review of the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV (2012), found that in part as a result of the National Accelerated Plan, the government has created space for women living with HIV to provide input into HIV decision-making processes. Overall, program experts feel there that there has been an increased inclusion and targeting of women in interventions during the NSP implementation period.<sup>404</sup> Women and girls were deliberately engaged in the MTR of the NSP 2009-2012, the development of the National Elimination of Mother-to-Child Transmission Strategy, and in working with Rwandan parliamentarians on the East African HIV Bill.<sup>405</sup>


There is still a need to strengthen female participation in umbrella organizations working in the HIV response at the national level, such as RRP+, the network of faith-based organizations (RCLS), and the network of journalists.<sup>406</sup> Although women are present in these umbrellas, they often lack the skills, capacity and funds to effectively participate in national policy and decision-making. In 2012, RBC/IHDPC and UN Women began working with RRP+ on a capacity building and restructuring plan which will result in the creation of “gender desks” within the organization – specific positions that will deal specifically with the issues of women, men, and young people respectively. This initiative is a direct result of a call made by women and young people living with HIV that their needs are not adequately represented in the current structure.

### **3.2.3.3 Key and marginalized populations**

Rwanda also recognizes the critical need to engage key populations, including female sex workers and MSM, in HIV policy and decision-making. The NSP includes specific strategies to ensure greater participation of these two groups in program planning, development, implementation, monitoring, and evaluation. In recent years, female sex workers and MSM have been actively engaged in designing and implementing research on key populations, such as the Female Sex Worker Size Estimation Survey (2012) and the study on Exploring HIV Risk among MSM in Kigali (2009). Marginalized groups such as people with disabilities are well represented at the national level through umbrella organizations that advocate for them (i.e. the Umbrella of People with Disabilities in the Fight Against HIV (UPHLS)) and represent them in program planning and management issues.

Some female sex workers are also involved in Female Sex Worker Coordination Committees working at the district-level in eight of Rwanda's 30 districts. The committee's role is to support coordination and M&E of HIV programs for sex workers at the district level. The committees are composed of health service providers, police, vice mayors of social affairs, district authorities in charge of youth, representatives of the National Women's and National Youth Councils, sex workers themselves, and other key stakeholders (e.g. implementing NGOs). Within the committees, sex workers have a key role to play in defining their needs and developing services targeted towards them. RBC/IHDPC is currently working with districts to expand and make these committees fully functional.

At the national level, the mid-term review of the NSP found that female sex workers and MSM have little to no representation and are not routinely participating in national-



level planning events.<sup>407</sup> Experts expressed a need to facilitate key populations to attend national meetings and planning events so that they are well represented on TWGs (e.g. the sub-group on most-at-risk populations (MARPs)). District-level experts and program beneficiaries noted that key populations are more involved in planning and implementation at the decentralized level. Recently, several organizations of MSM and LGBTI have been created, however due to the criminalized nature of sex work, no single sex-worker led organization has been created with the aim of advocating for sex worker rights.

#### **3.2.3.4 Capacity building and allocation of resources**

Capacity building is necessary to ensure that women, girls, women living with HIV, women's organizations and key populations who have traditionally been underrepresented in HIV decision-making, can meaningfully participate. Capacity building requires a political commitment from Government and implementing partners for meaningful participation, as well as the necessary financial and technical resources needed to empower individuals and organizations and facilitate them to participate in decision-making processes. The commitment to promote meaningful participation in national HIV strategies must therefore be matched with adequate budgets and resources to support capacity building.

In Rwanda, the National Accelerated Plan includes specific strategies and an accompanying budget for capacity building of women, girls, women's organizations, and women living with HIV to participate in the HIV response. These strategies include support to strengthen the institutional capacity of women's organizations to advocate for the needs and rights of women and girls, coalition building among CSOs, as well as supporting women's organizations to attend regional and international meetings. The National Accelerated Plan also provides for the establishment of a TWG on Gender and HIV to increase women's participation in national HIV programming and planning (currently planned for 2013). However, as noted above, funding for capacity building and meaningful participation of women's organizations and other key groups remains inadequate to ensure truly meaningful participation.

#### **3.2.4 Eliminating GBV and Discrimination**

Gender inequality is a fundamental driver of gender-based violence, which is both a cause and consequence of HIV transmission.<sup>408</sup> It is crucial that national HIV responses identify the elimination of gender-based violence as a priority and include specific strategies to a) respond to gender-based violence and b) to prevent violence in the first place.<sup>409</sup> Rates of gender-based violence in Rwanda remain high, with nearly half of all women aged 15-49 having ever experienced either physical or sexual violence.<sup>410</sup> The NSP acknowledges that GBV is a contributing factor in the epidemic and takes a two-pronged approach, incorporating strategies to i) promote primary prevention of GBV and ii) respond to violence.

In recent years, there has been a substantial development of new GBV policies and strategies designed to improve awareness and accessibility of services, and to better coordinate the work of a diverse range of stakeholders. In 2011, Rwanda adopted a new National Policy and Strategic Plan on Gender Based Violence. In addition, a Prime

Ministerial Order on the Implementation of the 2008 GBV Law was released in 2012. These documents provide a strong policy framework for implementing initiatives to prevent and respond to GBV, and clarify the roles of the different actors (gender, health, legal, judiciary, etc.). They also provide opportunities for greater integration of GBV and HIV activities.

### **3.2.4.1 Responding to GBV**

The HIV NSP aims to ensure that all HIV infections resulting from gender-based violence are prevented by training health care providers and equipping health facilities to provide PEP to victims of violence. The national strategy also seeks to better enable comprehensive care of victims of sexual and gender based violence by reinforcing the linkages and referral systems between the community, police and health service providers. In 2011, 72% of health facilities reported having functional referral systems for GBV victims in place with the police and community-based organizations, and PEP was available in 75% of health facilities to prevent HIV infection.<sup>411</sup>

One challenge to timely PEP provision (within 72 hours) to GBV victims is that the legal system (police) has traditionally been the first point of entry for victims, which can delay the provision of urgent medical attention.<sup>412</sup> The NSP identifies the need to address this challenge at the policy level and of recent, new protocols for providing care and support to victims of violence have been developed. These include referral pathways to clarify the entry point for victims of violence and the correct referral mechanisms between health care providers, police, and other stakeholders. Trainings on the clinical management of GBV have also been conducted with health facilities, police, and local authorities.<sup>413</sup> Some confusion about the referral system persists for victims and service providers, in part due to some health service providers' insistence that GBV victims go to the police first to obtain the necessary forms (which they need to access free GBV services).

Another challenge to ensuring access to PEP and support services is women's hesitancy to seek care following episodes of violence. According to the DHS 2010, only 42% of women who have experienced either physical or sexual violence ever sought help. In fact, women who have experienced (only) sexual violence are the least likely to seek help (35%), while women who have experienced *both* physical and sexual violence were more likely to seek help (54%).<sup>414</sup> Among those who ever sought help, most sought help from friends or family, while only 7% reported seeking help from the police.<sup>415</sup> An earlier study from 2009 found that only about 10% of GBV victims reported consulting a physician, indicating that very few rape victims were likely to access PEP.<sup>416</sup>

A number of social, cultural and economic factors discourage women and girls from reporting cases of violence and accessing care and support services. In addition to the lack of clear referral mechanisms and limited awareness of the law, other factors include a fear of being stigmatized by community members, and social or economic dependency on the perpetrator of the violence.<sup>417</sup> GBV victims in Rwanda may fear coming forward because domestic violence has traditionally been considered a private, 'family matter' and reporting it can be a source of shame for the victim and her family.<sup>418</sup> Where the perpetrator of violence is the sole or primary earner in the



household, reporting GBV can have serious economic consequences on the victim and the entire family.<sup>419</sup> For these reasons, a significant number of GBV cases are not reported or are reported, but later withdrawn and do not lead to prosecution.

The Government has established GBV One Stop Centers as a means to increase service availability, quality of care and improve referral mechanisms between the different service providers. By 2013, four One Stop Centers (OSCs) had been established to provide comprehensive, holistic services to victims of violence, located in Gasabo, Rusizi, Rubavu and Nyagatare districts. The OSCs bring together law enforcement, health care providers, psychologists and social workers in a single setting to assist victims in accessing the different services in a safe environment. Police stations have also established Gender Desks for responding to GBV and other cases of gender-related discrimination. At the decentralized level, local GBV Protection Committees work in collaboration with the police and health facilities to refer victims of violence to services. Through greater awareness and availability of services, it is possible that help seeking has and will continue to increase. A national strategy is in place to decentralize the OSCs in each of Rwanda's 30 districts.

Unfortunately, some marginalized populations, including MSM and people with disabilities, are disadvantaged in accessing GBV services.<sup>420</sup> MSM have expressed that despite experiencing GBV, they are unsure whether they may seek redress at the police or if they are allowed to access OSC services, as such services traditionally target women.<sup>421</sup> In addition, they noted some reluctance to report cases of GBV due to confusion regarding their rights under the law. Female sex workers also noted some challenges, including fear of discrimination or harassment from police (due to the criminal nature of sex work) as obstacles preventing them from seeking redress for acts of violence.<sup>422</sup> The sex workers interviewed requested advocacy with the police and local defense forces to reduce these issues and improve the reporting of GBV within their community.

### **3.2.4.2 Preventing GBV**

The HIV NSP promotes primary prevention of GBV through two key strategies: i) the integration of information on the unacceptability of GBV into HIV communication tools; and ii) community outreach to encourage reporting of sexual and gender based violence.<sup>423</sup> GBV has systematically been integrated into HIV behavior change communication (BCC) and information education communication (IEC) messages for different target populations (e.g. general population, young women 15-24, female sex workers). As a result, there has been good progress in integrating GBV into all HIV outreach activities, including trainings on gender equality and GBV for student anti-AIDS clubs and women's organizations.<sup>424</sup>

The National Accelerated Plan also highlights the need to comprehensively address GBV within HIV prevention efforts and to address all forms of violence against women and girls in the context of HIV. The plan emphasizes raising community awareness of violence as a cause and consequence of HIV and promoting change in gender norms and behaviors.<sup>425</sup> The accelerated plan has led to an increase in the number of activities promoting an integrated approach to preventing GBV and HIV at the community level, with community-based initiatives being implemented to raise awareness and promote

behavior change through Umuganda<sup>4</sup> and other local campaigns and activities. A greater number of outreach and social mobilization efforts targeting women, girls, men and boys are being conducted through other sectors (e.g. gender, education, legal).

More can be done to effectively address gender inequality as part of GBV and HIV prevention efforts, including integration with SRH services, and addressing the underlying norms and behaviors that fuel violence against women and girls. For example, some health centers have integrated IPV screening within HIV/PMTCT services, although these are limited to specific projects and donors. In addition, stakeholders and beneficiaries of the HIV response have expressed the need to more seriously address issues of gender equity, including power imbalances and gender roles, at the community level, especially in rural areas.<sup>426</sup> Attitudinal changes among women and girls must also be promoted to address high levels of acceptance towards violence. Engaging men and boys is one important way that should be explored to address negative gender norms that perpetuate GBV (refer to section 3.2.5.2).

### 3.2.5 Addressing gender equality in HIV programmes

In order to promote gender equality within the HIV response, it is important that HIV prevention, treatment, care and support programmes work to tackle the underlying gender inequalities and issues of social exclusion and marginalization that contribute to HIV risk and vulnerability. This includes ensuring that HIV programmes addressing the specific needs and rights of women, girls, men, boys and key and vulnerable populations and working with men and boys to address issues of masculinity and negative gender norms. The following section examines how well HIV programmes in Rwanda are promoting gender equality and addressing and challenging inequalities.

#### 3.2.5.1 Women and girls

HIV programmes can address a number of key issues in order to help promote gender equality and reduce the vulnerability of women and girls to HIV infection, including: a) empowering girls and young women to exercise better control and autonomy over their own bodies and lives; b) addressing the imbalance of unpaid caregiving and household labour; c) providing women and girls with better access to and control over financial resources; and d) helping women and girls to know and claim their rights. By integrating interventions to address these components, HIV programmes can begin to address the contributing factors to HIV transmission and reduce the impact of HIV and AIDS on women, girls and their families.

#### **Empowering girls and young women to exercise control and autonomy over their bodies**

The Government, development partners and civil society organizations in Rwanda have emphasized the importance of empowering women and girls within the HIV response. The NSP acknowledges that the empowerment of women, especially

<sup>4</sup>

*Umuganda, meaning 'community service' in Kinyarwanda, is a mandatory half-day of community service that is held on the last Saturday of each month in Rwanda.*





young women, is essential to make progress in preventing gender-based violence and improving women's ability to negotiate condom use or decide on family planning.<sup>427</sup> This recognition has resulted in a number of targeted activities to empower women and girls with knowledge and skills to negotiate safer sex, and to access family planning and GBV services.

The NSP prioritizes specific interventions to address the vulnerabilities of young women 15-24, and a minimum package of friendly services for young women has been mainstreamed within other youth packages. Outreach activities with young women have been conducted to promote safe sexual behaviors, condom use, and referral for HIV testing and STI diagnosis, reproductive health, GBV and PMTCT services, including outreach via student anti-AIDS and anti-GBV clubs.<sup>428</sup> Despite these strong advances, young people have identified challenges in providing gender-specific services targeted to young women and their particular vulnerabilities and have expressed the need for more female peer educators.<sup>429</sup> Cross-generational sex was identified as a particular challenge that requires more interventions. The ASRHR Policy also recommends developing concrete strategies to address this phenomenon.

In 2012, the Ministry of Health adopted an innovative new strategy for empowering young girls with skills and information to better exercise control and autonomy over their bodies and their lives. The 12+ programme, which will be launched nationwide, is a ten-month health, economic and social assets development approach that targets girls before they reach puberty.<sup>430</sup> The programme incorporates training, mentorship, safe spaces, and community engagement and activities for parents with the aim of helping girls make better, more informed choices. The curriculum includes specific activities to address the social and cultural norms that reduce girls' ability to negotiate their own health and sexuality.<sup>431</sup>

### **Addressing the imbalance of unpaid household labour and caregiving**

Women and girls in Rwanda face a disproportionate burden of unpaid household labour and caregiving responsibilities. Traditional gender norms often result in women and girls spending more time on household labour and unpaid caregiving compared to men, as noted in section 2.2.1.2. Traditional gender norms also create social barriers that may discourage men from participating in caregiving, who would otherwise like to.<sup>432</sup> The time and cost of women and girls' unpaid household labour and caregiving responsibilities can leave them vulnerable to the impacts of HIV, put them at risk of infection, and reduce their accessibility to services.

Rwanda's HIV strategies recognize the impact of unpaid household labour and caregiving on women and girls, noting that 'from childhood, women in Rwanda are more burdened with household duties and sibling care than their male peers...[and] assume the bulk of caregiving when their families and male partners fall ill.'<sup>433</sup> However, no clear strategy or interventions have yet been implemented to ensure that domestic and caregiving roles are shared more equitably and/or that remuneration is provided to caregivers of people living with HIV, despite being called for. The national Gender Assessment workshop recommended that clear strategies be devised to a) promote awareness of women's disproportionate burden of household labour and caregiving, and b) to address traditional gender norms and promote behaviour change so that men and boys share in the responsibility of household labour and caregiving.



The Gender Assessment workshop also highlighted the need for strategies to alleviate the burden of unpaid caregiving on women and girls by scaling-up community support mechanisms (e.g. community health workers in providing palliative care) and by compensating informal caregivers. UNAIDS recommends that in order to strengthen the continuum of care for people living with HIV, national HIV responses must: a) recognize and value care work and its impact on women; b) promote the participation and involvement of home-based care networks and caregivers in shaping national policies and solutions; c) develop policies and programmes which address caregiving in national HIV strategies; and d) facilitate the greater involvement of men in caregiving roles and the equal sharing of care work between women and men.<sup>434</sup> The role of unpaid/informal caregivers should be recognized and linkages with the formal health system created, including clear guidelines for the distribution of care.

### **Women and girls have better access to and control over financial resources**


The national HIV response recognizes the importance of economically empowering women and girls as a means of reducing HIV risk and vulnerability. As previously noted, women and girls in Rwanda have traditionally had lower rates of access to credit and less financial decision-making power within the family. This is particularly pronounced for women living with HIV, who face additional challenges to obtaining employment and accessing credit. In order to address these challenges, the national response has promoted training, capacity building and income-generating activities for people living with HIV, the majority of whom are women, as well as those affected by HIV (e.g. OVC).

The NSP outlines the need to provide education and skills to people living with and affected by HIV (including child heads of household) to enable economic opportunities, as well as the creation of income-generating cooperatives. The NSP also promotes the need to ensure that people living with and affected by HIV have access to credit (individually or collectively). The National Accelerated Plan further notes the need to ensure that women living with and affected by HIV access vocational training opportunities and financial support for IGA. However, neither plan incorporates broader strategies to empower women and girls' with access to and control over financial resources as part of a comprehensive, preventive approach to HIV.

Since 2009, there has been significant progress in increasing the number of cooperatives of people living with and affected by HIV, and in providing them with financial and technical support, including support to develop business plans and internal savings and lending groups (ISLG) to improve access to credit.<sup>435</sup> A number of cooperatives have been provided with start-up capital for income-generating activities (IGA) or have accessed credit through microfinance mechanisms or lending groups. However, cooperatives still identify a lack of access to credit and capital as a challenge to successfully participating in IGA.<sup>436</sup> There is a need to establish more sustainable, long-term mechanisms to provide financial support to cooperatives for income-generation activities.

### **Women and girls are empowered to know and claim their rights**

One of the goals of Rwanda's National Accelerated Plan is to ensure that women and girls are informed about laws and policies that protect their rights and are empowered to claim them. The strategy recognizes the importance of women and



girls being informed about laws and policies that protect their rights in the context of HIV, including laws against gender based violence and laws protecting their rights to property and inheritance. In recent years, the Government, development partners and civil society organizations have supported a number of initiatives to inform women of their rights under the law. Many laws and policies have been simplified, translated into Kinyarwanda, and disseminated at the local level, with sensitization taking place at Umuganda and other community events to raise awareness among men and women. However, as noted in the Gender Assessment workshop, traditional norms may discourage women from claiming their rights despite high levels of awareness of the laws.

Civil society organizations, especially women's organizations, have played an important role in providing legal aid, counseling and advice to women and girls making legal claims. The review of the implementation of the law on matrimonial regimes found that overall there has been an increase in the number of women claiming their rights, although some women are still hindered by social and cultural barriers.<sup>437</sup> One of the challenges is to ensure equitable coverage of efforts to inform and empower women and girls. This is made difficult by the varied and disparate efforts of a myriad of actors working on these issues, including international and national NGOs, local associations and community-based organizations, faith-based organizations and educational institutions.

### **3.2.5.2 Men and masculinities**

In recent years, there has been a growing focus on the need to address the role of men and boys in promoting gender equality within the HIV response.<sup>5</sup> The 2011 Political Declaration calls for sensitizing and encouraging the active engagement of men and boys in promoting gender equality as a means to address the underlying inequities contributing to the spread of HIV. There is growing recognition of the need to work with men and boys to address harmful masculinities, acknowledge unequal relations of power, address stigma and discrimination faced by marginalized populations, and to help men and boys understand and respect the rights of women, girls, and/or marginalized populations.

In Rwanda, the NSP acknowledges that gender inequality contributes to the epidemic and that men are also impacted by gender norms. It notes for example, that strict gender norms are the origin of stigmatizing attitudes towards MSM, and can also contribute to men living with HIV receiving lower levels of support than women.<sup>438</sup> However, the NSP does not include specific plans to address or transform the strict gender norms that it identifies as contributing to the epidemic.<sup>439</sup> For example, there is little discussion of how men can be engaged in work promoting gender equality or included in efforts to prevent GBV.<sup>440</sup>

The NSP focuses more broadly on involving men in reproductive health services, such as couples VCT, PMTCT and family planning. This has resulted in the successful uptake of male partner involvement in PMTCT (refer to section 3.2.2.3). In 2012, PSI also launched the *Umugabo Nyawe* ('the real man') mass media campaign, which

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Regional and global commitments on engaging with men and boys include: ICPD 1994; Beijing Platform for Action 1995; Global Symposium on Engaging Men and Boys on Achieving Gender Equality 2009; UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010.

challenged masculinities by encouraging men to support their partners in using modern contraceptive methods. One important area in which men and boys have been inadequately targeted is in addressing social, cultural and gender norms that discourage men's condom use. For example, the NSP has no mention of including men in initiatives to promote safer sex practices or work to address men's attitudes towards condom use.<sup>441</sup>

Since the development of the NSP, Rwanda has taken a more concerted look at engaging men and boys in HIV and GBV prevention. The National Accelerated Plan, created in 2010, includes specific provisions for engaging men and boys to transform harmful gender norms that contribute to violence and HIV at the community level. The plan identifies the need to work with boys and young men to develop innovative projects to address GBV and promote peer education regarding gender norms. The 2011 GBV Policy also recognizes that strategies to prevent and respond to GBV must include 'dialogue between men and women, boys and girls aimed at changing the cultural, social, economic and other systems and structures that deny human rights and equality between women and men.'<sup>442</sup> Importantly, the plan also recognizes the needs of men and boys who are victims of violence.

The Rwanda Men's Resource Center, a member of the MenEngage Africa regional network, has spearheaded efforts to engage men and boys in Rwanda. However, activities to engage men and boys remain limited in size and scope, and there is limited capacity among CSOs and implementing partners to promote 'MenEngage'<sup>6</sup> strategies. In 2012, RBC/IHDPC held a national workshop to identify strategies for engaging men and boys in HIV and GBV prevention. The workshop emphasized the need to integrate MenEngage strategies in the new NSP and to promote positive male leadership at national and local level. The 2012 NSP mid-term review also highlighted the 'urgent need to involve men in gender and HIV activities, as it is impossible to improve the role and status of women without the participation of men...gender-specific activities should not neglect the crucial role that men play in empowering women as well.'<sup>443</sup>

### 3.2.6 Addressing marginalization of key populations and vulnerable groups

It is crucial that national HIV strategies acknowledge the ways that marginalization, stigma and discrimination hinder the provision of HIV prevention, treatment, care and support to particular groups and include strategies to address them. The underlying causes of marginalization must be addressed, such as strict gender norms, legal restrictions, and traditional values, to ensure that all individuals have equal access to services to prevent and treat HIV that are free of stigma, discrimination and violence. This section examines the ways in which national HIV policies and programmes address the specific issues of marginalization, including reducing barriers to care and treatment, addressing stigma and discrimination, and helping marginalized groups to know and claim their rights.

<sup>6</sup>

MenEngage is a global alliance of NGOs and UN agencies that seeks to act as a collective voice to promote a global movement of men and boys engaged in and working toward gender equality and questioning violence and non-equitable versions of manhood. [www.menengage.org](http://www.menengage.org)



### **3.2.6.1 Reducing barriers to care and treatment**

Rwanda's NSP recognizes that the marginalization and social exclusion of certain groups may make them more vulnerable to HIV and limit their access to HIV services. The role of marginalization in hindering access to HIV services is expressly identified for key populations such as female sex workers, MSM, prisoners, and vulnerable groups such as people with disabilities and OVCs. Barriers to access are identified as originating at different levels, including: the attitudes of service providers and community based organizations towards marginalized groups; the capacity of service providers and community based organizations to respond to the specific needs of these groups; and the existence of barriers within policy and legislative frameworks that mean the rights of these groups are not protected.<sup>444</sup>

The NSP also acknowledges that prioritization of marginalized groups in national strategies does not always result in prioritization on the ground. The plan includes strategies for ensuring that HIV services are provided in a confidential and nonjudgmental manner and notes the need for special training for health care providers to ensure that marginalized groups receive adequate care, regardless of the prejudices service providers may have towards them. It also acknowledges that marginalized groups require specially adapted services that respond to their needs, which were not readily available at the time of the NSP development.<sup>445</sup> More broadly, the NSP commits to ensuring greater participation of marginalized groups in assessing their needs, designing programmes, and advocacy.

#### **Female sex workers**

The NSP notes that stigma can be a significant barrier for female sex workers to access HIV prevention, treatment, care and support services, who may be discouraged by the negative attitudes of some healthcare providers. In order to ensure female sex workers have access to services, the plan prioritizes outreach, access to comprehensive prevention programs and 'friendly' STI diagnosis and treatment services, and to address the socioeconomic vulnerabilities of female sex workers. Since the launch of the NSP in 2009, a minimum package of services for female sex workers has been developed and there has been an increase in organizations providing services and HIV prevention materials adapted to the needs of female sex workers at the district level.<sup>446</sup> Between 2009 and 2011, HIV program implementers provided more than 30,000 different HIV prevention services to female sex workers and service provision has steadily increased each year.<sup>447</sup> Female sex workers report improved access to services including VCT, PMTCT and ART services.<sup>448</sup>

Although the size and scope of HIV services for female sex workers has vastly improved, some barriers continue to hinder sex workers from seeking out and obtaining quality, rights-based services. Female sex workers report mixed experiences with the health system, with some reporting positive attitudes from health care providers and others experiencing stigma.<sup>449</sup> There is a need to sensitize health care providers and auxiliary staff working in health facilities to know and respect the rights of female sex workers. In addition, some sex workers expressed a need to improve the quality of counseling services provided during mobile VCT, which may impact a woman's decision of whether to access treatment. Low rates of health insurance coverage among sex workers may also pose a barrier to services, with only 20% of female sex workers in one study reporting having health insurance.<sup>450</sup>

The national response also recognizes the role of criminalization in preventing access to HIV prevention, treatment, care and support. The former CNLS and the RBC have been involved in high-level advocacy with Parliamentarians, civil society organizations and development partners to remove punitive barriers for sex workers. Unfortunately, sex work remains criminalized and sex workers report barriers to accessing and adhering to treatment while in detention. A 2011 study found that 45% of female sex workers had ever been imprisoned, which they stated interfered with their ability to access and adhere to ARVs.<sup>451</sup> Some sex workers reported spending up to several days in jail on the weekends, during which time their requests for medication were ignored.<sup>452</sup>

### **Men who have sex with men**


Rwanda is one of the few countries in Eastern and Southern Africa to include specific provisions for men who have sex with men in its national HIV strategy. Most significantly, Rwanda is one of only three NSPs to acknowledge stigma and to draw the connection between social stigma and reduced access to HIV services for MSM.<sup>453</sup> The NSP includes specific interventions including the provision of 'friendly' STI diagnosis and treatment services, the provision of water-based lubricants, and the inclusion of MSM in designing and implementing research and programs targeting them. Since 2009, efforts to increase access to services for MSM have included the development of a minimum package of HIV services, training health care providers to provide MSM-friendly care, and opening three MSM-friendly clinics in Kigali.<sup>454</sup> In addition, more than 100 men have been trained as HIV peer educators.

Although stigma and discrimination persist, MSM report an increase in services provided to them and a real change in their inclusion in the national program.<sup>455</sup> There is a need to expand these efforts. Program experts note that coverage of services needs to be improved, as services are currently concentrated in Kigali.<sup>456</sup> More healthcare workers need to be trained on MSM-specific issues, and IEC/BCC tools must be better adapted to same sex behaviors.<sup>457</sup> There is also a need to ensure that MSM have access to water based lubricants, which has been limited due to a lack of availability and limited affordability. In addition, health care workers providing GBV services must be trained to receive MSM, who have expressed challenges in accessing these services.<sup>458</sup>

### **People with disabilities**

The NSP also recognizes that people with disabilities are particularly vulnerable due to social marginalization, which makes them less easy to reach through regular information campaigns and services. When the NSP was developed, a limited number of tools and services adapted to the needs of people with disabilities were available. For example, people with visual impairments did not have access to educational materials, which were designed for the general population, and people with hearing impairments could not use regular counseling services.<sup>459</sup> Access to facilities was also a problem for those with physical disabilities.

A significant amount of work has been done with the Umbrella of People with Disabilities in the Fight against HIV (UPHLS) to identify gaps in service availability and to scale-up services adapted for people with different disabilities. The number of



people with disabilities reached by HIV services has increased since 2009, and people with disabilities report an increase in services provided to them, especially access to VCT and IEC materials.<sup>460</sup> Despite these achievements, there are still relatively few organizations working with people living with disabilities and there continues to be a lack of IEC materials adapted to the needs of various types of disabilities, including deaf or blind community members.<sup>461</sup>

### **3.2.6.2 Addressing stigma and discrimination**

The NSP recognizes that key and marginalized populations face stigma and discrimination from the community and when accessing health services.<sup>462</sup> The NSP also recognizes that stigma and discrimination of people living with and affected by HIV can hinder access to services, economic opportunities, and overall quality of life. The NSP includes a number of provisions to address stigma and discrimination against people living with HIV, and to a lesser degree for certain marginalized and key populations.

#### **People living with and affected by HIV**

The NSP identifies the role of stigma and denial in the spread of HIV and has strategies to address discrimination facing people living with HIV. Impact Three of the NSP is devoted to ensuring that people living with and affected by HIV have the same opportunities as the rest of the population, including equal access to education, employment and credit. The plan recognizes that in order to do so, the causes of stigma must be addressed. Interventions include assessing the legal framework to ensure laws and policies are supportive of the rights of people living with and affected by HIV, and by increasing awareness of the rights of people living with HIV. The NSP aims to increase the proportion of the population expressing accepting attitudes of people living with HIV from 46% of women and 51% of men (2005) to 90% by 2012.<sup>463</sup>

There has been an increase in the number of community-led activities to reduce stigma and discrimination of people infected and affected, including orphans and other vulnerable children. During the midterm review of the NSP, people living with HIV reported receiving improved counseling services and perceived that stigma and discrimination has reduced in the community.<sup>464</sup> In addition, there have been several initiatives to educate people living with HIV on their rights and an increase in legal support services provided. However, evidence indicates that despite a strong legal and policy framework prohibiting discrimination, stigma may still be a problem at the community level. In 2010, only 53% of women and 64% of men expressed accepting attitudes of people living with HIV, indicating slow progress since 2005.<sup>465</sup>

Young people living with HIV have expressed that HIV-related stigma is still high among young people, leading to fear of disclosing their status at school.<sup>466</sup> During the Gender Assessment workshop, young people living with HIV noted particular challenges at school, where accessing ARVs on campus hinders confidentiality and identifies them as HIV-positive to their peers. Youth expressed the need for more specific services tailored to the needs of young people in schools, including counseling services.<sup>467</sup> Specific strategies should be developed to support young people living with HIV in schools and to ensure that they can access treatment in a confidential and discrete manner.



### Female sex workers

The NSP notes that female sex workers face stigma and discrimination in the community, including from local authorities and law enforcement agents, and when accessing income generating activities, adult education programs, and education for their children.<sup>468</sup> The NSP outlines the need for programs to incorporate advocacy with local authorities and law enforcement agencies in order to ensure an enabling environment for HIV prevention, to tackle discrimination, and to improve access to opportunities that reduce the vulnerability of sex workers. Recent research indicates that sex workers have limited awareness of their rights and information on social support programs that might benefit them or their families, such as the Nine Year Basic Education program and the community-based health insurance scheme.<sup>469</sup> Additional effort is needed to reach sex workers with information so that they are aware and empowered to claim their rights.

As discussed in Chapter II, sex workers continue to report experiences of harassment, stigma and discrimination, including physical violence from police and local authorities.<sup>470</sup> In some instances, fear of discrimination or harassment from the police prevents sex workers from reporting cases of gender based violence or harassment, which inhibits them from claiming their rights and reduces their ability to negotiate safer sex with their clients. There is a clear need to strengthen initiatives at the community level, working with police and local authorities to address discrimination and ensure an enabling environment. The sex worker coordination committees currently operating in eight districts provide a mechanism for addressing such issues and should be scaled-up in all relevant districts.

### Men who have sex with men

The NSP recognizes that MSM face stigma and discrimination within the community, although greater attention is paid to addressing discrimination within health care settings. Research conducted with MSM has provided the opportunity to raise awareness of their existence and also to document their experiences of discrimination. During the midterm review of the NSP, MSM stated that they are gradually feeling more open to express themselves in the community despite the existence of strong stigma and auto-stigma.<sup>471</sup> This indicates that although stigma and discrimination is still high, some improvement is being made.

Training of MSM peer educators has included training on human rights for leaders in the MSM community, which is likely to have increased awareness of their rights. Although homosexuality is not criminalized in Rwanda, MSM report that there is still some confusion and misinformation about the law in the MSM community.<sup>472</sup> In cases where individual rights are violated, such as harassment or violence, it is likely that the high levels of stigma and discrimination may prevent men from seeking help or claiming their rights. There is a need to incorporate activities to address stigma and discrimination against MSM at the broader community level to ensure an enabling environment for HIV services, including strategies to ensure men are aware of their rights and supported to claim them.



## **People with disabilities**

People with disabilities are recognized within the NSP as a marginalized group prone to social exclusion and discrimination. Although the NSP recognizes that people with disabilities are vulnerable to HIV due to social exclusion, it does not include specific provisions to address marginalization or discrimination outside of health care settings. People with disabilities report that they are highly stigmatized and discriminated and that many of them are victims of sexual and gender based violence.<sup>473</sup> Effort should be made to better document and address the experiences of discrimination experienced by people with disabilities and create linkages with other sectors to address the underlying factors that lead to marginalization and social exclusion.

### **3.2.7 Accountability for Gender Equality in HIV: Coordination, Capacity, Monitoring and Evaluation, and Budgeting**

An effective gender and HIV response requires accountability for achieving gender equality at all levels. The promotion of gender equality, including the elimination of gender-based violence and promoting sexual and reproductive health and rights, must be supported by clear coordination mechanisms, improved capacity of institutions and human resources, strong monitoring and evaluation systems, and budgets dedicated to addressing gender inequalities. This section examines how accountability for promoting gender equality in the HIV response is currently addressed in the areas of coordination, capacity, monitoring and evaluation, budgeting and expenditure tracking.

#### **3.2.7.1 Coordination of the gender and HIV response**

RBC/IHDPC is the government institution responsible for coordinating the HIV response, including the financial and technical support from development partners, bilaterals, international organizations and local civil society organizations. At the national level, all ministries and sectors are responsible for mainstreaming HIV within their programmes and policies, and are required to have an institutional HIV focal point. A number of technical working groups and coordination mechanisms led by RBC/IHDPC support the planning, implementation, monitoring and evaluation of the response at the national level. At the decentralized level, RBC/IHDPC works with district AIDS coordination committees (CDLS) who coordinate the work of implementing partners in all 30 districts.

The Ministry of Gender and Family Promotion is the government ministry responsible for leading the implementation of the National Gender Policy, ensuring effective gender mainstreaming, and the full participation of women in all activities related to socioeconomic development. Other key government institutions involved in promoting gender equality include the Gender Monitoring Office (GMO), the regulatory body for monitoring compliance of gender principles and the fight against gender based violence, and the National Women's Council (NWC), a social forum for women and girls working at the local level. Together, these institutions encompass the 'national gender machinery', which also includes a number of coordination bodies



that bring together the different institutions and their partners in the promotion of gender equality.

RBC/IHDPC has established several national HIV Technical Working Groups (TWGs) in the areas of prevention, clinical care, monitoring and evaluation, and key populations ('MARPs'), among others. To date, there is no specific coordination mechanism for gender and HIV at either the national or decentralized level. However, there is a strong commitment to mainstream both gender and HIV across all sectors, and most government institutions do have gender or HIV focal points. The different coordination bodies do not currently have clear mechanisms to ensure that gender and HIV are central to their work or adequately handled. RBC/IHDPC plans to launch a Gender and HIV TWG with the specific aim of coordinating gender and HIV research, policies and programmes in 2013.

A number of coordination bodies and technical working groups exist that directly or indirectly deal with the intersecting issues of gender and HIV. At the national level, the Ministry of Health leads a GBV TWG with key development and implementing partners that provides a space for addressing the interrelated issues of GBV and HIV, although it focuses on clinical management of GBV and not on broader issues of prevention. Other coordination bodies provide some infrastructure for addressing GBV at the national, district and local levels, although the existence, functionality and capacity of these mechanisms vary at different levels. The National Gender Cluster coordinates the activities of Government institutions, development partners and CSOs related to gender equality. However, HIV is not specifically included in its mandate and the cluster does not meet regularly. At the district level, representatives of the National Women's Council in charge of gender can provide an entry point for addressing HIV.

The midterm review of the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in Rwanda found that there is a strong need to strengthen coordination between the gender, GBV and HIV sectors in Rwanda for a more effective gendered HIV response, including among the United Nations and other development partners.<sup>474</sup> The main stakeholders in these three sectors often work in isolation, with those working in HIV working under RBC/IHDPC and those working in Gender or GBV working with the Ministries of Gender or Health. It is often unclear which institutions are responsible for addressing gender equality within HIV, as is the case in many countries. Clearer coordination mechanisms are needed to ensure strong collaboration and information sharing among the different actors, and to ensure complementarity and avoid duplication of efforts. To date, there have been disparate attempts to improve coordination, which were localized to specific areas and projects.

### ***3.2.7.2 Capacity for implementing a gendered HIV response***

An effective, multi-sectoral and comprehensive gendered HIV response requires that key institutions and individuals are equipped with the knowledge, skills and capacity to effectively identify and address the links between gender inequality and HIV. This includes awareness and knowledge of gender equality principles and women's rights, the consequences of inequality between men and women, and the impact of marginalization on key and vulnerable populations. Such knowledge and awareness should be reflected in HIV planning, programming, monitoring and evaluation and



should be evidenced by clear activities and interventions to address gender-related gaps and barriers. The capacity to effectively address the gender-related aspects of the epidemic should not be confined to gender focal points or advisors, but should be systematically promoted for all staff working in the HIV response.

In 2010, the National Accelerated Plan called for improved capacity of government institutions, development partners and civil society organizations to address gender equality in the HIV response. The plan called for training of relevant government staff on gender and HIV in order to better integrate the needs and rights of women and girls in the planning, design, and budgeting of the HIV response. Since 2011, RBC/IHDPC and its partners have undertaken a number of initiatives to train government (at national and decentralized levels) and civil society organizations to effectively mainstream gender equality in HIV planning and programming, including interventions that address gender-based violence and sexual and reproductive health and rights. All staff and organizations working in the response have yet to benefit from such training and there is no system in place to measure staff knowledge of gender and HIV. RBC/IHDPC plans to conduct a Gender Audit in 2013.

During the Gender Assessment workshop, participants expressed that programme managers working in the HIV response are aware of the gender dimensions of the HIV epidemic, the need for disaggregated data, and the ways in which gender and HIV are linked. However, it was agreed that there is lesser understanding of how to translate this information and knowledge into gender-transformative programming. It was also agreed that knowledge and capacity is greater with regard to addressing economic factors rather than social and cultural ones, which has resulted in more targeted programs for income-generation and economic empowerment. The participants also noted that some knowledge of how marginalization impacts key populations exists and there has been concerted effort to increase capacity in this area.

Overall, there is still a need to build the capacity of both government and civil society to be able to translate knowledge into programming. There is also a need to increase the number of staff that are mandated to address gender and HIV at the levels of planning, monitoring and evaluation, and research. The midterm review of the NSP found that although significant achievements have been made in mainstreaming gender, RBC/IHDPC has relatively few staff dedicated to gender.<sup>475</sup> The midterm review highlighted the urgent need to strengthen the number and capacity of human resources dedicated to Gender within the national response.

There is also a need to strengthen district-level coordination and capacity for implementing gender-transformative programming. It is not currently known how well district development plans (DDPs) are addressing the interrelation of gender and HIV. Gender Assessment workshop participants expressed the idea that as the country strengthens its focus on decentralization, it will be important to build the capacity of district level authorities to effectively plan, implement, monitor and evaluate activities that address the gender specific dimensions of the epidemic. It was also noted that the capacity of the National Women's Council could be strengthened in order to support greater gender mainstreaming within HIV at the district level.

### 3.2.7.3 Gender in HIV monitoring and evaluation

Monitoring and evaluation is a critical component of the national HIV response. Often, national HIV strategies identify gender equality as a key priority, but fail to reflect this with clear gender indicators, or with sex and age disaggregated data necessary to evaluate a gendered HIV response. Rwanda has recognized the need to improve the collection, dissemination and use of sex-disaggregated data in the HIV response, including among implementing partners and at the district-level.<sup>476</sup> Since 2010, a number of initiatives have been undertaken to build the capacity to collect, analyze and use sex-disaggregated data to inform and monitor HIV planning and programming, however, partners could still improve the collection and use of sex-disaggregated data.<sup>477</sup>

By 2011, nearly all of the national HIV indicators required the collection of sex-disaggregated data for most programmatic and outcome data.<sup>478</sup> Routine data is collected through a number of databases including TRACnet, which collects program data from health facilities, and CNLSnet, which collects community-based data from implementing partners. Partners are required to use the CNLSnet database to provide data on their activities, which are disaggregated by age and sex. However, while data are collected disaggregated by sex, they are not always disaggregated when consolidated at the national level or presented in national HIV reports. This suggests that the use of sex-disaggregated data in HIV planning and programming on a consistent basis may be limited.

The extent to which sex-disaggregated data are used to inform or adapt the conceptual framework and design of the country HIV response can be improved. One of the challenges of ensuring that M&E systems are properly gendered is the limited capacity of planning and M&E technicians to analyze and use sex-disaggregated data. The development of the National Accelerated Plan provides a good example of conducting gender analysis at the national level. The creation of the plan included the collection and analysis of sex-disaggregated data to identify gender gaps, which were then used to define targeted programs to address the gaps. While analysis and use of data has been done at the national level, regular analysis of sex-disaggregated data can be improved at the district level.

In 2012, RBC/IHDPC led two initiatives to improve the analysis and use of gender and HIV data. A 'Know Your Epidemic from a Gender Perspective' exercise was conducted with MEASURE Evaluation to further disaggregate existing routine and survey data in order to better enable gender analysis (report forthcoming). In the same year, a regional workshop was held with MEASURE and UNAIDS to strengthen the capacity of stakeholders from eight districts to analyze and use sex-disaggregated data to inform district-level HIV planning and programming. The workshop provides a good model for strengthening capacity at district level that could be scaled-up.

In addition to ensuring that all national HIV indicators collect and report data disaggregated by age and sex, there is a need to include more gender specific indicators within the NSP. Indicators related to addressing gender inequities, promoting gender equality and sexual and reproductive health and rights should be incorporated into the NSP at the outcome and output levels. This is necessary to ensure that the impact of programs and policies on women, girls, sexual and reproductive health and rights and gender equality can be adequately measured and



that the commitment to promote gender equality is sufficiently reflected at the level of monitoring and evaluation.

#### **3.2.7.4 Gender in HIV budgeting and expenditure tracking**

In order to achieve a gendered HIV response, it is integral that national HIV strategies and policies include specific actions to advance gender equality that are costed, budgeted, and monitored. Rwanda has recognized that barriers and risks exist to ensure consistent expenditure on women, girls and marginalized populations within the national response. The National Accelerated Plan was designed in part to ensure that specific interventions for promoting gender equality in the HIV response were matched with corresponding budgets. Unfortunately, one of the challenges of having a stand-alone gender and HIV strategy (although it contributes to the goals of the NSP) is that its implementation, monitoring and evaluation is not institutionalized within existing HIV M&E structures. This means that tracking expenditure and implementation of activities within the National Accelerated Plan require additional, ad hoc efforts that are outside of routine M&E and expenditure tracking.

The mid-term review of the NSP 2009-2012 noted that very few data exist on resource allocation from a gender perspective and recommended that national and international partners should conduct gender responsive budgeting (GRB) of HIV interventions in order to determine and remediate issues with budget inequality relative to need.<sup>479</sup> In 2010, the National AIDS Control Commission recommended that specific mechanisms be established to track country-level expenditure and allocation of resources for women, girls, gender equality and HIV in the National AIDS Spending Assessment (NASA) and measurements of HIV expenditure.<sup>480</sup> In 2011, an assessment of GRB and resource flow of the HIV response was conducted and a draft gender budget statement (GBS) for HIV was developed, but never implemented.<sup>481</sup> Financial expenditure data is not currently disaggregated by age, gender or key population (aside from support for OVC), and no specific mechanism is in place to measure the proportion of HIV expenditure allocated to addressing gender inequalities.

The midterm review of the UNAIDS Agenda for Women and Girls also noted the challenges of having a separate gender and HIV strategy. Since the NSP is the guiding strategy for the HIV response and provides the foundation for the country's National Strategy Application (NSA) to the Global Fund, having a separate gender and HIV strategy means that the activities and strategies included in the Accelerated Plan do not benefit directly from major resources and funding allocation, which results in less resources available to monitor and evaluate the implementation of the plan.<sup>482</sup> Funding from the NSA was included in the costing of the National Accelerated Plan, however, it will require strict follow-up with the CCM and Global Fund Single Project Implementing Unit (SPIU) to ensure that activities funded by the NSA are also aligned to the National Accelerated Plan.







## IV. Key Recommendations

The Gender Assessment of the National HIV Response provided the opportunity to fully assess the extent to which the current response has incorporated gender equality as a core goal and adopted strategies to address the social, cultural, political and economic factors contribute to HIV risk and vulnerability. During the Gender Assessment, a number of key findings were made about the gender dynamics of the epidemic and the degree to which the HIV response has addressed them. As a result, a number of key recommendations were formulated for strengthening the promotion of human rights, including sexual and reproductive health and rights, and gender equality in the HIV response. These recommendations are outlined below.

The findings and recommendations of the Gender Assessment of the National HIV Response should be used to reorient current HIV programming and inform future planning, programming, monitoring and evaluation, and budgeting in order to ensure a sufficiently gendered response. The recommendations are targeted towards all partners working in the HIV response, including Government institutions, the United Nations and other development partners, international NGOs and local civil society organizations, and the private sector. They should be used to guide planning, programming, monitoring and evaluation of HIV programmes and activities, and interventions addressing gender equality, sexual and reproductive health and rights and/or gender-based violence.

### 4.1 Recommendations of the Gender Assessment

The key recommendations for strengthening a gendered HIV response are presented below according to several key themes that evolved out of the desk review and national consultation processes: i) addressing gender inequalities through HIV programmes and policies; ii) addressing stigma and discrimination of marginalized groups; iii) eliminating gender-based violence and discrimination; iv) integrating HIV within an SRHR approach; v) advocating for an enabling environment; vi) ensuring meaningful participation in the response; and vii) ensuring accountability for gender equality. One overall, guiding recommendation is provided for each theme and is complemented by a larger number of specific, targeted recommendations.

#### 4.1.1 Promoting gender equality in HIV programmes

The national HIV strategy should incorporate gender equality as a core goal and provide specific strategies to reduce HIV risk and vulnerability for women and girls, key and marginalized populations. This includes advocating for policy and social changes to address the contributing social, cultural, economic and political factors and structural determinants of HIV transmission for women and girls, men and boys, and key and marginalized groups.



### **Targeted recommendations:**

Adopt a dual approach to addressing gender inequality in the HIV response that both empowers women and works with men and boys to change attitudes and behaviors that perpetuate inequality and increase HIV risk and vulnerability for women and girls.

Establish programs to address underlying gender inequalities and promote more equitable distribution of domestic and household duties between men and women, in order to address the unequal burden of domestic work that increases women and girls' HIV risk and vulnerability. Promote interventions that support equal sharing of responsibility between women and men in families and in the community.

Recognize the significant role of women and girls in caregiving of people living with HIV and adopt concrete strategies to reduce the burden of care. Define clear roles and responsibilities for unpaid caregivers, including people living with HIV, within the broader health system and provide them with material and psychosocial support. Assess the possibility of providing financial compensation or other forms of remuneration to unpaid caregivers.

Address structural and financial barriers that reduce access to education for girls and young women and increase their vulnerability to violence and exploitation. Promote awareness of girls' right to return to school following pregnancy and encourage female dropouts to return to school.

Strengthen the engagement of young people, especially young women, girls, and young people living with HIV, in the planning, design, and implementation of interventions targeting them. Particular attention should be paid to involving girls and young women in the creation of girl-friendly activities and safe spaces within Youth Friendly Centers.

Involve girls and young women, including those living with HIV, in the development of campaigns to reduce cross-generational and transactional sex. Investigate innovative strategies, such as cash transfers, to reduce girls and young women's reliance on men for basic survival needs (e.g. education, food, etc.).

Target older (and wealthier) men likely to purchase sex or engage in cross-generational relationships with specific campaigns to promote attitude and behavior changes that will increase condom use and reduce violence, coercion and exploitation of girls and young women.

Promote women and girls' economic empowerment, especially for women and girls living with HIV, through access to income-generating activities, microfinance, and vocational training.

Engage men in women and girls' IGA activities to reduce the likelihood of reprisal violence or familial discord due to women's increased economic independence. Educate the male partners of women accessing microfinance and IGA on women's rights, including sexual and reproductive health and rights, and sharing the burden of domestic and household labor.



## 4.1.2 Addressing stigma and discrimination of marginalized groups

The national HIV response should define clear strategies to address stigma and discrimination of people living with HIV and marginalized groups such as MSM, female sex workers, and people with disabilities at both the community and health facility level. HIV programmes should incorporate strategies to halt and respond to all forms of discrimination in order to reduce vulnerability to HIV and ensure universal access to HIV prevention, treatment, care and support services.

### Targeted recommendations:

Strengthen community-based campaigns to address stigma and discrimination of people living with HIV at the family and community level. Engage community, cultural and religious leaders in promoting a stigma-free environment for women, men, boys and girls living with and affected by HIV at the national and local level.

Address stigma and discrimination of young people living with HIV in schools and create an enabling environment for accessing and adhering to treatment that is free of discrimination and violence. Develop strategies to provide psychosocial support to young people with HIV within schools and reinforce confidentiality when accessing ARVs.

Strengthen programs to educate people living with HIV on their rights, especially young people. Improve awareness of the rights of people living with HIV to work and access economic opportunities, to access credit, and to get married and have children.

Incorporate strategies to address stigma and discrimination of key populations, such as female sex workers and MSM, at the community level in order to reduce barriers to accessing HIV services and vulnerability to violence.

Sensitize health care providers, auxiliary staff working in health facilities and police, judiciary and local law enforcement authorities on the rights of all individuals, including female sex workers and MSM, to access and receive quality, confidential and rights-based health services under the Rwandan Charter on Patients Rights.

Educate female sex workers, MSM and other vulnerable and marginalized groups on their rights (right to health, access to justice, freedom from violence) and how to claim those rights under the law.

Increase the availability and accessibility of HIV services for female sex workers, for example through nighttime mobile VCT campaigns and distribution of condoms beyond hotspots in order to reach sex workers working from street-based venues.

Scale-up the availability of HIV services adapted to the needs of people with disabilities and ensure that tools are developed to ensure that all people with disabilities can be reached by HIV prevention messages, and HIV care,



treatment and support services. Develop community-based programs to tackle stigma and discrimination of people living with disabilities that increase their vulnerability to HIV and hinder access to services.

### 4.1.3 Eliminating gender-based violence and discrimination

The national HIV strategy should recognize gender-based violence as both a cause and consequence of HIV transmission and include strategies for responding to and promoting primary prevention of gender-based violence, including activities to engage men and boys in HIV and violence prevention. Attention should be paid to gender inequality as a driver of violence and to addressing violence in all its forms.

#### **Targeted recommendations:**

Further integrate strategies to prevent and respond to gender-based violence and HIV through more coordinated planning, programming and monitoring and evaluation between the different institutions and actors working in the HIV and GBV sectors.

Expand community-based strategies for raising women and girls' awareness of their rights, including laws and policies protecting women and girls from violence, and the means through which to claim those rights in a safe and empowering environment. Develop new strategies for addressing entrenched gender roles and women and girls' accepting attitudes towards violence.

Scale-up the provision of post-exposure prophylaxis to ensure that all individuals who are victims of sexual violence receive PEP in a timely manner to prevent HIV infection. Ensure that all individuals receive the full PEP package and develop adequate follow-up mechanisms to improve adherence and ensure victims receive the full course of treatment.

Incorporate screening for gender-based violence in HIV prevention, care and treatment programs both within and outside of PMTCT settings for women, girls, men and boys. This should include capacity building of HIV counseling and testing centers to be able to address issues related to sexual violence for couples who are HIV discordant.

Ensure the inclusion of interventions working with men and boys to challenge notions of violence, transform gender norms and address harmful masculinities within national HIV prevention policies and strategies. Establish mechanisms for coordinating activities to engage men and boys in HIV and violence prevention and gender equality promotion.

Work with the police, judiciary, local law enforcement authorities and sex workers to develop interventions to stop and address violence and discrimination against sex workers. Establish partnerships and referral systems to support sex workers to seek redress for violence free from fear of being discriminated or penalized (e.g. through sex worker coordination committees).

Recognize that MSM are also vulnerable to gender-based violence and ensure

that they are able to access services for victims of violence that are free from discrimination. Raise awareness among MSM on their rights under the law and where to seek services.

Develop targeted programs to engage men and boys in addressing sociocultural barriers to condom use and to create a favorable environment for women's negotiation of safer sex, including through the promotion of men's groups and the involvement of male champions or role models in community-based campaigns.

Develop strategies to address gender-based violence among people with disabilities, including research to know the scope of the problem and outreach to ensure people with disabilities are aware of their rights and know how and where to access services.

Work with police, judiciary, law enforcement authorities and health care providers to change negative or judgmental attitudes regarding gender-based violence that may bias their treatment or respect for victims of harassment or violence.

#### 4.1.4 Integrating HIV within an SRHR approach

The national HIV strategy should incorporate strategies to promote and ensure the full sexual and reproductive health and rights of women, girls, men, boys, key and marginalized populations, including linkages and integration of services for sexual and reproductive health, management of gender-based violence, and HIV. This includes engaging men and boys in sexual and reproductive health services.

##### **Targeted recommendations:**

Engage faith-based organizations and health facilities in discussion around family planning and where possible, identify alternative mechanisms for providing women and girls, especially women living with HIV, access to quality and comprehensive sexual and reproductive health and rights information and family planning services in the areas surrounding faith-based health facilities, without having to be referred to another public health facility (e.g. through community health workers).

Further integrate HIV and sexual and reproductive health and rights information and services, including family planning services, for people living with HIV and ensure that health care providers are trained on providing quality, rights-based sexual and reproductive health services to women living with HIV.

Scale-up comprehensive youth-friendly sexuality education for young people, with an increased focus on HIV and GBV within the existing reproductive health curriculum, including the provision of concrete skills in condom use and negotiation for young men and women. Ensure that both in and out-of-school youth are reached by such interventions. Scale-up financial and technical resources available to student anti-AIDS clubs.



Strengthen peer education opportunities for young people living with HIV, including engaging young people living with HIV in educating HIV-negative youth on SRHR, HIV, and GBV.

Strengthen the capacity of teachers and parents to impart knowledge and information on adolescent sexual and reproductive health and rights to young people. Develop tools and mechanisms to enable parents and teachers to feel comfortable discussing issues of sexuality, gender equality and HIV with young people.

Improve the availability of youth-friendly services for young people, especially young women. Ensure equitable access to male and female condoms for young men and women and address sociocultural, policy and funding barriers that limit condom access and use among young people, including advocating for a policy to enable condom availability in secondary schools.

Develop innovative ways to target older men, as clients of sex workers and as partners in cross generational relationships, with HIV prevention information, including information on women's rights and the importance of correct and consistent condom use.

Scale-up programs targeting men and boys to access sexual and reproductive health services including voluntary HIV testing and counseling. Develop strategies to increase men's health seeking behaviors surrounding sexual and reproductive health and ensure providers have the skills and capacity to address men's specific SRH needs. Examine Male Circumcision programmes as an entry-point to address men's wider SRH needs.

Scale-up SRH programs targeting men as partners through ANC and PMTCT programs to encourage men to participate more in reproductive health and family planning decision-making, as well as caregiving. Ensure that the promotion of male involvement does not negatively impact women who do not have male partners.

Promote integration and linkages between cervical cancer and HIV programmes, including engaging women living with HIV in raising awareness of the links between cervical cancer and HIV and scaling-up the availability of services to screen and treat cervical cancer.

#### 4.1.5 Advocating for an enabling environment

The national HIV response should continue to advocate for an enabling environment for the provision of HIV prevention, care, treatment and support services and the removal of all punitive laws and policies that form barriers to universal access to HIV services and commodities. The sociocultural environment must also be safe and empowering to enable women and girls living with and affected by HIV, sex workers, MSM and people living with disabilities to securely access services without fear of stigma, discrimination or violence. The response should also ensure that HIV programmes, plans and policies promote an enabling environment for gender equality.

**Targeted Recommendations:**

Continue to engage Parliament, civil society organizations and other key stakeholders in advocating for the removal of laws criminalizing sex work, which present a significant challenge to the provision of HIV services and increase the threat of violence.

Promote structural and policy changes to address the underlying factors which lead women and girls to engage in sex work (e.g. promoting access to education, preventing unplanned pregnancy and enabling girls to return to school) and continue to provide quality and comprehensive rights-based HIV services to female sex workers.

Address policy barriers to equitable access to condoms and contraceptives for vulnerable and key populations, including young people and prisoners. Create a dialogue with key national institutions to review and evaluate the impact of such policies on HIV prevention efforts and advocate for policies to enable condom availability in secondary schools and prison settings.

Work with women's organizations, organizations of women and young people living with HIV, to advocate for policy change with regard to laws and policies that institutionalize gender inequalities in order to ensure an enabling environment for the promotion of gender equality.

Continue to work with health care workers and relevant partners to ensure the successful integration of comprehensive, quality services for HIV, SRHR and the management of gender-based violence for women and girls, MSM, sex workers and people with disabilities, that are free of stigma, discrimination and violence.

### 4.1.6 Ensuring meaningful participation in the response

The national HIV strategy should include clear strategies for strengthening the meaningful involvement of women, girls, marginalized and key populations in national HIV decision-making, planning, programming, research, monitoring and evaluation. This includes the establishment of mechanisms to institutionalize their meaningful involvement and the provision of technical and financial support to enable them to participate in processes that affect their lives and wellbeing.

**Targeted recommendations:**

Sensitize women's organizations, organizations of women and young people living with HIV, and organizations representing key and marginalized populations on the opportunity and importance of participating in national HIV decision-making processes. Ensure they are invited to participate and are facilitated to attend key HIV planning, monitoring and evaluation, and decision-making processes.

Strengthen the capacity of women's organizations, including networks of women living with HIV, sex workers, MSM and people with disabilities, to participate



and provide leadership in the HIV response at national and decentralized levels. Allocate financial and technical resources to enable capacity building in the areas of advocacy, data analysis and monitoring and evaluation.

Increase the meaningful participation of female sex workers in the design, implementation, and monitoring and evaluation of HIV programmes and policies at national and decentralized level, for example by involving them in HIV technical working groups and by scaling-up sex worker coordination committees at district level.

Ensure the meaningful participation of other key populations, such as MSM, truck drivers, and prisoners and organizations working with these groups, in the HIV response by targeting them to participate in technical working groups and in the design, implementation, monitoring and evaluation of HIV programmes and policies at the national and decentralized level.

### 4.1.7 Ensuring accountability for gender equality

Ensure accountability for commitments to promote gender equality in the HIV response by strengthening the capacity to coordinate, monitor and evaluate interventions designed to advance gender equality among government institutions, and between development partners and civil society organizations. Ensure that gender specific actions and interventions are fully costed and budgeted within the NSP, and that mechanisms are in place to monitor expenditure on gender-related activities.

#### **Targeted recommendations:**

Improve collaboration and coordination between government institutions and key partners, including United Nations, other development partners and civil society organizations working in HIV and/or gender and define clear roles and responsibilities for designing, implementing, monitoring and evaluating programmes and policies regarding gender equality and HIV.

Develop stronger alliances and collaboration between the HIV response and institutions and organizations working to promote gender equality at the national, district, and local levels to enable greater coordination of a gendered HIV response (e.g. National Women's Council).

Launch the Gender and HIV Technical Working Group with a mandate for addressing gender equality and ensuring greater representation of women and women's organizations in the HIV response. Establish mechanisms for coordination and communication with existing HIV and/or gender working groups.

Implement Gender Responsive Budgeting practices within the HIV response to track resource allocation and expenditure on activities designed to address gender inequalities. Reassess the potential for utilizing the Gender Budget Statement for HIV or explore opportunities to incorporate GRB within existing expenditure tracking tools and processes (e.g. Health Resource Tracking Tool; National Health Accounts; NASA).

Ensure the national HIV strategy includes gender indicators, including a broader set of indicators around gender, sexual and reproductive health and rights, human rights and social change, and indicators to measure the impact of programs and policies on women and girls. Ensure that *all* national HIV indicators (and their targets) continue to collect and report data disaggregated by age and sex.

Strengthen the capacity of civil society organizations, including networks of women living with HIV and implementing partners in the HIV response to promote gender equality, including sexual and reproductive health and rights, in all HIV interventions and programmes. Build civil society capacity to effectively conduct gender-responsive budgeting and to integrate gender in HIV monitoring and evaluation.

Expand human resources devoted to gender and HIV within RBC/IHDPC and build the capacity of key stakeholders working in HIV and/or gender to analyze and use sex-disaggregated data and information on the gender dimensions of the epidemic to inform and strengthen HIV planning, programming, monitoring and evaluation, and resource allocation.





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