

**End-of- Programme Evaluation  
of EC-UN Women’s “Supporting  
Gender Equality in the Context  
of HIV/AIDS”**

**Final Report  
Volume III - Country Profiles**

By:  
*Universal Management Group*



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## Country Profiles – Introduction

The global programme “Supporting Gender Equality in the Context of HIV/AIDS” was implemented in five countries, each with a unique history and context. The programme’s overall objective was to ensure that gender equality and human rights were integrated into key policies, programmes and actions to address HIV and AIDS at the national level.

The following profiles of the programme in each country aim provide an overview of the national context and the programme’s evolution between 2009 and 2013, highlighting programme results (key outcomes and outputs), challenges in implementation, and prospects for sustainability. The profiles are based on review of documents and 5 days of consultations with key stakeholders in-country (see Volume II, Appendix IV). As per the agreement with UN Women, the profiles are brief (7-8 pages); thus the information and analysis in the profiles is not exhaustive. The profiles were not intended to provide an evaluation of the programme at country level.



# Appendix I Country Profile: Cambodia

## 1. Country Context

### State of the epidemic in Cambodia

Cambodia experienced a severe HIV epidemic in the mid-1990s. HIV prevalence peaked in 1998 at 2.4%. Substantive commitment from the Government of Cambodia and support from development partners through programmes and activities to combat HIV/AIDS has contributed to steadily decreasing HIV prevalence in Cambodia. The projected number of new infections decreased from 5,814 in 2000 (16 newly infected per day) to an estimated 1,473 in 2010 (4 newly infected per day). By 2010, roughly 90% of all infected adults and children were receiving antiretroviral therapy (ART) and data from the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) quarterly reports shows about 89.5% of the total eligible population have access to ART.<sup>1</sup>

While this result is encouraging, the incidence of HIV remains high among key populations at risk. This is particularly true for women; in fact, within the population living with HIV, the proportion of women living with HIV has increased from 38% to 55%,<sup>2</sup> with an estimated 44% of new infections in 2011 having occurred among women aged 15-49. Moreover, recent samples gathered among all pregnant women attending antenatal care clinics indicate that HIV prevalence among this group currently stands at 0.4%.<sup>3</sup>

New infections continue to occur mainly through heterosexual intercourse, sex work, mother-to-child transmission, and transmissions from husband to wife or wife to husband. While women are being infected by their spouses or long-term partners, an increasing proportion of new infections are occurring from wife to husband/spouse, reflecting the mature stage of the epidemic. Women's inferior social status to men and limited ability to negotiate safe sex in intimate relationships contribute to infection rates among women.<sup>4</sup>

Poverty, income inequality, lack of economic opportunities, restricted access to education and health care, as well as sexual norms in Cambodia make it difficult for women to protect themselves from unsafe sex and fuel the national HIV epidemic. Women living with HIV endure widespread stigma and discrimination, which has made it difficult for them to voice their issues and concerns, and to participate in coordinating and decision-making processes of the HIV response.

### Environment for promoting mainstreaming of gender

Gender equality forms part of the Cambodian constitution, a national commitment that was reiterated through Cambodia's ratification of major international agreements related to gender equality, human rights, and HIV/AIDS; including the Convention on the Elimination of All Forms of Discrimination

<sup>1</sup> Roberts J. (2009). *Preventing Spousal Transmission of HIV in Cambodia: a Rapid Assessment and Recommendation for Action*, UNIFEM East Asia and Southeast Asia Regional Office; Chhorvann, C., Vonthanak, S. (2011). *Estimations and Projections of HIV/AIDS in Cambodia 2010 – 2015*, National Centre for HIV/AIDS, Dermatology and STD, Ministry of Health, Kingdom of Cambodia, 59 p.; also see Cambodia National Center for HIV/AIDS, Dermatology and STD. *NCHADS Quarterly Reports*, available at: [www.nchads.org](http://www.nchads.org)

<sup>2</sup> UNAIDS (2012). *Global Report on the AIDS Epidemic 2012*, Geneva, UNAIDS, 106 p.

<sup>3</sup> HIV prevalence among pregnant women attending AnteNatal Care (ANC) has been the main source of HIV estimations and projections in Cambodia. See Chhorvann, C., Vonthanak, S. (2011).

<sup>4</sup> Cambodia National AIDS Authority (2012). *Cambodia Country Progress Report: Monitoring the Progress towards the Implementation of the Declaration of Commitment on HIV and AIDS, January 2010-December 2011*, Phnom Penh, 62 p.; also see Chhorvann, C., Vonthanak, S. (2011).

Against Women (CEDAW) and the 2011 Political Declaration on HIV/AIDS. The Government of Cambodia has recognized the important roles of women in the country's economic and social development, and it has included gender equality goals in key national policies such as the Rectangular Strategy for Growth, Employment, Equity and Efficiency (2008), the National Strategic Development Plan, and the Cambodian Millennium Development Goals.

In addition, systems have been put in place to help ensure gender mainstreaming and to monitor the implementation of international legal instruments. The Ministry of Women's Affairs (MoWA) is responsible for mainstreaming gender into government programmes, and works through institutionalized Gender Mainstreaming Action Groups (GMAGs) that have been established in line ministries since 2005. The Decentralization and De-concentration (D&D) reform also takes into account gender mainstreaming, introducing new systems and procedures so as to ensure that all citizens, especially women, vulnerable groups and indigenous minorities can participate in decision-making at provincial/municipal, district/khan and commune/sangkat levels. However, in practice, the inclusion of marginalized communities in decentralization and de-concentration systems and procedures has not been fully implemented.

Despite this progress, the existing systems to mainstream gender and HIV are not yet functioning effectively due to a lack of authority and resources. To date, GMAGs have focused mainly on providing training on gender and disseminating CEDAW through their network. Moreover, a lack of clear understanding of what is meant by "integrating gender equality into policies and programmes" has led to few concrete actions to mainstream gender equality in government programmes and actions, including with regard to HIV and AIDS.

In 2003, the MoWA adopted the *Policy on Women, the Girl Child and HIV* to address the link between gender inequality and the spread of HIV, and developed a strategic plan (2008-2012) to implement it, which included a national action plan for reducing intimate partner transmission. This strategic plan focused on empowering women and girls to make informed choices and adapt their behaviour to reduce vulnerabilities. Further, the National Strategic Plan (NSP) 2006-2010 (NSP II) recognized that "gender inequalities place women and girls in Cambodia to be more vulnerable to HIV infection" and expressed that this needed to be addressed and corrected for the national response to be truly effective.

Civil society organizations, including international and local NGOs, faith-based organizations, and community-based networks, continue to play an important role in promoting gender equality and women's human rights in the national response to HIV and AIDS. Key networks working on the issue include the Cambodian People living with HIV and AIDS Network (CPN+) and the Cambodian Community of Women Living with HIV/AIDS (CCW), which was established under the CPN+ in 2004 and became an independent network in 2008. Networks representing key populations at the highest risk include the Women's Network for Unity, which represents sex workers; the Bandanh Chaktomuk, which represents men who have sex with men and transgender people; and Korsang, which works with people who use drugs.

## Current situation

External financing to HIV/AIDS is in decline in Cambodia, and spending on prevention, care and treatment has decreased.<sup>5</sup> Nonetheless, the government's commitment toward HIV remains high; Cambodia has vowed to achieve the goals of the UN's three zeros strategy – "zero new infections, zero discrimination, zero AIDS-related deaths" – by 2020.

At the beginning of the programme, there was no national body dedicated to ensuring gender issues were addressed in the context of the national HIV response. But in 2011, the National AIDS Authority (NAA)

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<sup>5</sup> NASA 2011-2012 presented at the Validation Meeting of the Fourth National AIDS Spending Assessment on May 31 2013.

established its Gender Working Group (GWG) to ensure gender mainstreaming in NAA policies and programmes and in the HIV response. The GWG is an internal working group, bringing together representatives of the different departments in the NAA. The GWG focuses on disseminating CEDAW, for which it receives financial support from the government. However, no strategic plan exists to guide the implementation of this group's work, unlike most other GMAGs, which have adopted a Gender Mainstreaming Action Plan (GMAP) through donor support. The GWG reports to the Cambodia National Council for Women (CNCW) and the MoWA. The GWG was not involved in the direct implementation of programme, although the GWG provided inputs and participated in some of the Programme's activities, and participated in meetings of the National Committee on Gender and HIV and AIDS.

## 2. Evolution of the Programme

### Key Implementing Partners

The programme's implementation involved three main partners:

- The Cambodian Community for Women Living with HIV (CCW): Responsible for work around leadership and advocacy of women living with HIV. The CCW empowered rights holders through capacity building, community mobilization and planning.
- The Ministry of Women's Affairs (MoWA): Responsible for providing training and technical support, leading the integration of HIV concerns into gender equality and women's human rights work carried out by the MoWA.
- The National AIDS Authority (NAA): Responsible for leading, managing and facilitating the gender mainstreaming process into the national HIV and AIDS response in Cambodia, including in the formulation of NSP III, HIV programmes and action plans.

### From UNIFEM to UN Women: Role of Focal Point

At UN Women's Country Office, the programme was managed by two consecutive Focal Points. The Focal Points oversaw programme implementation, provided technical and advisory support to partners, and monitored progress to ensure that results were achieved.

### Funding and Implementation Period

Overall, Cambodia was allocated approximately USD 465,000 for implementing the programme, from January 2009 to March 2013. There were no delays in terms of programme start-up with the three implementing partners. However, the implementation of activities by CCW fell behind due to staff turnover. For this reason, the CCW sought two no-cost extensions.

### Programme Strategies and Key Activities

The following strategies and activities aimed at reaching the specific programme objectives:

#### Leadership and advocacy of women living with HIV

- ***Support to the CCW and women advocates working on HIV to prioritize their issues and develop their vision and agenda:*** National workshop to formulate CCW's mission, vision and inputs to the 2010 workplan; organizational assessment of CCW in 2011; assessment of Self-Help Groups (SHG) in 2012 and development of SHG Guidelines; support to the CPN+ General Assembly for including gender perspectives within their by-laws and strategic plan (currently being developed); support to consultations for the National Action Plan on Violence Against

Women (NAPVAW) (women living with HIV perspectives for inclusion within the NAPVAW).

- **Training and skills building in leadership and advocacy:** Development of a training curriculum on leadership and advocacy; at the national level, training on leadership and advocacy for the CCW’s members and women living with HIV representatives of partner organizations, and cascade training of women living with HIV in Kampong Cham and Battambang.

### **Commitment and action on gender equality and HIV at the national level**

- **Baseline audit:** Conducting a baseline gender audit and development of a capacity-building plan in 2010 around the capacity of the NAA and the MoWA to mainstream work on gender and sexuality.
- **Gender advisor positioned in the NAA:** From April 2010 to November 2012, a gender advisor was positioned in the NAA to coordinate important technical and capacity building activities linked to the integration of gender into the multi-sectoral HIV response.
- **Capacity development of the NAA:** Training on gender mainstreaming into the multi-sectoral HIV response through the development of training curriculum on gender-responsive budgeting (the training has yet to take place), development of a “Guideline for Mainstreaming Gender into the HIV response,” and visibility actions (advocacy briefs, TV debate).
- **Capacity development of the MoWA:** Trainings on the integration of HIV into gender activities and development of curriculum on mainstreaming HIV into gender; conducting policy dialogue/visibility actions and development of the Annual Work Plan for 2013.

## **3. Results of the Programme**

This section describes programme results that illustrate progress towards intended results associated with overall and specific objectives, as well as expected results. The results are based on the key outcomes, outputs or activities that interviewees noted and/or that the programme included in its reports on progress.

### **MoWA**

Stakeholders report that there is now stronger capacity in the MoWA to mainstream HIV into gender. The MoWA’s staff (especially senior management) became more aware of HIV and the need to integrate HIV into gender work. For this reason, they were more engaged in mainstreaming HIV in their programmes/activities. There is increased capacity and commitment within the MoWA to address cross-cutting issues, such as interconnections between violence and HIV. The MoWA has taken stronger ownership of gender equality in HIV work and of HIV in gender equality work by collaborating closely with the NAA to provide training to NAA and MoWA staff at different levels, and has participated in the development of NSP III.

These changes were enabled or facilitated by the following products, services, and activities, among others:

- In total, 153 MoWA staff and policy-makers have been trained on the integration of HIV into gender strategies, programmes and plans; and 30 District Committee on Women and Children focal points from 5 provinces were trained on gender and HIV/AIDS.
- A training curriculum on mainstreaming HIV into gender was developed and printed.

- The capacity of the MoWA Interdepartmental Committee on HIV/AIDS was strengthened through two trainings for committee members (25 persons) on gender, GBV, HIV/AIDS and monitoring and evaluation.
- Advocacy on gender and HIV/AIDS with high level policy-makers, including through a round table discussion event and a TV Debate on Gender and HIV/AIDS, in which also a woman living with HIV representative participated.
- Issues on gender and HIV were discussed in a debate/forum with 230 local authorities (commune/ Sangkat Council of Khan Daun Penh, Phnom Penh) in order to promote public awareness on gender, GBV and HIV/AIDS and mobilize strong support and participation from policy makers, authorities and society.
- Sensitization workshop on gender and HIV/AIDS was conducted for 24 MoWA policy makers to encourage them to respond to the commitment of the Cambodian government toward Three Zeros by integrating HIV/AIDS in gender programs.
- A 2013 Work Planner on Gender and HIV was developed and distributed at national and sub-national levels.

## NAA

The Programme Management Team (PMT), originally comprised of representatives from the NAA, the MoWA, the CCW, UN Women, UNAIDS and UNFPA, evolved into the National Committee on Gender Mainstreaming into HIV and AIDS Response (NCGHA) over the course of the programme. The NCGHA constitutes a national mechanism to ensure ongoing commitment to mainstream gender and HIV, and it includes members of civil society organizations and of community networks for people living with HIV and key populations at higher risk. The group also expanded to include the focal points from the NAA's seven national HIV working groups (prevention; care treatment and support; impact mitigation; effective leadership and management; legal and policies; monitoring and evaluation; and resource mobilization). The NCGHA is co-chaired by the CCW and meets regularly to enhance collaboration and consultation on gender equality issues among government, women living with HIV and CSOs.

The NAA is generally perceived externally as more responsive to the integration of gender equality into HIV policies and programmes, especially in the formulation of NSP III and in its efforts to achieve the “Three Zeros”. As interviews with NAA illustrated, this gender mainstreaming project was beneficial because it was based on results of gender audit, represented a joint effort between MoWA and CCW, and responded to the “Three Zeros” and the NSP 2011-2015, and also offered the possibility of building capacity at the grassroots level.

While there has been a reported increase in some NAA members' capacity and commitment regarding gender and HIV mainstreaming, there is a need to further strengthen the capacity of NAA staff as a whole to promote gender equality and women's human rights in HIV and AIDS. In addition, coordination within the NAA (across different departments and levels) needs to be strengthened in order to institutionalize commitment to gender equality and women's human rights (e.g., informants suggest that the concept of gender mainstreaming in HIV response has yet to be broadly applied).

*“The most appreciated aspect of the project is the capacity building program extended to grass root level in Sihanouk Vill, Keb, Kampot, KampongCham, Battambang, BattayMeanChey provinces. Gender and HIV/AIDS mainstreaming is the priority in the NSP and UN Women supported programme link with national system and respect NSP.”*

NAA representative

Many stakeholders appreciate that NSP III, which uses gender as a guiding principle, directly addresses gender norms and inequality that magnify the risk of HIV. Many of the programme partners interviewed believe that the successful integration of gender in NSP III results from the collective efforts of all

partners, rather than of the programme alone. Nonetheless, the gender advisor that the programme placed in the NAA helped catalyze actions on the integration of gender in NSP III, and assisted in collecting specific inputs from partners and building consensus on how to integrate gender equality issues in the NSP III. Partners consider that the programme has built synergies among stakeholders that help strengthen the NAA and the MoWA partnership and reinforce commitments to mainstream gender into existing policies and programmes on HIV and AIDS.

During the course of the programme, the NAA and the MoWA worked closely with the CCW. The level of collaboration was also evident at the provincial level. For example, the CCW in Battambang province was able to establish a Memorandum of Understanding with the Provincial Office of Women’s Affairs.

The following products, services and activities contributed to the results presented above, among others:

- In total, 120 persons trained on gender mainstreaming into the multi-sectoral HIV response, including focal points of NAA and 16 key line ministries from all the 24 provinces, as well as key HIV CSOs and local authorities from 7 provinces.
- A Training Curriculum and Guideline on gender mainstreaming in HIV/AIDS was developed.
- Training on gender-responsive budgeting was organized in collaboration with MoWA for 30 participants, including HIV focal persons of line ministries who are members of the Technical Advisory Board of the NAA, NAA GWG, representatives of MoWA Department of Health, women living with HIV representatives, and civil society representatives.
- A gender audit was conducted to analyze gender and HIV mainstreaming capacity within the NAA and the MoWA. The gender audit provides convincing evidence of political support and commitment to the integration of gender equality into the HIV response, and includes a capacity development plan.
- Gender specific inputs from key stakeholders, including government, civil society and development partners, were developed and integrated into the NSP III, with activities proposed for each of the 7 strategies of the NSP III with the gender adviser in NAA providing coordination and technical support to this process.
- A debate on Gender and HIV/AIDS was conducted with university students, televised on TVK (a national TV station).

## CCW

The consultations with stakeholders pointed to the stronger capacity of CCW members (e.g., members understand their roles, the organization’s vision and mission). The CCW was more visible and involved in various national committees (e.g., the CCW joined the government delegation to the Asia-Pacific High Level Intergovernmental Meeting).

There was also increased participation of women living with HIV in policy-making processes (e.g., CCW is co-chair of NCGHA, and CCW members provided inputs to NSP III and to NCGHA Action Plan). Members of the CCW

were invited by the MoWA and the NAA to participate in various public discussions and towards the end of the programme, to participate as experts in NAA and MoWA trainings on gender and HIV.

The women living with HIV consulted say that they now feel more confident and empowered to take on leadership roles (e.g., women

*“With support from the project the head of Self-Help Group and focal points have more leadership skills, more capacity on gender and have stronger commitment to work on gender and HIV. They are more courageous to talk about gender and HIV and to seek help in case of GBV; women living with HIV are brave to raise their voice through media TV or radio, and they also raise their challenges and needs to meeting of commune council.”*

Steering committee member, Kampong Cham

head Self-Help Groups - SHG), and the provincial focal points were able to organize meetings more effectively. They have a work plan for monthly meetings and are knowledgeable about the topics and techniques to facilitate meetings. As a result, members of SHG actively participated in meetings and found the SHG useful.

Women living with HIV in the community have increased understanding of their right to access services. They are also knowledgeable of gender inequality and gender norms and many have become so empowered as to challenge these issues in their everyday lives in a positive way (e.g., they are encouraged to seek services for gynecology or STIs, to engage in discussions on gender-based violence at home or in the community, and they have been able to support each other when needed).

*“The project has built capacity of women living with HIV to understand gender and HIV, leadership skills and to advocate for their need, for example, to raise concern to commune, district and provincial level, however, often local authorities did not pay attention to their concern, thus they raise their voice again and again. During the project support, the meetings of SHG members were conducted regularly and women living with HIV participated more in meeting to share knowledge and to follow up on any problem members of the group face, and to mobilize one voice to support each other in accessing health services, improving their livelihood or seeking help from commune.”*

Member of Self-Help Group, Battambang

The following activities, products and services illustrate the type of work that the programme carried out in Cambodia, which contributed to the above changes.

- The CCW enhanced collaboration with the CPN+, the NAA and other relevant NGOs to increase the voice of women at all levels of the public sphere.
- The CCW is co-chair of the NCGHA.
- The Guideline for Self-Help Groups (SHG) was developed and is used by members of SHG.
- A training manual on advocacy and leadership has been developed.
- In all, 80 women living with HIV, including members of the CCW and representatives of partner organizations, have been trained on advocacy and leadership.

## 4. Sustainability and Future Directions

The programme aimed to ensure continuity by strengthening government ownership and commitment around gender equality, women’s human rights and HIV, in addition to enhancing the leadership of women living with HIV. Stakeholders identified a number of key strategies and issues for sustainability:

- **Focus on NSP III.** Gender-responsive NSP III ensures long-term commitment to mainstreaming gender equality, women’s human rights and HIV, including the allocation of resources from the government, development partners and CSOs.
- **Coordinated policy discussion mechanism.** Transitioning from the NAA’s Programme Management Team into the NCGHA ensures ongoing consultation and coordination among partners involved and encourages monitoring of progress on mainstreaming gender and HIV.
- **Partnerships likely to continue.** The established partnership between the NAA, the MoWA and the CCW ensures engagement of rights holders and duty bearers in the process of gender-responsive policy/strategy development to address the HIV epidemic.
- **Government budget allocations.** The NAA’s and the MoWA’s commitment to integrating gender equality in the HIV response is stated in their policy and action plan. The MoWA and the NAA have allocated national budgets for gender and HIV activities (such as meetings and advocacy events with policy-makers). However, cuts in the national budget (allocated for NAA) could affect the implementation of activities and policy actions related to mainstreaming gender

and HIV. The NAA’s GWG is also funded through a limited allocation from the national budget.

- **Gender advisor position likely to be reintroduced in the NAA.** The NAA wishes to reintegrate the gender advisor position at the national level in order to have a staff dedicated to the coordination of the activities and programming linked to the integration of gender in the HIV response. The organization has included a request for funding of this position in a proposal it has submitted to the Global Fund.
- **Continuing the “One UN” approach to gender and HIV issues in Cambodia.** UN Women coordinated with UN agencies to ensure synergy of efforts to address gender equality, women’s human rights, HIV and capacity building of women living with HIV and key affected populations networks.
- **Long-term support for people living with HIV networks, including CCW.** Multi-year funding is a key issue for women living with HIV networks, including the CCW. The lack of core and operational funding makes it difficult for these networks to maintain human resources as well as implement activities. Long-term financial and technical support from donors to people living with HIV networks, including CCW, will be required to strengthen collective advocacy by organizations of people living with HIV in the context of HIV and gender policy formulation processes, with specific attention to ensuring the needs and strategic interests of women living with HIV are accounted for.

## Appendix II Country Profile: Jamaica

### 1. Country Context

#### State of the epidemic in Jamaica

Jamaica has gone through an increase of HIV cases over the past five years: out of a total population of 2,705,800, approximately 1.7% of the adult population (or 32,000 people) were living with HIV in 2011,<sup>6</sup> compared to 27,000 in 2008.<sup>7</sup> The HIV epidemic is concentrated in the most urbanized parishes (St. James, Kingston, and St. Andrews) and in tourist areas (North Western parishes). HIV prevalence is higher among populations such as men who have sex with men (32.8%), sex workers (4.1%), and homeless people (12%). In Jamaica, the HIV epidemic is closely tied to poverty, developmental and sociocultural issues including the slow rate of economic growth, high levels of unemployment, early sexual debut, culture of multiple partnerships, and informal drug and commercial sex sectors.<sup>8</sup>

According to available data, the HIV epidemic in Jamaica is going through a feminization process. In 2009, among the 10 to 19 age group, the male-female infection ratio was 1 male for every 2.84 females.<sup>9</sup> In 2011, approximately 10,000 women aged 15 or older<sup>10</sup> (or 31% of people living with HIV) were living with HIV in Jamaica. Although AIDS case rates among men exceed AIDS case rates among women, the difference is narrowing.<sup>11</sup> Indeed, studies show that male to female transmission is more likely than female to male transmission.<sup>12</sup> Further, Jamaica's rape rate is significantly higher than the global average (51 per 100,000 as opposed to 15 per 100,000 globally), which in turn perpetuates the exposure and vulnerability of Jamaican women to HIV/AIDS.<sup>13</sup> As indicated in Jamaica's 2012 Country Report to UNAIDS, "[h]armful gender norms such as masculine dominance and feminine submission, cross generational sex, multiple partners, gender based violence and homophobia are important factors in Jamaica's HIV epidemic."<sup>14</sup> Interviews conducted with key actors involved in the national HIV response in Jamaica pointed to a series of factors facilitating the spread of HIV infection among girls and women: dominant ideas of masculinity demand that men be strong, in control of women and sexually aggressive; traditional views of acceptable femininity that value sexual innocence and submissiveness, which can impede women's ability to demand or negotiate safe sex practices, such as condom use; societal norms and popular culture, which encourage young men into early sexual initiation and multiple intimate partnerships as signs of heterosexual virility; the rejection of condom use because it is considered as limiting sexual pleasure; and women are expected to be 'faithful' and insistence on condom use can be viewed as implying infidelity or 'loose' sexual standards. This expectation of censure can act as a barrier for women to exercise their right to protection.

In terms of programme implementation, challenges also include unwillingness to seek health care in relation to HIV/AIDS (due to denial as well as fear of stigma, of being scorned or of violence). Other women simply cannot afford transportation to access services, or are confronted with an unsupportive healthcare environment as well as significant delays in obtaining test results or medication. The vicious

<sup>6</sup> Jamaica National HIV/STI Programme (2012). *Country Progress Report Jamaica*, 70 p.

<sup>7</sup> National HIV/STI Programme, Jamaica (2010). *UNGASS Country Progress Report: 2010 Reporting – January 2008-December 2009*, 60 p.

<sup>8</sup> Jamaica National HIV/STI Programme (2012). *Country Progress Report Jamaica*, 70 p.

<sup>9</sup> National Gender Task Force. (2009). *Vision 2030 Jamaica – National Development Plan: Gender Sector Plan*, p. 22.

<sup>10</sup> UNAIDS. "Jamaica", *UNAIDS website*, available at: <http://www.unaids.org/en/regionscountries/countries/jamaica/>

<sup>11</sup> Jamaica National HIV/STI Programme (2012). *Country Progress Report Jamaica*, 70 p.

<sup>12</sup> National Gender Task Force. (2009). *Vision 2030 Jamaica – National Development Plan: Gender Sector Plan*, p. 22.

<sup>13</sup> Jamaica AIDS Support for Life, UN Women & European Commission (2012). *Human Rights Issues Confronted by HIV Positive Women in Jamaica*, Kingston, 53 p.

<sup>14</sup> National HIV/STI Programme (2012). *Country Progress Report Jamaica*, p. 25.

cycle therefore continues: while HIV infection increases Jamaican women's vulnerability to violence, violence against women can contribute to spreading HIV/AIDS.<sup>15</sup>

## Jamaica's response to HIV and AIDS

Existing normative, legal and policy frameworks at the international, regional and national level create an enabling environment in Jamaica for gender mainstreaming in the HIV response.

Jamaica is signatory to a series of international commitments on HIV/AIDS and gender equality, such as the Declaration of Commitment on HIV/AIDS (2001), the Political Declaration on HIV/AIDS (2006) and recommitment in 2011, the ILO Code of Practice on HIV and the World of Work (2001), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), the Programme of Action of the International Conference on Population and Development (1994), the Beijing Declaration and Platform for Action (1995), as well as the UN Millennium Declaration and the Millennium Development Goals (2000).

At the regional level, Jamaica is part of the Pan-Caribbean Partnership against HIV & AIDS (PANCAP), a partnership established by the Caribbean Community (CARICOM) in 2001. The PANCAP's Regional Strategic Framework for HIV/AIDS (2008-2012) emphasizes gender issues and key populations at higher risk as a way of recognizing the changing epidemiological profile of the epidemic in the Caribbean. It also pinpoints Caribbean gender roles as a contributing factor to the spread of HIV and identifies the integration of gender equality into national and regional HIV responses among expected national results. A guiding principle of the regional strategy, which focuses on key populations at higher risk, is that of inclusiveness and greater involvement of people living with AIDS (GIPA) in the design, implementation, monitoring and evaluation of the national response to HIV. However, the strategy does not explicitly identify women and girls as a key population at higher risk.

At the national level, Jamaica has fairly strong normative and policy frameworks related to the promotion of gender equality, gender mainstreaming, and the response to the HIV epidemic. The Gender Sector Plan, intended to operationalize the national development plan (*Jamaica 2030*), includes a gender action plan that highlights gender mainstreaming as one of the key strategies for achieving gender equality. A National Policy for Gender Equality was recently developed (2011) and includes HIV and AIDS as an area to study. Finally, and also with UN Women's support, the Bureau of Women's Affairs is developing a National Strategic Action Plan to Eliminate Gender-Based Violence, which will soon be submitted to the Cabinet for approval. The plan is also expected to outline HIV and AIDS issues as they relate to gender-based violence. Furthermore, political commitment to respond to the HIV epidemic is reflected in several key documents, such as the National HIV/AIDS Policy (2005), the Declaration of Commitment to Eliminate Stigma, Discrimination and Gender Inequality affecting Jamaica's HIV and AIDS Response (2011), the National HIV Strategic Plan 2012-2017,<sup>16</sup> and *Jamaica 2030*.

Work on gender mainstreaming in the national HIV response in Jamaica (and more generally in the Caribbean) is not new. In 2006, UNIFEM led an inter-agency project on *Capacity Building for Mainstreaming Gender Analysis into HIV/AIDS Programming in the Caribbean*. The programme built on this experience and aimed to address a challenge that emerged from the consultation process held for the National Strategic Plan for HIV and AIDS:<sup>17</sup> “the absence of broad understanding of gender among

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<sup>15</sup> Jamaica AIDS Support for Life, UN Women & European Commission. (2012). *Human Rights Issues Confronted by HIVPositive Women in Jamaica*, Kingston, 54 p.

<sup>16</sup> At the time of data collection in Jamaica, the National HIV Strategic Plan 2012-2017 was still in draft form. The National HIV Strategic Plan 2012-2017 (subsequent to the 2007-2012 plan) articulates the response to HIV according to the following components: enabling environment and human rights; prevention; treatment, care and support; monitoring and evaluation; governance and empowerment; and sustainability.

<sup>17</sup> UNIFEM Caribbean Office. (2007). *Capacity Building for Mainstreaming Gender Analysis in HIV and AIDS Programming in the Caribbean. Gender Checklist and Indicators for HIV and AIDS Policies and Programmes*.

stakeholders (including NAC staff) who have limited skills to conduct gender analysis.” The consultation process also revealed “[r]eluctance to review NSP from a gender perspective (Jamaica) after having had a consultation process and effort being made to integrate gender.” In its regional strategic framework (2008), the PANCAP noted that “[i]n spite of great efforts made by the countries over the last five years, the human resource capacity is insufficient with respect to number, skills, and various competencies. There is a need to ensure that all pre-service tertiary training adequately addresses the knowledge and skills required to prevent HIV infection and, where relevant, equips trainees to provide gender-sensitive non-discriminatory HIV services in the health, education, legal, social welfare, and other sectors.”<sup>18</sup>

In Jamaica, there are more than 100 key stakeholders involved in the HIV national response. The response thus far has focused on men having sex with men and sex workers. It receives support from the Global Fund to Fight AIDS, Tuberculosis and Malaria<sup>19</sup> and is guided by the National HIV/STI Control Programme (NHP), under the Ministry of Health. However, interviews conducted in Jamaica revealed that the country’s National AIDS Committee (NAC) is having difficulty covering the operating costs of coordinating the multi-sectoral response to HIV and AIDS. As a result, the NHP is playing part of the coordination role in the HIV response. Other key actors are the Ministry of Labour and Social Security, the Jamaican Network of Seropositives (JN+), Jamaica AIDS Support for Life (JASL), the Jamaica Independent Council of Human Rights, UNAIDS and the UN Theme Group on HIV/AIDS.<sup>20</sup> The Jamaica Business Council on HIV/AIDS (JaBCHA) is working to mobilize resources in the private sector and started a foundation to this effect (JaBCHA National Foundation) in 2011 to further sustain efforts.

According to a mapping exercise conducted in the framework of the programme, only two NGOs specifically target women living with HIV: the Jamaica Community of Positive Women (JCW), established in 2010 and registered as a NGO in early 2013; and Eve for Life, established in 2008 and registered as a NGO in 2009.

## 2. Evolution of the Programme

### Key Implementing Partners

Un Women signed agreement letters with the Jamaica National HIV/STI Control Programme (NHP) for implementing the component on strengthening the NAC’s capacities, and with the NGO Jamaica AIDS Support for Life (JASL) for the component on empowering women living with HIV and their organizations. National facilitators, trainers, and consultants were hired for delivering many of the planned capacity strengthening activities.

### From UNIFEM to UN Women: Role of Focal Point

The UNIFEM sub-regional office for the Caribbean (the UN Women Multi-Country Office for the Caribbean, since 2012), located in Barbados, was responsible for monitoring the programme. A focal point was identified to provide regular monitoring and reporting on the programme, in addition to her other tasks. Unlike the other four programme countries, UN Women did not have a country-based presence in Jamaica, and as such, the monitoring of day to day work was done virtually and via

<sup>18</sup> Caribbean Community (CARICOM) and Pan Caribbean Partnership against HIV/AIDS (PANCAP). (2008). *Caribbean Regional Strategic Framework on HIV and AIDS 2008-2012*, 78 p.

<sup>19</sup> The Global Fund has been one of the major donors in Jamaica for HIV and AIDS, with a total in-country investment of USD 62,149,769 between 2004 and 2013. (The Global Fund. “Investing in: Jamaica,” *The Global Fund website*. available at: <http://portfolio.theglobalfund.org/en/Country/Index/JAM>, visited on August 13, 2013)

<sup>20</sup> Jamaica AIDS Support for Life, UN Women & European Commission. (2012). *Organizations that Offer HIV-Related Services and Programmes to Women and Transgender in Jamaica - A Mapping Exercise*, Kingston, 71 p.

monitoring missions. UN Women is now placing a full time programme person in Jamaica to support overall programming in the country.

## Funding and Implementation Period

The programme was officially launched in January 2009, but implementation only started six months later. Delays were caused by the scheduling of the global Programme Inception and Planning Meeting several months after the programme start-date, slow receipt of funds by partners in Jamaica (as cheques were not collected from the UNDP office until the end of January/early February 2010), the replacement of JASL Executive Director (who had resigned), and challenges in identifying a suitable candidate for the position of gender advisor. The programme ended in March 2013. The total amount allocated to Jamaica was approximately USD 500,000.

## Programme Strategies and Key Activities

Capacity development was a key strategy used to support gender mainstreaming within the NHP, as well as the empowerment of women living with HIV. Capacity development was conducted through sensitization and training workshops, the placement of a gender advisor within the NHP to coordinate the gender equality mainstreaming initiatives, and the development of reference materials. A number of activities were carried out between 2009 and 2013, including:

### Leadership and advocacy of women living with HIV

- ***Sensitization and training workshops for women living with HIV:*** Sensitization and trainings on personal development, life skills, gender, HIV and human rights, advocacy, and the use of media and communication tools for advocacy purposes. Training workshops were also held on facilitation and leadership skills. A total of three trainings were conducted for women living with HIV.
- ***Business development and education grants:*** Training workshop to develop income generating activities, followed by the provision of business development and education grants to 68 women living with HIV.
- ***Advocacy symposium for women living with HIV:*** Symposium on gender and human rights issues for women living with HIV, outlining an advocacy plan for women living with HIV to incorporate priority issues and actions into their work.

### Commitment and action on gender equality and HIV at the national level

- ***Gender advisor positioned in the NHP:*** Placement of a gender advisor in the NHP, not only to manage capacity development activities, but also to support gender mainstreaming within NHP.
- ***Sensitization and training workshops for NHP staff:*** Following the sensitization workshop, the programme supported the training of NHP staff and their partner organizations on gender mainstreaming. The training consisted of a training workshop, a summer course on gender mainstreaming given at the University of West Indies in Jamaica, and finally, a training of trainers refresher workshop.
- ***Capacity building of gender focal points:*** Workshop on gender mainstreaming for gender focal points (previously trained by the Bureau of Women's Affairs) from various ministries and government agencies, held in collaboration with another project funded by UN Women's Fund for Gender Equality.

- **Gender budget analysis:** Analysis of the National Strategic Plan/Operational Plan focused on prevention and policy programming. To the knowledge of the evaluation consultant, at the time of the field visit in Jamaica, no actions had been taken yet by NHP to follow up on the findings from the gender budget analysis because of the process of merging the NHP with the Family Planning Board.

### 3. Results of the Programme

This section describes programme results that illustrate progress towards intended results associated with overall and specific objectives, as well as expected results. The results are based on the key outcomes, outputs or activities that interviewees noted and/or that the programme included in its reports on progress.

#### National policies, programmes and actions to address HIV

The programme contributed to policy-related results. Stakeholders interviewed agreed, for instance, that it was thanks to the programme that the *2011 Declaration of Political Commitment for the Elimination of Stigma, Discrimination and Gender Inequality* signed by the Prime Minister and the leader of the opposition party contained a reference to gender inequality. Additionally, two or three women living with HIV took part in consultations for the drafting of the National HIV/AIDS Strategic Plan 2012-2017, held by the NHP. The programme enabled these women to attend the consultation and speak in public.

#### NHP

Approximately 200 NHP staff and sub-recipients were trained on gender mainstreaming in HIV. Interviewed trainees reported to have gained a better understanding of the concept of gender and of the different effects that HIV programmes have on men and women as a result of the social construct of gender. Interviewed NHP staff mentioned having used this knowledge to improve the quality of their work (i.e. better capacity to support organizations/individuals) and provided examples where they used the knowledge and awareness acquired during the training activities on gender mainstreaming in their work (see sidebar). The knowledge acquired also enabled them to contribute to develop a more gender-sensitive National HIV Strategic Plan 2012-2017. However, they felt they didn't have yet the adequate tools and systems to measure whether NHP's organizational capacity for gender mainstreaming had improved as a result of the programme.

*“The programme increased my awareness and sensitivity to the issue and I started recognizing it as an issue and not as ‘things of life’”*

NHP staff

Further, using the feedback received from the Project Steering Committee, the NHP and JASL jointly developed a number of reference materials on HIV and gender mainstreaming,<sup>21</sup> as well posters and a docudrama.<sup>22</sup> Respondents saw the registry and the training materials as the most useful of these products. However, the extent to which the other products were disseminated among programme stakeholders and other national actors remains unclear.

<sup>21</sup> Human Rights Issues Confronted by women living with HIV in Jamaica; The Personal Development Needs and Realities of HIV Positive Women in Jamaica; Organizations that offer HIV and related services and programmes to Women and Transgender in Jamaica: A Mapping Exercise; Collection of Training Curricula for Women Living with HIV in Jamaica; A Handbook for New Entrepreneurs; Directory of Services: for the empowerment of women; National HIV/STI Programme, Ministry of Health, UN Women, European Commission. (2012). *Jamaica 2012 Registry of Gender Equality and HIV Resource Persons and Agencies*, Kingston.

<sup>22</sup> —. (2012). *Bundle Distress*. Video. Retrieved July, 2013 from <http://youtu.be/wDoD0LEkbiM>

## JASL

Representatives from the organization involved in the implementation of the programme agreed that the programme had contributed to their organization mainly by increasing: i) their awareness on gender inequality and its consequences on the HIV infection, and ii) their knowledge of the concepts of gender, gender inequality, masculinity, femininity and power relations, and on how the gender construct affects the relationships between men and women. As a result of it, the interviewed representatives felt that JASL has gained a better understanding of considerations specific to different groups (including women living with HIV, men who have sex with men, and sex workers). In their programming, this has resulted in the introduction of these concepts and understanding in their peer-educator programme.

### Examples of use of knowledge on gender equality mainstreaming by NHP staff

Monitoring indicators for NHP programmes are being revised as an indirect result of the increased awareness raised by the programme among NHP staff on gender mainstreaming in the national HIV response.

Thanks to the training funded by the programme, an NHP respondent is now able to have more detailed and informative discussions with companies to ensure they comply with the ILO Code of Practice on HIV and the World of Work. The informant also mentioned that gender is now included as a topic in the training curriculum on sexuality her unit delivers to companies to ensure that their programmes and policies are gender sensitive.

Following the training, an NHP informant has started making a deliberate effort to ensure that the media campaigns on HIV prevention include targeted messages for both men and women.

Moreover, interviewed representatives felt that JASL had been strengthened as an organization working for the promotion of gender equality in the national HIV response as the project coordinator - by going through the different capacity development activities conducted by the programme - has acquired enough knowledge to become JASL's gender and advocacy officer (this position was created as a consequence of the programme).

Furthermore, JASL representatives attributed recent discussions started with a couple of other Jamaican NGOs working on issues related to gender equality and gender-based violence to the programme as it increased the organization's visibility.

*"We are a socially-led entity – we recognized gender inequality (negotiation for using condoms, etc.) but we did not call it like that. Now we are able to put a name on it"*

JASL representative

Reports from the high-level dialogues organized by JASL include a total of forty-seven declarations of commitment<sup>23</sup> signed by various organizations (including media, parliament members, faith-based organizations, women's organizations, and cultural leaders) to reaffirm their decision to participate in the response to HIV and AIDS and raise awareness. According to JASL, ten of the 47 commitments have been fulfilled.

<sup>23</sup> Examples are: an NHP intervention officer committed to conduct sensitization of healthcare workers on stigma and discrimination; the executive member of the Jamaican pharmaceutical association committed to sensitize the membership on issues affecting women living with HIV; a member of the Parliament committed to encourage other members to support community HIV sensitization; and a representative from the media committed to give a voice to the persons who are affected by HIV and to educate the general public on how to reduce discrimination as well as prevention of HIV.

## Women living with HIV and other organizations advocating for women living with HIV

The various types of capacity building and support provided by the programme had a variety of effects on trained women living with HIV. According to the interviews conducted with 9 of the 79 trained women and as also reported by other stakeholders (trainers, facilitators, NHP staff) who had the opportunity to exchange with and observe these women, the most important results of the programme included: i) increased awareness

of human rights and gender equality related issues, as well as acquired knowledge of their rights (e.g. to have a child, to refuse abortion, to have sexual relationships), which they had

*“We learned about the difference between gender and sex. We talked about gender variation. Gender is how society thinks, sex is the biological aspect. I heard it before but now I have a full understanding of it. I didn’t know about that before.”*

Trained woman living with HIV

often been denied due to their HIV status; ii) increased level of self-esteem and confidence; and iii) acquired some advocacy skills, such as writing (catchy) letters to local or national authorities to advocate for changes in policies or practices. Stakeholders interviewed provided as evidence of these results the fact that, following the programme, two trained women living with HIV became President and Vice-President of the Jamaica Network of Seropositives’ (JN+) Executive Board; at the request of the Ministry of Health (MOH), selected women living with HIV trained by the programme were involved in a training session for health workers; and between three and six trained women living with HIV contributed to radio programmes, magazines, and public events related to HIV. In addition, some of the trained women started participating in policy-making processes (e.g. in three high-level dialogues with parliamentarians, media, faith-based organizations, women’s organizations and cultural leaders) and in international and regional events (e.g., participation of two trained women living with HIV in the World AIDS Conference in Washington, D.C. in 2012 and of three women living with HIV in the 2013 Caribbean Conference on Domestic Violence and Gender Equality, in Tobago).

One of the most important results mentioned by stakeholders interviewed was the success obtained by a group of trained women living with HIV in advocating for the change of discriminatory practices in a health clinic: nurses in a health centre in St. James, who used to wear t-shirts with the HIV logo, now dress like the other nurses so that people living with HIV cannot be easily identified by other patients at the clinic. Other advocacy efforts were also undertaken by trained women living with HIV with the support of the programme, such as sensitization of nurses, writing a joint letter for the decentralization of health services to improve access for small communities, and advocating for greater access to condoms.

Another area where the programme showed some contribution is the area of economic empowerment. Thanks to business development grants and training, 15 women living with HIV started small income-generating activities, such as cattle rearing or selling clothes, soap and other products. Women living with HIV interviewed during a focus group reported to have increased their economic independence thanks to the income-generating grant received through the programme.

Finally, an important (and unintended) result of the programme was the capacity strengthening of facilitators and trainers. Interviewees mentioned that the programme had been a formative experience and that they had already applied their new knowledge and awareness to some of the HIV-related initiatives in which they were involved. This is an important spillover effect of the programme, since some of these initiatives are likely to reach influential actors (such as the HIV-related programme implemented by Women’s Media Watch with faith-based organizations) as well as future professionals, policy makers and youth in the country and region (such as the institutionalization of the “Gender, Sexual and Reproductive Health and HIV/AIDS” course given by the Institute of Gender Development Studies at the University of West Indies).

## 4. Sustainability and Future Directions

Through the work conducted by the NHP and JASL, several elements emerged that are likely to support the sustainability of some of the achieved results. These include, among others, political will shown through the *Declaration of Commitment to Eliminate Stigma, Discrimination and Gender Inequality affecting Jamaica's HIV and AIDS Response* (2011), expressed willingness of many trained women living with HIV to engage in advocacy activities, and reference materials (training manuals, studies, etc.) developed with the programme's support. Moreover, at the time of the field visit to Jamaica, both JASL and the NHP were seeking additional funding from the UN Trust Fund to End Violence against Women to continue their work on HIV and gender equality. According to the most recent information received from UN Women during the phase of revision of the main evaluation report and country profiles, JASL has been awarded approximately USD 505,115 over 3 years by the UN Trust Fund to End Violence against Women.

Moving forward, a number of suggested actions were identified by interviewed stakeholders and/or emerged from the analysis of collected data:

- **Collaborating with other UN agencies.** The UN Women Multi-Country Office for the Caribbean should support the programme implementing partners in collaborating with other UN agencies working on HIV and/or gender equality so as to promote buy-in or uptake of some of the programme's activities or results.
- **Building on results achieved.** For JASL, this would include following up on the implementation of the 47 signed declarations of commitment and supporting trained women living with HIV in their advocacy efforts. In the case of the NHP, resources must be allocated in order to maintain a permanent gender specialist position as well as to continue capacity development in gender mainstreaming. In particular, the NHP and its partners must better understand the practical implications of gender mainstreaming from an organizational and programmatic point of view (e.g., the most effective strategies for mainstreaming gender in an organization, as well as the human and financial resources and systems required to make gender mainstreaming effective).
- **Ongoing support for the empowerment of women living with HIV.** Programme implementing partners and other actors working on HIV and/or gender equality should continue to support the empowerment and capacity development of trained women living with HIV, in particular the reinforcement of their leadership and advocacy skills as well as their resource mobilization capacity. This can be done via training activities as well as other capacity development strategies (e.g. mentoring, coaching, peer-to-peer learning, etc.).
- **Ongoing support for the strengthening of people living with HIV organizations.** Programme implementing partners and other actors working on HIV and/or gender equality should continue strengthening organizations of people living with HIV in order to increase their cohesiveness and ability to speak with one voice.
- **Disseminating advocacy materials and tools.** Programme implementing partners should develop strategies and identify resources for disseminating the Declaration of Commitment and raising awareness around it, in order to transform it into an advocacy tool for policy change. Programme implementing partners should also develop strategies and identify resources for disseminating and regularly updating the reference materials produced.

## Appendix III Country Profile: Kenya

### 1. Country Context

#### State of the epidemic in Kenya

The HIV epidemic in Kenya is generalized as well as concentrated, which means that HIV affects all sectors of the population and is concentrated among the key populations at higher risk (i.e. sex workers, men who have sex with men and people who inject drugs). However, prevalence varies according to location, gender and age. For example, HIV prevalence among females (8%) is nearly twice that among males (4.3%).<sup>24</sup>

Since Kenya recorded its first case of HIV in 1984, the HIV epidemic has evolved to become one of the central impediments to national health, wellbeing and development.<sup>25</sup> By 1987, HIV appeared to be spreading rapidly among the population, with an estimated 1-2% of adults in Nairobi living with HIV.<sup>26</sup> Among pregnant women living in the capital city, HIV infections significantly increased from 6.5% to 13% between 1989 and 1991.<sup>27</sup> HIV prevalence in the country is believed to have peaked between 1995 and 1996 at 10.5%, and it subsequently fell by 40%, remaining relatively stable for the last several years.<sup>28</sup> By 1994, an estimated 100,000 Kenyans had already died from AIDS and around one in ten adults were living with HIV.<sup>29</sup>

Nearly half of all new infections in 2008 were transmitted heterosexually while in a relationship, and 20%, during casual heterosexual sex.<sup>30</sup> Overall, 78% of Kenyans engaged in sexual partnerships do not know whether or not they are infected.<sup>31</sup> Consequently, couples often enter marriage without knowing that their partner is living with HIV. Between 8 and 12% of adults living with HIV who are engaged in a relationship transmit the virus to their partner annually.<sup>32</sup>

Various studies have also revealed a high HIV prevalence among a number of key affected groups, including sex workers, people who inject drugs, men who have sex with men (MSM), truck drivers and cross-border mobile populations. For example, an estimated 3.8% of new HIV infections are among people who inject drugs, 15.2% among MSM, and 18% among truck drivers.<sup>33</sup> Some of these groups are marginalized within society, and their practices are considered criminal. They therefore face difficulties in accessing HIV prevention, treatment and care services. Moreover, even though HIV transmissions can easily be prevented in healthcare centres, 2.5% of new HIV infections in Kenya occur in health facilities.<sup>34</sup>

<sup>24</sup> Kenya National Bureau of Statistics (2010)

<sup>25</sup> Kenya National AIDS Control Council. (2013). *The Kenya AIDS Epidemic - Update 2012*.

<sup>26</sup> AIDS Newsletter (1987). "Kenya", Item 254, April 10.

<sup>27</sup> Ayisi, J.G. *et al.* (2000). "Risk factors for HIV infection among asymptomatic pregnant women attending an antenatal clinic in western Kenya", *International Journal of STD & AIDS*, 11 (6), pp. 393-401.

<sup>28</sup> Kenya National AIDS Control Council. (2013). *The Kenya AIDS Epidemic - Update 2012*.

<sup>29</sup> AIDS Newsletter. (1994). "Economic Impact in Kenya", Item 46, May 23.

<sup>30</sup> Lupia, R. & S.-C. Chien (2012). "HIV and AIDS Epidemic in Kenya: An Overview", *Journal of Experimental and Clinical Medicine*, 4 (4), pp. 231-234.

<sup>31</sup> Kenya AIDS Indicator Survey. (2007). *Fact Sheet*.

<sup>32</sup> Kaiser, R. *et al.* (2011). "Factors Associated with HIV Infection in Married or Cohabiting Couples in Kenya: Results from a Nationally Representative Study," *PLoS One*, 6 (3), pp. 1-9.

<sup>33</sup> Kenya National AIDS Control Council. (2013). *The Kenya AIDS Epidemic - Update 2012*.

<sup>34</sup> Kenya National AIDS Control Council (2012). *The Kenya AIDS Epidemic – Update 2011*, Nairobi, 123 p.

Despite the increased availability of antiretroviral treatments, Kenya projects a relatively modest decline in HIV prevalence between 2007 and 2013. It is even expected that the number of individuals living with HIV will increase, nearing 1.8 million by 2015.<sup>35</sup>

## Kenya response to HIV and AIDS

In 1997, the Government of Kenya produced a Sessional Paper on AIDS in Kenya (No. 4) that laid down strategies for prevention and management of HIV and AIDS epidemics, followed two years later by the declaration of HIV and AIDS as a national disaster. To follow up on this declaration, in 1999, the Government established the National AIDS Control Council (NACC) within the Office of the President to coordinate the national response to the epidemic.

An important step in establishing a rights-based framework for an effective HIV response occurred in 2006, when the Government enacted the HIV and AIDS Prevention and Control Act. The law formally protects the rights of people living with HIV, makes it illegal for employers to discriminate on the basis of a person's HIV status, prohibits mandatory HIV testing, and forbids insurers from withholding services to people living with HIV or from imposing discriminatory premiums on them. In addition, an HIV/AIDS Equity Tribunal was inaugurated two years ago, and was the first of its kind. The tribunal has plans to devolve its functions to communities.

Since then, Kenya has reiterated its national commitment to addressing HIV and gender inequalities, as illustrated by the signature of major international agreements related to gender equality, human rights, and HIV/AIDS, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the 2011 Political Declaration on HIV/AIDS. The Government of Kenya has also included gender equality in the *Kenya National HIV and AIDS Strategic Plan 2009/10-2012/13*, and has developed various policies and guidelines to support programme planning and implementation with respect to specific aspects of the HIV response: the *Mainstreaming Gender in HIV Responses in Kenya: National Action Plan 2009/10-2012/13*, the *National Guidelines for Prevention of Mother- to-Child HIV/AIDS Transmission* (2000), the *National Reproductive Health and HIV and AIDS Integration Strategy* (2009), and the *National Reproductive Health Policy* (2007). These normative frameworks aim to ensure that Kenya's HIV response is aligned with the actual and real challenges faced by women and men affected by and living with HIV.

## 2. Evolution of the Programme

### Key Implementing Partners

The programmes' implementation involved two main types of partners:

- The National AIDS Control Council, which was responsible for leading the gender mainstreaming process in the NACC, including the organization of the national leadership conference for women living with HIV, and the development of gender-sensitive action plans and annual reporting formats.
- Civil society organizations of, or advocating for, women living with HIV, which were responsible for the work around leadership and advocacy of women living with HIV. These organizations empowered women living with HIV through capacity-building and self-help/support groups.

A baseline survey that mapped networks of women's organizations working on HIV was undertaken at the start of the programme. The baseline was carried out to guide targeted CSO partner selection, but also sought to identify successful programmes and activities, notably elements that could be replicated or

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<sup>35</sup> Kenya National AIDS Control Council. (2013). *The Kenya AIDS Epidemic - Update 2012*.

adapted in different settings. In addition, the survey aimed to outline gender dynamics that fuel the epidemic, including socio-cultural systems and structures that sustain high levels of risk among women.

A call for proposals followed the survey and served to find an appropriate combination of implementing partners for programme rollout. Eight organizations, each with different levels of experience, strengths and areas of outreach (oriented for instance toward religious communities, health, political advocacy or self-help) were selected: the Network of People Living with HIV in Kenya (NEPHAK), the Kenya Network of Religious Leaders Living with or Personally Affected by HIV (KENERALA+), Women Fighting AIDS in Kenya (WOFAK), the Health Rights Advocacy Forum (HERAF), WISUVIE Self Help Group, Lean on Me, Samoei, and the Kenya Voluntary Women Rehabilitation Centre (KVOWRC). These organizations were convened in an inception meeting to develop a common understanding of the purpose of the programme.

*“The Inception meeting with all partners under the programme enabled each organization to identify their comparative advantage in rolling out the activities. It was an efficient way of prioritizing and determining how resources would be allocated.”*

Implementing partner representative

## From UNIFEM to UN Women: Role of Focal Point

At the commencement of the programme, there was no dedicated UN Women staff for the project, and the recruitment of a focal point was completed one year later. A UN Women staff member backstopped for the initial groundwork. Due to the difficulties faced in the recruitment process, in February 2011, UN Women Kenya Country Programme decided to combine the gender advisor position (based in the NACC) with the focal point role of the programme. UN Women and the NACC agreed to this dual responsibility so that adequate support could be provided to both organizations.

## Funding and Implementation Period

Overall, Kenya was allocated approximately USD 435,000 to implement the programme, from January 2009 to March 2013. There were delays in programme start-up due to a willingness to align the programme with UNAIDS Joint Programming in the country and difficulties surrounding the recruitment of a gender advisor for the NACC and a UN Women focal point. Moreover, because the mapping exercise and call for proposals constituted a lengthy process, selected partners only had six months to implement activities.

## Programme Strategies and Key Activities

The following strategies and activities aimed at reaching the specific programme objectives:

### Leadership and advocacy of women living with HIV

- **First national leadership conference for women living with HIV:** The NACC, in collaboration with the NEPHAK+, organized the “Championing women’s leadership to end AIDS” conference for organizations of women living with HIV and women advocates to convene in order to prioritize issues and develop their vision and agenda for advocating gender equality in the HIV response.
- **Trainings and skills-building sessions:** Trainings on rights, lobbying and advocacy were provided to women living with HIV, so that they could ably engage in monitoring progress made in meeting national commitments and targets on mainstreaming gender equality in the HIV response.

- **Support to women living with HIV organizations to improve their proposal development/ budgeting and financial skills:** This activity involved one-on-one financial trainings with CSOs of, or advocating for, women living with HIV, as well as sharing of information about calls for proposals and guidance on proposal submissions.

### Commitment and action on gender equality and HIV at the national level

- **Gender advisor positioned in the NACC:** A gender advisor was positioned in the NACC to strengthen and mainstream the integration of gender equality in the HIV response, with a specific focus on the promotion of leadership and participation of organizations of women and people living with HIV. The advisor was responsible for developing core capacities of national AIDS coordinating mechanisms to promote human rights and gender equality in the HIV response. This included supporting the development of training resources as well as dissemination of the *National Action Plan for Gender Mainstreaming in the HIV Response in Kenya* to all counties.
- **Capacity development of the NACC:** This group of activities included trainings on gender mainstreaming in the national HIV response, as well as the design of an online training tool to expand the reach of the gender guidance and training and to support on-going learning within line ministries involved in the HIV response.
- **High-level dialogues and partnerships development:** Dialogues were organized and partnerships were forged between the NACC and other governmental institutions/actors (e.g. national women’s machineries, other line ministries, and parliamentarians), key international donors (e.g. decision-makers within the Global Fund’s Country Coordinating Mechanism), as well as gender champions, leaders, and advocates from groups of women living with HIV, women’s organizations, and men’s groups working on gender equality.

## 3. Results of the Programme

This section describes programme results that illustrate progress towards intended results associated with overall and specific objectives, as well as expected results. The results are based on the key outcomes, outputs or activities that interviewees noted and/or that the programme included in its reports on progress.

### NACC

The gender advisor in NACC has contributed to the development of the *National Action Plan for Gender Mainstreaming in the HIV Response* (2011), which involves key stakeholder participation in monitoring the implementation of prioritized actions towards accelerating progress to achieve gender equality in HIV responses. Through the gender advisor, the NACC has also contributed to the integration of gender action points in some county-level action plans on HIV.

In addition, the gender advisor provided inputs around gender-sensitive programming for the development of a

number of policies including national Most-at-Risk Populations’ (MARPS) policy and the Public Sector HIV policy. By lobbying for their representation, the gender advisor has also contributed to the inclusion of women living with HIV in the MARPS’ technical working group.

Finally, the NACC has worked to make its monitoring and evaluation framework, particularly data collection tools, more gender-sensitive.

The following products, services and activities contributed to these changes, among others:

*“The programme has demonstrated that targeting vulnerable groups is one way of implementing the rights-based approach as well as assuring that developmental dividends in HIV prevention are shared.”*

UN agency representative

- A training manual on gender mainstreaming and human rights-based approach in the national response to HIV has been developed by the NACC, and different partners use it to implement the gender-sensitive training.
- In total, 58 senior and mid-level managers at NACC as well as 28 NACC field and M&E officers were trained on gender mainstreaming in the national HIV response. Following the training, the MIS division incorporated a gender component in the E-Learning Portal for NACC, to ensure that gender mainstreaming trainings were available on-demand to all staff.
 

*“Following the training of managers on gender, the NACC was able to get commitment for cascading the training to all levels.”*

NACC informant
- Thirty AIDS Control Units representatives from various government ministries were sensitized on gender mainstreaming in the national HIV response.
- As a result of the initial trainings above, the NACC used resources from the Global Fund, earmarked for capacity building, to train a further 30 staff members involved in programmes and supportive logistics to programmes.
- Having understood the importance of gender dimensions and issues, several NACC staff members have expressed the need for enhanced trainings on gender mainstreaming.

### **Women living with HIV and CSOs advocating for women living with HIV**

Through this programme component, a strong collective voice among women living with HIV has been generated, mainly through the national leadership conference that continues to influence and guide programming and resourcing for the HIV response. Women living with HIV advocates have also carved their niche in articulating and engaging the NACC.

Indeed, some women living with HIV take leadership roles in the community by informing others of their rights, participating in public meetings at the local administration level, becoming members of organizations of women living with HIV and support groups, seeking elective office in national assemblies and vetting committees, building stronger linkages with the law enforcement mechanisms, and fighting for the respect of their rights.

*“The skills’ strengthening has had transformative impacts on some of the community members upon realisation that they have rights and that there are avenues to protect themselves.”*

Woman living with HIV

Woman living with HIV

Further, there is increased participation of women living with HIV in policy-making processes (e.g., engagement in the campaign towards EMTCT and in the Joint AIDS Programme Review meetings hosted by the NACC at county and national levels; participation in the gender technical committee and in high-level policy and programming meetings) and in international events around HIV/AIDS (e.g., one woman living with HIV represented Kenya civil society at the XIX International AIDS Conference held in Washington, D.C. in 2012).

A number of campaigns have also been developed among implementing partners and CSOs, which will help sustain results. For instance, KENERALA+ has developed a new prevention and response campaign to stop new HIV infections as well as reduce discrimination against women living with HIV. The campaign is called Safer Practices, Access to Treatment, Voluntary testing and counseling and Empowerment (SAVE). Advocacy materials, such as leaflets, have been produced as part of this campaign.

Another example is that of a Wasuvie community-based organization in Nguluni, which has chosen the HIV/AIDS mobilization campaign message “Prevention with Positive” (PWP) that embodies three themes, namely the right to treatment, children’s rights and women’s rights. Finally, NEPHAK’s major advocacy work in the “Robbed of Choice” campaign, focused on ending forced sterilization in profiling testimonies of women living with HIV, has significantly impacted the levels of caution and care taken by health facilities, which are closely monitored by human rights and gender equality organizations.

These changes were enabled or facilitated by the following activities and their direct results, among others:

- In total, 35 women living with HIV have been trained in a national-level advocacy workshop, and approximately 425 women living with HIV have been trained in 17 county-level advocacy workshops (at least 25 women living with HIV per workshop).
- Women living with HIV note increased individual self-esteem, self-confidence, and capacity to confront stigma, as well as increased solidarity and sisterhood between women living with HIV.
 

*“The workshops and seminars helped to empower us to speak to other women. I knew that once I decided to speak, it would help me move beyond stigma and discrimination. Today, I can speak openly about my status and also know much about rights of women. I am grateful to UN Women and look forward to more resources so we can reach more women.”*

*“[Following the training], women know that they cannot be oppressed and that they have rights and mechanisms through which to seek redress.”*

Women living with HIV
- Informants indicated that women living with HIV have a better understanding of their right to access services and are knowledgeable of gender inequality and gender norms. For instance, sex workers now recognize that harassment from policy is a violation of their rights.

## 4. Sustainability and Future Directions

As previously explained, the programme has achieved a number of results, but the extent to which they will be sustainable varies. Stakeholders identified a number of key strategies and issues for sustainability:

- **Transfer of skills and knowledge:** The capacity and skills (i.e. advocacy, mobilization and leadership) acquired through the programme have already been deeply integrated within some partner organizations’ ongoing programmes. Indeed, interviewed partners noted that *“The UN Women programme enabled us to diversify and integrate gender within our work. There is no opportunity to reverse this.”* For example, NEPHAK and KENERALA+ are transferring the skills acquired through the programme to the support groups and other community groups that are already part of their prevention awareness activities. As some beneficiaries also highlighted, *“TOT methodology provides a good basis for sustaining results – the knowledge resides amongst the TOTs and they can replicate training beyond the programme life span.”*
- **Women living with HIV engagement in national processes and communities:** Women living with HIV are involved in various national committees, such as the gender technical committee, and the MARPS technical working group. Moreover, individual empowerment has taken place, as evidenced by women living with HIV who became rights champions in Kibera and Nguluni and have consistently “stood up” against discrimination and violations. As one beneficiary indicated, *“being trained and named a ‘champion’ is a sure way of raising the profile of an individual who can confidently mobilize and sensitize others.”* Some women living with HIV have also forged partnerships with referral institutions (e.g. the police, the local chiefs, legal aid organizations) to intervene and seek redress where rights have been violated.

- **National women living with HIV leadership conference:** The women living with HIV national leadership conference provided a strategic space for women living with HIV to voice specific concerns in terms of HIV prevention and response. Informants qualified this conference as the most impactful activity of the programme, at the individual level, as it provided highly transformative training and enhanced the visibility of women living with HIV. This goes much beyond the impact of self-help groups. For these reasons, this conference should be hosted on a regular basis so as to sustain the momentum created by the first edition.



# Appendix IV Country Profile: Papua New Guinea

## 1. Country Context

Papua New Guinea is the largest nation in the Pacific, both in population and in land area, encompassing 600 associated islands. The country's geographical features make many of the areas inaccessible by road; indeed, access to rural communities is often difficult, slow and expensive. There are large socio-cultural differences within and between the country's 22 provinces and 89 districts: around 800 languages are spoken in PNG.<sup>36</sup> The lack of law and order, high levels of violence and lawlessness within many communities, in addition to increasing state institutional violence targeting citizens, present challenges within the context of this programme. Government institutions, especially the health sector and the HIV and AIDS architecture in the national response, have various levels of capacity and are not yet able to meet the demands for delivery of public goods and services in the rural and remote communities.

### State of the epidemic in PNG

Although there is an upward trend in HIV prevalence since 2006, PNG's HIV epidemic in 2013 is considerably smaller than what was predicted when the first cases appeared in 1987. Forecasts predicted that by 2010, there would be around 120,000 people living with HIV in PNG,<sup>37</sup> and other studies and projections showed a similar pattern. Nevertheless, according to 2012 data, there are 25,000 people in PNG living with HIV; about 12,000 of them are women over the age of 15, and more than 3,000 are children under the age of 14.<sup>38</sup>

The data available to assess the extent of the HIV epidemic in PNG (case reporting, antenatal testing, and some limited behavioural and prevalence surveys) has improved over the past decade. Although the picture remains far from complete, it allows policy-makers and practitioners to make much firmer conclusions compared to a decade ago. If the epidemic is proving to be less extensive and less explosive than predictions, it may well be that factors such as geographic and transport barriers and the predominantly rural settings have limited contacts that might otherwise have generated higher levels of transmission. It is also possible that the prevention, treatment and other policies enacted over the past decade have had an impact, although there is no direct evidence of that. Though it is unlikely that PNG will see a radical change in the patterns of its HIV epidemic in the immediate future, it appears that the same warning signs that prompted concern in the past (e.g. high levels of other sexually transmitted infections and high levels of sexual risk behaviour) remain present. In more recent years, an additional factor to consider has been the resources boom that is increasing many individuals' income and mobility, but which in turn also increases their risk of HIV.<sup>39</sup>

Stigma and discrimination are major barriers to an effective HIV response. They constitute serious deterrents for people living with HIV and particular groups such as sex workers and men who have sex with men when it comes to seeking HIV prevention services such as testing, counselling, and care and treatment services (e.g. antenatal services).

<sup>36</sup> WHO (2010), *Country Cooperation Strategy at a glance: Papua New Guinea*, 2 p.

<sup>37</sup> National AIDS Council of Papua New Guinea (2012). *Global AIDS Report 2012: Country Progress Report Papua New Guinea - January 2010-December 2011*, 273 p.

<sup>38</sup> UNAIDS. "Papua New Guinea HIV and AIDS Estimates 2012", *UNAIDS website*, Available at: <https://www.unaids.org/en/regionscountries/countries/papuanewguinea/>

<sup>39</sup> National AIDS Council Secretariat. *National HIV and AIDS Strategy 2011-2015*

Another challenge is the access to anti-retroviral (ARV) medication. According to a recent media report, despite a general increase in access to anti-retroviral medication, many parts of PNG are still not being reached, in particular the rural areas.<sup>40</sup>

Although attention has been given to the relationship between HIV, gender inequality and gender-based violence (GBV) in the national response, integrating gender in the implementation of programmes has been slow. However, PNG has a long history of engaging with difficult issues surrounding gender inequality, sexual violence and rape, including marital rape, family violence, child sexual abuse and sorcery, which are factors that increase vulnerability to HIV. Today, about 80% of HIV prevention programs report that they have interventions for sexual and gender-based violence.<sup>41</sup> While many clinical and non-clinical service providers and partners are aware that GBV is both a cause and a consequence of HIV, the National AIDS Council Secretariat (NACS) and the National Department of Health (NDOH) have made limited progress in facilitating effective implementation of the relevant National HIV and AIDS Strategy (NHS) objectives.<sup>42</sup> High levels of GBV continue to be a source of concern.

One of the factors affecting progress in these areas is the limited participation of people living with HIV in the response to the epidemic; very few have been involved in planning, service delivery or decision-making. Groups of people living with HIV have existed for several years, but prior to 2011, they were only based in Port Moresby and did not have the ability to reach out nationally. At the NACS, there is a position for a people living with HIV and a women's representative. In 2013, the representative for people living with HIV is a woman. However, there is generally very little representation of women in decision-making positions at all levels of government, which limits their ability and power to influence public policy in this area (there are only three women members of Parliament in the current National Parliament; at least one of them participates in the Special Parliamentary Committee on HIV).

Further, public sector leadership in the HIV response has been weak, as HIV has not been prioritized by government agencies and provincial governments in their planning and budget processes. The NACS needs to enhance its collaboration with the whole of government in order to increase the general comprehension of the NHS, as well as each department's roles and responsibilities in implementing it for 2011-2015.

## PNG response to HIV and AIDS

The National Strategic Plan (NSP) (2006-2010) had seven focus areas that guided the national response to HIV and AIDS: Education and Prevention; Treatment, Counseling, Care and Support; Epidemiology and Surveillance; Monitoring and Evaluation; Social and Behavior Change Research; Leadership, Partnership and Coordination; and Family and Community Support. In addition, a National Gender Policy and an implementer's guide were developed. Despite the strategy and the tools in place, the PNG national response was still not implemented in a way that took into account gender dimensions, come the end of the NSP 2006-2010. Nonetheless, many activities under the NSP were still relevant and informed the development of the National HIV and AIDS Strategy 2011-2015. The 2011-2015 Strategy, which was launched in December 2010, is organized around three core areas of prevention: Prevention; Counseling, testing, treatment care and support; and Systems strengthening. This strategy includes a stronger emphasis on gender and the greater involvement of people living with HIV and AIDS (GIPA) principles, as evident in the inclusion of gender and GIPA in all strategic objectives and key activities of the three priority areas.

As the national HIV response coordinating body, the NACS brings together about 50 agencies, including 20 Provincial AIDS Committee Secretariat (PACS), NGOs, private sector and umbrella organizations

<sup>40</sup> —. (2012). "HIV drugs not reaching many areas in PNG", *Papua New Guinea Post-Courier*, December 3, p.2.

<sup>41</sup> Godwin, Peter *et al.* (2013). *Mid-Term Review of Papua New Guinea HIV Strategy (2011-2015)*, 120 p.

<sup>42</sup> *Ibid.*

such as Churches Alliance, Igat Hope, Youth Alliance, and Business Alliance. In addition to government, it is important to note that over 50% of the HIV response in PNG is driven by the private sector, civil society and faith-based sectors. Today, there are a number of these organizations implementing GIPA and gender principles in their projects, including Anglicare PNG Inc, Baptist Union PNG, Catholic HIV&AIDS Services, Save the Children PNG, Poro Sapot, National AIDS and HIV Training Unit (NAHTU), Igat Hope, and PNG Sexual Health Society. As of December 2012, 60% of NGO partners implementing the national response involve or include people and women living with HIV either as implementing partners or targets for services.<sup>43</sup>

Key development partners are also involved in supporting the national response, including the UN system and bilateral donors such as AusAID. Many of these development partners provided funding and technical support to implement the NSP 2006-2010 and facilitated the development and implementation of the NHS 2011-2015 through financial and technical support.

Within civil society, there have been several women living with HIV who have been very visible in the HIV and AIDS response. For example, for the last three years, the President and Vice President of Igat Hope were women living with HIV. Founded in 2006, Tru Frens (Mt Hagen women living with HIV) was formally included in a Baptist Union PNG funding proposal and participated in HIV/AIDS advocacy and other activities. WABHA (National Capital District women living with HIV) was formed in 2009. Prior to the start of the programme, UN System and other development partners, as well as national and international non-governmental and private sector organizations, had already begun to identify existing and potential leaders among women living with HIV and provide leadership training. The programme was then able to build and further some of these efforts.

## 2. Evolution of the Programme

### Key Implementing Partners

The main partners involved in implementing the programme have been the NACS, Igat Hope, an association of people living with HIV, and Hope World Wide PNG.

### From UNIFEM to UN Women: Role of Focal Point

During the initial phases of programme implementation, restructuring within the NACS made it challenging to place a gender advisor there. As a result, UN Women requested EC permission to find a programme coordinator in the country office who would also advocate for the inclusion of gender issues in the HIV response and to encourage the participation and engagement of women living with HIV.

Focal point duties were initially assigned to a UN Volunteer based in Fiji, who led the key activities related to the programme. However, oversight from the Fiji office did not provide for easy implementation due to its geographic isolation. In late 2011, the UN Women Country Programme Manager (CPM) came on board, and in May 2012, UN Women sought funding from UNAIDS for a project officer based at UN Women offices. Since then, the CPM, along with a UNAIDS-funded in-country focal point, managed the programme. The NACS component was implemented with UN Women and NACS, while the women living with HIV component was implemented primarily through UN Women with initial assistance from Hope PNG and, towards the end of the programme, with assistance from Igat Hope.

<sup>43</sup> Quality at Implementation Reports from implementing partners to AusAID

## Funding and Implementation Period

The overall allocation to PNG for implementing this programme was approximately USD 470,000. Implementation technically began in 2010, but during the initial year and a half there were a number of constraints that affected the programme:

- State bureaucracies, health system implementation failures, and a low functioning health system impeded the national HIV/AIDS policies on gender and human rights to be achieved in practice.
- Internal reforms at the NACS, staff turnover, and violence precluded the location of a programme-funded gender advisor in NACS.
- On-going electoral violence during most of 2012 hindered working with women living with HIV in the designated areas of the Highlands, and work was suspended for security reasons.
- The limited capacities of organized women living with HIV groups made the identification of implementing partners difficult.
- Because of these delays, a programme that was initially planned for three years was really implemented in 18 months. Several stakeholders note that the original timing was just not right in 2009/2010. By 2012, the programme was able to operate in a much more fertile context.
- The NACS Gender and Special Interests officer suffered bouts of ill health and was absent from NACS for considerable periods of time.

## Programme Strategies and Key Activities

Due to country context and the delays in getting started, stakeholders in PNG developed alternative approaches to some of the expected programme strategies (such as placement of a gender advisor in the NACS). In broad terms, the main strategies employed were:

### For strengthening the NACS:

- **Gender audit process:** The gender audit process provided a first entry point to understanding the gaps with regard to mainstreaming gender and identifying training needs. The process included consultations and briefings.
- **Gender advisor:** Because of poor security and non-compliance with UN MOSS standards, UN Women was not able to place a gender advisor in the NACS. Instead, an alternative approach was developed, where the programme provided technical assistance, training and mentoring to the existing NACS Gender and Special Interests Officer in order to build capacity on gender equality and HIV. A Gender Equality Core Working Group was also established within NACS, supporting the Gender Equality and Special Interests Officer in conducting two regional Training of Trainer (ToT) workshops.
- **Capacity development of the NACS staff:** As mentioned above, two ToT workshops were developed and delivered through the support of the NACS Gender Equality Core Working Group. While ToT was provided to a number of NACS staff, three out of four PNG Regional PACS received TOT and gender sensitization training. Further, two trainings on gender programme planning and budgeting were given to senior management.

### For contributing to leadership of women living with HIV:

- **Mobilization of women living with HIV:** A mapping exercise of women living with HIV leaders was conducted in 2011, and during the early stages of implementation, mobilization and consultation workshops with women living with HIV took place in Simbu and the Western Highlands.

- **Training and skills building on advocacy:** Mentoring and training activities with a particular focus on advocacy were conducted, as this was the main topic of interest identified by women living with HIV during early consultations and training needs assessments; media advocacy also took place through national radio and newspapers.

### 3. Results of the Programme

This section describes programme results that illustrate progress towards intended results associated with overall and specific objectives, as well as expected results. The results are based on the key outcomes, outputs or activities that interviewees noted and/or that the programme included in its reports on progress.

#### NACS

Given that the National HIV and AIDS Strategy 2011-2015 (NHS) was already in place and considered to be strong on the mainstreaming of gender, the programme's key contribution was with regard to operationalization of the gender dimensions of the NHS.

In particular, stakeholders note that the programme helped to move policy to action by responding to a need and interest from the NACS staff in understanding what gender means, and what it means to integrate or mainstream into programming. Staff was concerned because they knew they had the duty to implement the NHS gender components, but they did not know how.

Moreover, because the NACS staff now have greater understanding of what it means to integrate gender into the response, they report that they can better explain to partners what is required in the funding applications especially (gender considerations were already a requirement in the funding provided by the NACS, but now the staff can give better examples to applicants about what is meant by that).

*"The programme helped us to be more aware of [integrating] gender inclusion in our roles and those we work with."*

NACS informant

Finally, testimonials gathered from NACS staff show a strong response to gender sensitization, which is being utilized for personal and professional use.

In a relatively short period of time, there have thus been expressions of enhanced awareness among individuals of the NACs. In addition, the continued existence and functioning of the Gender Equality Core Working Group is considered to be critical. This group participated in the development and delivery of the training programme for the NACS staff in the Secretariat and in the provinces. More recently, the NACS is being recognized as a gender resource for other ministries – there are reports that the Ministry of Agriculture and the Ministry of Education have recognized the mainstreaming work done by the NACS and requested assistance from the NACS with gender mainstreaming in the context of the Ministry's HIV and AIDS Policy implementation.

*"NACS is a success story and well ahead of other government agencies in gender equality skills and knowledge."*

NACS informant

Nevertheless, there is still a need to continue to strengthen the capacity of the NACS and its key gender equality mechanisms (Gender Equality Core Working Group) and positions (Gender and Special Interests Officer) and continuously seeking buy-in of the senior leadership.

For instance, the Gender Equality Core Working Group/NACS expressed that they require further training, beyond Gender 101 and over a longer period of time, on how the NACS and its partners can facilitate, monitor and report on the gender-inclusive implementation of the NHS. Specifically, they hope to gain the technical ability to translate global concepts into activities that can be implemented locally,

according to PNG’s national HIV context and response. In addition, the NACS’ capacity to guide implementation and report against the NHS implementation of gender- and GIPA-inclusive response could be enhanced by further understanding of how gender and GIPA are included in the NHS and how to report on progress. (The gender equality manual produced through the programme aims to mainstream gender within the NACS and its sub-national level PACS.) Further, as one manager stated: *“The NHS 2011-2015 is a very good gender- and GIPA-inclusive budget strategy, but there is no budget to implement it.”*

In addition, the current arrangement of having a senior policy planning officer as Gender and Special Interests Officer and having a Gender Equality Core Working Group made up of officers who already have heavy work load means that the NACS capacity to facilitate and implement a gender inclusive national response may not progress very much, or as quickly as desired. Having an experienced and fully dedicated Gender and Special Interests Officer in the NACS would boost the organization’s capacity and ensure consistency in the inclusion of gender and GIPA in the HIV response.

The above results within NACS were enabled or facilitated by the following products, and activities, among others:

- Gender audit tool and findings have been developed.
- Training programmes (manuals) for the NACS staff have been developed.
- An introductory gender equality training programme was delivered to 35 NACS staff at the national office. An adapted version of the same training was delivered to 13 NACS senior managers.
- Each participant to the introductory gender equality training programme developed their own gender action plan for personal and work-based changes.
- Three regional “Training of Trainers” workshops took place for Provincial AIDS Committees on mainstreaming gender into the HIV/AIDS response.

### **Women living with HIV and organizations advocating for women living with HIV**

Overall, stakeholders note that there is growing engagement of women living with HIV in the national and provincial response. Women living with HIV also launched an advocacy campaign in Simbu in May 2012 and has been described as *“one of the most important initiatives to date in Chimbu on HIV/AIDS work.”*<sup>44</sup> As one informant from a UN Agency stated, *“the programme has raised the advocacy agenda and the role of people and women living with HIV in advocacy.”*

Igat Hope now has technical competency to run a media campaign on its own as a result of its engagement in the programme. A media advocacy strategy was launched prior to World AIDS Day, with press coverage on key issues for women living with HIV, such as the need for ARV drugs to be delivered to rural areas.<sup>45</sup> As part of the advocacy campaign, Igat Hope published an open letter to all Members of the PNG Parliament in the newspaper and mailed it to all 111 PNG Parliamentarians. The letter was drafted by women living with HIV and addressed their main concerns, i.e. access to services, insufficient involvement of people living with HIV in the national HIV response, as well as stigma and discrimination.

Several of the participants in the programme have gone back to their communities and are applying the knowledge and skills

*“All of us are leaders, so this advocacy training will help us to advocate as leaders in our communities.”*  
Member of an organization of women living with HIV

<sup>44</sup> Hope Worldwide PNG. (2013). *Implementation Progress Report – Supporting Gender in the Context of HIV/AIDS*, p.5

<sup>45</sup> —. (2012). “HIV drugs not reaching many areas in PNG”, *Papua New Guinea Post-Courier*, December 3, p.2

acquired. For example, the programme reports that 18 women living with HIV are now engaged in clinics as peer counselors. Others are continuing to play (or have added) different roles at the national level, such as participating on boards of national organizations. In addition, one of the participants is now establishing an association of teachers living with HIV (HIV Care and Support Teacher's Association). It is important to note that three of these women leaders emerged from UNDP's Leadership Development Programme, which set the foundations for the further training that was provided by the programme. Based on the needs identified by these women leaders, the programme focused on advocacy training.

Stakeholders involved in programme implementation as well as women living with HIV who participated in the activities conducted consider that the programme has made contributions that create important synergies and built on previous efforts of UN partners and others, such as AusAID. Indeed, interviewed women living with HIV mentioned that the trainings allowed them to meet other women living with HIV and to share experiences during the workshop, but since they had already participated in other programmes, such as the UNDP Leadership Development Programme, or had worked for many years with the Baptist Union (through an AusAid initiative), it was difficult for them to tell the extent to which the programme had, in and of itself, made a difference to their lives.

The following activities and their direct results have contributed to the above changes:

- Thirty women living with HIV and two male champions have been trained in advocacy.
- Four women living with HIV have been trained and mentored in radio media advocacy.
- A media advocacy strategy was put together by all partners to lead up to the event for World AIDS Day; four women living with HIV shared their stories and advocated for the plight of people and women living with HIV through radio, broadcast and print media before the World AIDS Day 2012. Unfortunately, as one women living with HIV indicated, this remains a one-off campaign that cannot be continued without further funding.
- Igat Hope and women living with HIV gained lobbying skills and learned how to work with the media.

## 4. Sustainability and Future Directions

Stakeholders identified a number of key strategies and issues for sustainability of the programme results in PNG:

- **Institutionalization of gender equality within the NACS:** The NACS stakeholders report that some members of the NACS Gender Equality Core Working Group (about 4-5 people) are taking full ownership of on-going gender equality trainings and have continued to provide trainings at the provincial level. The staff time and other costs of the workshops are being funded through the annual plans and budgets of the NACS. However, to further this institutionalization of gender equality, as increased funding for HIV is provided, gender sensitization needs to be extended to the sub-national level, where much of the HIV response will be implemented. It might also be important for the NACS to develop and provide more specific tools for integrating gender into HIV and AIDS activities, and more guidance on the meaning of gender-sensitive programming and reporting within the context of the HIV response. A gender equality implementation guide within the context of HIV and AIDS response would be very helpful. In addition, the Mid-Term Review of PNG HIV Strategy 2011-2015 recommended that the NACS and the National Department of Health develop a framework on gender-based violence. This has now been included and budgeted in the NACS plan for 2014.

- **Strengthening partnerships:** One interviewee, who was a member of a partner organization, remarked: *“I would like another opportunity to work with UN Women under different circumstance,”* for example over a longer period of time, or to be more involved in consultations around selecting target beneficiaries. Indeed, in order to sustain the work with women living with HIV and keep the momentum created by the programme, closer partnerships between Igat Hope and the NACS may be required, including integration of Igat Hope as one of the NACS member organizations. Moreover, it could be worth developing stronger links between the NACS and the National Council of Women (NCW), which has the potential to reach out to many partners otherwise not involved in the national HIV response, especially at the sub-national and rural levels. This would assist the NCW implement its own mandate of advocating for the rights of all women in PNG including those living with HIV. Women living with HIV could affiliate with the NCW and participate in and contribute to the activities of the women’s movement in PNG and mainstream their own involvement and concerns within the movement in order to strengthen the critical mass of support.
- **Developing networks of women living with HIV:** Women living with HIV are building more networks at local and provincial levels, and this effort is likely to continue on its own. Interviewed women living with HIV expressed a need for programme tools like handbooks, CDs with advocacy messages or toolkits/packets. While respondents were confident in terms of knowing what they had to do, they now felt they lacked the tools and resources to be able to actually conduct advocacy activities. High-level informants (e.g. from partner NGOs, the NACS) also underscored the importance of increased and continued access to resources for the women living with HIV component of the programme especially.
- **Seeking additional funding:** UN Women has sought additional funding from AusAID to implement a complementary programme focused on the economic empowerment of women living with HIV as a means to support their roles as leaders and advocates. The programme “Strong Women, Strong Life: Interventions to Sustain Work and Health amongst Women Living with HIV in PNG” was designed based on research conducted amongst women living with HIV during several training and advocacy meetings over the course of the programme and thanks to additional funding from UNAIDS. Research was also conducted amongst medical and support staff at hospitals.

## Appendix V Country Profile: Rwanda

### 1. Country Context

In early 2007, Rwanda became one of the eight pilot countries<sup>46</sup> for the UN System’s Delivering as One (DaO) initiative. Over the years, the UN has taken a number of measures to further its reform agenda and reduce UN programme fragmentation and duplication. These measures included the development of various documents, such as the United Nations Development Assistance Framework (UNDAF) 2008-2012, the Rwanda Common Operational Document (2008), and Consolidated Action Work Plans and recently the United Nations Development Assistant Plan (UNDAP). The UNDAF covered the same period as the Economic Development and Poverty Reduction Strategy (EDPRS) I (2008-2012), and contributed to achieving both the EDPRS and the Millennium Development Goals (MDG). The UNDAP which is the current business plan of all the UN agencies, funds and programmes in Rwanda covers the period July 2013 to June 2018 and is aligned to the EDPRS 2 (2013-2018).

The UN reform aims at encouraging collaboration between all UN agencies through technical and thematic working groups, notably the inter-agency Gender Task Force. Within the context of this collaboration, UN Women continues to play an important role in two thematic groups (i.e. governance, which has a gender component and HIV/AIDS). UN Women has shared the programme’s plans, reports, experiences, best practices and achievements at these working groups’ meetings in order to avoid duplication with other UN partners’ programming.

#### State of the epidemic in Rwanda

According to the Rwanda Demographic and Health Surveys (RDHS), national HIV prevalence among Rwandans aged 15-49 has remained stable at 3% since 2005.<sup>47</sup> In 2011, there were approximately 210,000 people living with HIV in the country, among which 27,000 were children under the age of 14.<sup>48</sup> Prevalence varies in urban and rural areas, with much higher rates in the former (7.1%) than in the latter (2.3%).<sup>49</sup>

There have been improvements in the population’s knowledge of HIV risks and the behaviors related to those risks. According to the RDHS 2010, over half of women (55.5%) and men (51.6%) demonstrated knowledge about HIV transmission and prevention.<sup>50</sup> Given that multiple sexual partnerships increase the likelihood of HIV infection, it is encouraging to note that the number of individuals who have many partners has decreased among both men and women aged 15-49.<sup>51</sup> However, only 27.5% of men and

<sup>46</sup> The other countries are Albania, Cape Verde, Mozambique, Pakistan, Tanzania, Uruguay, and Viet Nam.

<sup>47</sup> Institut National de la Statistique du Rwanda (INSR) and ORC Macro (2006). *Rwanda Demographic and Health Survey 2005*, Calverton, Maryland, U.S.A., INSR and ORC Macro, p. xxix; National Institute of Statistics of Rwanda (NISR) Ministry of Health (MOH) [Rwanda], and ICF International (2012). *Rwanda Demographic and Health Survey 2010*, Calverton, Maryland, USA, NISR, MOH, and ICF International, p. 211

<sup>48</sup> UNAIDS. “Rwanda”, *UNAIDS website*, available at:

<http://www.unaids.org/en/regionscountries/countries/rwanda/>

<sup>49</sup> Rwanda Biomedical Center/Institute of HIV/AIDS, Disease Prevention and Control (2012). *Country Progress Report: Rwanda*, p. 3.

<sup>50</sup> National Institute of Statistics of Rwanda (NISR) Ministry of Health (MOH) [Rwanda], and ICF International (2012). *Rwanda Demographic and Health Survey 2010*.

<sup>51</sup> Institut National de la Statistique du Rwanda (INSR) and ORC Macro (2006). *Rwanda Demographic and Health Survey 2005*; National Institute of Statistics of Rwanda (NISR) Ministry of Health (MOH) [Rwanda], and ICF International (2012). *Rwanda Demographic and Health Survey 2010*, p. 216.

28.9% of women that have multiple sexual partners reported using a condom during their last sexual encounter.<sup>52</sup>

Across the different age groups, HIV prevalence in Rwanda is higher among women than men. Indeed, the RDHS 2010 highlighted that 3.7% of women aged 15-49 years were living with HIV, while 2.2% of men in the same age group were living with HIV.<sup>53</sup> Various factors explain why women are at higher risk of HIV infection than men: in some areas, stigma and discrimination still surround matrimonial and familial structures and roles, and many women lack the knowledge and skills required to protect themselves and others against HIV. In addition, women and young girls have little or no time to seek out information on HIV through media and by attending meetings and, having received less formal education than men, a number of women have low self-confidence and self-esteem. Finally, as a result of high illiteracy among women, many cannot read public sensitization materials in public places or at health centers, and high poverty levels, economic dependency and limited leadership skills are also important realities that increase women's risk of HIV infection. Another determining factor in the prevalence of HIV among this population is the Rwanda genocide, during which many women were raped or widowed. The linkages between the prevalence rate of gender-based violence and HIV among women and girls cannot be underestimated.

### Rwanda's response to HIV and AIDS

Rwanda has made significant progress in reaching international and national goals on HIV and gender equality, as set out by international instruments and mechanisms like the Protocol to the African Charter on Human Rights and People's Rights on the Rights of Women in Africa, the Convention on the Elimination of All Forms of Discrimination Against Women, MDG 3 on promoting gender equality and women's empowerment, and MDG 6 on responding to HIV/AIDS, malaria and other diseases.

Since the launch of Rwanda's 2005-2009 National Multi-Sector Strategic Plan (NMSP), the country has made significant progress towards its goal of providing universal access to HIV and AIDS services. Indeed, the Government of Rwanda has developed various legal frameworks and policies on gender mainstreaming and HIV prevention, care, treatment and support services, in collaboration with development partners, civil society organizations and donors. The following policies demonstrate the country's political will and strong commitment regarding gender equality and HIV:

- *Rwanda Vision 2020* (2000) states that women, who make up 53% of the population, have less access to opportunities than men and are poorly represented in decision-making positions. In order to achieve equality and equity, Rwanda is committed to continuously updating and adapting its legal framework on gender. It will work to support universal education, eradicate all forms of discrimination, fight poverty and practice positive discrimination in favor of women. In addition, gender will be integrated as a cross-cutting issue in all development policies and strategies.
- The *Economic Development and Poverty Reduction Strategy (EDPRS I) 2008-2012* recognizes gender and HIV/AIDS as cross-cutting issues. Both will be integrated into the EDPRS 2013-2018.
- The *National Gender Policy* (2010) includes HIV considerations and mentions the need “[t]o ensure that women and men have equal access to HIV-related information for prevention, treatment and care [...] with a special attention to women” (p. 24).
- The *National Policy against Gender-Based Violence* (2011) has contributed to achieving the EDPRS I and MDG 3 (promote gender equality and empower women) and 6 (combat

<sup>52</sup> National Institute of Statistics of Rwanda (NISR) *et al.* (2012). *Rwanda Demographic and Health Survey 2010*.

<sup>53</sup> *Ibid.*

HIV/AIDS, malaria and other diseases). This strategic plan on gender-based violence (GBV) states that the Rwanda Biomedical Center (RBC) is responsible for raising awareness on the links between GBV and sexually transmitted diseases, particularly HIV and AIDS. The RBC also addresses issues of stigma and how it relates to sexual violence.

- The *Rwanda National Strategic Plan (NSP) on HIV and AIDS 2009-2012* recognizes gender equity as a cross-cutting issue.
- The *National Accelerated Plan for Women, Girls, Gender Equality and HIV (2010-2014)* is a four-year strategy that promotes gender equality and works to decrease women's risk of HIV by ensuring that women and girls have equal access to services and are empowered and protected.

In addition to these legal frameworks and policies, the Government of Rwanda adopted a multi-sectoral and decentralized structure to respond to the HIV epidemic.

A number of actors are involved in Rwanda's response to HIV, providing financial and technical support. In 2009-2010, Rwanda spent nearly USD 173.6 million on the HIV response, of which 90.2% (USD 156.7 million) came from external sources, and 9.6% (USD 16.6 million) from public contributions.<sup>54</sup> However, this strong reliance on external funding in the response to HIV represents a challenge as well, as it perpetuates Rwanda's dependence on international aid. Indeed, as external resources continue to decline and the country struggles to increase its domestic budget for the response to HIV, the sustainability of this response is threatened.<sup>55</sup>

At the international level, key development partners and donors involved in the HIV response in Rwanda comprise the UN System, the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as bilateral donors like the United States President's Emergency Plan for AIDS Relief (PEPFAR).

At the government level, actors include the Ministry of Health, the Rwanda Biomedical Center/Institute of HIV Disease Prevention Control (RBC/IHDPC), the Ministry of Gender and Family Promotion, the National Women Council, the Rwanda National Youth Council, and 30 District AIDS Control Committees (*Comités de District de Lutte contre le SIDA – CDLS*, in French).

Similarly, civil society is active in the HIV response and encompasses actors such as the Rwanda Network of People Living with HIV (RNP+), Kigali Hope Association, the Rwanda NGOs Forum on HIV/AIDS, and Pro-Femmes Twese Hamwe, an umbrella organization of more than 52 women's associations. Faith-based organizations and the Rwanda Private Sector Federation also participate.

## 2. Evolution of the Programme

### Key Implementing Partners

Over the course of the programme, the main partners responsible for implementation have been the Rwanda Biomedical Center's Institute of HIV Disease Prevention Control (RBC/IHDPC), previously known as the *Commission Nationale de Lutte contre le SIDA* (CNLS, in French), and the Rwanda Network of People Living with HIV (RPN+). The project was anchored in the RBC/IHDPC, under the Ministry of Health.

<sup>54</sup> Rwanda Biomedical Center/Institute of HIV/AIDS, Disease Prevention and Control (2012). *Country Progress Report: Rwanda*, p. 18.

<sup>55</sup> UNAIDS. "Rwanda – Key challenges," *UNAIDS website*, available at: <http://www.unaidsrstea.org/region/countries/rwanda/rwanda-key-challenges>

## From UNIFEM to UN Women: Role of the Focal Point

The programme in Rwanda has been managed by a programme officer at the UN Women office who took on the coordination and supervision of the programme, in addition to other tasks and responsibilities.<sup>56</sup> Changes or transitions in the focal point position did not affect the project, thanks to the close collaboration with the gender advisor placed in the RBC. However, the fact that the focal point also had other responsibilities sometimes slowed implementation of activities.

## Funding and Implementation Period

The total allocation to Rwanda for this programme was approximately USD 470,000. Even though the project was launched in 2009, a written agreement between the RBC and UN Women was only signed in 2010 – partly as a result of lengthy government procedures –, and the first allocation of funds was disbursed in June 2010. Prior to this agreement, some activities had been implemented, including the recruitment of a senior gender advisor. While the original 36-month timeframe was extended to 51 months to allow for full activity implementation, the extension remained insufficient due to various factors including the restructuring of the RNP+ and conflicts between NGO partners, which caused some delay.

## Programme Strategies and Key Activities

The following strategies and activities aimed at reaching the specific programme objectives:

### Leadership of women living with HIV and organizations of/advocating for women living with HIV

- **Mapping exercise:** The exercise served to map and assess organizations and networks of women living with HIV, as well as to identify capacity needs and prioritize trainings and other capacity-development interventions for strengthening organizational leadership, strategic planning, advocacy and networking skills of associations and cooperatives of/working for women living with HIV.
- **Technical assistance to organizations of/advocating for women living with HIV:** A consultant was recruited to provide technical assistance to seven organizations of/advocating for women living with HIV, specifically to help with developing competitive proposals to the Global Fund.
- **Support to the RNP+'s restructuring process:** The RNP+ decided to conduct internal restructuring as a result of advocacy activities conducted by various actors (e.g. the gender think tank of women living with HIV, the Rwandan Community of Women living with HIV [RCW+]) and discussions held with different groups. Indeed, as one woman living with HIV informant stated: “*Advocacy has influenced decision-makers to recognize the gaps and has led to the restructuring of the RNP+ by integrating women and youth as a special group with specific needs.*” UN Women and the RBC hired a consultant who provided technical support to review the RNP+'s legal framework so as to integrate gender equality and human rights, as well as to restructure the network and ensure the representation of women, from the district to the national level. Elections were held to select women living with HIV that would fill various positions within the network.
- **Economic empowerment of women living with HIV:** The programme provided support to women living with HIV by training them and helping them start an economic activity. For example, members of FSNSF+ (*Femmes séropositives de Nyabihu pour le counselling et le soutien économique des femmes infectées et/ou affectées*, in French), a local organization of women living with HIV received training in tailoring and were provided with 17 sewing

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<sup>56</sup> At certain times during programme implementation, the coordination and supervision responsibilities were shared among two staff members.

machines. They were also given access to financial services and to the market, where they could sell their products (e.g., schools are buying uniforms made by the women).

- **Training and skills building in leadership and management:** Activities in this category included the development of training materials and tools, as well as trainings on leadership and management to women living with HIV (the RCW+ and Rwandan Women living with HIV/AIDS and fighting against it [*Femmes rwandaises séropositives dans la lutte contre le VIH/SIDA – FRSL+*, in French]).

### Commitment to and action on gender equality and HIV at the national level

- **Gender audit:** The institutional gender audit of the RBC contributed to the review of the NSP, in which there was a need to mainstreaming gender. As a result, NSP+ II integrates gender.
- **Gender advisor positioned in the RBC:** Prior to the transfer of funds for the programme, in June 2008, a gender advisor was positioned in the RBC to support staff in organizing trainings and mainstreaming gender in the HIV response.
- **Capacity development of the RBC:** Programme activities included training on mainstreaming the needs and rights of women and girls in the planning, design, monitoring and budgeting of the HIV response; workshop on data demands and use strategy for gender mainstreaming, in collaboration with MEASURE Evaluation; as well as training on areas of social impact mitigation, non-clinical and clinical prevention, and psycho-social and behavioral change, in collaboration with UNAIDS.

## 3. Results of the Programme

This section describes programme results that illustrate progress towards intended results associated with overall and specific objectives, as well as expected results. The results are based on the key outcomes, outputs or activities that interviewees noted and/or that the programme included in its reports on progress.

### National policies, programmes and actions to address HIV

To begin, the programme was a key partner, along with other UN agencies, that contributed to the development of the *National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010-2014*, having provided both funding and technical assistance.

Further, the NSP 2009-2012 mid-term review included recommendations from organizations of women living with HIV for improving service delivery according to the specific needs of women and young girls. It also took into account gender equality and human rights. The programme contributed to this process by inviting women living with HIV to different consultation meetings to review the NSP and facilitating their participation (i.e. covering their transportation and meal costs). Gender is considered in the NSP+ 2013-2018.

Similarly, the national Elimination of Mother-To-Child Transmission (E-MTCT) strategic plan integrates gender equality priorities through awareness and advocacy activities. Representatives from organizations of women living with HIV were encouraged to participate in a consultation workshop so as to provide recommendations that would inform the final strategic plan.

### Women living with HIV and organizations of/advocating for women living with HIV

As a result of the programme, Rwandan women and girls living with HIV who participated in the programme are building their social networks and have demonstrated improved leadership skills through their participation in regional and international meetings (e.g. the International Conference on AIDS and STIs in Africa, held in Addis Ababa in 2011, and the XIX International AIDS Conference in Washington, D.C. in July 2012).

Over and above the restructuring of the RNP+ noted above, the advocacy work of organizations of women living with HIV (including the gender think tank) has influenced changes in policy development and strategy updates such as greater gender focus in the NSP+ II, the E-MTCT policy and the RNP+ legal framework, as well as the development of a work plan on gender equality and the improvement of service delivery – taking into account the specific needs of women and girls – in health centers. Informants see these advancements as a result of the commitment of partner organizations as well as a key strength and outcome of the programme.

The following activities and their direct results have contributed to the above changes experienced by women living with HIV:

- Forty civil society organizations working on gender and HIV were trained on leadership and management. All of the key informants interviewed acknowledged that the leadership capacities of women living with HIV and organizations advocating for women living with HIV have improved.
- As a result of the increased self-confidence and self-esteem gained through the trainings, many women living with HIV actively participated in groups or networks of women living with HIV, such as the RCW+, FRSL, the gender think tank, and the Kigali Hope Association of Positive Youth. This increased participation is one of the most important contributions of the programme in Rwanda.
 

*“The project created a safe space for women living with HIV. Today we have self-confidence, which helps us to participate actively in decision-making processes. We meet, share information and experiences, find strategies and plan together for advocacy, for realities and priorities of women living with HIV.”*

*“We sensitized our peers on human rights, Preventing Mother-to-Child Transmission (PMTCT), and responsibility vis-à-vis HIV. [...] [This sensitization] helped our peers to have a good understanding and to make decisions/choices related to PMTCT. The number of newborns among women living with HIV are decreased due to the knowledge acquired and the increased responsibilities and decisions taken by women living with HIV themselves.”*

Women living with HIV trained by the programme
- The tailoring workshop and subsequent support provided to some women living with HIV in the FSNSF+ empowered them economically, which in turn increased their ability to participate in the economic development of the district. Since then, these women living with HIV feel more confident to participate in the community works organized each month by the district, thus increasing their voice in community dialogues as well as their ability to develop their vision and agenda. As one informant noted, “[programme beneficiaries] reported that their family life has changed positively – they paid the school fees for their children, they have a market where they sell their products.”
- UN Women and the RBC developed the terms of reference and played a coordination role in the creation of a gender think tank for women living with HIV, as well as participated in the capacity building of its 15 members. The think tank met regularly at UN Women’s offices, providing input and guidance on HIV programming and influencing discussions on gender and HIV at the national level.
- As mentioned above, the programme provided technical assistance to seven organizations of women living with HIV in order to strengthen their skills in project proposal
 

*“The advocacy done by UN Women and the RBC through the programme has contributed to the development of women living with HIV: we received other partnership and funds from the Global Fund, ICWE, UNAIDS, and others thanks to that advocacy.”*

Woman living with HIV trained by their programme

writing and submission to the Global Fund. Two of the proposals were successful and the selected organizations (FRSL and FSNSF+) are now sub-recipients of the Global Fund.

- As previously mentioned, the RNP+ was restructured to include women living with HIV in decision-making positions, thus enhancing the leadership of women: indeed, 31 women and 31 girls were elected to represent women living with HIV at all levels of the organization, from the district to the national level. Informants recognized that this “[had not been] an easy task,” however. The programme supported the organizational review of the RNP+’s strengths and weaknesses and proposed gender-sensitive structures and approaches.

## RBC/IHDPC

Individual roadmaps for mainstreaming gender equality and human rights were developed by trained RBC/IHDPC staff (25 people), and clear steps to monitor the implementation of key action plans were identified. All staff that participated in the training will be evaluated on gender and human rights mainstreaming in their end-of-year assessments. In addition, District Development Plans and District Plans for responding to HIV are integrating gender equality as a result of the trainings organized by the RBC for CDLS members and RBC staff (40 people). Gender issues are also considered in the RBC’s budget – eventually, the RBC plans to require all partners in the national HIV response to adopt gender-responsive budgeting as a standard practice.

These changes were enabled and/or facilitated by the following activities and their direct results:

- In total, 25 RBC/IHDPC staff were trained on gender-sensitive programming, monitoring and evaluation, as well as social impact mitigation, non-clinical and clinical prevention, and psycho-social and behavioral change.
- In total, 30 coordinators of the District AIDS Control Committees (CDLS) were trained on gender mainstreaming in the planning, design, monitoring and budgeting of HIV response, as well as on data demand and use strategies for gender mainstreaming.
- Trainings have resulted in increased capacity of the RBC/IHDPC staff to mainstream gender equality and human rights in the HIV/AIDS response. According to participants interviewed, trained staff members have changed their mindset on the concept of gender: they have greater willingness to integrate gender equality in their work and mainstream it in the HIV response. For example, since the training, a senior staff member has actively supported the inclusion of gender in the review of the NSP and the RBC planning process. In addition, District Development Plans also now take gender equality into account, as do national operational work plans against HIV/AIDS.
- CDLS coordinators continue to integrate the needs and rights of women and girls living with HIV in the planning, design and budgeting of the HIV response at the district level.
- The RBC/IHDPC and UN Women commissioned a study to use the HIV resource allocations for 2006-2009 as a baseline for improving gender-equitable distribution of resources in the NSP 2009-2012. The study produced a six-step gender-responsive budgeting tool for HIV and influenced the RBC/IHDPC thinking around introducing a mandatory gender budget statement to all partners in the national HIV response, forcing them to systematically conduct a gender gap analysis in their programmes/interventions and address those gaps in their budgets.

*“We understand gender better than before the trainings received from the programme, and we act in ways that are gender sensitive thanks to the knowledge acquired. Now, in our planning and reporting process, we consider gender needs and issues more.”*

Government respondent

## 4. Sustainability and Future Directions

The programme aims to ensure continuity by strengthening national ownership and commitment around gender equality, women’s human rights and HIV, in addition to enhancing the leadership of women living with HIV. Stakeholders identified a number of key strategies and issues for sustainability:

- **Integrating representatives of women living with HIV into the structure of the RNP+:** By adding a gender unit to its structure and integrating women living with HIV representatives at various levels of the organization, including in decision-making positions, the RNP+ intends to make its work around HIV more gender-responsive. However, the capacity of the women selected for these positions still needs to be strengthened.
- **Continuing the work of the gender think tank:** The creation of the gender think tank was a strategy to ensure the sustainable participation of women living with HIV in the HIV response. The think tank is an interesting initiative that has the potential to help secure future funding from donors. Members are highly motivated to strengthen their leadership and advocacy skills and to have their voices heard, and so willingly participate in the think tank’s meetings.
- **Funding opportunities:** There are funding opportunities to continue some of the programme’s activities. Indeed, UN Women has developed partnerships with other UN agencies through joint planning and has continued mobilizing financial resources through the UN’s DaO initiative (e.g. for activities aiming at strengthening the RNP+’s gender unit).

- **Broadening the targeted stakeholders:** It is important to involve other mechanisms and structures for effectively mainstreaming gender equality and human rights in the HIV response (e.g. the Ministry of Gender and Family Promotion and the Gender Monitoring Office) since their collaboration and involvement are key for the implementation and monitoring of action plans. As one UN Women representative aptly observed: *“Project deliverables are supported by others community mechanisms and synergies – collaborative partners/stakeholders [...] [help create] the conducive environment [for sustainability].”*

*“[There can be] no sustainability if there are no partners to support the work plan. We are just bone, and we need strengths.”*

Representative from a CSO