Know Your HIV/AIDS Epidemic from a Gender Perspective

Rwanda Report

MEASURE Evaluation

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by

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This research has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement GHA-A-00-08-00003-00 which is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill with Futures Group, ICF International, John Snow, Inc., Management Sciences for Health, and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. TR-14-98 (May 2014). Cover photo courtesy of Arne Hoel, World Bank.

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Contents

Acknowledgments

MEASURE Evaluation is extremely grateful to the members of the Collaborative Team (CT) in Rwanda, who provided us invaluable guidance and facilitated government commitment throughout the activity. We are especially grateful to Ms. Sidone Uwimpuhwe (who was then the Gender and HIV Advisor at the Rwanda Biomedical Center) who recruited collaborative team members and coordinated the meeting and feedback processes. The other CT members were: Mr. Joseph Ndengeye (RBC), Mr. Eric Remera (RBC), Ms. Carine Umulsia (RBC), Dr. Charles Ntare (Ministry of Health), Ms. Carolina Mukasine (Ministry of Health), Ms. Candy Basomingera (Measure Evaluation, Rwanda), Mr. Kyampof Kirota (Measure Evaluation, Rwanda), Ms. Kate Doyle (UNAIDS), Ms. Josefin Wiklund (UNAIDS), Dr. Jeannine Condo (National University of Rwanda, School of Public Health), and Mr. Edouard Munyamaliza (Rwanda Men's Resource Centre). Andrew Koleros, Futures Group, also provided critical support and facilitated connections throughout the process of obtaining data.

Executive Summary

Decades of research from around the world has demonstrated that gender inequality negatively affects a range of health outcomes for adults, and gender inequality has been recognized as a key driver of the worldwide HIV epidemic. Managers at the national and subnational levels need information on the intersection of gender and HIV to address gender in the planning and implementing of HIV programs. Policy makers need information on interventions that are effective in accounting for gender inequities for decision making on national and global levels. This report presents the results of a gender-based analysis conducted in Rwanda that used all HIV- and gender-related data made available to the MEASURE Evaluation team. The exercise was called "Know Your Epidemic from a Gender Perspective."

In Rwanda, women and girls are disproportionately infected with HIV, comprising approximately 59% of all infections. The difference is particularly striking among young women aged 20–24, who have nearly five times higher prevalence than their male peers (2.4% compared to 0.5%), and the highest prevalence rate among women is the 35–39 age group, at 7.9% compared with 3.8% of men in the same age group. The government of Rwanda (GoR) has shown a strong commitment to promoting gender equality, and this has extended to the country's HIV response. One of the major investigations of a mid-term review of Rwanda's HIV National Strategic Plan (NSP) was the degree to which the NSP implementation addressed its overarching principles, including gender equity and human rights.

For the Know Your Epidemic from a Gender Perspective, MEASURE Evaluation conducted a gender-based analysis in Rwanda, using HIV-related routine and nonroutine data. Sex-disaggregated variables from routine sources examined the difference, or the gender gap, between the number or proportion of men/boys and women/girls using services and reached by programs. Data from special surveys conducted during the past five years were used to explore structural factors related to gender and HIV. Working with a multisectoral national-level collaborative team in Rwanda, the activity was designed to enable program managers at the national level to understand how to use their data for a gender-sensitive and effective HIV response.

Two sources of routine data were used for the analyses: TracNet, which is Rwanda's national HIV-related clinical database, and CNLSNet, which is the database that stores all HIV-related community-based programmatic data. Survey data used for the exercise drew on four sources: one nationally representative survey (Rwanda Demographic and Health Surveys 2010), and three that were community-based probability samples of different populations: people living with HIV (People Living with HIV Stigma Index Study), school children (The School Children's Survey), and workers on three coffee cooperatives in Rwanda (engaging men to prevent gender-based violence, The Coffee Cooperatives Survey).

The results from analyzing the facility-based data showed some consistent patterns. Among patients age 14 or younger, there was virtually no gender gap between boys and girls. Age 15 and higher, the burden of HIV is carried by women in all age groups. The most disproportionate burden is among young people aged 15–24. In general, there were about double the number of women than men in HIV treatment services. However, prevalence rates of young women relative to young men are up to almost five times

more. Thus, we would expect a higher ratio of women to men in services than what was observed, and it is likely that young women are not being reached by treatment. Among adults age 25–49, the gender gap observed was closer to the observed prevalence rates for this age group, indicating that these women are being adequately reached by services. Many of the programmatic reach indicators were difficult to interpret because the inconsistencies in the patterns and trends appeared to be a product of data or documentation error. The indicators that could be interpreted with confidence showed that more men than women were being reached. The numbers of people being reached by community-based programs appeared to be growing substantially.

The survey data also showed that girls and women were at a disadvantage in Rwanda, with prevailing norms and behavior reinforcing gender inequality and contributing to women and girls' vulnerability to HIV. The Stigma study showed a consistent gap between women and men in all areas explored within the Stigma index, with a consistent gap of about 15 percentage points across indicators. From the School Children's Survey, we learned that the roles and expectations related to household duties fall disproportionately on girls and their mothers, and beliefs and perceptions reflecting gender inequality persist in many areas. However, from the questions asked of respondents about how they would act in their future households, there appears to be a generational shift in gender-related attitudes when compared with what they believe their parents' perceptions are. Large numbers of children witness verbal and physical abuse of their mothers, and even more children report experiencing it themselves. Data from the Coffee Cooperatives Survey indicate that the ideas expressed about adults in the School Children's Survey were true to form: most of the men and women interviewed expressed beliefs and behavior that contribute to gender inequalities. Although none of the surveys were nationally representative, the findings from the Rwanda DHS 2010 mirror what was observed in all three of the surveys: there is a high level of gender-based violence in Rwanda, gender-inequitable norms are expressed with regard to the acceptability of intimate partner violence, and women's autonomy in several dimensions is low.

There were several lessons learned pertaining to the process of the gender-based analyses (GBA) of existing gender and HIV-related data and important conclusions drawn based on the results of the exercise.

- Analyzing the routine and nonroutine sources of data together and employing a gender focus that used sex-disaggregated and gender-sensitive indicators offered important information about Rwanda's HIV epidemic that would not have emerged from a traditional analysis. The government of Rwanda has demonstrated a strong commitment to addressing gender within its HIV response. The results of this report provide information the government can use for that endeavor.
- The steps of this exercise can be repeated for other countries using a similar process, yielding results that will enable program managers and policy makers at the national level to effectively address gender within their HIV response.
- Involving all stakeholders in the process is critical to success. The multisectoral team ensured that the exercise succeeded from accessing the data to interpreting and using the results.

- Data quality was an issue. In the routine data, there were some patterns that appeared to be caused by gaps in reports and other sources of error. In both routine and survey data, lack of adequate documentation meant that many indicators (and in some cases, whole sources of data) could not be used. Teams seeking to do this type of exercise should ensure that data are well documented, including questionnaires, variable names, the meanings of codes, and so on. Often, people working with the data are familiar enough with its structure that such documentation (e.g., codebook) does not exist and needs to be developed.
- In analyzing the gender gap in services and programmatic reach, there is only an inequity if the difference between the sexes does not mirror HIV infection rates and prevalence. In the case of Rwanda, though there was a gap between younger men and women using services and being reached by programs, the difference was much smaller than the gap in HIV prevalence. Therefore, not enough younger women were in services or being reached by programs.
- All survey data pointed to the high prevalence of gender-based violence (GBV) in Rwanda. Since GBV is a major driver of HIV among women, addressing GBV should be a priority for programs and policies.
- High proportions of individuals in all the surveys expressed norms and attitudes that perpetuate gender inequalities, directly contributing to outcomes such as intimate partner violence (IPV) and indirectly to HIV. However, the School Children's Survey showed that there may be a generational shift taking place. This points to how powerful gender-transformative programs and policies can be among youth in Rwanda to support lasting changes and success into the future, improving HIV and other health-related outcomes.

Acronyms

ARVs	Antiretrovirals
AVVAIS	L'Association des Veuves Vulnérables Affectées et Infectées par le VIH/SIDA
CNLS	National AIDS Control Commission, Rwanda
DHS	Demographic and Health Survey
GBA	Gender-based analysis
GBV	Gender-based violence
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
IPPF	International Planned Parenthood Federation
IPV	Intimate partner violence
M&E	Monitoring and evaluation
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PIT	Provider-initiated testing
PLWHA	People living with HIV/AIDS
RBC	Rwanda Biomedical Center
RRP+	Le Réseau Rwandais des Personnes Vivant avec le VIH
RWAMREC	Rwanda Men's Resource Centre
STI	Sexually transmitted infection
TRAC Plus	Centre for Research Treatment on AIDS, Malaria, Tuberculosis and Other Epidemics
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women

Key Definitions

Gender

is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated with being female and male, as well as the power relations between and among women and men, boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time and often intersect with other factors, such as race, class, age, and sexual orientation. Transgender individuals, whether they identify as men or women, are subject to the same set of expectations and sanctions.[1]

Sex

refers to the biological characteristics that define humans as female or male. These sets of characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as male or female.[2]

Gender equality

is the concept that all human beings, men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality means that the different behaviors, aspirations, and needs of women and men are considered, valued, and favored equally. It does not mean that women and men have to become the same, but that their rights, responsibilities, and opportunities will not depend on whether they are born male or female.[3]

Gender equity

is the process of being fair to women and men, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field.[4]

Gender-based analysis

is a systematic way of looking at the different effects of development, policies, programs, and legislation on women and men that entails, first and foremost, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others.[5]

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[1] Interagency Gender Working Group (IGWG). Defining Gender and Related Terms. Training resources. Available at: http://www.igwg.org/igwg_media/training/defingenderrelatedterms.pdf.
[2] World Health Organization. Sexual and reproductive health: Gender and human rights. Available at: http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
[3] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Global Fund Gender Equality Strategy*. Available at: http://www.theglobalfund.org/documents/core/strategies/Core_GenderEquality_Strategy_en/.
[4] Interagency Gender Working Group (IGWG). Defining Gender and Related Terms. Training resources. Available at: http://www.igwg.org/igwg_media/training/defingenderrelatedterms.pdf.
[5] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Global Fund Gender Equality Strategy*. Available at: http://www.theglobalfund.org/documents/core/strategies/Core_GenderEquality_Strategy_en/.

A gender-transformative AIDS response

refers to policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by (1) fostering critical examination of inequalities and gender roles, norms, and dynamics; (2) recognizing and strengthening positive norms that support equality and an enabling environment; (3) promoting the relative position of women, girls, and marginalized groups, and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.[6]

Key populations

are defined as those populations that have significantly higher levels of risk of acquiring and transmitting HIV and those with higher rates of mortality and/or morbidity within a defined epidemiological context. Key populations often have significantly lower access to or uptake of relevant services than the rest of the population. Depending on the type of epidemic and the country context, some population groups may require explicit attention (e.g., people who inject drugs, sex workers, and men who have sex with men).[7]

Other vulnerable populations

are those groups of individuals who may be vulnerable to HIV compared with others in the population, and who also have lower access to or uptake of relevant services. These include women and girls, transgender persons, clients of sex workers, prisoners, refugees, migrants or internally displaced populations, people living with HIV, adolescents and young people, orphans and vulnerable children, people with disabilities, ethnic minorities, people in low-income groups, people living in rural or geographically isolated settings, or other group(s) specific to the country context.[8]

Gender-sensitive measuring and assessment mechanisms

are formulated to identify differences between women and men in perceptions, attitudes, opportunities, and access to resources and decision making and to assess how projects, programs, and policies affect social understandings of what it means to be a woman or a man and on gender relations in the household, community, economy, and beyond.[9]

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[6] Interagency Gender Working Group (IGWG). (2013) *Gender Integration Continuum Training*. Available at: http://www.igwg.org/training/ProgrammaticGuidance/GenderContinuum.aspx.

[7] UNAIDS. (2011). *Global AIDS Response Progress Reporting 2012: Guidelines Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf.

[8] Ibid.

[9] UN WOMEN. (2012). *Transforming the National AIDS Response: Mainstreaming Gender Equality and Women's Rights into the 'Three Ones*. Available at: http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/Library/Publications/2012/EN-Transforming%20the%20AIDS%20Response-blue%20pdf.pdf.

Introduction

Background

Decades of research from around the world has demonstrated that gender inequality negatively affects a range of health outcomes for adults, including HIV and AIDS. Gender inequality has been recognized as a key driver of the HIV epidemic by all organizations focused on responding to the global pandemic.[10] From a societal perspective, gender inequities in the access to and control over resources, along with the lower status of women compared to men, increases the vulnerability of women and girls to HIV. Violence against women and girls, which stems from gender norms and gender inequality, has also been identified as a major driver of the epidemic.[11] Gender norms and practices related to masculinity have played a key role in men's and boys' risk of HIV. Gender norms cause differentials between men/boys and women/girls in health services uptake, the ability to adhere to medical regimens, and various other factors that contribute to HIV-related risks and outcomes.[12] From an epidemiological perspective, there is consensus that effective and sustainable reductions in new HIV infections will only be achieved when HIV prevention, care, and treatment strategies account for gender inequalities.[13]

It follows that to address gender in the planning and implementing of HIV programs, managers at the national and subnational levels need information on the intersection of gender and HIV. Policy makers need information on interventions that are effective in accounting for gender inequities for decision making on national and global levels. These needs account for the recent demand for gender-responsive reports on the progress and results of HIV programming by international donor organizations.[14]

There has been an increasing recognition of the need for data and research that highlights gender differences in HIV/AIDS prevention, treatment, care, and support, which will lead to gender-sensitive monitoring and evaluation (M&E) systems for HIV/AIDS programming. Global and national stakeholders have promoted activities focused on building the capacity to use sex-disaggregated data analyses to inform objectives and strategies. The results of these sex-disaggregated analyses are also

[10] UNAIDS. *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-2014. Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf.

[11] UNAIDS, UNICEF & WHO. (2013). *Global AIDS Response Progress Reporting 2013: Construction of Core Indicators for Monitoring the 2011 UN Political Declaration on HIV/AIDS*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf.

[12] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Global Fund Gender Equality Strategy*. Available at: http://www.theglobalfund.org/documents/core/strategies/Core_GenderEquality_Strategy_en/.

[13] Trasi, R., Fritz, K., Burns, K., & Douglas, Z. (2011). *An Action Guide for Gender Equality in National HIV Plans: Catalyzing Change through Evidence-based Advocacy*. International Center for Research on Women (ICRW). Available at: http://www.icrw.org/files/publications/Action%20Guide%20for%20Gender%20Equality%20in%20Naitonal%20HIV%20Plans.pdf.

[14] The United States President's Emergency Plan for AIDS Relief. PEPFAR: Addressing Gender and HIV/AIDS. Available at: http://www.pepfar.gov/press/2011/157860.htm.

being used to provide benchmarks for gender-sensitive indicators used to track progress in HIV/AIDS response and beyond.[15]

Gender-sensitive M&E in the context of HIV is consistent with the "Three Ones" principles, guiding national responses to HIV/AIDS.[16] There is a dearth of gender-responsive HIV national-level strategic plans and a need for guidance on how they should be developed.[17] One gender-sensitive M&E system should incorporate gender-responsive budgeting to enable sex-disaggregated data collection and analysis. HIV gender-responsive indicators should be measured in all areas, such as prevalence, incidence, sexual behavior, knowledge, and access to services. There is a need for sex-disaggregated indicators that highlight the gender gap between women/girls and men/boys related to access to and the reach of HIV/AIDS prevention, care, and support programs. These measures will show where gender inequalities exist in health programming and policies. Gender-sensitive indicators, those constructed to measure gender-related behavior and norms, help us understand why these inequalities in health outcomes exist. Gender-sensitive indicators monitor and evaluate progress made by programs in reducing the inequalities that lead to differentials in HIV risk and impact. This type of information is not included in most routine data collection systems designed for HIV programs, but is ordinarily gathered through special studies and surveys.

Measuring both sex-disaggregated and gender-sensitive indicators is part of a gender-responsive HIV M&E system. Because such a system will track and evaluate the progress of programs and strategies to address gender within the context of the HIV response, a greater programmatic impact will be achieved.[18] The information resulting from a gender-responsive M&E system can be used to guide programmatic and policy decision making. Conducting gender-based analyses (GBA) by combining data collected routinely from programs and that gathered periodically in special studies creates a full picture of a country's HIV epidemic and response from a gender perspective. The overall aim of this study, "Know Your Epidemic from a Gender Perspective," was to create such a picture in Rwanda, using all data available to the MEASURE Evaluation team in 2012.

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[15] UN WOMEN. (2012). *Transforming the National AIDS Response: Mainstreaming Gender Equality and Women's Rights into the 'Three Ones*. Available at: http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/Library/Publications/2012/EN-Transforming%20the%20AIDS%20Response-blue%20pdf.pdf.

[16] UNAIDS. (2004) *"Three Ones" key principles: "Coordination of National Responses to HIV/AIDS" Guiding principles for national authorities and their partners*. Conference Paper 1: Washington Consultation, April 25, 2004. Available at: http://data.unaids.org/una-docs/three-ones_keyprinciples_en.pdf.

[17] Trasi, R., Fritz, K., Burns, K., & Douglas, Z. (2011). *An Action Guide for Gender Equality in National HIV Plans: Catalyzing Change through Evidence-based Advocacy*. International Center for Research on Women (ICRW). Available at: http://www.icrw.org/files/publications/Action%20Guide%20for%20Gender%20Equality%20in%20Naitonal%20HIV%20Plans.pdf.

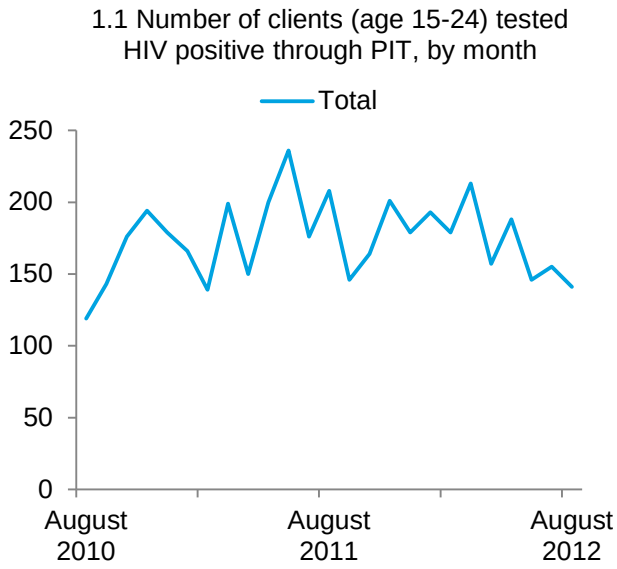
[18] UN WOMEN. (2012). *Transforming the National AIDS Response: Mainstreaming Gender Equality and Women's Rights into the 'Three Ones*. Available at: http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/Library/Publications/2012/EN-Transforming%20the%20AIDS%20Response-blue%20pdf.pdf.

Why Gender Matters in the HIV/AIDS Response

Gender is the manifestation of socially constructed roles, norms, and expectations that are placed on people, based on their biological sex. The parameters of socially acceptable behavior for women and men vary widely between societies, are dynamic over time in the same place, and have far-reaching effects on health status. It has long been observed that gender-related factors, such as expressed norms about men's and women's roles, women's autonomy, spousal relationship quality, and experience with and attitudes about intimate partner violence (IPV), demonstrate an impact on health outcomes everywhere in the world. These effects are especially pronounced for HIV-related outcomes. UNAIDS and other groups have recognized that gender-based violence, which stems from gender inequality, is a major driver of the HIV/AIDS epidemic.[19]

Much of the research in this area has taken place in special studies involving primary data collection or demographic and health surveys. There have been no efforts to use all country-level data, such as data routinely collected by health systems and special studies, to examine the effects of gender-related factors on HIV/AIDS risk and related service utilization. The current global focus on gender and health has created a sense of urgency for information on how gender inequities can best be addressed by programs and policies, particularly in the HIV/AIDS arena. Both types of data are critical to inform program and policy-related decision making.

Figures 1.1 and 1.2 are drawn from routine facility-based data pertaining to new infections in Rwanda. The difference between the figures demonstrates how much more information is yielded, simply by conducting sex-disaggregated analyses. Figure 1.1 depicts the total number of young clients who have tested positive for HIV over a two-year period, calculated by annual quarters (every three months). The notable fluctuation between periods could be explained by many factors, such as variance in the number of reports tallied at the national level. The overall level of new infections is fairly constant from the beginning to the end of the period. However, apart from the age group of the clients, we have no idea how new infections are distributed through the population, and we could wrongly assume that the numbers of young men and

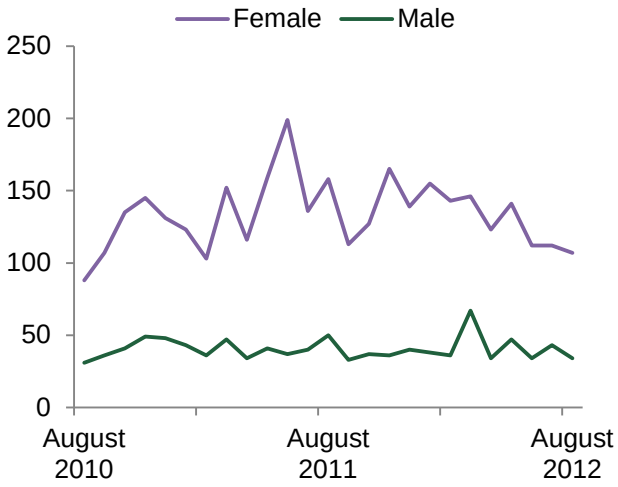


[19] UNAIDS. (2010). *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV – Operational plan for the UNAIDS action framework: addressing women, girls, gender equality and HIV*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf.

women presenting with new infections are approximately the same. When examining the same statistic in Figure 1.2, we can see that there are more than twice the number of young women than young men presenting with new infections in this age group, and this difference is more or less consistent across the time period. Therefore, we understand that young women are more at risk for primary HIV infection in Rwanda than young men, and that this proportional risk between men and women has not changed in two years. These results lead to other questions, such as: Are prevention programs adequately reaching younger women? What are the factors that put younger women at higher risk for HIV than younger men? The information provided in Figure 1.2 is critical for addressing HIV risk in Rwanda.

This example serves as general guidance on how to use existing data to conduct gender and HIV analyses at the country level enhance the use of and generate demand for more gender-related HIV data.

1.2 Number of clients (age 15-24) tested HIV positive through PIT, by month, sex-disaggregated



HIV in Rwanda

In Rwanda, women and girls are disproportionately infected with HIV, making up approximately 59% of all infections.[20] According to the 2010 Rwanda Demographic and Health Survey (RDHS), HIV prevalence among 15–49-year-olds in Rwanda is 3.0%, the same as reported in the 2005 RDHS. In 2010, HIV prevalence among women was higher than among their male peers in nearly every age group. For example, HIV prevalence among women age 15–49 was 3.7%, whereas among men in the same age group was 2.2%.[21] The difference is particularly striking among young women aged 20–24, who have nearly five times higher prevalence than their male peers (2.4% compared to 0.5%), and the highest prevalence rate among women is the 35–39 age group, at 7.9% compared with 3.8% of men in the same age group. The gender gap is observable in urban versus rural residence as well. In urban areas, 8.7% of women were infected compared with 5.4% men, and in rural areas the figures were 2.8% women and 1.6% of men.

HIV prevalence among most-at-risk populations is even higher. The Behavioral and Biological Surveillance Survey among Female Sex Workers conducted in 2010 showed an estimated HIV prevalence rate among sex workers at 51% (95% CI, 48–54%).[22]

[20] UNFPA, UNAIDS & UNIFEM. (2010). *Republic of Rwanda: National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010–2014*. Available at: http://www.unicef.org/aids/files/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf.
[21] MEASURE DHS & ICF International. (2012). Rwanda and Healthy Survey (RDHS) 2010 Final Report.
[22] Republic of Rwanda, Ministry of Health; Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics. (2010). *Behavioral and Biological Surveillance among Female Sex Workers, Rwanda – 2010*

Besides women and girls' biological susceptibility to HIV, a number of socioeconomic, cultural, and legal factors increase women and girls' vulnerability to and risk of HIV. In Rwanda, these factors include gender inequality, poverty, lack of education, denial of inheritance and property rights, and sexual and gender-based violence.[23]

Government of Rwanda and Gender-Sensitive HIV Response

Rwanda adheres to the UNAIDS "Three Ones" principles of national HIV/AIDS response coordination: the existence of one national AIDS coordinating authority, one national strategic HIV/AIDS plan of action, and one HIV/AIDS national monitoring and evaluation system. Rwanda's response to HIV and AIDS was directed by the National AIDS Control Commission (CNLS) and TRAC Plus under the supervision of the Ministry of Health (MOH) from 2000 to 2010. The CNLS was responsible for coordinating the national multisectoral response to HIV/AIDS with particular focus on key functions such as national policy development, partnerships, monitoring, and evaluation. TRAC Plus was responsible for coordinating the clinical aspects of the HIV response. In an effort to further mainstream the HIV response into the overall health sector at both the national and district levels, in 2010 the government of Rwanda created the Rwanda Biomedical Center (RBC). The RBC's mission is to promote quality affordable and sustainable health care services to the population through innovative and evidence-based interventions and practices guided by ethics and professionalism. The RBC, established by law in January 2011, initiated the merger of 14 Rwandan health-related agencies—including CNLS, TRAC Plus, the National Medical Referral Laboratory, the Centre for Blood Transfusion, and the national procurement agency for medical equipment, drugs and supplies—to eliminate the duplication of job responsibilities across different institutions, increase output, and improve efficiency of delivery of services. One of the most important activities of the RBC in this capacity is the development of the National Strategic Plan (NSP) on HIV and AIDS.

The government of Rwanda (GoR) has shown a strong commitment to promoting gender equality through the national constitution and other policy documents that include but are not limited to the following: the National Accelerated Plan for Women, Girls, Gender Equality and HIV (2010–2014), the National Gender Policy of 2010,[24] the National Policy Against Gender-Based Violence (GBV)[25] and its strategic plan,[26] liberalities and succession to promote women's rights and gender budgeting[27][28] efforts that

Survey Report. Available at: http://rbc.gov.rw/IMG/pdf/behavioral_and_biological_survey_among_female_sex_workers_rwanda_2010.pdf.

[23] UNFPA, UNAIDS & UNIFEM. (2010). *Republic of Rwanda: National Accelerated Plan for Women, Girls, Gender Equality and HIV 2010–2014*. Available at: http://www.unicef.org/aids/files/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf.

[24] Republic of Rwanda, Ministry of Gender and Family Promotion. (2010). *National Gender Policy*. Available at: http://www.gmo.gov.rw/uploads/media/NGP-FINAL_VERSION_02_JULY_2010.pdf.

[25] Republic of Rwanda, Ministry of Gender and Family Promotion. (2011). *National Policy against Gender-Based Violence*. Available at: http://www.migeprof.gov.rw/IMG/pdf/GBV_Policy-2_1_.pdf.

[26] Republic of Rwanda, Ministry of Gender and Family Promotion. (2011). National Strategic Plan for Fighting Against Gender-Based Violence 2011-2016. Available at: http://www.migeprof.gov.rw/IMG/pdf/GBV_Policy_Strategic_Plan-2.pdf.

[27] Republic of Rwanda, Ministry of Finance and Economic Planning (MINECOFIN). (2008) *Gender Budgeting Guidelines*. Available at: http://www.migeprof.gov.rw/IMG/pdf/GENDER_BUDGETING_GUIDELINES-2.pdf.

consider gender issues in all development programs. In addition, the GoR has ratified international human rights treaties and conventions related to the gender equality, such as the Convention on Elimination of All Forms of Discrimination against Women. The GoR has also participated in international and regional conferences related to gender equality such as the Africa MenEngage symposium (Johannesburg, 2009) and the first global consultation on Integrating Strategies to Address Gender-based Violence and Engage Men and Boys to Advance Gender Equality through National Strategic Plans on HIV and AIDS held in Nairobi, Kenya, in 2010.

Consequently, GoR and donors have made efforts to monitor the processes and outcomes of their combined efforts. In 2011, the midterm review (MTR) of the Rwanda National Strategic Plan for HIV and AIDS 2009–2012 (NSP) started. This process was conducted at the national level and included a multisectoral representation of stakeholders. One of the main areas of MTR investigation was the degree to which NSP implementation addressed its overarching principles, including gender equity and human rights. A national consultant to the RBC, funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) gender challenge funds and UN Women, was hired to focus specifically on these issues during the MTR.

The MTR used a participatory approach to evaluation that involved all stakeholders in the HIV response. This evaluation employed a mixed-methods nonexperimental design, extracting quantitative data from existing data sources with purpose-built standardized tools, and collecting qualitative data through key informant interviews and facilitated discussions with key experts, focus group discussions with HIV target populations and beneficiary groups, and direct observation at direct service delivery sites. Results showed that the NSP Operational Plan included 3 strategies and 16 activities pertaining to interventions implemented from a gender perspective. These largely included interventions targeting women and programs focused on GBV prevention, education, and service delivery for GBV victims. Overall, findings indicated that program experts has been observing an increase in the inclusion and targeting of women in interventions during the NSP implementation period, as well as stronger coordination of gender equity activities. Stakeholders also stated observing an increased visibility of gender initiatives in the country. They also generally agreed that gender equity is now considered in all program planning activities. Some key successes in this program area include the development of the National Gender Policy,[29] which incorporates HIV as a cross-cutting issue, and increased support and capacity building to women's organizations and associations of women living with HIV. Program beneficiaries confirmed these findings at the community level. Youth expressed an increased awareness of issues around gender equity and stated that information reached them through HIV interventions.

Some challenges were shared as well, such as translating policies into practice and ensuring good implementation at decentralized and lower levels. Women expressed lack of confidence and limited

[28] Julius, M. (2011). *Progress Towards Achieving Gender Response Budget in Rwanda: A CSO Response to Sectoral GB Statements for the FY 2011/12*. Rwanda Civil Society Platform (RCSP). Available at: http://www.rcsprwanda.org/IMG/pdf/Final_GB_statements_Asessment_Report_1_.pdf.

[29] Republic of Rwanda, Ministry of Gender and Family Promotion. (2010). National Gender Policy. Available at: http://www.gmo.gov.rw/uploads/media/NGP-FINAL_VERSION_02_JULY_2010.pdf.

capacity as barriers to effective participation at community and national levels. Women's organizations are not well represented in the key national HIV coordination forums or technical working groups and face challenges due to low institutional capacity and underfunding, thus reducing their ability to take part in national-level meetings.

Know Your Epidemic from a Gender Perspective: Rwanda

MEASURE Evaluation conducted a gender-based analysis (GBA) in Rwanda, using HIV-related routine and nonroutine data. Sex-disaggregated variables from routine sources examined the difference, or the gender gap, between the number or proportion of men/boys and women/girls using services and reached by programs. Data from special surveys conducted over the past five years were used to explore structural factors related to gender and HIV. The results of analyzing these two types of data together are presented here to show the current state of the epidemic in Rwanda from a gender perspective. Although Rwanda was the subject of this particular study, this type of analysis can be readily conducted in any country.

Working with a multisectoral national-level collaborative team in Rwanda, the activity was designed to enable national program managers to understand how to use data for a gender-sensitive and effective HIV response. Results were disseminated at a national workshop with the collaborative team and other actors from government and nongovernmental organizations who work on the HIV response. The workshop entailed an indicator mapping exercise, using a forthcoming list of standard gender and HIV indicators, to demonstrate how many factors would be applied to existing data in Rwanda. This resulted in a commitment to incorporate some of the gender and HIV indicators into the NSP.

This workshop was followed by a regional one, Facilitating Data Use for Gender-Aware Health Programming, with district-level HIV program officials from Rwanda and national HIV program representatives from Botswana and Zambia. Participants in the regional forum learned about the importance of gender analysis to inform evidence-based decision making, reviewed their HIV-related service data from a gender perspective, identified information on gender differences at the district (national) level in service usage, and developed programmatic action plans to address gender disparities at the district (national) level as well as routinely monitor data to assess progress. This workshop could also be replicated in another country.[30]

Methods

The GBA was conducted using all routine and survey HIV/AIDS-related data in Rwanda that were made available to MEASURE Evaluation staff in the spring of 2012.

Data Acquisition

MEASURE Evaluation team members traveled to Rwanda in February 2012 to gather national HIV and survey data from partners in country. The researchers participated in the Joint Review Steering

[30] MEASURE Evaluation, Iris Group & Interagency Gender Working Group (IGWG). (2013). *Facilitating Data Use for Gender-Aware Health Programming: Guidance For Workshop Facilitators*. Available at: http://www.cpc.unc.edu/measure/publications/ms-13-81.

Committee meeting for the National Strategic Plan (NSP) Midterm Review, offering basic gender training and advocating for the inclusion of gender-based indicators in the Midterm Review as well as the updated NSP.

MEASURE Evaluation team members visited Rwandan Ministry of Health facilities, National Institute of Statistics Rwanda, Gender Monitoring Office, Maternal and Child Health Department, PEPFAR, the Rwanda Men's Resource Centre (RWAMREC), and other offices to explore what data were available.

Data Sets Used

1) Routine Health Systems Data

Routine HIV data from the health system came from two sources: TracNet and CNLSNet.

TRACnet is Rwanda's clinical database, a dynamic information system designed to collect, store, retrieve, and disseminate critical program, drug, and patient information related to HIV/AIDS care and treatment. TRACnet was founded in 2007 as part of TRACPlus (Center for Treatment and Research on AIDS, Malaria, Tuberculosis, and Other Epidemics) under the supervision of the Ministry of Health, but is now housed at the Rwanda Biomedical Centre (RBC), which was established in 2010 to streamline research, data, and M&E regarding infectious disease, education, and research, including on HIV and AIDS. Data are collected and reported monthly by facilities offering HIV-related services and are aggregated at the district level as a standard set of indicators, which are then sent to the RBC.

The CNLS was created in 2000 for the overall coordination of the national HIV response (community interventions, impact mitigation, care and treatment, etc.). Housed at CNLS (National AIDS Control Commission, Rwanda), CNLSNet has been a web-access database designed to collect, store, retrieve, and disseminate community-based HIV data. CNLSNet is accessible to all authorized partners and managed by CNLS and CDLS. When the RBC was established in 2010, CNLSNet came under its mandate.

2) Survey Data

Survey data provided was both nationally representative and specific community-based probability samples. The Rwanda Demographic and Health Surveys (RDHS) 2010 collected data from all districts in Rwanda on various aspects relating to HIV, gender-based violence (GBV), and other gender-related areas, such as household decision making and economic independence. The People Living with HIV Stigma Index Study collected information related to stigma and discrimination among HIV-positive members of the Rwanda Network of People Living with HIV and AIDS.

The GBA used two community-based surveys that drew probability samples. Plan International, and the Rwanda Male Engagement Center (RWAMREC) conducted the School Children's Survey. This was a survey among school children in Rwanda (age 10–18) to be used as part of a global report, "Because I

Am a Girl: State of the World's Girls 2011."[31] Data were collected in four schools in Rwanda, two in rural areas and two in urban areas. The survey includes information on gender norms pertaining to a range of areas. Instituto Promundo collaborated with RWAMREC to conduct the Engaging Men to Prevent Gender-Based Violence (Coffee Cooperatives).[32] This survey was conducted among women and men working on three coffee cooperatives in Rwanda as part of an impact evaluation study completed in four countries. Information was collected about the roles of women and men, gender norms, spousal communication, norms around GBV, experience of GBV among women, and perceptions of GBV among women and men.

Analyses of the routine data started with all sex-disaggregated indicators to focus on exploring the gender gap in programmatic reach and health facility-based data. Survey data analysis focused on gender-related factors that had been shown to influence HIV/AIDS-related outomes, such as attitudes and norms among school children, individuals working on coffee cooperatives, and a larger sample of men.

One of the major challenges in using the routine data was incomplete documentation. In most instances, there was no codebook to explain what variables meant or how they were collected. When questionnaires were available, variables were not specifically coded to systematically follow the order of the questions. Through an iterative process with in-country partners, enough information was obtained to use several data sets within the TracNet and CNLSNet systems. Data sets without documentation or information to understand the variables were not used. Data management and analyses of all data sets was completed using SAS.

[31] Van der Gaag, N. (2011). *Because I am a Girl Report: The State of the World's Girls 2011: So, what about boys?* Plan International. Available at: http://plan-international.org/files/global/publications/campaigns/BIAAG-Report-2011.pdf.

[32] Instituto Promundo. (2012). *Engaging men to prevent gender-based violence: A multicountry intervention and impact evaluation study*. Report for the UN Trust Fund.

2. Health Systems Data

A glance at the figures in this section will show many sharp increases and decreases from reporting period to reporting period. These fluctuations are caused primarily by a shift in the number of facilities reporting to the system during a given period, rather than a true trend over time. The focus of the analyses of the health systems data is on the gender gap rather than on the patterns of the numbers over time. The gender gap is the difference between the numbers or proportions of males and females. The gap should represent what we expect to see. If the numbers of men and women in a society are equally affected by HIV, then we would expect to see little if any gap between men and women and girls and boys if services and programs are reaching everyone the way they should. However, if there is an unequal distribution of HIV prevalence among males and females, as is the case in Rwanda, we would see the gender gap in service access and programmatic reach reflect the same difference if both women/girls and men/boys are being appropriately reached (see Figures 1.1 and 1.2) If the gender gap does not reflect this difference, showing either too few men or too few women for what we would expect, program managers need to investigate why and how to rectify this disproportion.

2.1 HIV Facility-Based Information (TracNet)

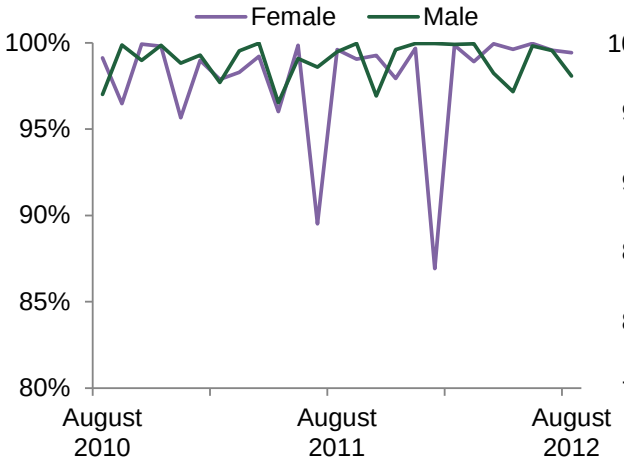
HIV facility-based results were disaggregated by sex for several different indicators across several service databases. The databases covered in this section are voluntary counseling and testing (VCT), provider initiated testing (PIT), pre-antiretroviral services (pre-ART), antiretroviral services (ART), and post-exposure prophylaxis services (PEP). Some indicators sound similar to others because they are reported from these different services. The data are presented by quarters over a two-year period, from August 2010 through July 2012.

Girls and Boys under Age 15

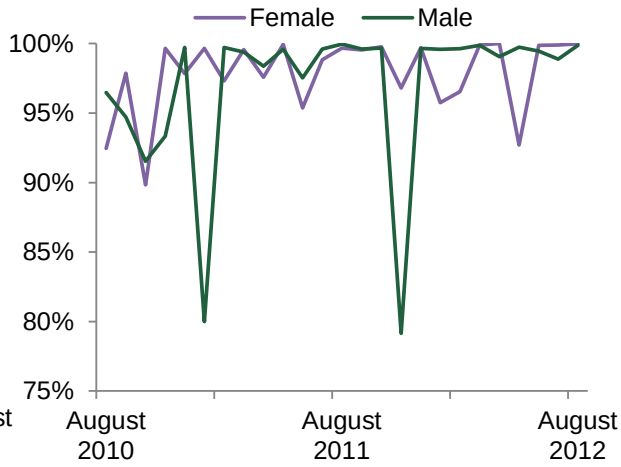
Figures 2.1 through 2.6 show service delivery for numbers of girls and boys under age 15. There is no gender gap in service provision for this age group. Figures 2.4 and 2.5 show slightly more girls testing positive and being enrolled in care across the periods, but the numbers are too small to be of much significance. These results are not surprising, since there has been some evidence showing a slightly higher risk HIV acquisition rate among female infants, but there numbers are fairly close.[3334] In Rwanda, there is little observed difference in infections rates at this age group.[35]

[33] Taha, T. E., Nour, S., Kumwenda, N. I., Broadhead, R. L., Fiscus, S. A., Kafulafula, G., ... & Hoover, D. R. (2005). Gender differences in perinatal HIV acquisition among African infants. *Pediatrics*, *115*(2), e167-e172.
[34] Biggar, R. J., Taha, T. E., Hoover, D. R., Yellin, F., Kumwenda, N., & Broadhead, R. (2006). Higher in utero and perinatal HIV infection risk in girls than boys. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *41*(4), 509-513.
[35] MEASURE DHS & ICF International. (2012). Rwanda Demographic and Healthy Survey (RDHS) 2010 Final Report.

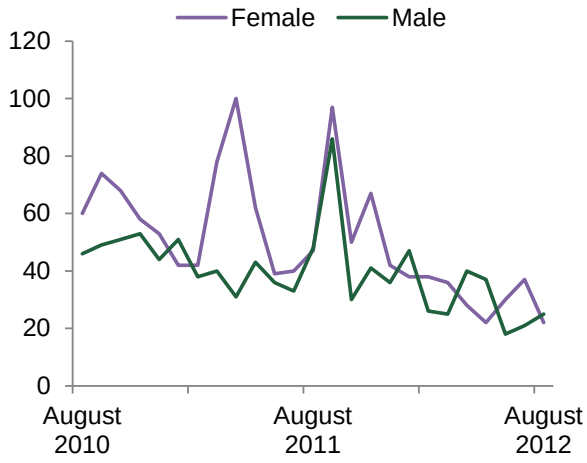
2.1 Proportion of people (<15 years) counseled & tested who have received their results



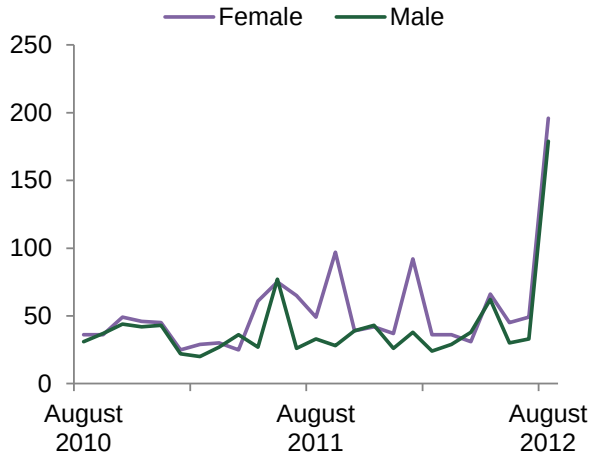
2.2 Proportion of people (<15 years) counseled & tested though PIT who have received their results, by month

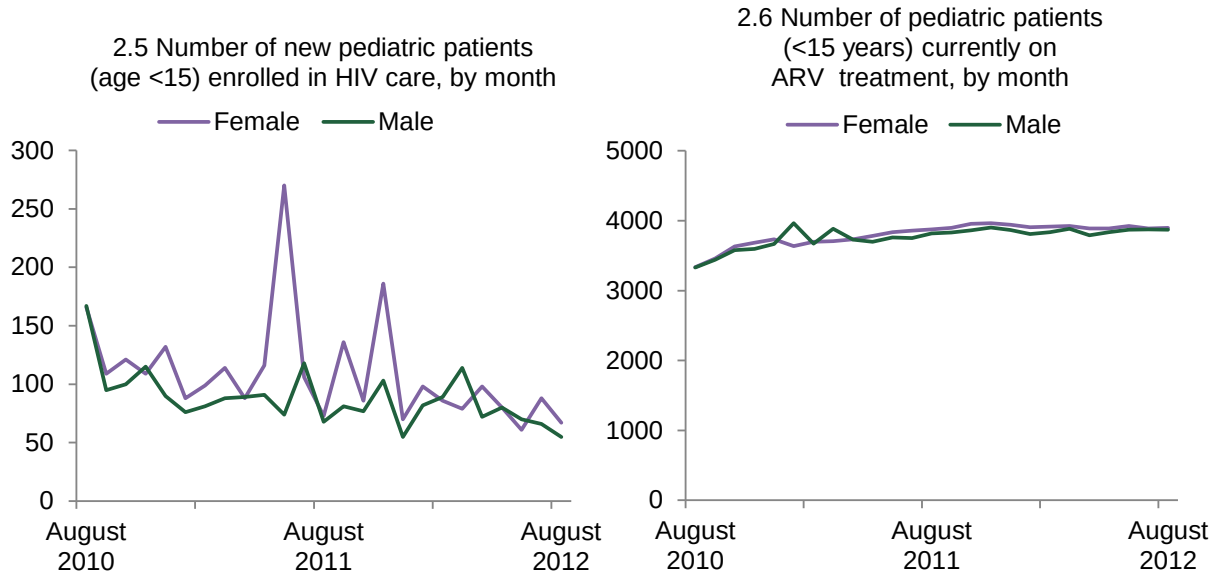


2.3 Number of HIV positive clients (age <15), by month



2.4 Number of clients (age <15) tested HIV positive through PIT, by month



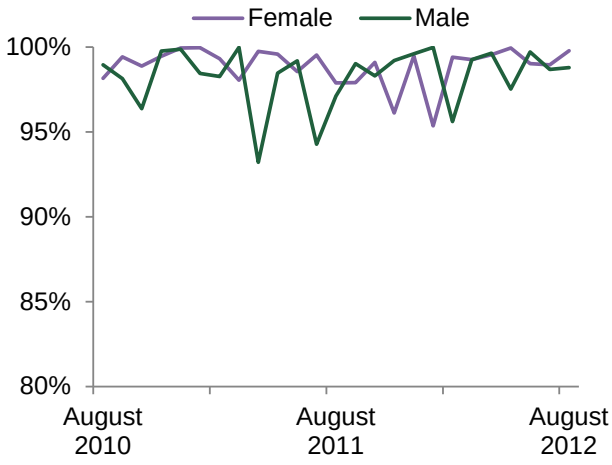


Young Women and Men Aged 15–24 Years

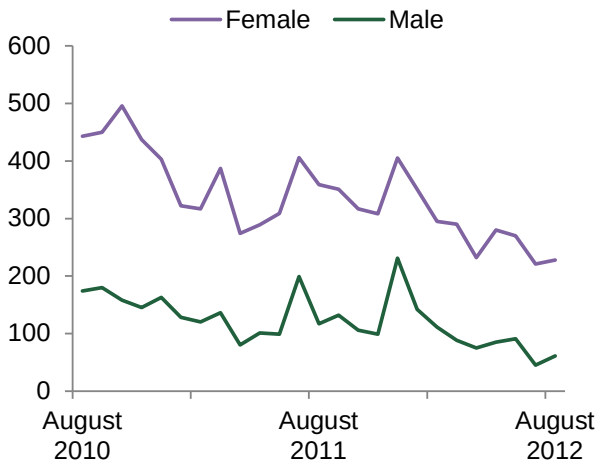
The sharpest differences in HIV prevalence between males and females in Rwanda (0.5% compared to 2.4%) were observed among young women and men,[36] and thus we would expect to see almost five times the number of women at HIV services. Figures 2.7–2.10 show the patterns for young men and women in testing services. There is little difference between young women and men in the proportions of those tested and who have been given their results (Figures 2.7 and 2.9). This indicates that both young men and women are equally as likely to receive their results once they are tested. The numbers of women testing positive through both VCT services (Figure 2.8) and PIT (Figure 2.10) reflect the disproportionate HIV burden among young Rwandan women, with more than two and a half times the numbers of young men testing positive. New patients enrolled in ART (not shown here) reflect the same gap between young women and men. These figures indicate that greater numbers of young women are testing positive and being treated for HIV, as we would expect, but the gap is not as large as indicated by the prevalence rates detected in the RDHS. This may indicate that more women need to be reached.

[36] Ibid.

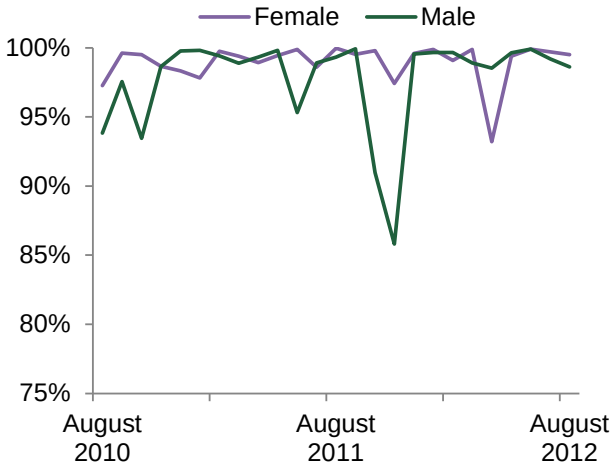
2.7 Proportion of people (age 15-24) counseled & tested who have received their results



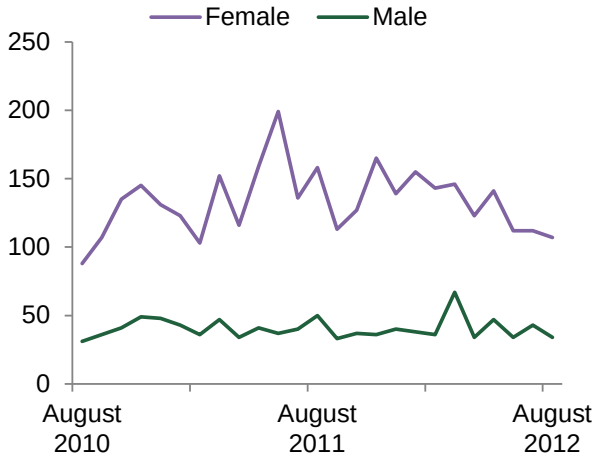
2.8 Number of HIV positive clients (age 15-24), by month



2.9 Proportion of people (age 15-24) counseled & tested through PIT who have received their results, by month



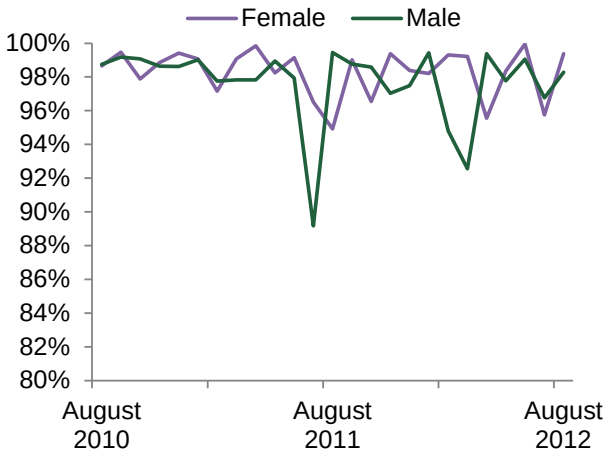
2.10 Number of clients (age 15-24) tested HIV positive through PIT, by month



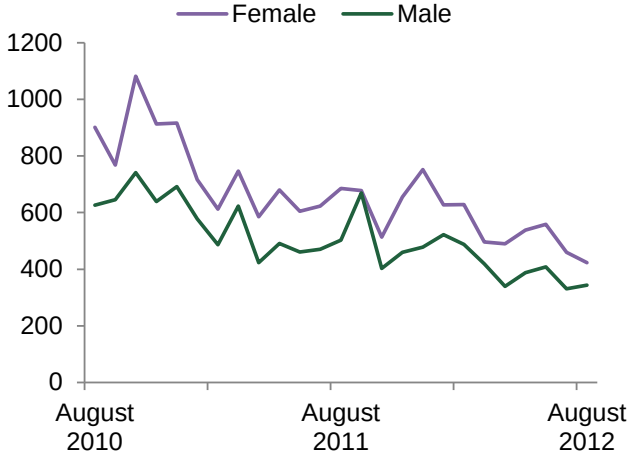
Adult Men and Women Age 25 Years and Older

Figures 2.11–2.17 depict the patterns of service use by adult women and men aged 25 years and older. Again, the proportion of adult women and men who were both tested and received their results were very similar, both through VCT and PIT services (Figures 2.11 and 2.13, respectively). The RDHS observed that HIV was more prevalent among adult women than among adult men. The difference was smallest at the oldest age groups.[37] A little under a third more adult women than men tested positive for HIV, and the gap remained fairly stable over the two-year period. Figures 2.15 and 2.16 show the numbers of new people enrolled in HIV services each month, and new patients starting HIV during the reporting month. The gap in those beginning HIV services is fairly consistent across the observation period for those enrolling in HIV care (Figure 2.15), but the gap fluctuates a little more for those starting ARV treatment (Figure 2.16). The differences are small, however, and could be due to the variation in reporting. The gap is about what we would expect, given the findings of the RDHS. Finally, Figure 2.17 shows the number of adults already on ARV. As we would expect, the totals increase over time, and the gap stays fairly consistent, slightly wider at the latest reporting period.

2.11 Proportion of people (age 25+) counseled & tested who have received their results

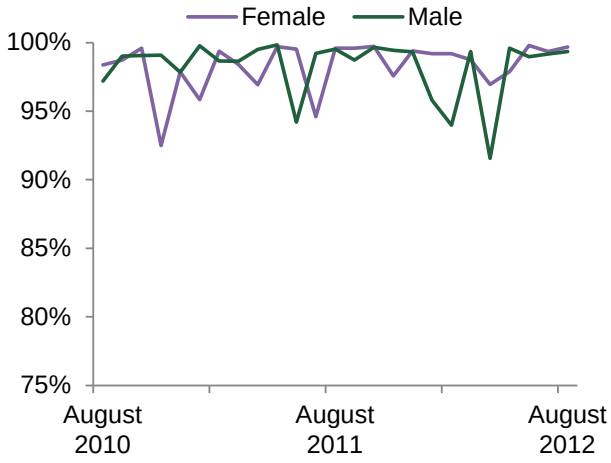


2.12 Number of HIV positive clients (age 25+), by month

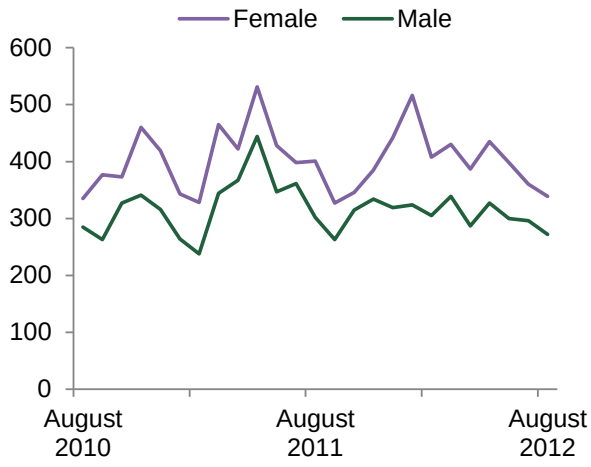


[37] Ibid.

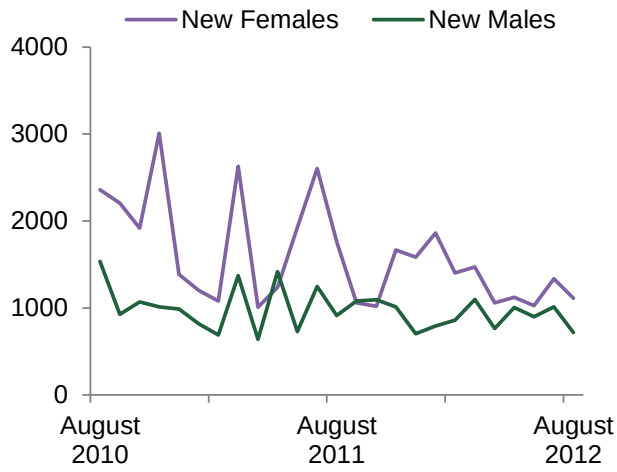
2.13 Proportion of people (age 25+) counseled & tested through PIT who have received their results, by month



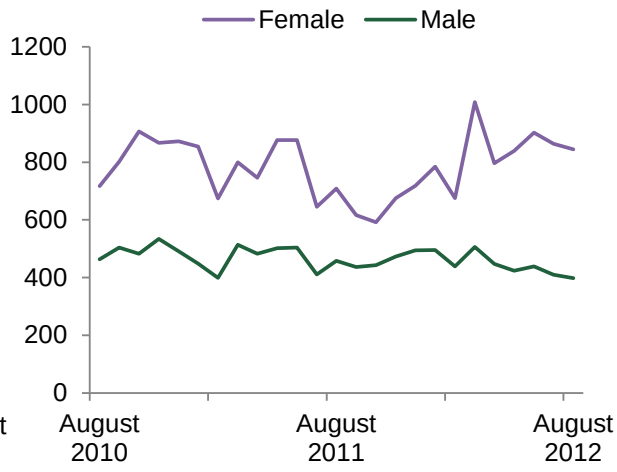
2.14 Number of clients (age 25+) tested HIV positive through PIT, by month



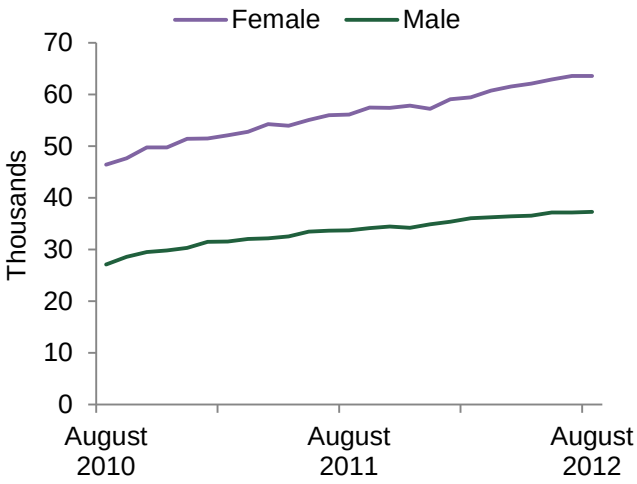
2.15 Number of new adult patients enrolled in HIV care this month



2.16 Number of new adult patients starting ARV treatment, by month

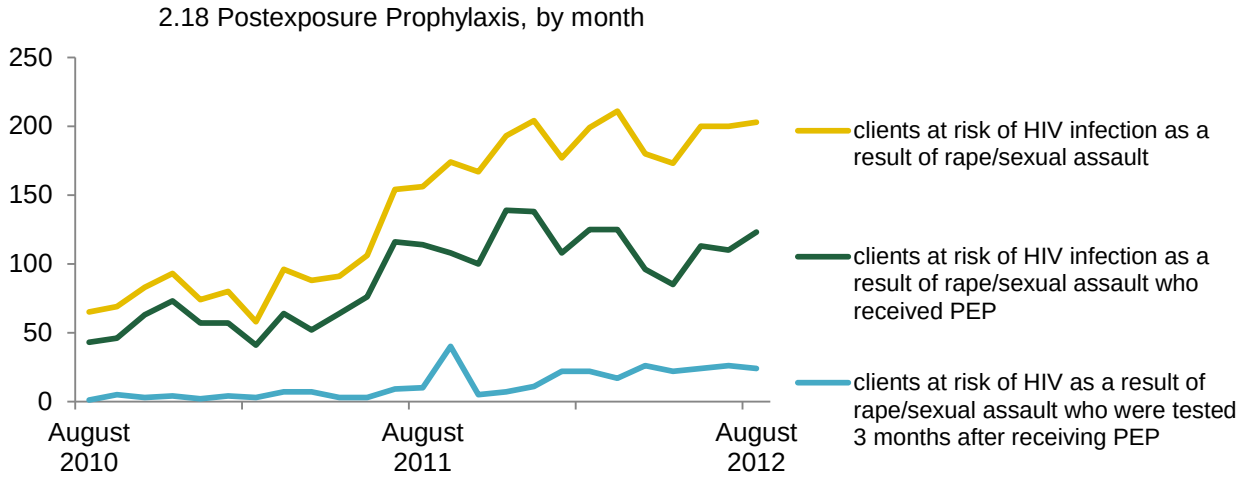


2.17 Number of adult patients on ARV treatment, by month

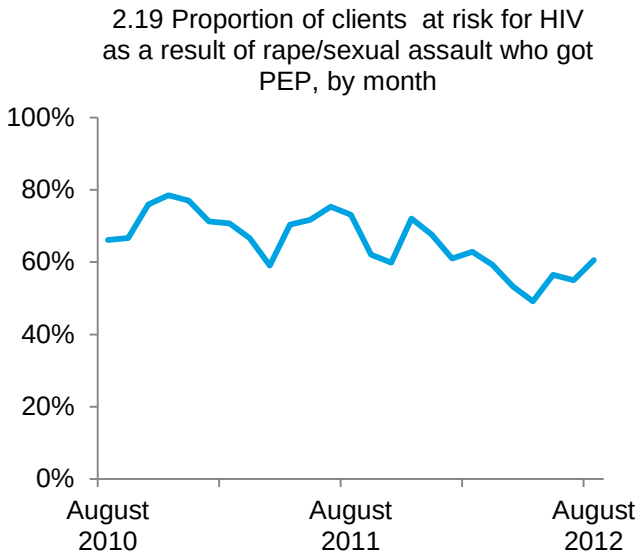


PEP by Month

Figure 2.18 shows the number of clients who reported possible exposure to HIV as a result of being raped. Although these data are not sex-disaggregated, the vast majority of these clients are women. The number of reported rapes appeared to rise steadily through the reporting period. The number of raped



individuals who received PEP appears to decline over time. Figure 2.19 shows the proportion of individuals who were at risk of exposure due to rape and received PEP, which declines from about 65% to about 50% by the end of the observations period. Very few of these women were tested after three months (Figure 2.18). Many of these individuals present to the system and are then referred out to facilities with protocols around sexual assault. These individuals probably receive PEP at the referral facility, which explains the declining numbers. It is possible that they are tested after three months as well. It would be beneficial to track these individuals through the referral facilities to ensure that they are receiving appropriate HIV-related services, which would mean creating some mechanism for reports back into the data system.

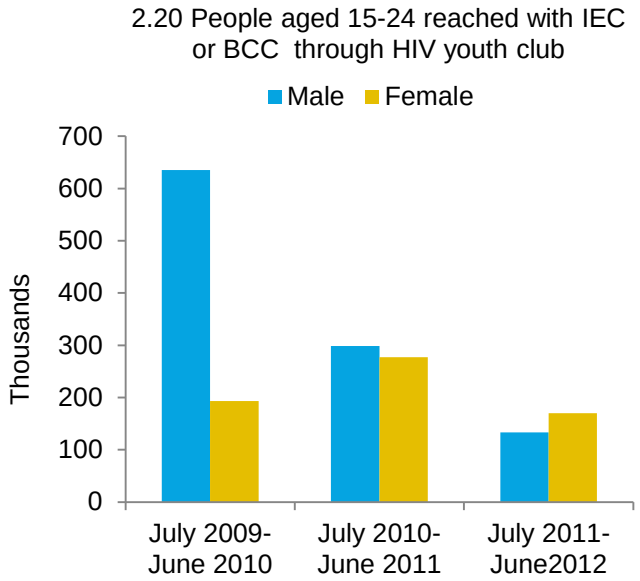


Conclusions on HIV Facility-Based Reports

Several conclusions can be drawn from the facility-based data. Among pediatric patients, most of the changes in the levels were due to the month-to-month fluctuations in reporting. There was virtually no gender gap in the number of pediatric patients currently on ARV treatment. There may be some difference in HIV prevalence in the general population of girls and boys under age 15 as observed elsewhere in Africa (there are no prevalence studies in Rwanda among this very young population), but we would only expect small differences between young boys and girls because HIV at that age is primarily contracted through mother-to-child transmission.

Once past the period where the risk is largely biological, the burden of HIV is carried by women in all age groups. The most disproportionate burden is among young people aged 15–24. In this age group, one study observed a large proportion of girls reporting inconsistent condom use and testing positive for sexually transmitted infections (STIs), and 29% of them reported experiencing forced sex.[38] The largest differentials between males and females testing positive for HIV—through both the VCT and PIT data—were reported for this age group. For those enrolled in treatment and already on ARV (results not shown here), there were about double the number of women than men. However, the RDHS indicates that women in this age group have prevalence rates up to almost five times that among young men. Therefore, the ratio of women to men on treatment should be closer to 5:1, not 2:1. It is likely that young women are not being reached by treatment. Among adults, the gender gap observed was fairly consistent through all the service statistics with almost double the number of women than men in services, which was closer to the observed prevalence rates for this age group, indicating that these women are being reached by services.

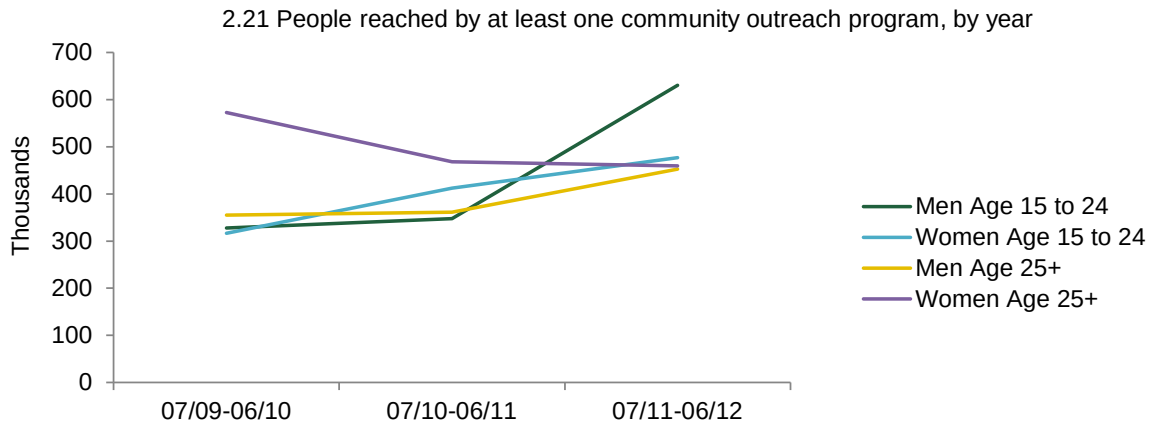
Because most people reporting sexual assault are referred elsewhere for follow-up, the related statistics are difficult to interpret. It is recommended that these reports be sex-disaggregated to examine the gender gap in these data. Additionally, data should be reported by referral facilities to track whether people are getting the care they need.



2.2 Information on HIV Programmatic Reach (CNLSNet)

Figures 2.20–2.37 depict the results from HIV prevention, care, and support programs being implemented in communities and covers key populations and other groups of people vulnerable to HIV. Some of these data

[38] Test, F. S., Mehta, S. D., Handler, A., Mutimura, E., Bamukunde, A. M., & Cohen, M. (2012). Gender inequities in sexual risks among youth with HIV in Kigali, Rwanda. *International journal of STD & AIDS*, *23*(6), 394-399.



have been sex-disaggregated, and some pertain to populations that are affected by gender norms and expectations, such as men who have sex with men or female sex workers. The programmatic reach data aggregated into the CNLSNet system was by three-month quarters and is presented by year: July 2009–June 2010, July 2010–June 2011, and July 2011–June 2012. Figure 2.24 did not have the last six months tallied into the figure, so the last period is only six months rather than a full year, as covered by the rest of the figures.

Figure 2.20 shows the reach of information, education, and communication, as well as behavior change and communication campaigns among youth populations, conducted through youth HIV clubs. The gender gap was very wide during the first year shown, but the differential diminishes in the following two years: about the same number of young women and men are reached by these programs.

Figure 2.21 shows the number of women and men who were reached by at least one community outreach program and further disaggregates the data into those aged 15–24 and those 25 years and older. Although there is a sharp increase in the number of young men reached over the three-year period, the number of young women rises only slightly. Among older women there is actually a decrease over the period, with a corresponding slight increase among adult men. Among both age groups, the gender gap widens over time. The trends in new people reached by at least one program (Figure 2.22) appear to show a more consistent rise overall, but the rise is sharper among young men than among young women. More new older women and men are reached over time, but again the rise is sharper among men than among women. Given the risk that younger women in Rwanda face, these figures are of some concern since programs ought to reach at least as many younger women as men.

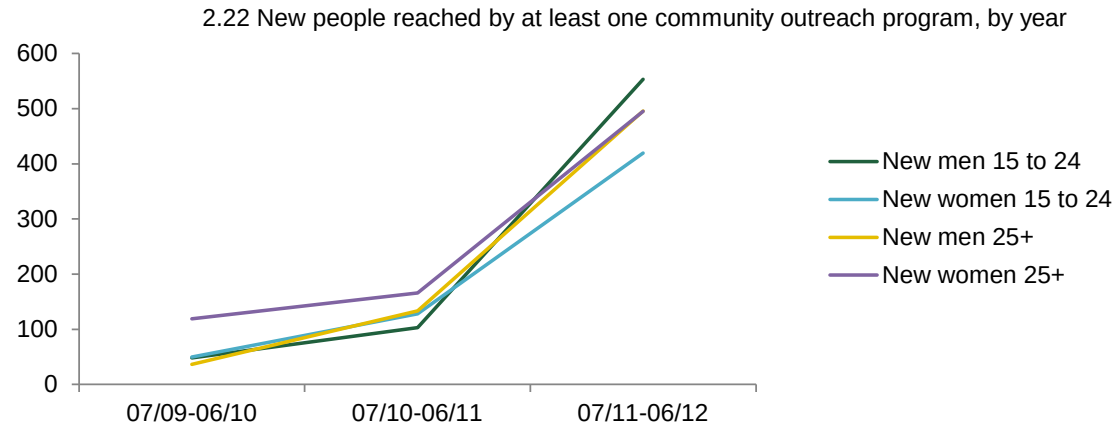
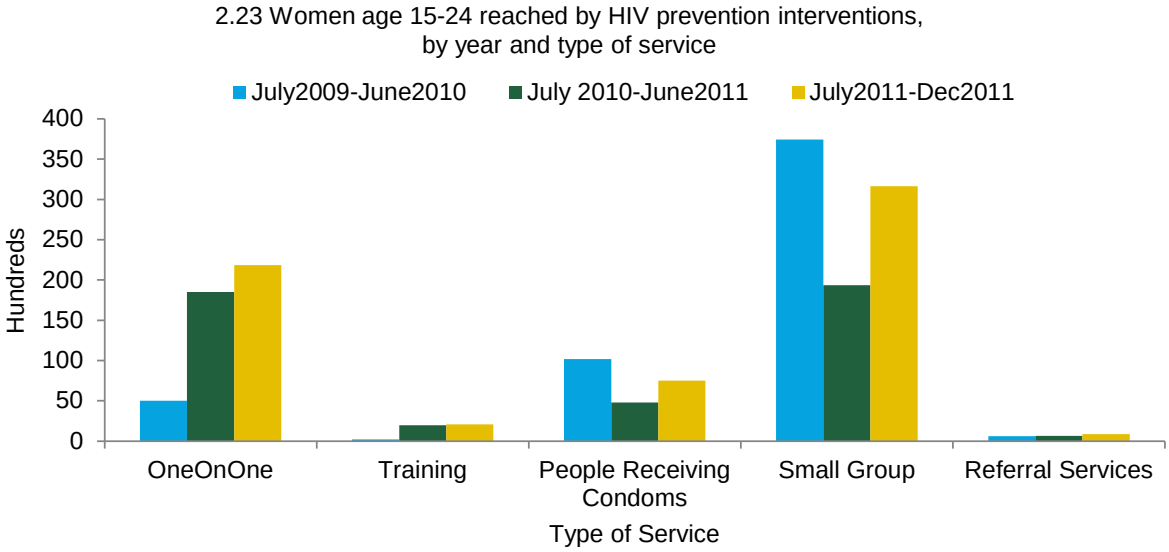


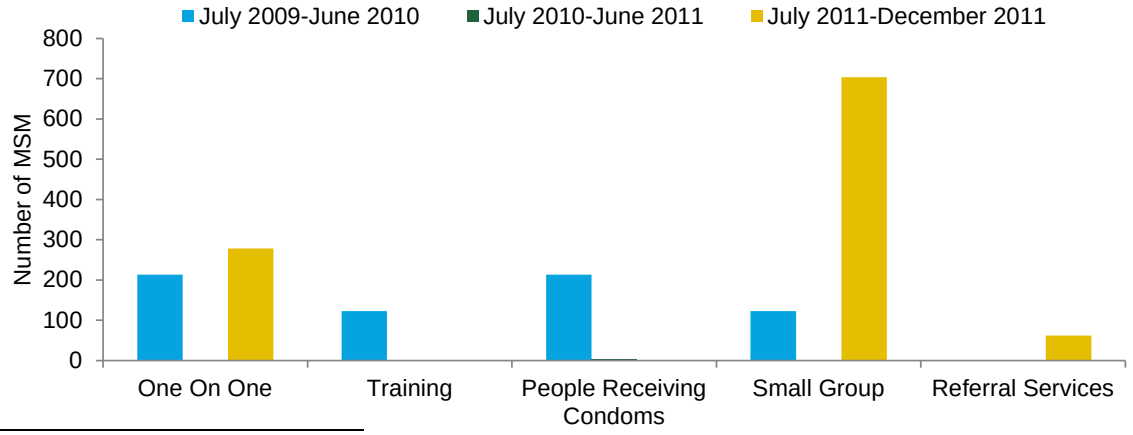
Figure 2.23 shows the numbers of young women aged 15–24, the highest HIV risk group in the country, reached by HIV prevention programs. There is an upward trend in the one-on-one training programs, but the remaining interventions seem to swing up and down with no consistent pattern over the three-year period. Part of this may be due to the number of programs being launched or to reporting errors. Since this population of women is so important, we would want to see more and more of these women targeted with prevention activities.



Figures 2.24 and 2.25 show the numbers of people reached by interventions targeted to female sex workers (FSWs) and men who have sex with men (MSMs), two key populations are affected by gender norms. FSWs are at risk from exposure to multiple partners, frequent sexual encounters with strangers, and other factors, and are also at a disadvantage for negotiating safe sex. Studies have shown that FSWs

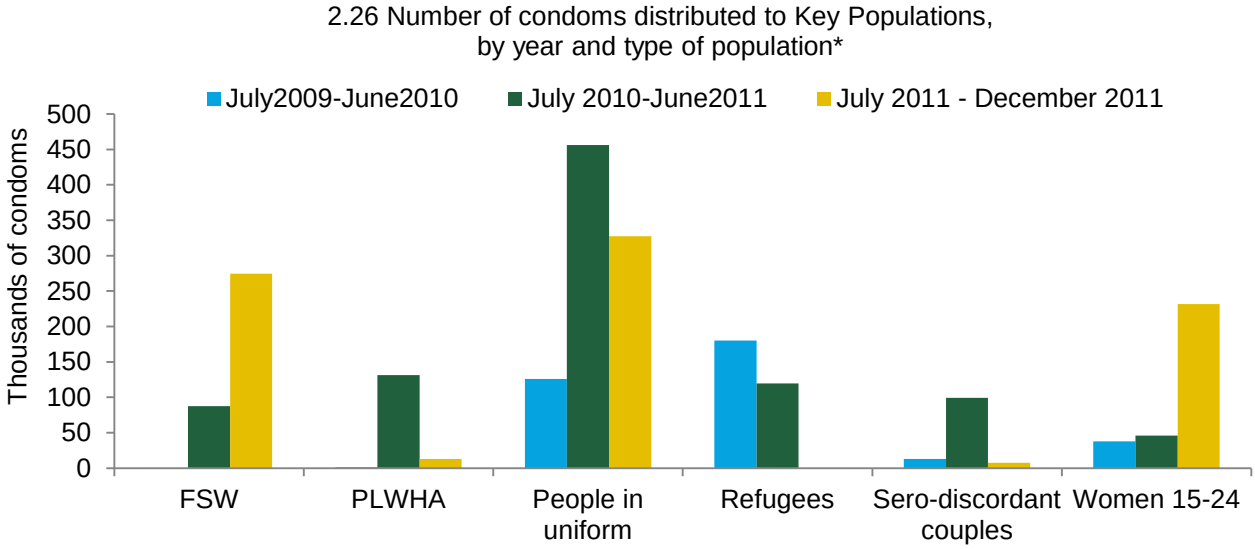
are vulnerable to violence, which increases their HIV risk, as a result of condom negotiation.[39] The stigma around MSMs in Africa stems from expectations around gender roles and sexual relationships. The stigma also carries into the legal arena, as in many places on the continent MSM activity is against the law.40 Therefore, the results of programmatic reach to these populations are important to a gender-based analysis of HIV in a country. There is an upward trend in the numbers of FSWs reached across the three time periods, with a notable increase during June 2011–July 2012 (Figure 2.24). The numbers reported appear to be incomplete for MSMs for various interventions and time periods (Figure 2.25). For both FSWs and MSMs, the largest numbers of people were reached through small group interventions, and among FSWs, the second largest number of people reach were by condom distribution programs.

2.25 Men who have sex with men reached by HIV prevention interventions, by year and type of service



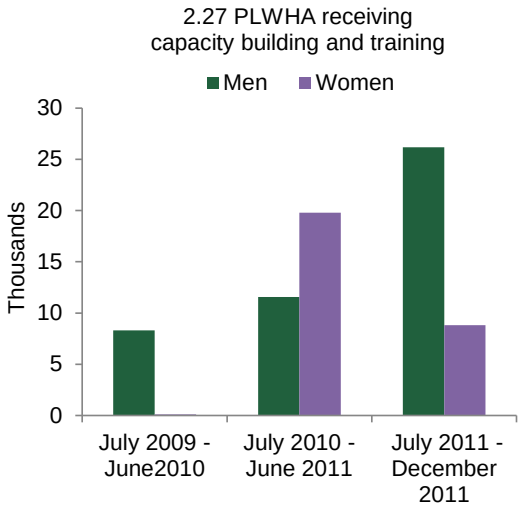
[39] Okal, J., Chersich, M. F., Tsui, S., Sutherland, E., Temmerman, M., & Luchters, S. (2011). Sexual and physical violence against female sex workers in Kenya: a qualitative enquiry. *AIDS care*, *23*(5), 612-618.
[40] Taegtmeyer, M., Davies, A., Mwangome, M., van der Elst, E. M., Graham, S. M., Price, M. A., & Sanders, E. J. (2013). Challenges in providing counselling to MSM in highly stigmatized contexts: results of a qualitative study from Kenya. *PloS one*, *8*(6), e64527.

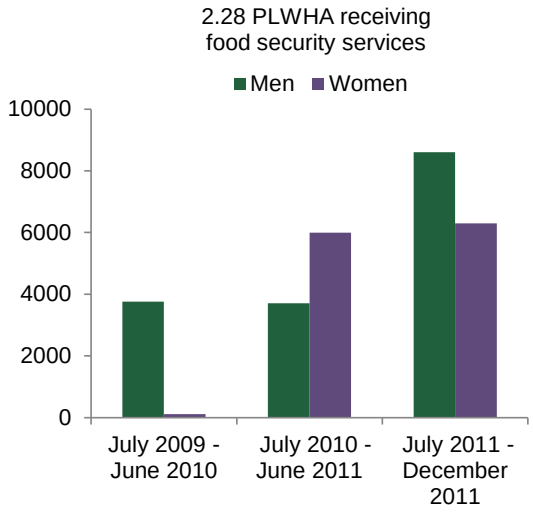
Figure 2.26 shows the number of condoms (in thousands) distributed to key populations. These were not sex-disaggregated data. It would have been helpful to see the number of men and women in the PLWHA, refugees, and sero-discordant couples categories. It also appears that the data were not reported consistently for this indicator, as the trends for some of the groups listed do not follow a pattern. The most condoms distributed from June 2011 to July 2012 were among people in uniform, followed by FSWs.

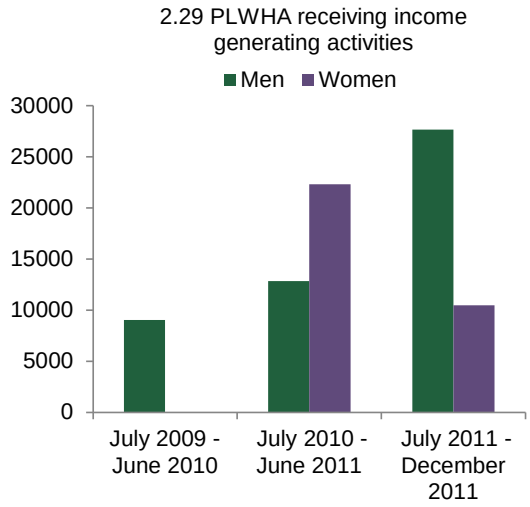


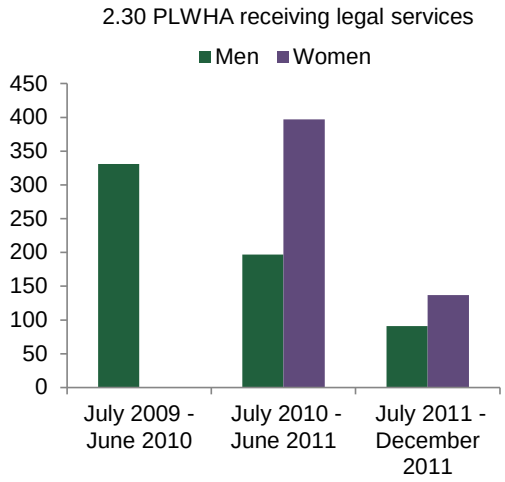
*Condoms distributed to MSM, mobile workers, and people with disabilities were less than 10,000 and are not graphed.

Figures 2.27–2.30 show the results of interventions aimed at people living with HIV/AIDS (PLWHAs), and are disaggregated by sex. For all the interventions apart from legal services, many more men living with HIV/AIDS were reached than women in both the first and third years shown. From July 2010 to June 2011, more women living with HIV/AIDS were reached by the same interventions. Legal services were provided to more women in both the last years than men (Figure 2.30). In the first year shown, there were no women reported reached. It is unclear if the results for that year are due to how the data were aggregated (i.e., not a true representation of what was reported). Since the same trend is observed for the next set of slides pertaining to orphans and vulnerable children (OVCs), it seems likely that the results are not representative of the programs, but due to an oversight in the data reporting process.


2.27 PLWHA receiving capacity building and training
Men
Women
Thousands
30
25
20
15
10
5
0
July 2009 - June2010
July 2010 - June 2011
July 2011 - December 2011

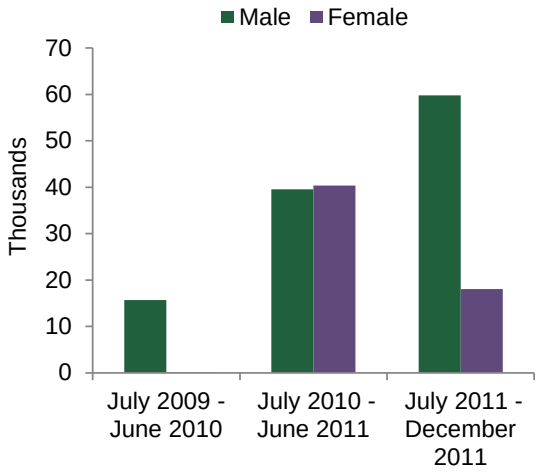

2.28 PLWHA receiving food security services
Men
Women
10000
8000
6000
4000
2000
0
July 2009 - June 2010
July 2010 - June 2011
July 2011 - December 2011


2.29 PLWHA receiving income generating activities
Men
Women
30000
25000
20000
15000
10000
5000
0
July 2009 - June 2010
July 2010 - June 2011
July 2011 - December 2011

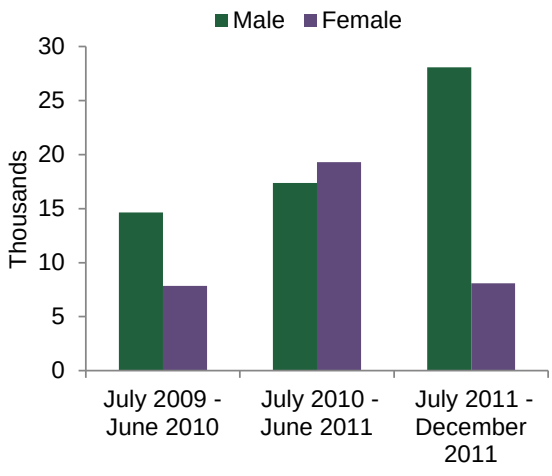

2.30 PLWHA receiving legal services
Men
Women
450
400
350
300
250
200
150
100
50
0
July 2009 - June 2010
July 2010 - June 2011
July 2011 - December 2011

last set of figures (2.31–2.37) show the results of interventions reaching girls and boys identified as OVCs. In the middle reporting year (July 2010–June 2011) an even number of boys and girls were reached with the various interventions. For the first and third years shown, many more boys than girls were reached. If these reports are accurate, there is cause for concern because there is no reason to expect that there are many more boys than girls in the OVC population in Rwanda.

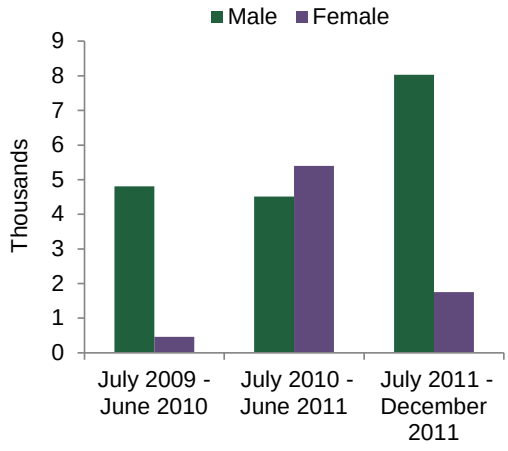
2.31 Number of OVC receiving educational support services



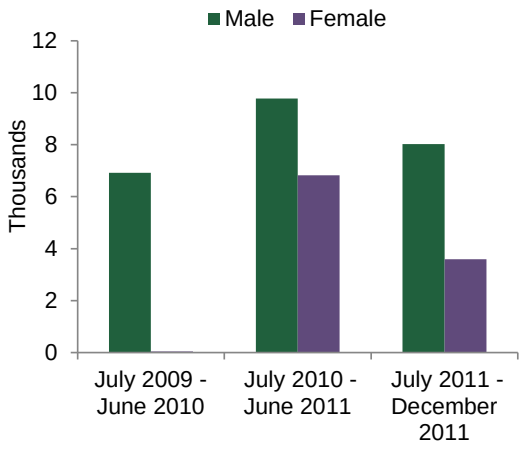
2.32 Number of OVC receiving health services

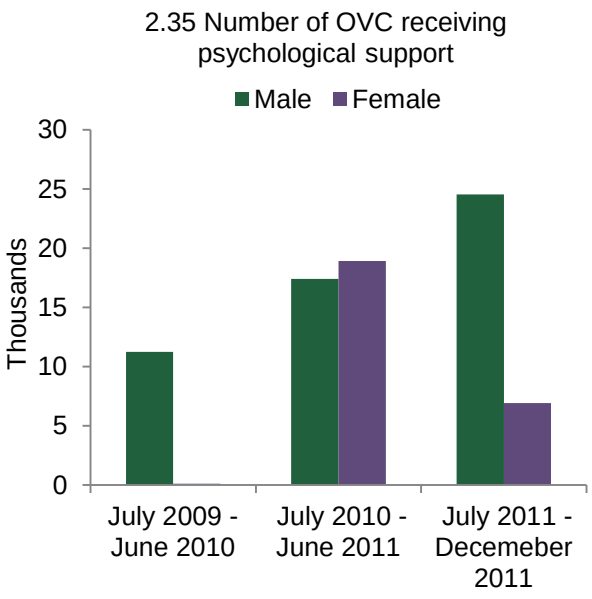


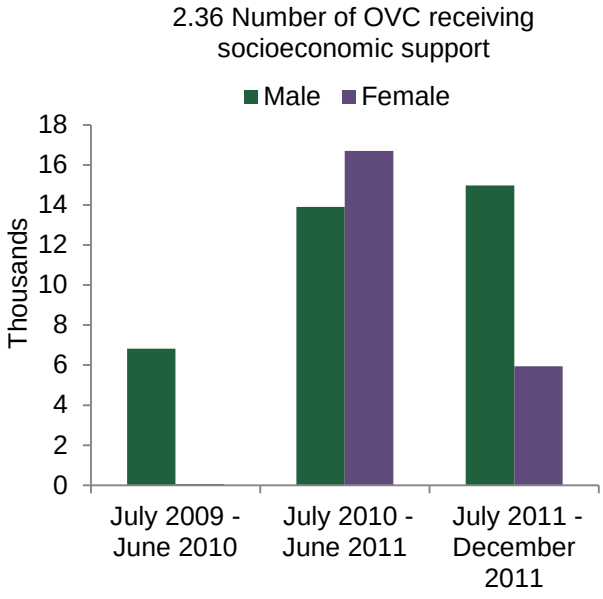
2.33 Number of OVC receiving legal protection

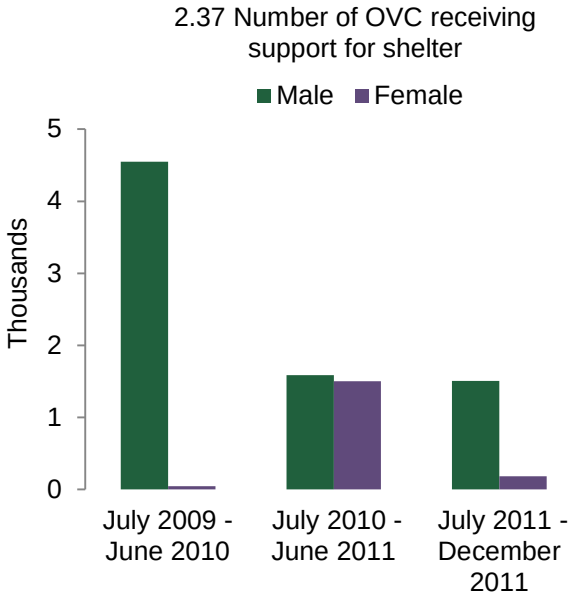


2.34 Number of OVC receiving nutritional support




2.35 Number of OVC receiving psychological support
Male
Female
Thousands
30
25
20
15
10
5
0
July 2009 - June 2010
July 2010 - June 2011
July 2011 - Decemeber 2011


2.36 Number of OVC receiving socioeconomic support
Male
Female
Thousands
18
16
14
12
10
8
6
4
2
0
July 2009 - June 2010
July 2010 - June 2011
July 2011 - December 2011


2.37 Number of OVC receiving support for shelter
Male
Female
Thousands
5
4
3
2
1
0
July 2009 - June 2010
July 2010 - June 2011
July 2011 - December 2011

Conclusions on Programmatic Reach for HIV Interventions

These data appear to have some systematic discrepancies that are probably due to lack of consistent reports, errors in aggregation or compilation, or other data quality–related issues. Therefore, it is difficult to be very conclusive about some of the results. Patterns that appear to be based on consistent data are reported here.

Among the care and prevention programs, the gender gap started out large, with many more men being reached, but then diminished over time. The opposite pattern was observed for young people being reached by community outreach programs, where the gap was widest in the most recent year. Since young women are the most vulnerable to HIV, this trend is of concern. The several programs targeted toward FSWs appear to be reaching larger and larger numbers over time. Small group interventions reached the most sex workers among both women and MSMs. In the programs targeted toward PLWHAs, many more men than women appeared to be reached, except by legal services. Among OVCs, many more boys than girls were reached by all services. This is of particular concern because the number of male and female OVCs is about the same.

These indicators are all very important from a gender perspective, because they document how much of the affected community is reached by prevention, care, and support interventions and will shed light on whether women/girls and men/boys enjoy equal access to these interventions. Some of the programs target key areas for ameliorating the impact of restrictive gender norms, such as outreach to key populations. It would be helpful to have more information on any programs that pertain to transforming gender norms that contribute to stigma that hampers the AIDS response, if they exist.

3. Survey Data

3.1 Rwanda Stigma and Discrimination Index Survey, 2009

Stigma and discrimination are associated with lower uptake of preventive services, testing, and counseling; reduced and delayed disclosure of HIV status; and postponing or rejecting care or seeking healthcare services outside one's community for fear of breach of confidentiality. Research shows that stigma and discrimination affect women and girls more severely than men and boys, and for vulnerable populations such as sex workers, widows, prisoners, and TB patients, more than people in the general population.[41][42]

The methodology for the People Living with HIV Stigma Index study was developed by global experts convened by IPPF, Global Network of People Living with HIV/AIDS (GNP+), ICW, and UNAIDS beginning 2005 (IPPF, 2008).[43] Rwanda was one of the first countries to roll out the stigma index survey. In Rwanda, L'Association des Veuves Vulnérables Affectées et Infectées par le VIH/SIDA (AVVAIS) initiated the study and collaborated with Rwanda Network of PLWHA (RRP+), the umbrella body in the implementation of the survey, and provided secretarial support for the survey. The study was funded by UNAIDS with technical assistance from CNLS.

The overall objective of the Rwanda stigma and discrimination survey was to collect information on perceptions of stigma and discrimination among HIV-positive members from the RRP+. The results of the survey were intended to contribute to the understanding and reduction of stigma and discrimination in PLWHAs. The specific objectives of the assessment was to document the various experiences of people living with HIV regarding HIV-related stigma and discrimination in Rwanda, and second, to provide an evidence base for advocacy, policy change, and programmatic interventions to address stigma and discrimination related to HIV. It was expected that the preliminary study would yield information that would improve on operational programs and services provided by RRP+.

The study population consisted of the people living with HIV who are members of recognized associations of PLWHAs in Rwanda and who are at least 18 years old. A simple random sampling technique was applied to select respondents and sites for this study, and EPI-INFO software was used to determine the required sample size for this study, which yielded a sample size of 1,638 PLWHAs. It should be noted that the study findings cannot be generalized back to the whole population of PLWHAs in Rwanda. The fear of stigma prevents others from joining the association, and those not part of the association may be more disenfranchised, thus have different experiences of stigma.

[41] Ogden, J & Nyblade, L. (2005). Common at Its Core: HIV-Related Stigma. International Center for Research on Women (ICRW). Available at: http://www.icrw.org/files/publications/Common-at-its-Core-HIV-Related-Stigma-Across-Contexts.pdf.

[42] UNAIDS. (2007). Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes – A resource for national stakeholders in the HIV response. Available at: http://data.unaids.org/pub/report/2008/jc1521_stigmatisation_en.pdf.

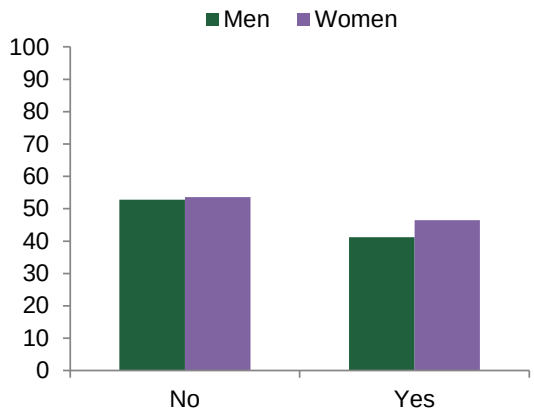
[43] The English and French versions of the index are available from the website: http://www.stigmaindex.org or http://www.ippf.org.

Overall, the survey results confirmed that stigma was an issue for the PLWHAs in this sample. The analysis of sex-disaggregated data showed that there was a small but persistent gender gap, with women disproportionately affected by stigma compared with men. The gender gap was observed in almost all areas covered by the survey: denial of services, harassment, knowledge of legal recourse, and so on.

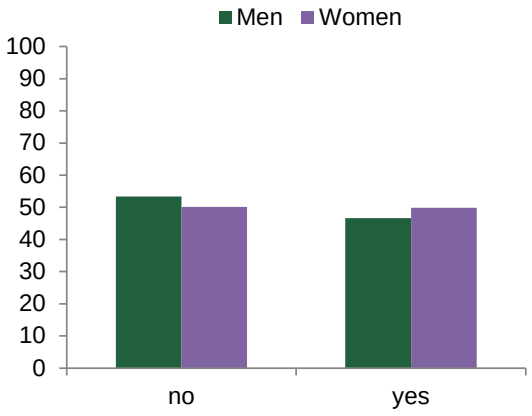
Notably for the purpose of this project, while overall low (below 10% for both sexes), there was no significant difference by sex in the percentage of people who reported they had been denied health services in past year. Although as many as a fifth of respondents reported coercion for HIV testing, the proportion was equal for women and men.

There were gender differentials in perceptions about and actual manifestations of stigma and discrimination. Although there was no difference in the proportions of women and men who stated that HIV status caused them to feel they should be punished in the past year, a slightly higher proportion of women said HIV status caused them to feel ashamed in the past 12 months (Figure 3.1.1).

3.1.1 Feelings of shame: Percent of people stating that their positive HIV status caused them to feel ashamed in the past 12 months (n=1189)



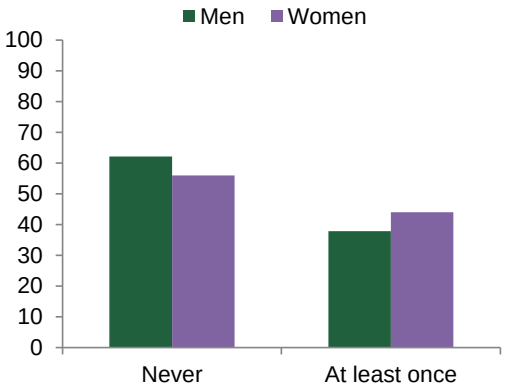
3.1.2 Percent of people in the past year who feared being gossiped about (n=1274)



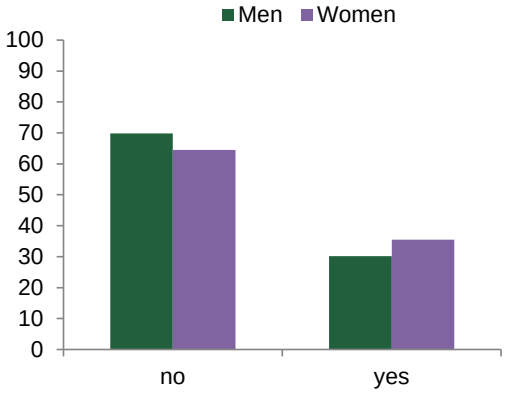
Women's perception of stigma appeared more acute: a larger proportion of women feared being gossiped about (Figure 3.1.2), and women were more likely to report instances of being gossiped about at least once in the past year (Figure 3.1.3). Women were slightly more likely to have felt xcluded from social gatherings or activities.

The differences between women and men were not as notable (less than 10%), when it came to the likelihood of people feeling excluded from social gatherings (40% for both women and men), and when choosing not to attend social gatherings in the past 12 months due to their positive HIV status (slightly over 10% for both sexes).

3.1.3 Gossip took place: % people aware they were gossiped about at least once in the past year (n=1344)

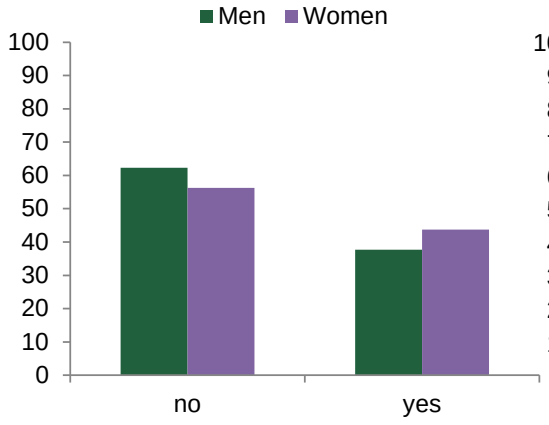


3.1.4 Physical Stigma: % of people who feared being physically insulted, harassed, or assaulted at least once in the past year (n=972)

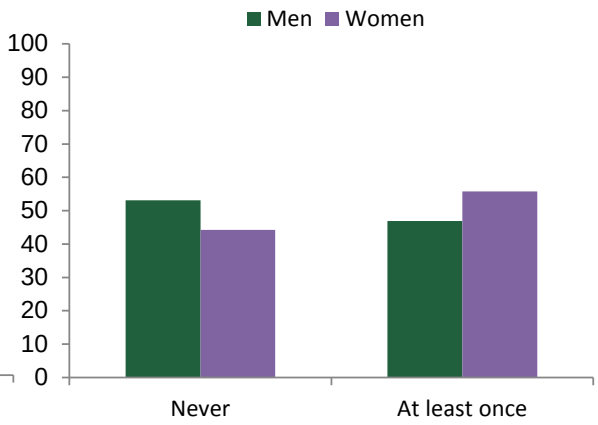


Overall, the fear of being physically insulted was lower than fear of being verbally insulted among both sexes. However, more women than men feared being physically insulted, harassed, or assaulted; the same applied for fear of verbally insulted, harassed, or threatened (see Figures 3.1.4–3.1.5). Additionally as Figure 3.1.6 shows, more than half of women (55%) reported that an insult took place, compared to 45%

3.1.5 Social Stigma: % people who feared being verbally insulted, harassed, or threatened at least once in the past year (n=1116)



3.1.6 Verbal insult took place: % people who experienced verbal insults or harassment in past year (n=1398)



of men who experienced verbal insults or harassment in past year.

In certain domains differences by sex were not as large (less than 10%) but worth mentioning as women were still at a disadvantage:

- Fewer women knew of organizations or groups to help if they experience stigma or discrimination.
- Smaller proportions of women have heard of the Declaration of Commitment on HIV/AIDS.

The Rwanda stigma survey report had very limited analysis of the gender dimensions of stigma and discrimination experiences of PLWHAs.44 The findings indicated that a lower percentage of respondents reported exclusion from religious activities, followed by exclusion from family activities. More females reported exclusion from family activities and being gossiped about more often than males.

Conclusions on the HIV Stigma Report

The survey findings indicate a consistent gender gap, with women as a disadvantage in almost all domains explored in the stigma index. In the majority of areas, the differences between the proportions of women and men reporting feeling stigmatized did not exceed 15 percentage points, but the consistency of this gap across almost all areas points to the need of increasingly more gender-sensitive interventions to address stigma and discrimination, either perceived or experienced by both sexes.

3.2 School Children's Survey

Plan International and the RWAMREC collaborated on a survey of school children in Rwanda to be used as part of the report "Because I Am a Girl: State of the World's Girls 2011."[45] The analyses discussed in this report have been drawn from the primary data collected in Rwandan schools as part of the larger *Because I Am a Girl* (BIAAG) report. (Full report available online at http://becauseiamagirl.ca/2011GirlReport.)

The surveys for the BIAAG project were completed in four schools in Rwanda, two in rural areas and two in urban areas.[46] Plan International selected one district based on population diversity, availability of child protection mechanisms, and travel costs. Schools were selected randomly after stratification based on socio-geographical criteria of the selected district. Students ages 12 to 18 were sampled, with a goal of 1,500 students and 50% male and 50% female; the final sample included 667 boys and 550 girls.[47] The sample represented approximately 27% of all students in the four schools. The students invited to participate were selected randomly. Ethical considerations were taken into account and efforts were made to preserve the rights and well-being of all participants. The nonresponse rate was 3.2% of the questionnaires distributed.[48]

Looking at Figure 3.2.1, students consistently report their mothers do the cooking, clothes washing, and house cleaning more often than their fathers. According to these students, their mothers were much more likely to do these chores often. This is not surprising, as women are traditionally more responsible for household duties than men in Rwanda and in the rest of Sub-Saharan Africa.

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[44] L'Association des Veuves Vulnérables Affectées et Infectées par le VIH/SIDA (AVVAIS). (2009). Rwanda Stigma and Discrimination Survey Report. Available at: http://www.avvais.org/publication/.

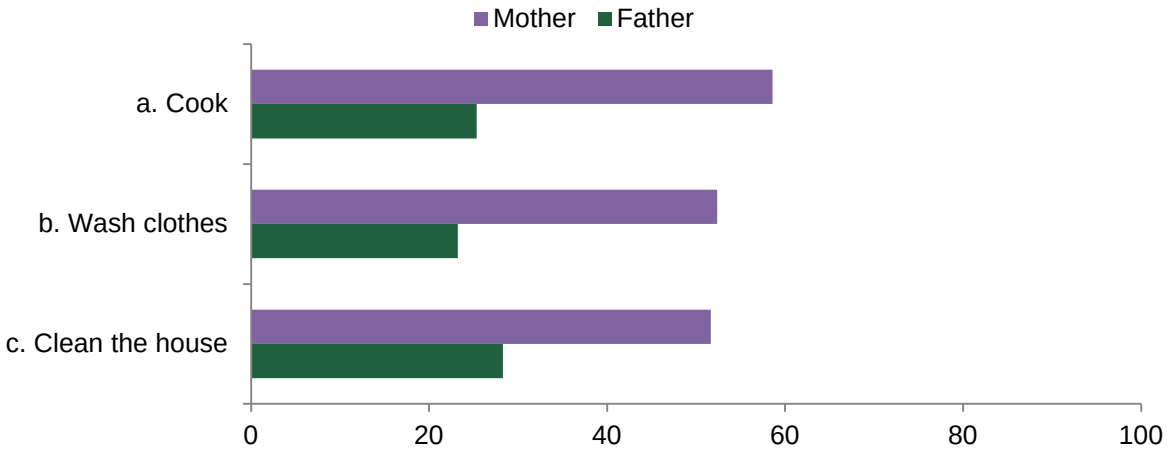
[45] Van der Gaag, N. Because I am a Girl Report: The State of the World's Girls 2011: So, what about boys? Plan International. 2011. Available at: http://plan-international.org/files/global/publications/campaigns/BIAAG-Report-2011.pdf.

[46] Personal communication, Edouard Munyamaliza, October 21, 2012.

[47] Van der Gaag, N. Because I am a Girl Report: The State of the World's Girls 2011: So, what about boys? Plan International. 2011. Available at: http://plan-international.org/files/global/publications/campaigns/BIAAG-Report-2011.pdf.

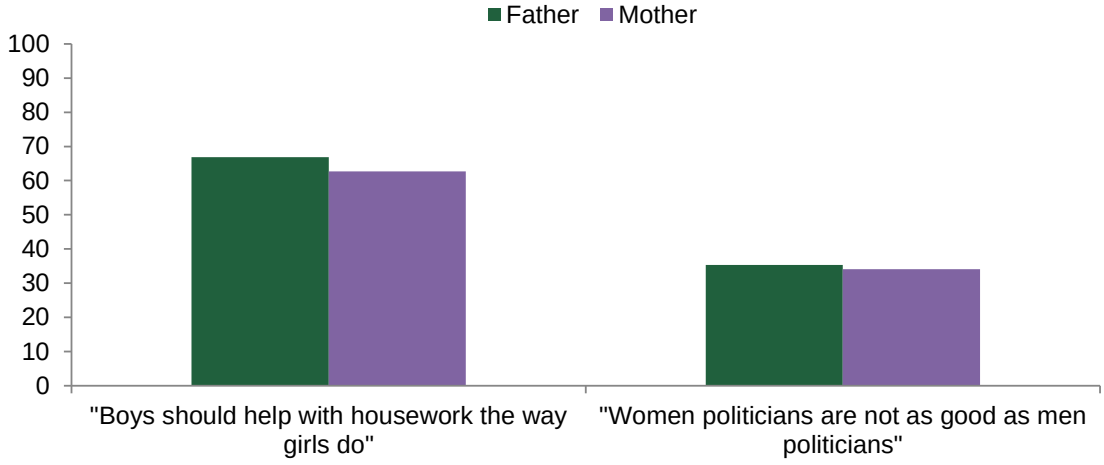
[48] Personal communication, Edouard Munyamaliza, October 21, 2012.

3.2.1: Percentage of students who report their mother and father do specific chores often



When looking at whether students think their parents would agree with the statements about gender norms in Figure 3.2.2, the gap between what students perceived about their mothers' and fathers' beliefs are much smaller. The majority of students think their fathers (67%) and mothers (63%) would agree that boys should help with housework the same way girls do. This is interesting considering that students very clearly report a gendered distribution of labor among their parents as shown in Figure 3.2.1. There appears to be a gap between perceptions and behavior or a changing expectation of labor between boys and girls and, as they get older, men and women.

3.2.2 Proportion of students who think their father or mother would agree to the following statements

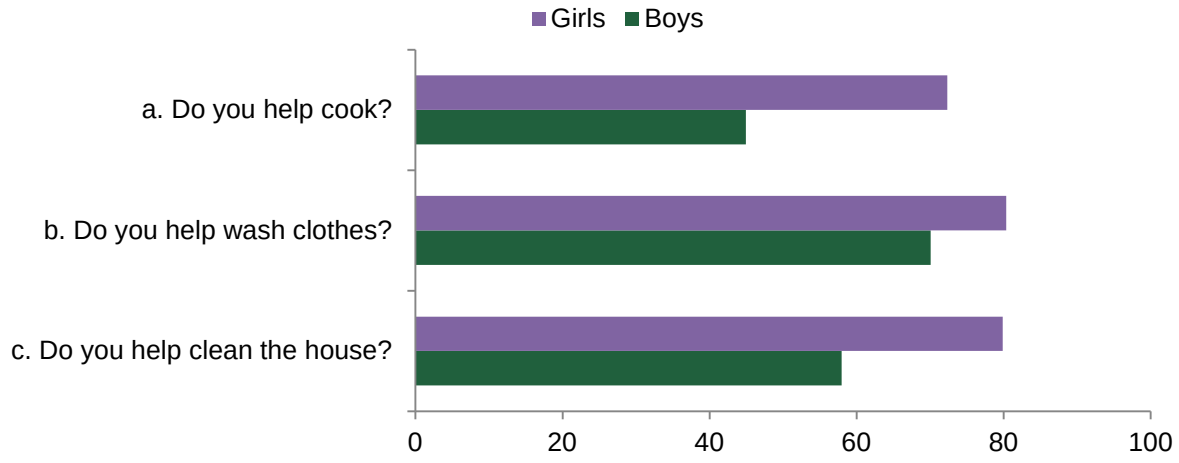


Slightly over a third of students believe their parents think women politicians are not as good as men politicians. This is particularly notable, given that the Rwandan government has made significant efforts to promote gender equality and women's involvement, including a mandate that requires that 30% of

public offices are held by women, and 24 seats in Parliament reserved for women.[49] Laws such as these will eventually help transform attitudes and norms toward women in power.

Figure 3.2.3 shows that girls are more likely than boys to perform household chores, such as cleaning the house, cooking, and washing clothes. Eight in 10 girls report they help clean the house and wash clothes often, whereas 58% and 70% of boys report they clean the house and help wash clothes, respectively. There is a larger gap between girls and boys when it comes to cooking, with 72% of girls helping cook often, and only 45% of boys. Again, this indicates a potential difference in the reported belief that parents agree boys should help with housework the way girls do and the reality of what girls and boys report doing on a regular basis at home.

3.2.3 Proportion of students that report doing the following chores "very often"



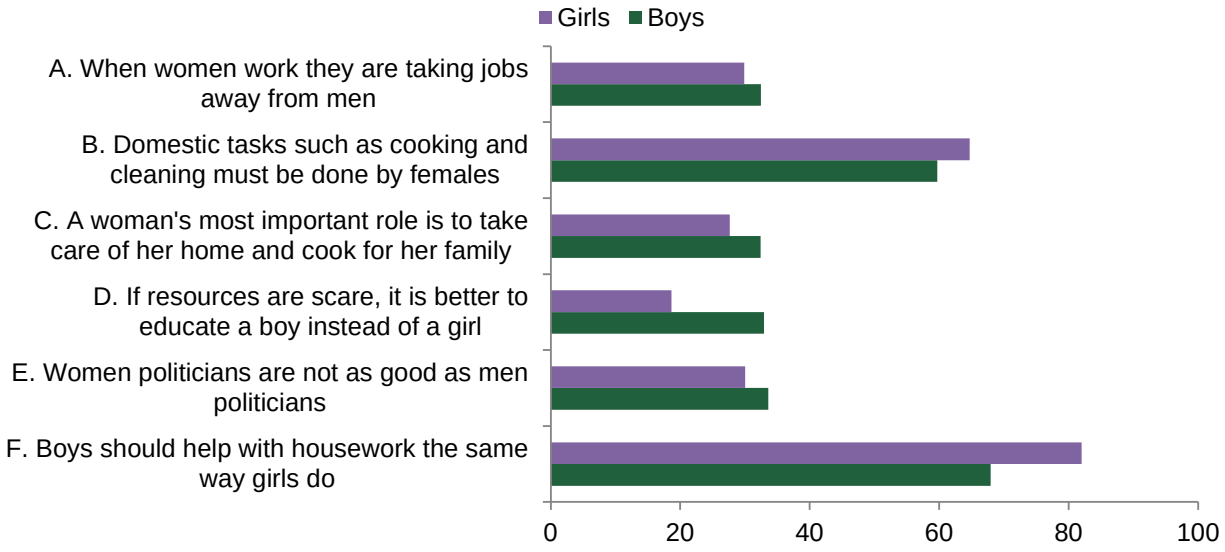
Beliefs about gender roles and norms among students are illustrated in Figure 3.2.4. In most cases, fewer girls agree with the statements supporting gender inequalities. For example, girls more readily disagree with the statement "if resources are scarce, it is better to educate a boy than a girl." More boys tend to agree with these statements, except in the case of: "domestic tasks such as cooking and cleaning must be done by females," which shows slightly more girls in agreement than boys (65% and 60%).

Girls' and boys' opinions on gender equality differ as well. When looking at opinions about the statement, "boys should help with housework the same way girls do," slightly over 80% girls agree that boys should help with housework the same way girls do, while only 68% of boys espoused this belief.

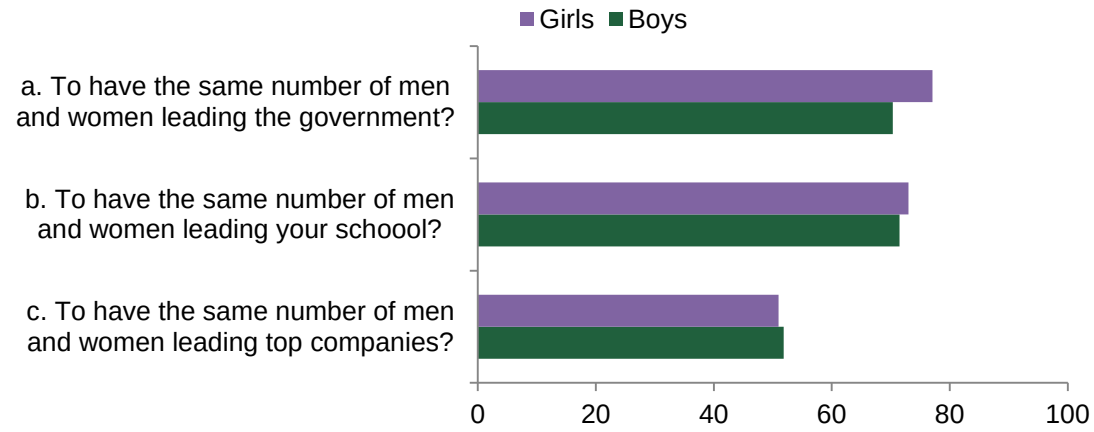
Figure 3.2.5 shows students' opinions related to positions of leadership and power in various domains. Findings on students' actual beliefs are more gender equitable when compared with what they

[49] Abbott, P. and Rucogoza, M. 2011. Legal and Policy Framework for Gender Equality and the Empowerment of Women in Rwanda. Institute of Policy Analysis and Research-Rwanda. June 2011. Available at http://www.ipar-rwanda.org/index.php?option=com_docman&task=doc_download&gid=32&Itemid=151.

3.2.4 Proportion of students who agree with the following statements

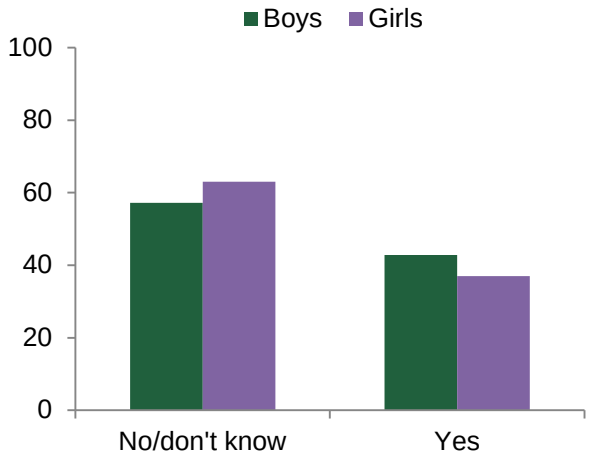


3.2.5 Proportion of students who responded they think: “Yes, it would be good...”



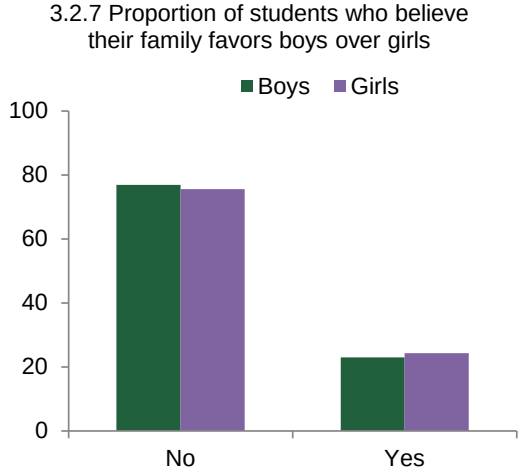
believe their parents feel. When it comes to government and school, over half of boys and girls believe it would be beneficial to have an equal number of men and women in leadership. Girls are only slightly more likely than boys to agree with a concept of equal leadership in both school and government positions. When it comes to leadership in top companies, the proportions female and male students agreeing are about equal, but lower than in the other two contexts. Only just over half (51% of girls and 52% of boys) of the students agree with equal leadership among men and women in business, compared to a higher 70–80% of students who support gender equality in leadership in government and schools.

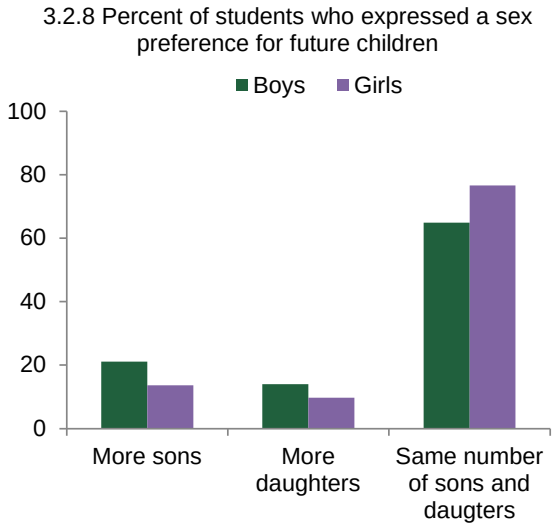
3.2.6 Proportion of students who think laws in Rwanda protect girls better than boys



More than half of students felt that laws protect girls better than boys. Figure 3.2.6 shows that a slightly larger proportion of boys than girls expressed this belief.

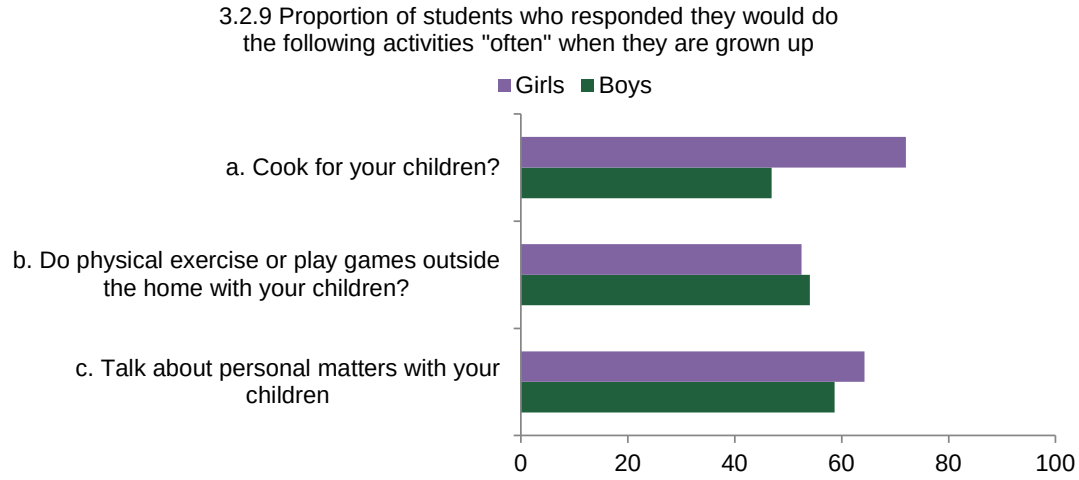
Figures 3.2.7 and 3.2.8 pertain to gender dimensions in family matters. The vast majority of both boys and girls expressed that they did not believe boys were favored over girls in their families (Figure 3.2.7). Although nearly a quarter of students believe that their families prefer boys over girls, existing research suggests sons and daughters are similarly important for mothers in Rwanda.[50] Figure 3.2.8 shows how students felt about sex preferences in their future families. Larger proportions of boys had a preference for more children of one sex, with a slightly higher proportion expressing that they wanted more sons. A slightly higher proportion of girls had a preference for equal numbers of boys and girls. These findings support the research that confirms the importance of having both boys and girls in a traditional Rwandan family.[51]



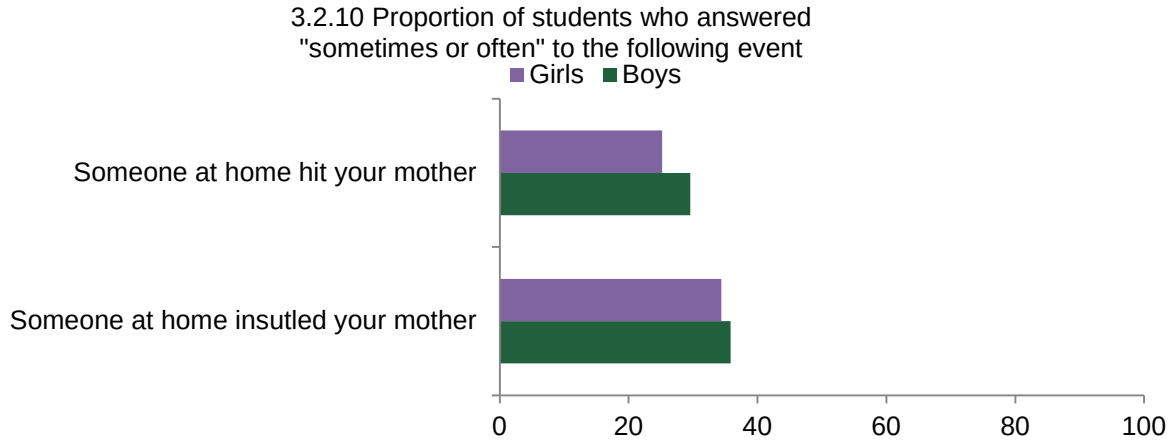


When asked how often they would do various activities with their children when they grow up (Figure 3.2.9), almost equal proportions of boys and girls responded that they would exercise or play games and would talk about personal matters. However, nearly a third more girls than boys stated that they would often cook for their children: 72% of girls said they would, compared with only 47% of boys. This suggests the continuation of strong gender norms around women doing the household cooking.

[50] Habimana Kabano, I., Broekhuis, A., & Hooimeijer, P. (2013). Fertility Decline in Rwanda: Is Gender Preference in the Way?. *International Journal of Population Research, 2013.*
[51] Ibid.



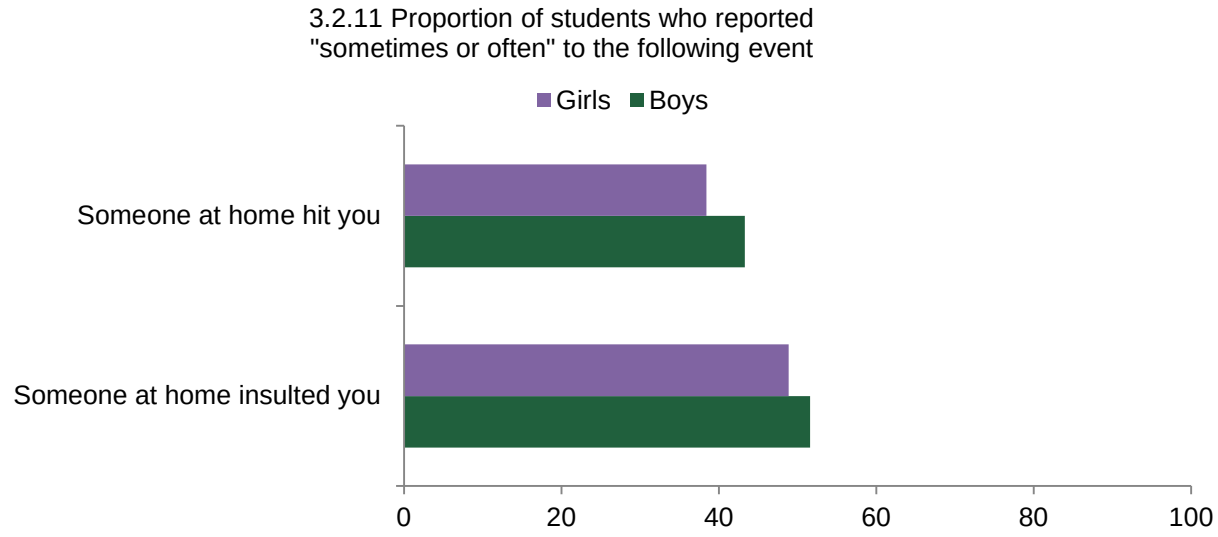
Figures 3.2.10 and 3.2.11 illustrate findings related to children witnessing verbal, physical, and sexual abuse in the home or experiencing it themselves. One study demonstrated that psychological abuse (one form of which is insulting or berating a person) is linked to HIV risk in Rwanda, and there was a positive association between HIV prevalence and witnessing parental violence.[52][53] This factor potentially mediates HIV risk for both the mothers and the children surveyed here. According to Figure 3.2.10, approximately one third of students report that someone at home insults their mother sometimes or often, and one quarter of students report their mother is hit at home sometimes or often. Among students who witnessed these behaviors at home, there was a slightly larger proportion of boys than girls. The same gender pattern is also visible in Figures 3.2.10 and 3.2.11, pertaining to physical and psychological violence. Over a third of boys and girls witnessed physical violence perpetrated against their mother, and almost half reported that they themselves had been hit at home.



[52] Kayibanda, J. F., Bitera, R., & Alary, M. (2012). Violence toward women, men's sexual risk factors, and HIV infection among women: findings from a national household survey in Rwanda. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *59*(3), 300-307.

[53] Dude, A. M. (2011). Spousal intimate partner violence is associated with HIV and Other STIs among married Rwandan women. *AIDS and Behavior*, *15*(1), 142-152.

Figure 3.2.11 shows that nearly half of students (49% of girls and 52% of boys) report they were insulted sometimes or often at home, with 38% of girls and 43% of boys reporting being hit as well. While there are limited data regarding the prevalence of child abuse in Rwanda to use as a comparison, these findings show that violence in the home is a common practice among survey respondents. These



data also indicate that boys report being hit slightly more often than girls. The gap may reflect what takes place at home, or boys may have been more willing to report violence than girls. Fear of retribution, shame, powerlessness, lack of support or services can all affect an individual's willingness to report violence. Violence is often underreported due to these factors, and it is possible that they affect girls more than boys.

Consistent with the higher rates of hitting reported by boys, a larger proportion of boys reported sexual abuse when compared with girls. This pattern may be true to what happened, or other factors may explain the difference in girls' and boys' reports. Sexual abuse is underreported in general due to all the factors listed above pertaining to physical violence, and girls are disproportionately affected by these factors. Another plausible explanation may be that boys recognize abuse as something wrong more readily than girls do, who may have been taught to accept abuse as normal or common, thus decreasing their likelihood of reporting it. Still, it is concerning that one in five boys report that they were victimized by actual or attempted forced sex in the home (Figure 3.2.12).

3.2.12 Students who answered "sometimes" or "very often" to the following events

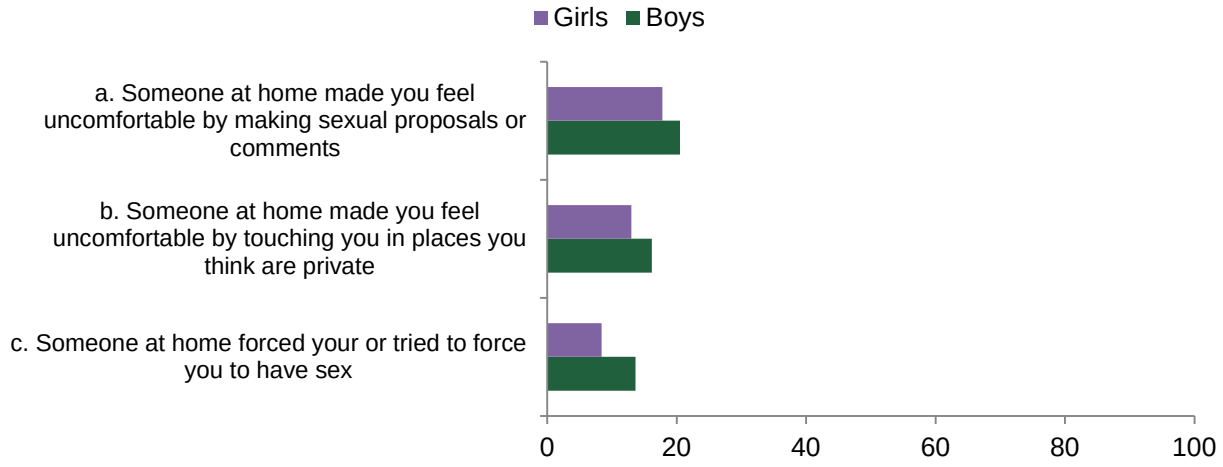
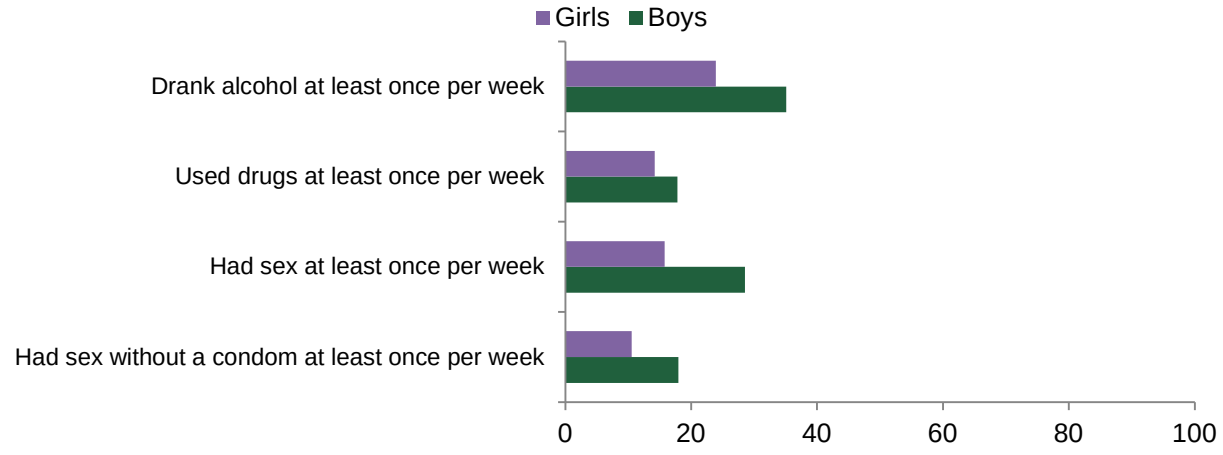


Figure 3.2.13 shows findings related to risky sexual behaviors that are linked to HIV. Among students reporting that they engaged in these behaviors, including the use of alcohol, drugs, having sex, and having sex without a condom, there were more boys than girls. Thirty-five percent of boys report drinking alcohol and 18% reported using drugs at least one time a week in the past year; among girls, the proportions were 24% and 14%, respectively. While almost a third (29%) of boys report having sex at least once a week in the last year, only 16% percent of girls reported the same. The actual gap in reported risky behavior may vary from what was observed. Similar to other surveys based on self-report, a number of biases will influence how answers about risky behavior are given. The factors that may influence how adolescents report these behaviors include their cognitive understanding of the question, social desirability, the acceptability or stigma around such behavior.[54] Some research suggests that boys or men tend to over-report their sexual experience, whereas girls or women in the same community under-report

3.2.13 Proportion of girls and boys reporting risky behavior in the last year



[54] Brener, N. D., Billy, J. O., & Grady, W. R. (2003). Assessment of factors affecting the validity of self-reported health-risk behavior among adolescents: evidence from the scientific literature. *Journal of adolescent health*, *33*(6), 436-457.

the same.[55] For example, if boys perceive that sexual experience is part of what it means to be masculine, they may be more likely to over-report sexual behavior. Likewise, if norms around girls' sexual experience are more conservative than for boys, they may fear stigma and thus under-report their sexual behavior.

Figure 3.2.13 shows the proportion of all students surveyed who reported having sex without a condom at least once a week in the past year. A slightly smaller proportion of girls (11%) than boys (18%) reported having sex without a condom. If you take the proportions of students reporting having sex without condoms among just those who reported having sex (not all respondents), 69% of girls had sex without a condom and 62% of boys reported the same. In Rwanda, HIV is primarily spread through heterosexual sex,[56] meaning that girls and boys who do not use condoms are at high risk for infection. This is of special concern, since young people between the ages 15 and 24 carry the highest burden of HIV.[57] One study among young adults age 15–24 found high levels of sex without a condom among girls, and nearly 30% of girls reported forced sex.[58]

Conclusions from School Children's Survey

The results of the School Children's Survey offers a picture of school girls and boys ages 12–18 with regard to their experience of HIV-risk-related behavior and their perception of gender norms and roles in Rwanda. Overall, it is evident that roles and expectations related to household duties fall disproportionately on girls and their mothers, and beliefs and perceptions reflecting gender inequality persist in many areas. At the same time, a generational shift in gender-related attitudes is observed, compared with what they believe their parents' perceptions are.

The questions about what children expect to do within their own families demonstrate the generational shift taking place in gender norms. Half of boys stated that they expect to cook for their children, when only a quarter reported that their fathers cooked for them. That more boys think they will help cook when they are adults even though not many see their fathers doing these chores indicates a positive change for gender equality. Although some gender norms appear to be changing, especially among the younger generation, other norms still reinforce traditional roles for girls and women.

Both girls and boys participate in high-risk behaviors for HIV infection, but slightly more boys report doing so than girls, which is consistent with DHS data. Large numbers of children witness verbal and physical abuse of their mothers, and even more children report experiencing it themselves. This is worrisome because it is well documented that witnessing violence among parents influences the probability that the child will be involved in a violent relationship themselves. There are also sizable

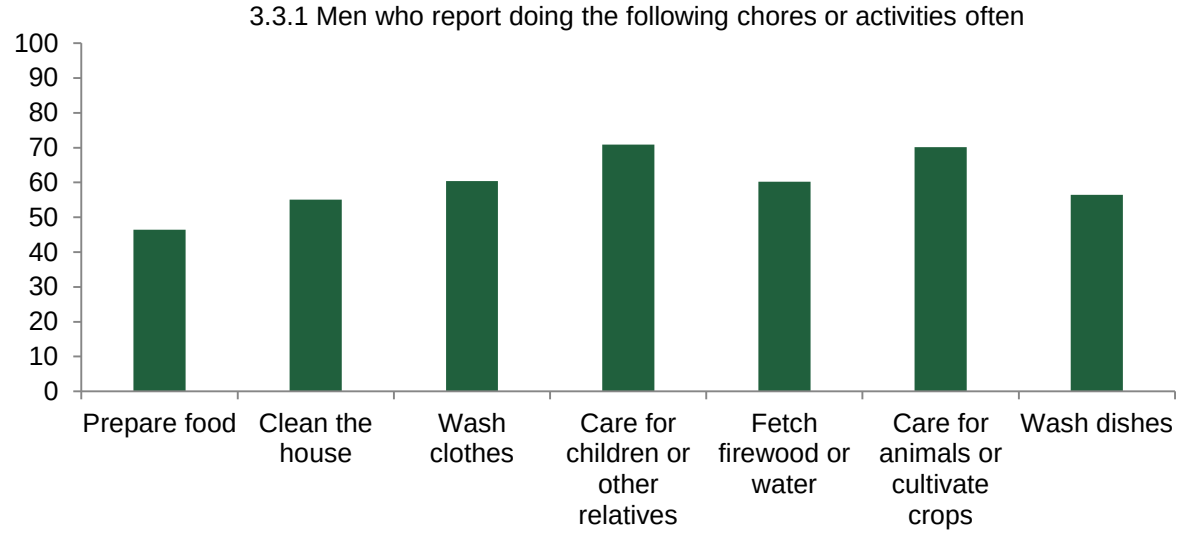
[55] Nnko, S., Boerma, J. T. J. T., Urassa, M., Mwaluko, G., & Zaba, B. (2004). Secretive females or swaggering males?: An assessment of the quality of sexual partnership reporting in rural Tanzania. *Social science & medicine*,*59*(2), 299-310.
[56] MEASURE DHS & ICF International. (2012). Rwanda Demographic and Healthy Survey (RDHS) 2010 Final Report.
[57] Ibid.
[58] Test, F. S., Mehta, S. D., Handler, A., Mutimura, E., Bamukunde, A. M., & Cohen, M. (2012). Gender inequities in sexual risks among youth with HIV in Kigali, Rwanda. *International journal of STD & AIDS*, *23*(6), 394-399.

proportions of children reporting unwanted touching, sexual advances, and even forced sex. All of these behaviors and experiences lead to increased risk for many health negative outcomes, including HIV.

3.3 Survey of Coffee Cooperatives (2011)

The "Engaging men to prevent gender-based violence: A multi-country intervention and impact evaluation study" was conducting on three coffee cooperatives in Rwanda, surveying a probability sample of men and women working there. The study in Rwanda was conducted by Instituto Promundo, with support from the United Nations Trust Fund to End Violence Against Women, and in collaboration with local partner RWAMREC; it was also conducted in three other countries.[59]

These results reveal an in-depth picture of gender-related norms and attitudes among coffee workers in Rwanda. As per DHS results, the majority of women who were employed at the time of the survey



worked in agriculture (77%). Like women, the majority of working men are also employed in agricultural jobs (60%).[60]

Figure 3.3.1 shows the proportion of men who do various chores or activities often, categorized as once or more than once per week within the past three months. The most common chore that men help with often is caring for children or other relatives (about 70%), followed by those who care for animals or cultivate crops. Men were less likely to prepare food, wash dishes, and clean the house (46%, 55%, and 56%, respectively); almost half of men rarely or never help with those household duties. Slightly more men, almost three in five (60%), report washing dishes or fetching firewood or water at least once a week.

[59] Instituto Promundo. (2012). *Engaging men to prevent gender-based violence: A multicountry intervention and impact evaluation study*. Report for the UN Trust Fund.
[60] MEASURE DHS & ICF International. (2012). Rwanda Demographic and Healthy Survey (RDHS) 2010 Final Report.

These questions were not asked of female participants in the survey, so it is not possible to compare these proportions to how often women do these chores, though it is likely women do them regularly.

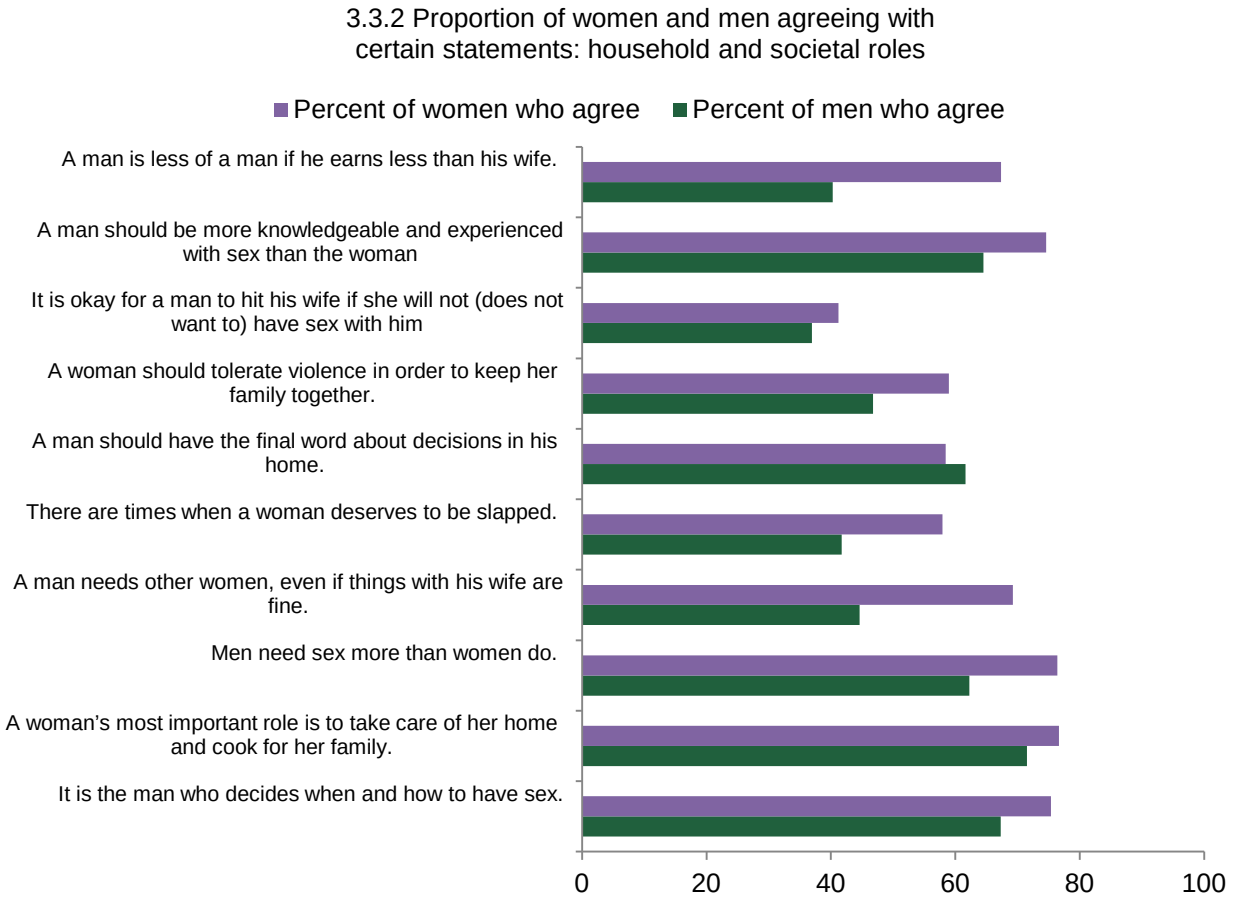


Figure 3.3.2 shows the percent of men and women agreeing with particular statements related to unequal gender roles or norms. Overall, the majority of men and women agree with statements reflecting gender inequality in reference to roles in the household (e.g., "A woman's most important role is take care of her home and cook for her family") and sexual activity (e.g., "Men need more sex than women do; It is the man who decided when and how to have sex; A man should be more knowledgeable and experienced with sex than the woman"). Large proportions of men and women also agree with statements pertaining to the acceptance of intimate partner violence: 47% of men and 59% of women agree that a woman should tolerate violence from her spouse to keep her family together, and 37% of men and 41% of women agree that it is acceptable for a man to hit his wife if she will not have sex with him. Additional information related to these norms from the Rwanda Demographic and Health Survey (RDHS) is presented in section 3.4.

An interesting pattern observed for the statements reflecting gender inequality is that for all but one of the statements, larger proportions of women than men "agree." The largest gap between proportions of

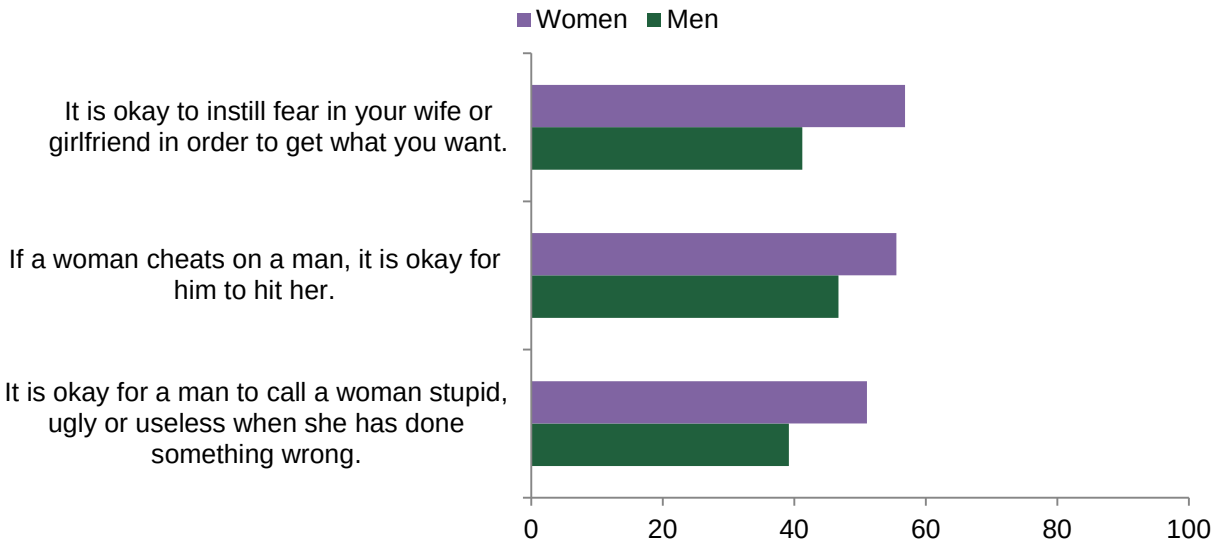
women and men pertain to the statement "A man is less of a man if he earns less than his wife," with nearly 70% of women and only 40% of men agreeing. Among workers at the coffee cooperatives in Rwanda, women strongly relate income generation and money with masculinity.

Furthermore, it is important to remember that although fewer men agreed with these statements reflecting gender inequality, a large enough proportion of men support them. In addition, like all answers based on self-report, men could have answered these questions based on what they think is a more desirable response. The study acknowledged that social desirability is a limitation of using these assessments.61

Interestingly, the only statement for which more men than women agree was "A man should have the final word about decisions in his home." In this case, 58% of women compared with 63% of men agreed that men should hold more power for final decisions in the household. A woman's lack of power and control within the home has linked to HIV risk. Related findings are provided in section 3.4 of this report on the RDHS.

Figures 3.3.2 and 3.3.3 show that norms around gender inequalities are perpetuated by women as well as men. The perceived roles and responsibilities of men and women are internalized and carried on by both genders. Figure 3.3.3 provides additional information on the views of men and women about different

3.3.3 Proportion of women and men agreeing with certain statements: harassment and violence



situations of violence. Again, larger proportions of women than men agree with these statements. Between 40% and 60% of women and men interviewed believe that it is acceptable for men to instill fear in their partners, hit their partners, and verbally abuse their partners. Related information from a general population perspective is presented in section 3.4.

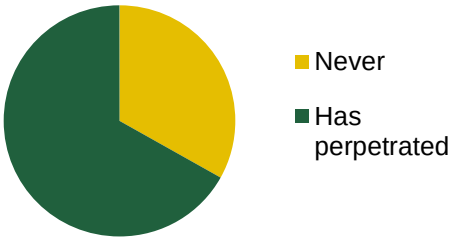
[61] Instituto Promundo. (2012). *Engaging men to prevent gender-based violence: A multicountry intervention and impact evaluation study*. Report for the UN Trust Fund.

In addition to respondents' views on violence, the survey also collected data on the experience of violence (Figures 3.3.4–3.3.9). Violence was defined as the male partner having done any of the following to his

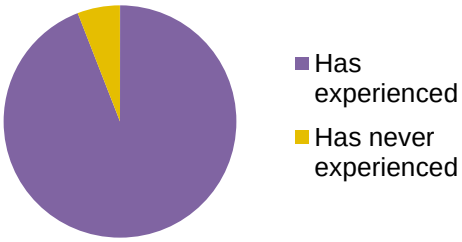
wife or girlfriend: slapped; thrown something at her; pushed; punched; hit with an object; kicked; dragged on the ground; tried to strangle; burned or attempted to burn; used a firearm, knife, or other weapon; or threatened to use a weapon against her.

Figures 3.3.4–3.3.9 show that intimate partner violence is a common occurrence among the men and women sampled. The men's and women's reports differ somewhat, with smaller proportions of men stating that they ever perpetrated violence on their partners (Figure 3.3.4), and 94% of women reporting ever having experienced violence from their partners (Figure 3.3.5). There are several ways to interpret this discrepancy. This could mean that more women have experienced violence because they have been with the same two thirds of men that report using violence, men are not accurately reporting their use of violence, or some combination of both. Regardless, studies have shown that women who experience violence from their partners are at increased risk for HIV, in Rwanda and other areas of Sub-Saharan Africa.[62][63]

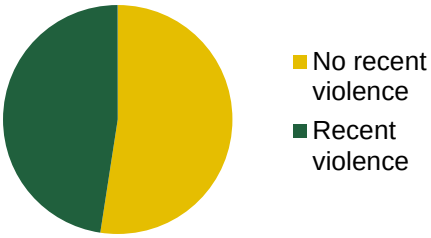
3.3.4 Proportion of men who have perpetrated violence on their partners



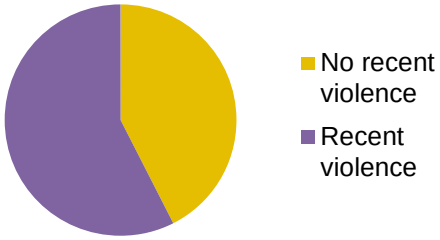
3.3.5 Proportion of women who have ever experienced violence from her partner



3.3.6 Proportion of men who have perpetrated violence on their partners in the last four months

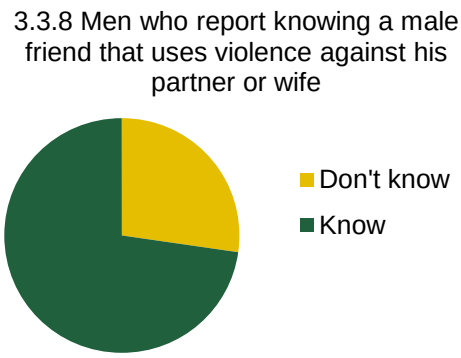


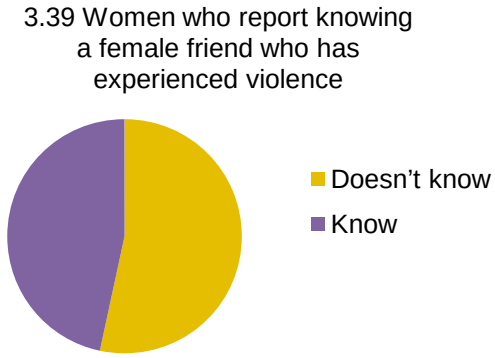
3.3.7 Proportion of women who have experienced violence in the last four months



[62] Kayibanda, J. F., Bitera, R., & Alary, M. (2012). Violence toward women, men's sexual risk factors, and HIV infection among women: findings from a national household survey in Rwanda. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *59*(3), 300-307.

[63] Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntryre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The lancet*,*363*(9419), 1415-1421.





When looking at violence within the past four months (Figures 3.3.6 and 3.3.7), fewer men again report perpetrating violence (48%) than women experiencing violence (57%). This gap is smaller. By looking only at the past four months, it is more likely individuals will be reflecting on the same relationships, and that the numbers should be relatively equal if respondents are reporting accurately. Since there is a gap in men's and women's reports, the difference may be due to reporting biases, such as social desirability, in which an individual under-reports violence because they think it might be unfavorable. Social desirability has been shown to bias reports of perpetration of violence and the experience of violence.[64]

Figures 3.3.8 and 3.3.9 show friends of women and men who have experienced or perpetrated violence. Figure 3.3.8 shows that almost three quarters of men (73%) know a male friend who uses violence against his female partner. This could be a more accurate depiction of how many men perpetrate violence because social desirability is less likely to affect answers since they are not talking about themselves. On the other hand, Figure 3.3.9 indicates that less than half of women (43%) know a female friend who experiences violence from her partner. This is an interesting finding because 94% of women responded that they have ever experienced violence, and 57% report experiencing violence in the past four months. One possible reason for this is that it is taboo to discuss abuse and/or women are ashamed, embarrassed, or afraid of stigma associated with violence, so they do not readily admit their experience of violence to their friends. This is an interesting finding for program managers and community members, perhaps suggesting that communication and campaigns about the experience violence could help women feel less isolated and more empowered to discuss and report violence.

Conclusions about the Coffee Cooperatives Survey

These data clearly demonstrate that women and men continue to hold gender-inequitable norms and expectations, and that gender-based violence is a significant problem for women and men responding to this survey. This is particularly concerning given the relationship of gender-based violence and HIV risk. This sample is not generalizable to the larger Rwandan population; however, it offers a picture of gender norms, experiences, and perspectives from this group. According to the *Engaging Men to Prevent Gender-based Violence* report, following the gender-based violence prevention trainings, there was a

[64] Sugarman, D. B., & Hotaling, G. T. (1997). Intimate Violence and Social Desirability A Meta-Analytic Review. *Journal of Interpersonal Violence, 12*(2), 275-290.

reported but unmeasured increase in women reporting or denouncing violence in the community and increase surrounding education and advocacy against gender-based violence.[65]

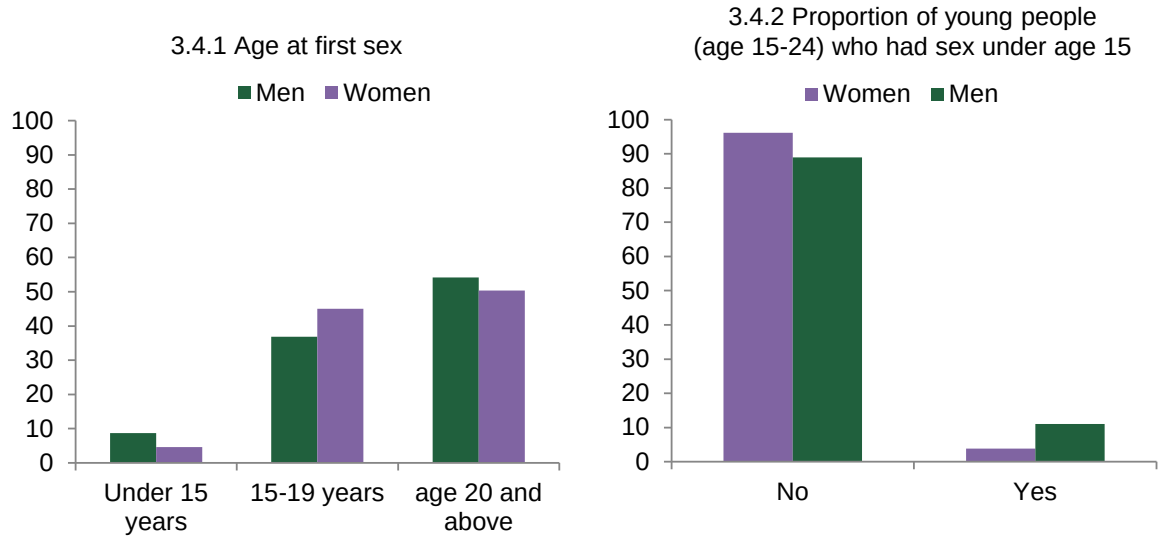
3.4 Rwanda Demographic and Health Survey, 2010

The Demographic and Health Surveys have a long history in Rwanda, with the first one conducted in 1992. The HIV/AIDS-specific module was added in 2005, when HIV testing was incorporated into the survey for the first time as well. For the purposes of this project, we used data from the fourth DHS conducted in Rwanda by ICF International and the Rwanda National Institute of Statistics in 2009. This survey targeted a nationally representative sample of 10,272 households using two-stage cluster sampling design, based on the list of the general population and housing census carried out in 2002 in Rwanda. All women aged 15–49 who were usual residents in the selected household were interviewed, as were men aged 15–59 of every second selected household. All men and women in half of the selected household were eligible for HIV testing. Blood samples were collected from all eligible men and women who volunteered to be tested.

It should be noted that unlike the HIV Stigma Index, the RDHS results are representative of the attitudes of the general population regardless of their HIV status, since the sample was designed to be nationally representative of the selected age groups. Although many of the aspects that were examined in the analyses in line with the internationally agreed on HIV/AIDS indicators presented in the RDHS report, the values vary a little because of the way indicators were constructed.

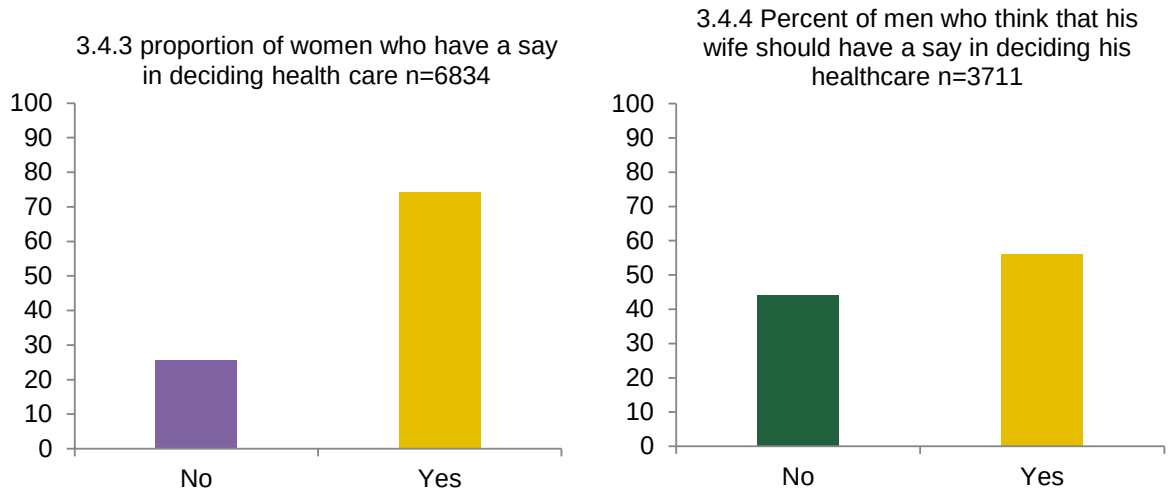
As previously mentioned, sexual transmission is the main way HIV is transmitted in Rwanda. Younger women are at an increased risk for HIV, in large part due to societal gender roles. According to Figure 3.4.1, a larger proportion of women than men aged 15–19 reported having had sexual intercourse for the first time (45% versus 37%). Slightly higher proportions of men stated that their first intercourse was below ahe 15 and above age 20. Figure 3.4.2 shows the proportion of youth who reported they had sex by age 15. About 11% were men and less than 5% were women.

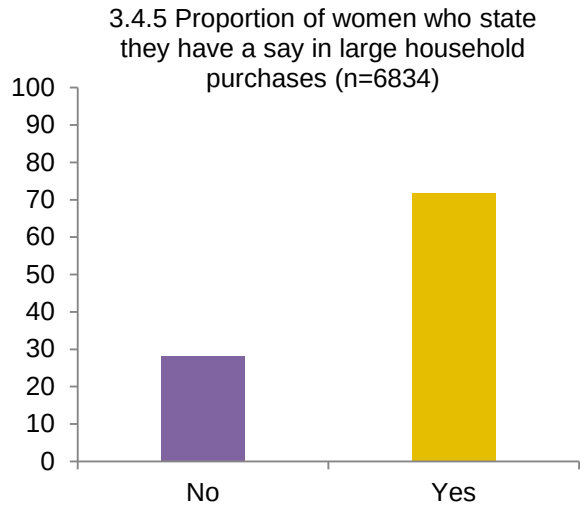
[65] Instituto Promundo. Engaging men to prevent gender-based violence: A multicountry intervention and impact evaluation study. Report for the UN Trust Fund. 2012.

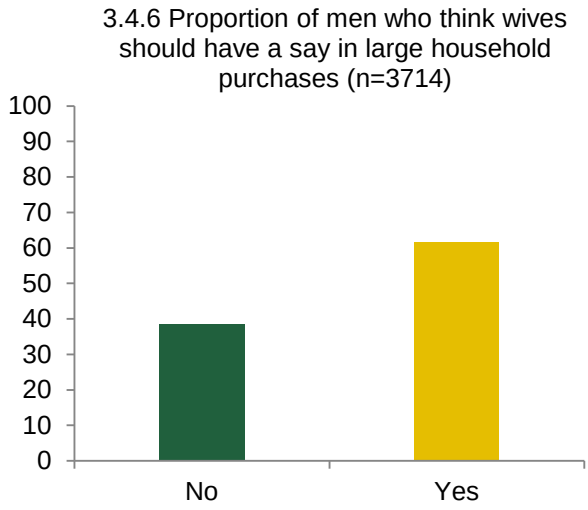


People's behavior and views on household decision making are reflected in the next several figures. Figure 3.4.3 and 3.4.4 pertain to health care decision making. Seventy-five percent of women said that they have a say in making decisions about their own care. However, only 55% of men stated that women should have a say in heath-related issues. Women and men have are equally likely to have been tested for HIV and the rates are almost at 100% (data not shown).

A similar discrepancy in gender attitudes and practices between women's and men's reports is observed when asked about women's say in large household purchases. As Figures 3.4.5 and 3.4.6 illustrate, while more than 7 in 10 women reported having a say in large household purchases, 6 in 10 men said that wives should have a say in large household purchases. Consistent with previous findings, 7 in 10 women reported having an input in spending their husbands' earnings. A similar proportion of men (slightly less than 80%) think a wife should have input in spending her husband's earnings. More than four in five women (over 80%) reported that having a say in visiting family.

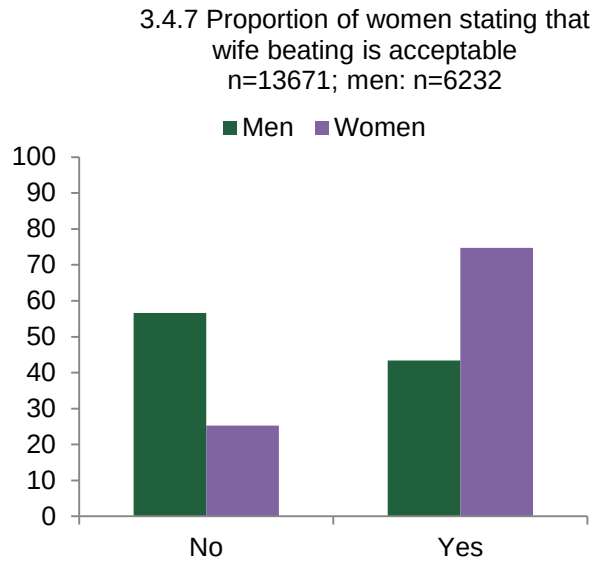


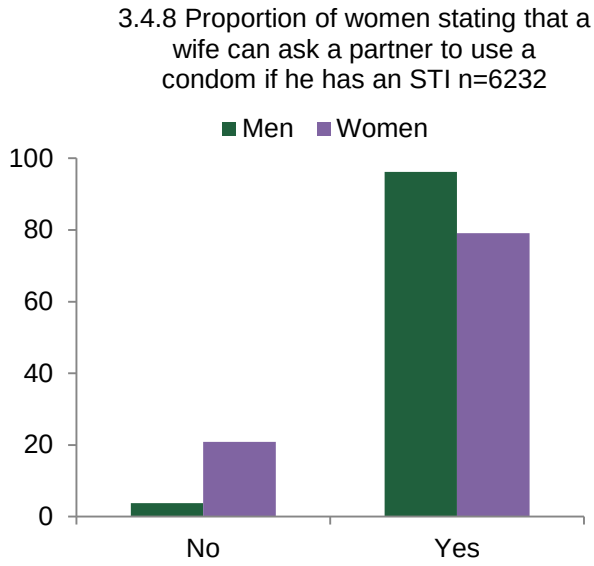




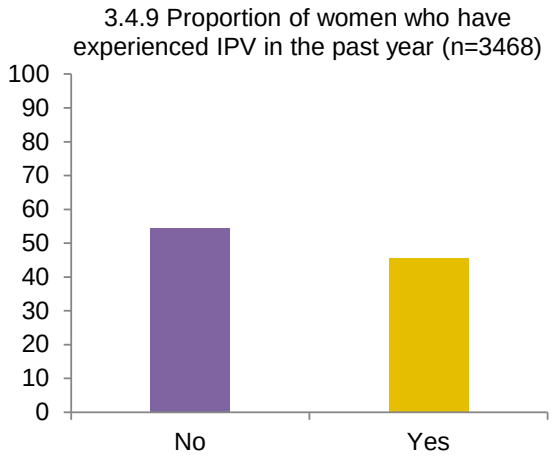
Consistent with the views and practices already discussed, indicating a certain level of independence and freedom of movement, according to the survey findings, almost 6 in 10 women reported having a house or land, alone or jointly with their husband.

Figures 3.4.7 and 3.4.8 show data on attitudes and practices related to intimate partner violence. According to Figure 3.4.7, as many as 75% of women state that wife-beating is acceptable under one circumstance or the other, whereas only 45% of men express the same. At the same time, almost all men and only four in five women expressed that a wife can ask her partner to use a condom if he has an STI. This is a very important indicator of household power, and one directly associated with the risk of HIV (Figure 3.4.8).

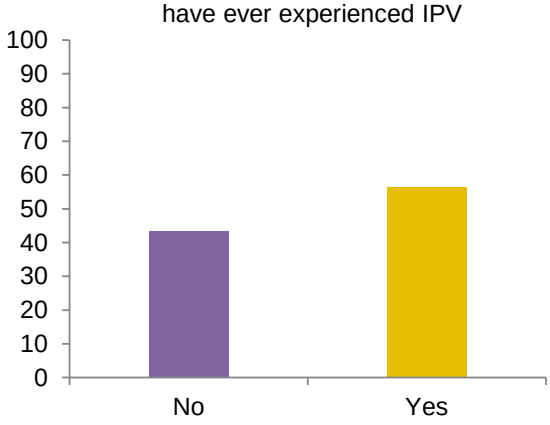




More than half (56%) of women stated that they had experienced intimate partner violence (IPV) at some time in their life (Figure 3.4.10). Recent IPV—any violence taking place during the past 12 months—was reported by 45% of women (Figure 3.4.9). These figures are higher than those reported by students in the School Children's Survey (Figure 3.2.10) and lower than those reported by farmers in Coffee Cooperatives Survey (Figures 3.3.5 and 3.3.7). However, all three surveys point to a high level of IPV taking place in Rwanda. IPV stems from unequal gender power relationships and norms and is the most damaging expression of them. IPV is also directly and indirectly linked to the risk of HIV and is recognized as a major driver of the epidemic worldwide. For these reasons the patterns observed by all three surveys point to a critical need for more attention to programming and interventions to respond to and prevent GBV in Rwanda.



3.4.9 Proportion of women who have experienced IPV in the past year (n=3468)



3.4.10 Proportion of women who have ever experienced IPV

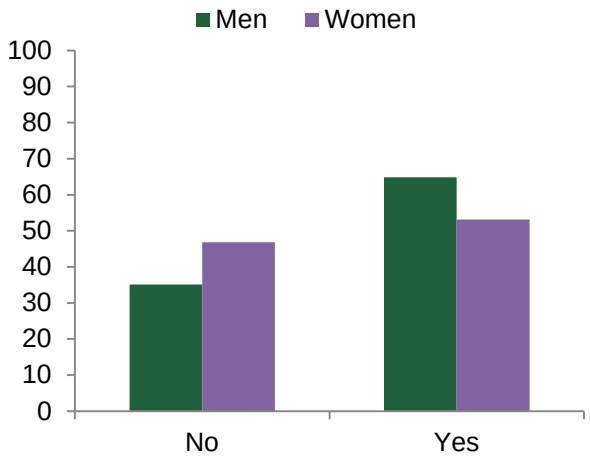
The RDHS also collected data on knowledge of HIV prevention and transmission. According to the international HIV/AIDS M&E guidelines, people are considered to have comprehensive knowledge about AIDS when they know that condom use and limiting sex partners to one uninfected person are ways to prevent HIV and AIDS, they are aware that a healthy-looking person can have HIV, and they reject the two most common local misconceptions about HIV transmission (e.g., through a mosquito bite). More women age 15–49 in Rwanda have more comprehensive HIV knowledge than men (55% of women versus 45% of men). The same is true when level of HIV prevention and transmission is assessed among youth 15–24 years of age.

Similar to other surveys, RDHS asked respondents about behavior associated with higher risk of HIV exposure. Although the likelihood of high-risk behaviors is relatively low (less than 10% for both women and men), twice the proportion of men have had one or more nonmarital partners in the 12 months preceding the survey. The pattern observed is similar to the data shown from School Children's Survey (Figure 3.2.13). It appears that the rates of high-risk behavior are higher in youth compared to adults.

In the 2010 RDHS, a number of questions were posed to respondents to measure their attitudes toward people living with HIV and AIDS (PLWHAs). As seen from Figure 3.4.11, consistent with the findings

from the HIV Stigma Index survey, men are more likely to have accepting attitudes toward PLWHAs than women: 65% of men, as compared with 55% of women, indicated their acceptance on four domains: willingness to buy vegetables from an infected vegetable seller, letting others know the HIV status of family members, caring for relatives who have HIV in their own household, and allowing an HIV-positive female teacher who is not sick to continue teaching.

3.4.11 Proportion of women who express accepting attitudes towards PLWHA



Studies have found that higher levels of women's autonomy are associated with lower fertility and greater contraceptive use,[66] better care during pregnancy and delivery,[67] and higher HIV-related knowledge.[68] Women's economic empowerment is considered necessary for equitable and sustainable economic growth and development and better health outcomes for women and families. As previously noted, in addition to sex-disaggregated data and certain HIV/AIDS related indicators pertaining to gender attitudes and practices, the 2010 RDHS included HIV testing of the general population and collected significant amounts of data pertaining to women's health, such as fertility, preferences for ideal number of children and education (for both women and men), women's (and men's) employment, and more. Findings related to these areas are helpful in setting the societal context for knowing your HIV epidemic from a gender perspective:

- Education and economic independence influence a wide range of HIV outcomes both directly and indirectly. RDHS questions related to women's employment included formal employment as well as work in the home, on family farms, in family businesses, and in other informal sectors, many of which are not as likely to be considered employment by women themselves. Findings indicate that at the national level, only 11% of women were not working at the time of the survey even if they reported working in the preceding 12 months, and more than three in five women (73%) were employed at the time of the survey.

[66] Gage, A. J. (1995). Women's socioeconomic position and contraceptive behavior in Togo. *Studies in Family Planning*, 264-277.
[67] Bloom, S. S., Wypij, D., & Gupta, M. D. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a north Indian city. *Demography*, *38*(1), 67-78.
[68] Bloom, S. S., & Griffiths, P. L. (2007). Female autonomy as a contributing factor to women's HIV-related knowledge and behaviour in three culturally contrasting states in India. *Journal of Biosocial Science*, *39*(04), 557-573.

- Related to household spending, only 18% of women reported deciding for themselves how their earnings are used, and 66% of women make joint decisions with their husbands. Fifteen percent of the married women responded that decisions regarding how their earnings are spent are made mainly by their husbands. Women's reports on who makes decisions about how their husband's earnings are spent were somewhat comparable to men's reports.
- For prevention of mother-to-child transmission programs, there are also important findings. The RDHS results show that overall, there is not much variation in use of maternal health care services by indicators of women's empowerment. Women who participate in none of the decisions are slightly less likely to receive antenatal care from a skilled provider, receive delivery assistance from a skilled provider, and receive postnatal care from a skilled provider within the first two days after delivery than women who participate in one or more household decisions.
- Experience of spousal physical or sexual violence was varied with marital status. Divorced, separated, or widowed women were more likely to have experienced each type of violence than were other women. As expected, women not participating in household decisions were more likely to experience spousal violence than women with high levels of autonomy. Women who did not agree that violence was acceptable in any circumstance were the least likely to have ever experienced IPV.
- Reported recent experience of spousal violence (i.e., within the past 12 months) varied by age and employment status. Among women who have ever experienced IPV, 88% of women age 20–24 experienced such violence in the past year, compared with 68% of women age 40–49. Unemployed women experienced more recent spousal violence and also experienced such violence more often than employed women.

Conclusions about RDHS Data

The selected RDHS findings provide a good picture of gender-related perceptions, knowledge, and practices among the general population in Rwanda. The associations with age, education, and other characteristics, summarized above, are presented in detail in the full Rwanda DHS report. The purpose of displaying indicators here was to illustrate how DHS data fits into the overall gender-based analyses, and that many of the patterns observed for the smaller surveys were also seen in a nationally representative survey. The RDHS findings confirmed the findings in other surveys pertaining to:

- High levels of perceived stigma and discrimination and the low level of acceptance of PLWHAs;
- High rates of IPV experienced by women, and high levels of acceptability of such violence between partners, expressed by both women and men;
- Persistent support for traditional gender norms that perpetuate inequalities between women and men.

4. Conclusions and Lessons Learned

The "Know Your Epidemic from a Gender Perspective" exercise was based on a GBA that used all available data that directly or indirectly related to gender and HIV risk in Rwanda. The results have yielded a rich picture of the HIV epidemic in Rwanda from a gender perspective. There were several important conclusions drawn based on the results of the exercise as well as lessons learned pertaining to the process of the GBA of existing gender and HIV-related data.

Analyzing routine and nonroutine sources of data together and employing a gender focus that used sex-disaggregated and gender-sensitive indicators offered important information about Rwanda's HIV epidemic that would not have emerged from a traditional analysis. The government of Rwanda has demonstrated strong commitment to addressing gender within its HIV response. The results of this report provide information the government can use for that endeavor.

Disaggregated analyses of routine data allow an examination of the gender gap in HIV services and programmatic reach. In analyzing the gender gap, there is only an inequity if the difference between the sexes does not mirror HIV infection rates and prevalence. A larger number of younger women were using services than were men, but this difference was much smaller than the difference in HIV prevalence between the sexes. Therefore, strategies are needed to engage younger women because too few were being reached by services.

Programmatic reach is somewhat more complex, as prevention programs should reach men and women alike, but target sectors of the population where risk is high. We would expect programmatic efforts to target young women and men, based on what is known about the pattern of HIV prevalence in Rwanda. The gap between the number of younger women and men being reached by programs increased over time, with women at a disadvantage, meaning that programs need to find ways of reaching younger women.

Survey data allows an examination of gender-related norms, patterns, and behaviors that contribute to HIV risk. One of the most striking findings across all the surveys was the persistent high level of reported IPV. IPV has been recognized as a driver of the HIV epidemic worldwide. UNAIDS recently added the measurement of recent IPV to the Global AIDS Progress Reporting for countries, due to this connection.[69] Also apparent was the high proportion of individuals expressing norms and attitudes that perpetuate gender inequalities, directly contributing to outcomes such as IPV and indirectly to HIV. Addressing GBV and related norms has become priority for many countries in Sub-Saharan Africa and is garnering strong support from international donors. Prioritizing GBV response in Rwanda will positively affect the HIV epidemic there.

Finally, it should be noted that only part of the gender effects on the HIV epidemic will be captured by quantitative measures. Qualitative research would provide deeper insight into the gender equality dimensions of HIV/AIDS, by exploring people's experiences, opinions, attitudes, and feelings that are not

[69] UNAIDS, UNICEF & WHO. (2013). *Global AIDS Response Progress Reporting 2013: Construction of Core Indicators for Monitoring the 2011 UN Political Declaration on HIV/AIDS*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

possible to measure with quantitative methods. Qualitative studies complement quantitative findings, and should be undertaken to enable a culturally and gender-sensitive and more comprehensive response.[70]

Conclusions from Routine Service and Programmatic Data

- There was virtually no gender gap in the number of adult patients currently on ARV treatment. This was of concern because prevalence is higher among women than men, so presumably there should be a higher number of women in treatment than men. The most disproportionate burden of HIV is among young people aged 15–24. This is indicated by HIV prevalence as recorded by the RDHS and in the routine data on males and females testing positive for HIV through both VCT and PIT. For those enrolled in treatment and already on ARV, there were almost double the number of women than men. With RDHS indicating that women in this age group have prevalence rates up to almost five times that of young men, it is likely that enough young women are not being reached.
- Data on sexual assault were difficult to interpret, mostly due to the fact that victims are referred elsewhere for follow-up. Thus, it was hard to tell what levels of assault cases were being treated with PEP. Having sex-disaggregated data for these indicators would also facilitate examining the gender gap, and special effort should be made to monitor referral outcomes.
- There was a sufficient amount of data related to PLWHAs at both the programmatic level and in regard to their experiences. Additional information from hard to reach populations would benefit the GBA. These indicators are all very important from a gender perspective, because they document how much of the affected community is reached by prevention and care and support interventions, and will shed light on whether women/girls and men/boys enjoy equal access to these interventions. It would be helpful to have more information on any programs that pertain to transforming gender norms that contribute to stigma that hampers the AIDS response, if they exist.

Conclusions from Survey Data

- Report findings from the HIV Stigma Survey indicate that there is a consistent gender gap, unfavorable to women, in almost all domains explored. Even though in the majority of areas the differences did not exceed 15%, their persistence across domains points to the need of gender-sensitive interventions to address HIV-related stigma and discrimination in Rwanda.
- The consistency of findings across different populations (school girls and boys ages 12–18, farmers at coffee cooperatives, and the general population in the RDHS) illustrate that gender roles and expectations of household duties fall disproportionately on girls and their mothers. Beliefs and perceptions reflecting gender inequality persist in many areas, from household to community. On a positive note, gender norms appear to be changing among the younger generation, as indicated by respondents' vision of how they would act in their own future households.
- As mentioned, the patterns and levels of IPV across all survey data is alarming, especially when analyzed in conjunction with views on the acceptability of violence by both men and women, along

[70] UN WOMEN. (2012). *Transforming the National AIDS Response: Mainstreaming Gender Equality and Women's Rights into the 'Three Ones*. Available at: http://www.unwomen.org/~/media/Headquarters/Attachments/Sections/Library/Publications/2012/EN-Transforming%20the%20AIDS%20Response-blue%20pdf.pdf.

with children witnessing verbal and physical abuse of their mothers. The lack of sex-disaggregated data on victims once they report to facilities, and who are then referred for follow-up and their referral outcomes, prevents ability to have a comprehensive picture at the service level.

This exercise also serves as general guidance on how to use existing data to examine a country's HIV epidemic from a gender perspective, enhancing the use of and generating demand for more gender-related HIV data. The steps of this exercise can be repeated for other countries using a similar process, yielding results that will enable program managers and policy makers at the national level to effectively address gender within their HIV response.

Lessons Learned from the Process

- Involving all stakeholders in the process is critical to success. The multisectoral team ensured that the exercise succeeded from accessing the data to interpreting and using the results. There was a high level of interest in looking at gender within all the sectors dealing with routine and survey data needed to conduct these analyses. Countries must express an interest, and that commitment must be present across sectors, because access to many sources of data are needed. Without sustained commitment to the process, an exercise of this kind would not be possible. For example, permission was obtained to access data from several different government and nongovernmental agencies because stakeholders at various agencies were invested in the process.
- Data quality was an issue. In the routine data, there were some patterns that appeared to be caused by gaps in reports and other sources of error. In both routine and survey data, lack of adequate documentation meant that many indicators (and in some cases, whole sources of data) could not be used. This means that a questionnaire must be available, along with a code that will enable the analyst to understand which questions are covered by which variables. This may seem rather straightforward, but staff providing access to data they use regularly may not provide such documentation automatically, since they are so familiar with their own data that they do not need it.
- Rwanda had made great strides in disaggregating many indicators in their routine data by sex. The hope is that this process will continue and more factors will be disaggregated by sex in the future. For example, it would have been very helpful to have reported sexual assault disaggregated by sex.

Although gender-inequitable norms and attitudes were observed across all the surveys, the results of the School Children's Survey showed that there may be a generational shift in gender-related values and norms taking place. Children were aware of the attitudes of their parents, but when asked what they intended to do in their future families, they expressed a desire to have more equitable relationships with their spouses. This points to how powerful gender-transformative programs and policies will be among youth in Rwanda, to support lasting changes and success into the future.

MEASURE Evaluation

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