



**National AIDS Council
of Papua New Guinea**

NATIONAL GENDER

POLICY AND PLAN

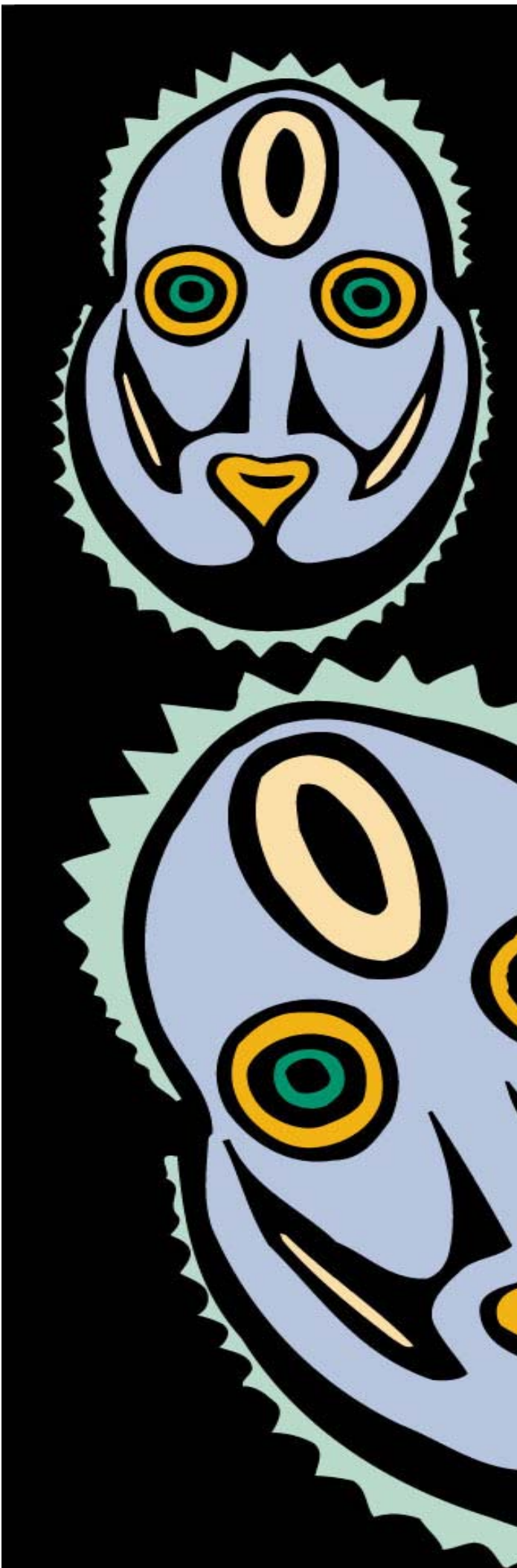
ON

HIV AND AIDS

2006-2010

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1.

FOREWORD

ACKNOWLEDGEMENTS

The National AIDS Council and the National AIDS Council Secretariat appreciate and acknowledge the many men and women from all sectors who have contributed towards the development of this National Gender Policy Plan on HIV and AIDS.

This initiative has been assisted from the outset by UNDP with financial resources and technical expertise, and their support is gratefully recognised. Special thanks, too, are due to AusAID, for their contribution of financial and technical resources.

ABBREVIATIONS AND ACRONYMS

ABCD	Abstain from sex (or delay first intercourse), Be faithful, use Condoms, Do other things (than penetrative sex).
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CSO	Civil Society Organisation (can include FBOs)
DAC	District AIDS Committee
FBO	Faith Based Organisation
FSVAC	Family and Sexual Violence Action Committee
FSW	Female Sex Worker
GBV	Gender Based Violence
HAMP Act	HIV/AIDS Management and Prevention Act 2003
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HIV+	HIV positive
HSIP	Health Sector Improvement Programme
IEA	International Education Agency
IMR	Institute of Medical Research
LJSP	Law and Justice Sector Programme
MDGs	Millenium Development Goals
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NCD	National Capital District
NCW	National Council of Women
NDOH	National Department of Health
NGO	Non Governmental Organisation
NHASP	National HIV/AIDS Support Programme
NGP	National Gender Policy and Plan on HIV and AIDS 2006-2010
OVC	Orphans and Vulnerable Children
PACSO	PNG Alliance of Civil Society Organisations
PEP	Post Exposure Prophylaxis
PLWHA	Person Living With HIV or AIDS
PMGH	Port Moresby General Hospital
PPCT	Prevention of Parent to Child Transmission
STI	Sexually Transmitted Infection
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
UNICEF	United Nations Organisation for Children and the Family
UNIFEM	United Nations Fund for Women
USAID	United States Agency for International Development
WHO	World Health Organisation
WO	Women's Organisation
YO	Youth Organisation
VCT	Voluntary Counselling and Testing

DEFINITION OF TERMS

Sex and gender: The term “*gender*”, as defined by UNAIDS, describes the various characteristics assigned to women and men by the society in which they live. The term “*sex*” refers to biological characteristics. Using the term “gender” highlights the fact that men and women behave differently not only because of their biological sex (what they were born with), but also because of what their society or community has taught them about how men and women are supposed to behave.

An example of a *sexually defined role* is that women give birth to babies and breastfeed them, because only females have this biological capacity. When caring for babies and small children is seen as women’s work, this is a *gender role*, because both males and females have the biological capacity to perform this role. Men are physiologically able to care for children, and if they are encouraged to do so, they may find that there are many benefits to themselves, their children and their relationships.

Gender behaviours and expectations are learned, and can vary from culture to culture, and over time due to changes in social or environmental conditions. This is an important point, because expectations about behaviour, and behaviours themselves, can and must be changed, if they increase people’s risk of HIV and AIDS.

Gender roles vary in different cultures and time periods. Breaking down *gender barriers or stereotypes* for both men and women brings important adaptational advantages for a society, especially one, such as PNG, facing an escalating epidemic of HIV and AIDS.

Gender is the primary organizing principle of all human societies. Children are treated differently according to their gender even in infancy, and are taught what is expected of “good” men and women from a very early age. Gender conditioning therefore runs very deep and is difficult to change. This is especially so when people believe that gender roles are biologically fixed, or when the system of gender relations is highly unequal and one sex (usually men) enjoys considerably more privileges and advantages than the other. In PNG, both these conditions apply.

Gender analysis: the process of collecting and analysing information about gender differences in behaviours, attitudes, beliefs, knowledge, needs, problems and strengths.

Gender equality: means that women and men have equal value, equal rights, and equal opportunities to participate in every aspect of life, at every level of society.

Gender equity: refers to fairness in the access to benefits for men and women, rather than absolute equality. For example, if 80% of teachers are women, a gender equitable approach to promotion would ensure that 80% of head teachers are women, rather than aiming at 50% women and 50% men (which would represent gender equality).

Gender balance: requires that both men and women be represented, either in equal numbers, or in proportion to their presence in relevant population.

Gender relations: are the ways in which men and women relate to each other, based on the expectations for male and female behaviour in that particular culture or society.

Gender issues: are differences between men and women which need to be addressed for the achievement of gender equity, or for an effective response to the problem under discussion.

For example, power is a gender issue. In most parts of PNG, men are better able to protect themselves against HIV and AIDS than women are, because men have more power over their lives than women do. Unequal power between men and women is therefore an important gender issue that needs to be addressed in policy and programming.

Sexual double standard: refers to the different expectations about appropriate sexual behaviours for men and women, which condone much greater sexual freedom for men, while condemning women who have more than one sexual partner or take initiative sexually.

Sexual harassment: refers to any unwanted sexual behaviour, ranging from unwanted sexual touching through to rape. In a work or education environment, the sexual double standard interferes with the protection of women from sexual harassment, and women victims of harassment from a male superior are often blamed and penalized as much or more than the offender.

Any sexual behaviour between a person (usually a male) in authority and a subordinate (usually a female) is an abuse of the power relationship, for which only the person in the powerful position is responsible.

Discordant couples: where one partner is infected with HIV and the other is not.

PEP (Post Exposure Prophylaxis): is treatment given to a rape victim, or someone accidentally stuck with a needle containing HIV-infected blood, to prevent them from becoming infected with HIV.

Transactional sex: when a person exchanges sex for money, goods or favours.

Vertical transmission: from mother to baby during childbirth or breastfeeding.

EXECUTIVE SUMMARY

Papua New Guinea's National Strategic Plan on HIV/AIDS 2006-2010 (NSP) recognised that gender is a key factor shaping both the epidemic and the national response to it. Gender refers to the holistic experience of being male or female, which is only partly determined by an individual's biological sex. Gender roles are based on what a society expects, are learned (not set by nature), and vary according to culture and context. The biggest single factor affecting a person's risk of contracting HIV, and the consequences of infection, is gender.

To ensure that the gender dimensions of the epidemic receive sufficient attention, the National AIDS Council (NAC) commissioned this National Gender Policy and Plan on HIV and AIDS (NGP). It is based on extensive consultations and research carried out between 2004 and 2006, including the UNDP/UNIFEM sponsored gender audit of the NSP and a gender impact evaluation of NHASP's activities. The NSP and the NGP together comprise the "one national HIV/AIDS plan of action" called for by the United Nations.

The NGP uses a gendered approach to HIV and AIDS, which ensures that the different needs of males and females (adults, youth and children) are identified and addressed in the design, planning, implementation, monitoring and evaluation of all HIV and AIDS related activities. It requires also the full involvement of both sexes as participants and as beneficiaries, and the reduction of gender inequalities which affect the spread and impact of the epidemic. Since women are disadvantaged in many ways relative to men, more interventions for women are needed, many of which will also involve men.

Part One, the Policy Framework, identifies eight key policy issues.

1. **Addressing Gender Inequality:** women and girls are more vulnerable to HIV infection than men but less able to protect themselves, because of their dependent situation. The NGP will promote gender equality in access to prevention, treatment and care, strengthen the leadership of women, improve the ability of women and youth to protect themselves with less reliance on men's choices, create partnerships for reducing gender inequality, and mainstream gender into all HIV and AIDS activities.
2. **Gender Mainstreaming:** NACS will act as lead agency for mainstreaming a gendered approach to HIV/AIDS across all sectors, providing mechanisms and training personnel to ensure that gender considerations are integrated into the planning, implementation, monitoring and evaluation of the response.
3. **Gender Based Violence:** physical and sexual violence are major sources of risk to women and girls, requiring a major emphasis in programming.
4. **Poverty:** affects women and girls disproportionately, especially those with HIV or AIDS. Efforts must be made to alleviate economic hardship.
5. **Involving Men:** men's co-operation and participation as "champions for gender equality" and healthier, violence-free sexuality will be sought.
6. **Stigma, Discrimination and Risk:** are analysed for their effects on transmission.
7. **Burden of Care:** Women and girls carry most of the load of caring for the sick and orphans in home-based and community-based care. Interventions must reduce this unbalanced division of labour.
8. **Young People:** must be protected from sexual violence and exploitation and supported in practicing safer sex behaviours.

Part Two describes the characteristics of the epidemic, and the groups at special risk. These are men in all-male or mobile occupations that take them away from home, or who have access to large amounts of cash; men who have sex with men; women who have sex for money, good or favours, due to economic hardship; women and girls (and some boys) who are the victims of physical or sexual violence; young people with low life prospects and a sense of hopelessness; and the male or female sex partners of any of the above. Women are infected at a younger age, and overall, more women than men are infected.

The impacts of HIV and AIDS on individuals, families and communities, the economy and wider society are described. Impacts on women and girls are greater, because of the sexual double standard and the many ways in which they are disadvantaged, especially economically and through gender violence.

The different ways in which women and men are vulnerable to HIV and AIDS are described. The HIV virus and STIs pass more easily from men to women than from women to men because of biological factors, especially with girls and young women, or where sex is rough or violent. Entrenched male dominance backed up by physical and sexual violence, women's lack of power and rights in marriage and sexual relations, their lesser access to information, education and income, and discriminatory attitudes affect the vulnerability to HIV and AIDS of women and girls.

Men's vulnerability relates to gender norms condoning multiple sex partners and violent sexuality, risk-taking behaviours such as alcohol and drug use, work which takes them away from home and puts cash in their pockets, the cultural and modern practice of male-to-male sex, and the sexual abuse of boys.

Part Three describes the Strategic Plan, and matches the Focus Areas, goals and objectives of the NSP. These are:

1. Treatment, Counselling Care and Support
2. Education and Prevention
3. Epidemiology and Surveillance
4. Social and Behavioural Change Research
5. Leadership, Partnership and Collaboration
6. Family and Community Support
7. Monitoring and Evaluation

The gender issues affecting each Focus Area are described, and a brief summary given on progress in that area so far. Strategies are identified which will ensure that activities carried out under the NSP objectives will take gender considerations fully into account. Some of the strategies apply to several focus areas, for example the need for gender sensitization and skills training, the establishment of organisational infrastructures to ensure implementation of the gender strategies, the collection of information disaggregated by sex and age, and the equitable involvement of both sexes as participants and beneficiaries (gender balance).

Part Four establishes priorities. The successful implementation of all the gender strategies is dependent on the creation of institutional mechanisms for mainstreaming gender within NACS and its partners, in particular the appointment of personnel with the responsibility, skills and resources to ensure implementation. The sensitization to gender issues of high level leadership is essential. Gender violence must become more high profile, with PEP provided for rape victims. More efforts must be made to prevent transmission to babies. Men's role as "champions for gender equality" must be supported, as well as greater outreach to youth.

Part Five describes the implementation arrangements for the NGP, identifying the timeframe, organisations responsible and performance indicators. No separate monitoring and evaluation framework is given, because the gender sensitive indicators listed in the implementation arrangements are to be incorporated into the revised monitoring and evaluation framework for the NSP.

PART ONE: POLICY FRAMEWORK

1.1 Introduction:

PNG now has a generalised epidemic of HIV. This means that all sectors of the population are potentially at risk of

- a) becoming infected themselves, and
- b) having to cope with the consequences of members of their family and community, and of the country's workforce, becoming infected.

The biggest single factor that affects these risks, and what a person can do about them, is whether a person is male or female.

Males and females have different roles and responsibilities. Some of these are determined by their biological sex - what a person is born with (e.g. only females can give birth and breastfeed). But most are determined by their gender – the **learned** ways in which each society expects men and women to behave differently from each other (e.g. looking after small children is usually seen as a woman's role; being a leader is often seen as a man's role. For more explanation about "gender", see the Definition of Terms).

PNG's National Strategic Plan on HIV/AIDS 2006-2010 (NSP) recognises that men and women are vulnerable to HIV/AIDS for different reasons and in different ways, and that gender inequality is a key factor in the vulnerability to HIV/AIDS of the nation as a whole. Special measures are therefore needed to address these issues and counteract the impacts of the epidemic.

1.2 Purpose of the National Gender Policy and Plan on HIV and AIDS 2006-2010 (NGP):

The purpose of the NGP is to reduce the spread and impact of HIV infection by ensuring that all activities of the national response to the HIV epidemic identify and address the needs of males and females (adults, youth and children), involve and benefit males and females equally, and reduce the gender inequalities that contribute to PNG's high levels of vulnerability to the HIV/AIDS epidemic.

1.3 Relationship of the NGP to the National Strategic Plan (NSP):

The NGP supplements and supports the NSP, and is a companion document to it. It is intended that all HIV and AIDS related activities of government, civil society, the private sector, donors and development partners shall be guided by both the NGP and the NSP together. These two documents jointly comprise the "one national HIV/AIDS plan of action" called for by the United Nations "Three Ones" policy.¹

¹ The other two are "one national HIV/AIDS co-ordinating authority", and "one national monitoring and evaluation system".

1.4 Background to the NGP:

The NGP was commissioned by the National AIDS Council to strengthen the integration of gender into all aspects of NSP implementation, in recognition of the key significance of gender factors in shaping PNG's epidemic.

The NGP is based on extensive research and consultations between 2004 and 2006, and in particular a gender audit of the NSP² and a gender impact evaluation of work carried out under PNG's National HIV/AIDS Support Programme (NHASP).³

1.5 National and International Policy Foundations :

The NGP is founded on the principles of equality of the sexes embodied in PNG's National Constitution, the National Policy for Women, and the Government's Medium Term Development Strategy 2005-2010 (MTDS).

The MTDS explicitly recognises that "reversing the course of the epidemic will depend, to a significant degree, onempowering women" (p27).

In addition, the government has signed a number of international conventions and agreements committing it to work towards gender equality in general, as well as in the specific context of HIV and AIDS. These are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Declaration on the Elimination of Violence Against Women (DEVAW); the Convention on the Rights of the Child (CRC); the UN Declaration on Women 2000: Gender Equality, Development and Peace; the Millenium Development Goals (MDGs); and the United Nations Special Session on HIV/AIDS (UNGASS).

The third goal of the MDGs is "to promote gender equality and empower women". The three main articles of UNGASS, describing how "human rights, gender equality, and women's empowerment provide the foundation for combating HIV/AIDS" are given as Annex One.⁴

1.6 Guiding Principles:

Strategies and activities of the NGP will be interpreted and implemented based on the following principles.

Development approach:

1. Recognition that HIV/AIDS is a fundamental cross-cutting development issue, involving all sectors of society, not simply a public health issue.

² UNDP 2005, *The National Strategic Plan on HIV/AIDS of Papua New Guinea 2006-2010: A Gender Audit Report*. UNDP Port Moresby.

³NHASP 2005, Milestone 95: *Gender Impact Evaluation of the National HIV/AIDS Support Programme*. Report to AusAID.

⁴ UNFPA, UNAIDS, UNIFEM 2003, *Women: Meeting the Challenges of HIV/AIDS*.

Human rights:

2. Respect for the full human rights of all Papua New Guineans of both sexes, as laid out in PNG's National Constitution and the National HIV/AIDS Management and Prevention Act 2003.

PNG culture:

3. Support for the culture and traditions of Papua New Guinea, except where these increase the risk of HIV infection to Papua New Guineans, whether male or female, or cause additional hardship to those of either sex infected or affected by HIV or AIDS.

Personal responsibility and empowerment:

4. The right of all citizens, whether male or female, to the information, services and conditions allowing them to protect themselves from HIV, independent, as far as possible, of dependence on the choices of others.

Do no harm:

5. Ensuring that interventions or processes do not worsen the situation for people based on their gender or age.

Men and women together:

6. Men and women as equal partners in finding solutions.

1.7 Goal:

The overall goal of the NGP is:

To reduce the HIV prevalence in the general population to below one percent by 2010, to reduce the vulnerability of males and females (adults, youth and children) to HIV, and to improve treatment, care and support for all people infected and affected by HIV and AIDS, using a gendered and rights-based approach.

1.8 What is a Gendered Approach?

A gendered approach is one which identifies and addresses the different needs and situations of males and females in the design, planning, implementation and monitoring and evaluation of activities.

At times it can appear that a gendered approach is only about women, since women are often disadvantaged relative to men, and usually more programmes are needed for them than for men. However, a gendered approach recognises that an understanding of men's needs and perspective, and of the power relations between men and women, is equally important.

A gendered approach benefits both men and women, because it aims at fairness for both.

1.9 Why HIV and AIDS Need a Gendered Approach:

Men and women are both at risk of being infected and affected by HIV and AIDS, but in different ways. In the context of HIV and AIDS in PNG, gender is a major factor determining:

- an individual's risk of contracting HIV;
- an individual's access to diagnosis, care and treatment of HIV or AIDS;
- the consequences to the individual of being diagnosed with HIV;
- the onset and progress of the illness;
- the impact of an individual's HIV-related illness and death on their family and community; and
- the socio-economic consequences for the country.

All major international authorities now recognise that a gendered approach to HIV and AIDS is critical.⁵ Research has established that “gender integration maximizes the effectiveness of programmes by reaching more people and reducing constraints to accessing and using information, technologies and services for all”, and that it “yields more sustainable results by lowering the incidence of infection and mitigating the negative consequences of AIDS”.⁶

Research by the World Bank has found that HIV and AIDS programmes which are not gendered can actually do harm, for example by reinforcing negative gender stereotypes, by providing the same interventions to men and women when their needs are different, or by providing different interventions when their needs are the same.⁷

1.10 Key Policy Issues:

1. Addressing Gender Inequality:

Gender inequality lies at the heart of the spread of HIV and AIDS in PNG. International authorities agree that “the key to overcoming the HIV/AIDS epidemic is through transforming relations between women and men, so that women will be able to take greater control of their lives”.⁸

⁵ For example, WHO 2003, *Integrating Gender into HIV/AIDS Programmes: A Review Paper*. IGWG and USAID 2004, *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organisations*.

The Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach*.

UNAIDS, UNFPA and UNIFEM 2004, *Women and HIV/AIDS: Confronting the Crisis*.

⁶ WHO 2003, cited above, p 41-2.

⁷ WHO 2003, cited above.

⁸ UNAIDS, UNFPA and UNIFEM 2003, *Women: Meeting the Challenges of HIV/AIDS*.

Ruxin J., Binagwaho A. and Wilson P., 2005, *Combatting AIDS in the Developing World*. London: Earthscan.

As will be described in Part Two, women and girls in PNG are more vulnerable to HIV infection than men and boys, but are less able to protect themselves against it because of the many economic, social, legal, political and cultural disadvantages they face.

Women have less access to education, are restricted in their income-earning opportunities, have limited rights to land and property ownership, and are therefore usually dependent on men for their economic survival. Customary payments at marriage and on the birth of children are seen as giving men the right to control their wives and children. The sexual double standard expects women to be monogamous and faithful, while allowing men to have multiple wives and sexual partners, and to be dominant in sexual relations. Women are vastly under-represented in public life and leadership at all levels, so their needs and concerns are not taken into account in decision-making.

Because of these disadvantages, women lack the power to decide for themselves about how, when and with whom to have sex. The ABC(D) prevention messages used in PNG and internationally therefore do not work for most women, especially married women. Young people of both sexes are also disadvantaged in the same way.

“The ABC approach will present viable options for women and girls only if it is part of a package of interventions that empower them to claim their rights”.⁹ UNAIDS defines these as ensuring access to education, securing women’s property and inheritance rights, reducing violence against women, and promoting women’s leadership.¹⁰

The NGP will address these issues in the following ways:

- a) ensuring gender equality in access to prevention, treatment and care;
- b) promoting the leadership of women;
- c) using strategies which empower women and youth to protect themselves against HIV and AIDS;
- d) working to reduce gender inequalities in PNG society generally through multi-sectoral partnerships; and
- e) mainstreaming gender into all HIV and AIDS activities.

2. Gender Mainstreaming:

Gender mainstreaming is the process of integrating a gendered approach into all systems and activities of an organisation. It is based on gender analysis, which is the analysis of an issue in terms of how it affects and is affected by gender roles and relations. The purpose is to ensure fair outcomes for both males and females.

International experience has shown that an effective gendered approach requires dual complementary strategies.¹¹ The mainstreaming of gender considerations into all

⁹ UNAIDS, UNFPA and UNIFEM 2004, *Women and HIV/AIDS: Confronting the Crisis*, p 2.

¹⁰ Global Coalition on Women and HIV/AIDS (A UNAIDS Initiative), 2005, *Keeping the Promise: An Agenda for Action on Women and HIV/AIDS*. www.womenandaids.unaids.org

¹¹ Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach*. p 14.

Womenwatch 2000, *UN Good Practices in Gender Mainstreaming*.

levels of planning, implementation and reporting must be teamed with targeted programmes for women and girls, or for men and boys in aspects where they are disadvantaged.

Experience in PNG has shown that although there is a growing awareness of the importance of a gendered approach to HIV/AIDS, there has been little development of plans and programmes to specifically address these issues, particularly at provincial and district levels.¹²

Effective mainstreaming of gender into the national response to HIV/AIDS requires the creation of appropriate structures, systems, mechanisms and processes to ensure that gender considerations are integrated at all stages, from planning through to monitoring and evaluation. The components of a gender mainstreaming framework are:

- an institutional gender policy and plan;
- a gender management system, with personnel trained and formally tasked to integrate gender at specific points in the project cycle;
- gender training, including sensitisation to gender issues for leaders at all levels and skills training in gender analysis for planners and implementers;
- sex-disaggregated data and gender sensitive indicators;
- gender balance in consultation and decision-making;
- budget allocation.

The National AIDS Council will act as the lead agency for the mainstreaming of gender at national, provincial and district levels, in both government as well as civil society, by:

- a) establishing gender mainstreaming within the NACS, PACs and DACs; and
- b) supporting the mainstreaming of a gendered approach to HIV and AIDS across all sectors.

3. Gender Based Violence:

Gender based violence refers to the various forms of violence which women and girls experience because of their gender: wife-beating (or domestic violence) and other forms of physical violence, rape (including marital rape), pack rape, sexual abuse and exploitation of girls (and, increasingly, of boys), sexual harassment in workplaces and schools, incest, forced prostitution, sexual abuse of females by authorities during conflicts, disasters and emergencies and by the police.¹³

Numerous studies have established that gender violence in PNG has become a massive problem which severely affects the lives of the majority of women and girls in this country, and is a major factor in the spread of HIV/AIDS.¹⁴ International

¹² NHASP Milestone 95, 2005, *Gender Impact of the National HIV/AIDS Support Project of PNG*.

¹³ Human Rights Watch, *Report on Police Brutality in PNG*, 2005.

¹⁴ Summarised in Bradley C. 2001, *Family and Sexual Violence in PNG: An Integrated Long-term Strategy. Report to the FSVAC*. Discussion paper No. 84, Port Moresby: Institute of National Affairs. See also Amnesty International 2006, *PNG: Violence Against Women: Not Inevitable, Never Acceptable!* London: AI International Secretariat; and Lewis, I., Maruia B., Mills D. and Walker S., *Violence Against Women and the Transmission of HIV in PNG*. Presentation at the PMH Medical Symposium, Sept. 2006.

authorities agree that “gender-based violence is now one of the leading factors in the increased rates of HIV infection among women”.¹⁵

Gender violence is both a cause and a consequence of HIV infection. Research in PNG and elsewhere has established that women who have experienced physical and sexual violence have higher rates of STIs and HIV.¹⁶ Conversely, women with HIV or AIDS often suffer violent reprisals when they tell their partners of their status.

Women’s fear of physical violence from their partners can prevent them from negotiating safer sex, as well as from seeking counselling and testing, STI treatment, reporting rape and receiving post-exposure prophylaxis against STIs and HIV (where available), disclosing their HIV status, and preventing transmission to their babies by taking nevirapine and following certain procedures for feeding their infants.

Rough or violent sex, whether within marriage and outside it, greatly increases the risk of HIV or STI transmission through the likelihood of some degree of genital trauma in the woman, and her inability to negotiate condom use or other safer sexual practices. With children or teenagers, physical damage and risk of HIV or STI transmission is even more likely.

In PNG, research has found that half the victims of rape are under 16 years old.¹⁷ Many girls who have been sexually abused turn later to sex work.¹⁸ Experience of childhood sexual abuse is linked with HIV risk in women. Research with HIV+ women in four provinces has found that 30% had been sexually abused as children, usually by relatives such as uncles and brothers.¹⁹

The NGP recognizes the direct links between gender based violence and the spread of the HIV/AIDS epidemic and will:

- a) integrate activities to prevent and respond to gender violence into HIV-related programming at all levels, moving beyond the raising of awareness to the development of programmes, services and skills;
- b) support partnerships with other governmental and non-governmental organizations to create responses in the health, justice, education, economic and social sectors aimed at reducing levels of gender violence throughout the country.

4. Poverty:

Gender inequality, gender violence and poverty have been identified as the three main threats to women’s protection from HIV/AIDS.²⁰ In PNG, where over 80% of the population still live on their land, lack of access to services and to opportunities for

¹⁵ UNAIDS, UNFPA and UNIFEM 2004, *Women and HIV/AIDS: Confronting the Crisis*, p3.

¹⁶ Lewis I., Maruia B., Mills D. and Walker S., *Violence Against Women and the Transmission of HIV in PNG*. Presentation at the PMH Medical Symposium, Sept. 2006.

Global Coalition on Women and AIDS and WHO 2004, *Violence Against Women and HIV/AIDS Information Sheet*.

¹⁷ Riley et al (ed.s), 1985. *The Management of Rape and Other Sexual Offences in Port Moresby*. p3.

¹⁸ Hamar L.,2006, “*It’s in Every Corner Now*”: results from a nationwide study of HIV, AIDS, STDs and sexual health”. Goroka: PNG IMR Operational Research Unit.

¹⁹ Lewis I., Maruia B. and Walker S., cited above.

²⁰ The Global Coalition on Women and AIDS, website homepage, www.womenandaids.unaids.org

participation in development and governance are as significant in defining poverty as low levels of cash income, which is the most common indicator of poverty used for international comparisons.

However poverty is defined, it is widely acknowledged, in PNG as elsewhere, that women and girls are the most affected. This can be expected to worsen as the AIDS death toll rises and women are left to care for increasing numbers of orphans, as has happened in Africa. A poverty assessment of PNG in 2002 observed that economic hardship for women had become worse over the previous five years.²¹ Already, studies have found that in all parts of the country, alarming numbers of women and girls, and some men and boys, are selling sex to meet their needs.²²

The NGP will support HIV-related activities which incorporate poverty reduction strategies, particularly for women and girls.

5. Involving Men:

The ABC prevention messages used so widely around the world have targeted mainly men for several reasons. Control of sexual relations is generally in the hands of men, men have more sexual partners than women, and men are more prone to other behaviours that increase the risk of HIV transmission, as will be described in detail in Part Two.

Equally important are cultural attitudes that associate “being a man” with the domination of women and expectations about male privilege in all aspects of life, not just sexually. These factors combined endanger men, and through them the women and children with whom they have sex, and whose lives they control.

It has been found, in PNG as elsewhere, that men are willing to become “champions of change” for gender equality, when offered the opportunity and the skills. Beginning with personal behaviour change, they become leaders for social and cultural change.

Homophobia, too, is best addressed through male leadership. For success, programmes must emphasise true male-female partnership in marriage, the community and society, and avoid using dominance-based concepts such as the husband as the head of the family.

The NGP aims to create more equitable sexual relations and norms of gender identity for both sexes, by involving men in redefining masculinity in terms of caring and supporting roles rather than on dominance and aggression, by promoting healthy sexuality based on mutual agreement and pleasure, and by supporting men’s involvement in family and sexual health programmes.

²¹ ADB 2002, *PNG Participatory Poverty Assessment*, para 96.

²² NHASP 2005, Milestone 83, *Social Mapping of 19 Provinces in PNG Summary Report*.

UNICEF and HELP Resources, 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Exploitation of Children in PNG*. Draft, January, Port Moresby.

UNICEF 2006, *Families and Children Affected by HIV/AIDS in PNG and Other Vulnerable Children*. May, Port Moresby.

6. Stigma, Discrimination and Risk:

Economic and cultural conditions in PNG put certain groups of people at particular risk of contracting HIV. Men whose occupations require them to be mobile or away from home for long periods can be identified and reach with preventive and treatment programmes, but the female and male sex workers who serve them, and men who have sex with men, are less easy to identify and reach because of stigma and discrimination, backed by outdated laws against prostitution and homosexuality.

A focus on high risk groups, while necessary, must not deflect attention from the fact that marriage itself is a major risk factor for women, as recent research by the PNG IMR has shown.²³ The wife or sexual partner of a man practising high risk behaviours is at just as much risk as he is, because she must usually have sex on his terms. This has not yet been sufficiently acknowledged in programming, nor have the overlapping networks of men who have sex with men and also with women.

The sexual double standard has led to the blaming of female sex workers and of young women as bearers of infection rather than the men with whom they have sex. Victims of rape or sexual harassment are often blamed for “provoking” the offence. The NSP calls for greater involvement of people living with HIV or AIDS, but this is especially difficult for women, because of the extra stigma they face.

The NGP will focus on the reduction of stigma and discrimination by extending programmes for high risk groups to include their regular partners, encouraging a more open attitude to the discussion of sexuality, avoiding information approaches which are fear- or blame- based, promoting the rapid roll-out of treatment and information about it, and advocating for the repeal of stigma-promoting laws on sex work and homosexuality.

7. Burden of Care:

The NSP recognises that health services are already unable to cope with the demand for in-patient care for people sick with AIDS related illnesses and calls for a move towards greater home based and community based care. While this strategy rightly recognises PNG’s strong community and family values, its effect is to unfairly burden women and girls.

Women and girls are traditionally the care-givers in PNG society. This gender role is taken for granted, and therefore remains unacknowledged and unremunerated. The true costs are hidden, especially when long-term caring is involved as in HIV and AIDS. Care-giving work is additional to women’s normal domestic and food-growing work, all of which is highly labour intensive in PNG. Carrying water to keep clean a person in the diarrhoeal stage of AIDS can itself take many hours daily.

Informal care-giving disadvantages women care providers by keep them away from market economies, girls from attending school, overstraining them physically and emotionally and generally undermining their own health. Yet while women provide care to sick male partners, they themselves seldom receive care when they fall sick.

²³ Hammar, L. 2006, *“It’s in Every Corner Now”*: results from a nationwide study of HIV, AIDS, STDs and sexual health”. Goroka: PNG IMR Operational Research Unit.

The NGP will mitigate the burden of care on women and girls by providing practical supports to families and communities and promoting the role of men and boys in sharing the work of caring-giving.

8. Young People:

Protecting young people from HIV infection offers the best hope of reversing the spread of the epidemic and reducing its impact on the country. It is crucial that young people are given full and accurate information about sexuality and risk factors, and non-judgmental access to condoms where needed. There is no evidence to suggest that this encourages sexual activity among youth.²⁴

Young people must also be protected from the sexual abuse and exploitation to which they are exposed in their families, schools and communities. AIDS orphans, and children in families affected by HIV or AIDS, will be even more vulnerable to sexual abuse.

Education levels are key to improving girls' and women's ability to protect themselves from HIV infection. More educated girls delay having sex, and are better able to insist on condom use.²⁵ As adults, they have better opportunities for economic independence.

However, without special measures, more and more girls will be denied an education as the epidemic spreads and they are kept home to help care for the sick, or because there is no money for their school fees. Females will become increasingly disadvantaged educationally and economically, conditions which will continue to fuel the spread of the epidemic.

The NGP will give high priority to the prevention needs of young people.

²⁴ Hargreaves J., Boler T., 2006, *The Impact of Girls' Education on HIV and Sexual Behaviour*. Actionaid International. Education and HIV Series 01

²⁵ UNAIDS, UNFPA and UNIFEM 2004, *Key Facts and Figures on Gender and HIV/AIDS*, www.genderandaids.org

Hargreaves J. et al, 2006, cited above.

PART TWO: GENDER AND HIV/AIDS IN PAPUA NEW GUINEA

2.1 Characteristics of the Epidemic in PNG:

HIV can be spread in three ways: through sexual contact, from mother to child during birth or breastfeeding, or through blood. In PNG, most detected cases are due to sexual transmission (both heterosexual and homosexual). The rest are due to mother to child transmission.

Injected drug use is not yet a significant factor in PNG. Transmission through blood transfusion appears to have been prevented through improved screening. Some cases of infection may result from traditional practices involving blood on shared instruments, such as in tattooing or group circumcision. Cross-infection in health care settings is not yet known to have occurred, though it is greatly feared by health workers, and is affecting care given to HIV+ patients.

HIV is transmitted more easily where an STI is present. Surveillance has found very high rates of co-occurrence of HIV and STIs (figures for 2004 and 2005 for Port Moresby show one in five STI patients tested positive for HIV).²⁶ PNG's rates of STIs are amongst the highest in the world.²⁷ Women have higher rates than men of untreated STIs.²⁸

In 2002, infection rates of HIV in the general population (as measured through testing of pregnant mothers at antenatal clinics) passed one percent, and PNG was declared the fourth nation in the Asia-Pacific region to have a generalised epidemic. This means that every sexually active person, male or female, is potentially at risk of infection.

Within this, there are groups of people whose risk is particularly high, through their own behaviours or the behaviours of others:

- * men in all-male or mobile occupations that take them away from home, or have access to large amounts of cash (e.g. resource royalty payments);
- * men who have sex with men (because anal sex transmits HIV and STIs more easily);
- * women (and smaller numbers of men) who have sex for money, goods or favours, due to poverty;
- * women and girls (and some boys) who are the victims of physical or sexual violence;
- * young people with low life prospects and a sense of hopelessness;
- * the male or female sex partners of any of the above, particularly wives (who are expected to obey their husbands and to bear children).

²⁶ NACS and NDOH 2004 and 2005, *HIV and AIDS in PNG Annual Surveillance Reports*.

²⁷ UNICEF and NACS 2006, *Families and Children Affected by HIV/AIDS, and Other Vulnerable Children*, p9

²⁸ Hammar L. 2006, *"It's in Every Corner Now": results from a nationwide study of HIV, AIDS, STDs and sexual health*. Goroka: PNG IMR Operational Research Unit.

Male and female HIV infection rates:

Data allowing a comparison of HIV infection rates between males and females are still inadequate in PNG. PNG's national surveillance system presents numbers of **notifications** of HIV+ diagnoses in males and females, not infection rates. Notification reflects rates of testing, not rates of infection. Because young child-bearing women are regularly tested in antenatal clinics, but there is no regular testing for men in this age group, the data are often misinterpreted to mean that young women are infected at several times the rate of young men.

In reality, since the main mode of transmission is by sexual intercourse between men and women,²⁹ and discordant couples are few, an infected woman's partner is almost certainly also infected. As the epidemic progresses, there is indeed a "feminisation" of the epidemic, because females are infected at a younger age than males (for various biological, cultural and socio-economic reasons described later) and therefore represent a larger proportion of the HIV+ population.

In a predominantly heterosexually driven epidemic, prevalence rates in antenatal testing are assumed to represent the rates for both sexes in the general population, while prevalence rates from STI, VCT and TB clinics are assumed to represent the prevalence rates for both sexes in higher risk groups.

For 2005, antenatal prevalence rates for the NCD have risen to 1.26%, with figures from the ten other sites where testing is conducted ranging from a low of 0.6% in Alotau to a high of 3.7% in Mount Hagen.³⁰ Prevalence rates of HIV at 12 VCT sites for 2005 range from a low of 2.4% in East Sepik to a high of 19.2% in the Western Highlands, with the NCD at 9.3%.³¹ The trend for all rates is upwards.

Increasing numbers of children (boys as well as girls) are testing positive for HIV, with sexual abuse a possible cause. The number of babies infected at birth is also rising, because only a small proportion of pregnant mothers are tested. Even at PMGH, where testing is supposedly routine, fewer than half women attending have been tested.³² Prevention of infections at birth is obviously vital for reducing the impact of the epidemic, as well as reducing stigma against HIV+ mothers.

2.2 Gender Impacts of the Epidemic in PNG:

Gender is a major determinant of the consequences of HIV/AIDS for individuals, families, communities and the wider society.

Impacts on individual men and women:

Men: When a man gets sick with AIDS, he is usually cared for by his wife and/or female family members. In most parts of PNG, it is customary for families to live on the land of the husband, so men normally have the support of their kin group and community. Traditions of male dominance mean that men are less likely to suffer

²⁹ There is considerable male-to-male sexual activity in PNG, and many of these men also have sex with women, serving as a "bridge" for the virus into the heterosexual population.

³⁰ NACS and NDOH 2005, *Annual Surveillance Report on HIV/AIDS 2005*.

³¹ These data are not presented disaggregated by sex or age in the Surveillance Report.

³² NACS and NDOH 2005, *Annual Surveillance Report on HIV/AIDS 2005*, p14.

abuse or neglect when diagnosed with HIV, but employed men may suffer from depression and loss of status when their sickness prevents them from working.

Women: Women face greater blame than men when they are infected with HIV because of the sexual double standard, and their lack of power makes the consequences of a positive diagnosis more severe in several ways. An HIV+ woman whose status is known may be:

- * beaten or abandoned by her husband;
- * maltreated by the community, because women often marry far away from home and relatives who could protect them (especially in the Highlands, where girls may be given in marriage to make alliances with other clans, sometimes enemy groups); cases are known where women have been tortured, abandoned in garden huts, burned, or otherwise murdered.³³
- * neglected at home, or abandoned in hospital. As one Highlands health worker said: “Women don’t count for much in this culture, so if a woman gets AIDS, they just throw her away”.

Women and girls in families where someone is sick with AIDS have the additional labour of caring for the sick person. If the husband is sick, his wife may have to shoulder the extra load of earning income for the family. This can mean selling sex, since few other income-earning opportunities exist for unskilled women in rural areas. Girls may have to leave school to help with the workload of caring for a sick parent, or for other children or orphans. If they stay in school, they may have to pay their own school fees by selling sex, since boys usually get preference when money is scarce.

AIDS widows are often thrown into poverty. When a man dies, his widow does not necessarily have automatic rights to stay on the land in patrilineal societies, especially if she has no adult sons, but she may also not be accepted back in her home village. A recent study in PNG has found that “female headed households are several times more likely to be below the absolute poverty line”.³⁴

Impacts on the family and community:

It is women’s daily work that feeds rural families, and their other many roles hold the family and the community together. Caring for the sick and for orphans means less time for women and girls to work in food gardens, or conduct economic activities, increasing economic hardship for the family. Children are less well cared for, more vulnerable to abuse, and less well fed. Since 30% of under-5s are already malnourished, children’s physical and mental development could become seriously retarded.³⁵

³³ UNICEF and NACS 2006, *Families and Children Affected by HIV/AIDS, and Other Vulnerable Children*. Port Moresby. May

Hammar L. 2005, *Fear and Loathing in PNG: sexual behaviour and sexual health amidst AIDS anxiety*. Paper presented at a Working Session on AIDS in Oceania, Association for Social Anthropology in Oceania.

³⁴ Centre for International Economics 2002, *Potential economic impacts of an HIV/AIDS epidemic in PNG*, p 70. Report to AusAID, February.

³⁵ As above, p 31.

Impacts on the economy:

Men: Infection in men will have more effect on the formal economy and the labour market, where the workforce is mostly male. HIV/AIDS will result in a loss of skilled and professional workers, a decline in productivity, and an increase in the cost of doing business through faster turnover of personnel and the need for more sustained investment in training. PNG's dependency ratio – the proportion of dependents to income-earners – is already high, at 80%, and is expected to rise as the epidemic worsens, throwing more households into absolute poverty.³⁶

Women: Infection in women will have more effect on the informal economy and food production. Up to three quarters of people infected live in rural areas.³⁷ It has been estimated that the impact on women and children at the household level will reduce production in subsistence agriculture by one quarter.³⁸ At national level, this could have serious implications for food security and political stability.

Impacts on society:

The ability of government to continue to fund non-productive programmes in the health, education, law and justice and social sectors will decline. Increasing stress and poverty will exacerbate already frightening rates of physical and sexual violence and the sexual abuse and exploitation of children, with women falling further and further behind men in education, employment, and political participation. This is a daunting prospect for PNG's women and girls, and for the development of the country overall. It is therefore vital that the NGP be rigorously and consistently implemented, to lessen the negative impacts of the epidemic in PNG.

2.3 Factors Affecting Women's and Girls' Vulnerability to HIV/AIDS:

Biological factors play some part in the immediate vulnerability of women and girls to HIV/AIDS, but social, cultural and economic factors relating to women's unequal status are far more decisive in the long-run. It is the combination of these that put women in a position where they are much less able than men to protect themselves against HIV infection.

Biological factors:

The HIV virus and STIs pass more easily from men to women than from women to men. Women are up to four times as likely to contract HIV from a single act of unprotected vaginal intercourse.³⁹

This is because:

- * female sexual organs present a larger surface area for the entrance of viruses or bacteria through lesions or breaks in the delicate tissues;
- * women are more likely to have untreated STIs;

³⁶ As above, p 69.

³⁷ Jenkins C. 2005, *Control of HIV/AIDS in PNG*, p17. Report to the World Bank, AusAID, and ADB

³⁸ Centre for International Economics 2002, p xiii..

³⁹ Population Reference Bureau 2006, *The Global Challenge of HIV and AIDS*, Population Bulletin Vol. 61, No. 1, March, p5.

- * there is a higher concentration of the HIV virus in semen than in vaginal fluids;
- * rough or violent sex causes tearing of tissues, especially in young girls and older women;
- * the female sexual and reproductive organs are not fully mature until the late teenage years or early twenties.

Women's unequal status:

The main cause of women's greater vulnerability to HIV and AIDS is their unequal status. Women in PNG are disadvantaged in relation to men, and in relation to women in other countries, in many significant aspects of their lives. This can be objectively measured in several ways.

- * PNG ranks lowest of all countries in the Pacific region on the UNDP's Gender-related Development Index (GDI), a composite index measuring indicators relating to women's life expectancy, health, knowledge and standard of living.⁴⁰
- * In most countries women live longer than men, but in PNG women's life expectancy is similar to men's, a condition that occurs in only a small number of countries in the world marked by poverty and low status of women.⁴¹
- * PNG's rate of maternal mortality is nearly double that of any other country in the Pacific region, at 300 per 100,000 live births.⁴²
- * Enrolment of girls in primary education is 69 per 100, the lowest in the Pacific region. For boys, the figures are 79 per 100, and the gap increases with each higher grade.⁴³
- * At national level, women's rates of political participation are among the lowest in the world. Currently, PNG has only one female member of Parliament (out of a total of 109), and only four women have ever been elected to Parliament since Independence in 1975. This puts PNG third from bottom of an international ranking of 121 countries, in 119th place.⁴⁴

Cultural, social and economic factors:

There are many cultural, social, and economic ways in which women's unequal status is perpetuated, preventing them from protecting themselves from HIV and AIDS.

Man as head of the family: In most PNG cultures, the husband is seen as the head of the family and the wife is expected to obey him in all things, including having sex with him even if she knows he may have an STI or HIV.

Bride-price payments: are seen in many parts of the country as giving a man "ownership" of his wife and her body, so she has no right to refuse sex, negotiate safer sex, or to leave an abusive or unfaithful husband.

⁴⁰ <http://hdr.undp.org/statistics/data/countries>

⁴¹ Schoeffel P., 2004, *Pacific Strategy 2005-2009: Gender Strategy for the Pacific*. ADB, p15.

⁴² ADB MDGs Online Report, 2005, www.adb.org/documents/book/key_indicators/2005/default.asp

⁴³ Figures for 2002, latest year available, in the ADB's On-line Report on the MDGs, at www.adb.org

⁴⁴ Schoeffel P 2004, cited above, p20.

Men control sex: even where bride-price is not paid, men are expected to be dominant in sexual relations, and women obedient. Women who appear to know too much, or who take the initiative sexually (such as by obtaining or suggesting condoms) tend to be branded as promiscuous and may be punished. Having more wives or sex partners is a status symbol for men, and women have little choice about this.

Violence against women: operates to keep women subordinate, and is also a direct means of transmitting HIV. Fear of being beaten prevents women from discussing safe sex with their partners, from getting tested for HIV or from asking their partners to get tested, from telling their partner about a positive HIV test result, and from ensuring they do not pass the virus to their unborn children. Rape, or sex using any kind of force, prevents women from protecting themselves and increases their risk of HIV and STIs.

Wife-beating is extremely common throughout PNG, affecting two-thirds of married women nationally, and up to 100% of women in parts of the Highlands.⁴⁵

Rape, or forced sex: is a major hazard for women and girls, including within marriage (*marital rape*). More than half of PNG's women have experienced some form of forced sex, according to IMR research.⁴⁶

Gang rape: exists in every province, and especially in areas of tribal fighting, or disasters. In some parts of the country, it was traditionally a way of punishing women or girls.⁴⁷

Sexual abuse of girls: Nearly half the victims of rape are under 16 years old, and half of those being under 12 years old. Many perpetrators are family members.⁴⁸ The situation is getting worse in conditions of urban overcrowding and poverty. This has serious consequences for the spread of HIV and AIDS, as 49% of the population is under 18 years old.⁴⁹

Sexual harassment and abuse: of women and girls by males in positions of authority in workplaces and schools, and by the police, is very common.⁵⁰

Sexual exploitation of women and children: is a rapidly growing phenomenon. Where money is short, some women and girls are compelled by husbands, fathers, brothers and other male relatives to sell sex.⁵¹

Male dominated justice systems: Mean that women cannot turn to the courts or the police for protection from violence or mistreatment.

⁴⁵ PNG Law Reform Commission 1992, *Final Report on Domestic Violence*. Report No. 14.

⁴⁶ NSRRT and Jenkins C. 1994, *National Study of Sexual and Reproductive Knowledge and Behaviour in PNG*. IMR Monograph No. 10.

⁴⁷ UNICEF and HELP Resources, 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG*. Draft, January

⁴⁸ Bradley C. 2001, *Family and Sexual Violence in PNG: An Integrated Long-Term Strategy*, p 7-10. Institute of National Affairs, Discussion Paper No. 84, Port Moresby.

⁴⁹ GOPNG 2004, *Papua New Guinea: UN Secretary General's Study on Violence Against Children*.

⁵⁰ GOPNG and UNICEF 1999, *PNG's Initial Report to the UN Committee of the Rights of the Child*.

⁵¹ NHASP 2005, *Social Mapping of 19 Provinces in PNG: Summary Report*.

UNICEF and HELP Resources, 2005, cited above.

UNICEF and NACS 2006, *Families and Children Affected by HIV/AIDS and other Vulnerable Children in PNG: A National Situation Analysis*.

Discriminatory attitudes against women: where women are blamed for spreading the infection, and the men who have sex with them are not. There are laws against prostitution, but not against using prostitutes. Rape or sexual harassment victims are often blamed for not keeping themselves safe or for behaving or dressing in certain ways, deflecting responsibility from the offender.

Early marriage: Girls are married earlier than boys, often because their parents want the brideprice.

Age-mixing: When older men choose young girls for sex or marriage, the men have even greater control, and the risk that the men already have the HIV virus and will pass it to the girl is even greater.

Need to have children: Every wife is expected to bear children, so using condoms is often not an option, even if she knows her husband has other partners.

No rights to children: Most of PNG's traditional cultures are patrilineal and children belong to the father's clan. Women usually tolerate bad treatment in marriage rather than leaving, and losing their children.

Fewer rights to land and property: In patrilineal cultures, men are the owners of the land. Women do not inherit land or property from their husbands if their husbands die of AIDS, and cannot count on being given land to garden on if they go home. This is especially so in the Highlands, where there is increasing shortage of land.

Less access to education, and information: Fewer girls are enrolled in school, especially at higher levels, so they have lower literacy, and less information about HIV/AIDS. Research has found that the more years of formal education a girl has, the more power she has to practice safer sex.⁵²

Women are poorer than men: Because they are disadvantaged in education and employment, and rights to land and property, most women are economically dependent on men. If they are widowed, abandoned, or neglected by their husbands, they often have no means of livelihood except exchanging sex for money or goods. This is happening more and more in all areas of the country, but especially in urban areas and along the Highlands Highway.

Heavy workload and poor health: Rural women's work in food gardening, fetching water and firewood, and caring for the family is physically very demanding. Child-bearing, long periods of breast-feeding, and greater difficulty in accessing health care also weaken their resistance to HIV. (84% of PNG's population is rural).

Few women in decision-making positions: Because leadership has traditionally been seen as a male role, women's interests generally, and their need to protect themselves against HIV/AIDS, have not received sufficient attention.

2.4 Factors Affecting Men's and Boys' Vulnerability to HIV/AIDS:

Although women and girls in PNG are infected in greater numbers, it is vital also to understand the factors affecting the vulnerability of men and boys to HIV and AIDS. Men generally have more sexual partners than women, and a man with HIV is

⁵² Hargreaves J., Boler T., 2006, *The Impact of Girls' Education on HIV and Sexual Behaviour*. Actionaid International.

therefore likely to infect more people over a lifetime than is a woman with HIV.⁵³ Yet men's behaviour is to some extent shaped by cultural, social and economic factors beyond their control.

Expectations about "being a man": Men are traditionally expected to have strong sexual urges and need regular sexual outlets, be knowledgeable about sex, have multiple wives or sex partners, use force to dominate women sexually, be aggressive, and face up to risks and danger. Practicing safe and non-violent sex, or needing to ask for information about sexual health, can therefore seem "unmanly".

Men leave home to work: PNG's economy is heavily dependent on enclave development (e.g. mines, plantations, logging, construction) and work opportunities for men often require them to be away from their wives for long periods at a time. They turn to paid or coerced sex to meet their sexual needs.

Men have more money: Through employment, commerce, cash crops, and royalty payments to male landowners, men have the money with which to pay for frequent sex with different partners.

Alcohol and drug use: are preferred male pastimes which can make them forget safe sex messages, and may also be used as an excuse for irresponsible or violent behaviour.

Loss of self-esteem: Traditional sources of a male sense of identity, such as through initiation rites, large scale ceremonies, the "haus man", trading and hunting expeditions, warrior training and warfare are being lost (though tribal warfare has made a comeback in parts of the Highlands). When men lose their traditional status, or are unable to look after their families as they want because of declining economic opportunities, they may turn to violence, alcohol and other risky behaviours involving the domination of women.

Gang rape: carries an increased risk to the man of contracting HIV through the semen of men ahead of him in the "line". Several studies have found that large numbers of PNG men participate in gang rape, many of them numerous times. Research suggests that gang raping may be a form of male bonding.⁵⁴

In the national study of sexual behaviour, 60% of men interviewed reported having participated in a gang rape, (known as line-ups), at some time in their lives, involving an average of ten men at a time.⁵⁵ In a study of 82 male youth, 31% of males had participated in gang rape, the majority of them numerous times. Forty per cent had forced women to have sex when acting alone. Another study of youth found that 24% of males admitted to taking part in line-ups, and a 1997 study of police found that 10% had participated in a line-up in the previous week.⁵⁶ Focus group discussions

⁵³ UNAIDS 2000, *Men and AIDS – a Gendered Approach: 2000 World AIDS Campaign*.

⁵⁴ NSRRT and Carol Jenkins, 1994, *National Study of Sex and Reproductive Behaviour in PNG*. Goroka: PNG Institute of Medical Research, Monograph No. 10, p102.

Other references cited in Bradley C. 2001, *Family and Sexual Violence in PNG: An Integrated Long-term Strategy*. Institute of National Affairs Discussion Paper No. 84, p14.

⁵⁵ NSRRT and Carol Jenkins 1994, cited above.

⁵⁶ Cited in Jenkins C. 2005, *Control of HIV/AIDS in Papua New Guinea: A situation assessment and proposed strategy*. The World Bank, AusAID and the Asian Development Bank, p7.

with soldiers revealed that line-ups with sex workers or coerced girls were a very regular occurrence in the barracks.⁵⁷

Male to male sex: Sexual activity between males is traditional in some cultures of PNG, but kept secret. There is a very high risk of the transmission of HIV during anal intercourse, and some risk in oral intercourse.

Homophobia: Sex between males is forbidden by outdated laws against homosexuality inherited from Australia, and therefore largely hidden, making men who have sex with men hard to reach with interventions.

Sexual abuse of boys: is being reported from all over the country, from both rural and urban areas.⁵⁸ The data do not allow a comparison across time, but anecdotal evidence suggests that it is increasing.

Customary practices and beliefs: Traditional circumcision rituals or other male initiation rites where blood is shed, such as tattooing, scarification or piercing, can put boys and young men at risk of HIV.⁵⁹ Beliefs about the use of semen in sorcery can make some men reluctant to use condoms.

Modern practices and beliefs: Modern fashions for inserting objects in the penis or for cutting the penis involve risk of HIV infection. Beliefs that condoms destroy male pleasure also increase risk.

⁵⁷ Pantumari J. and Baume P. 2002. *A Perception of Factors Associated with HIV/AIDS Infection Among Soldiers in Port Moresby, PNG*. Thesis submitted for MPH at the School of Medical and Social Science, UPNG.

⁵⁸ Bradley C. 2001, *Family and Sexual Violence in PNG: an Integrated Long Term Strategy*. Insitute of National Affairs, Discussion Paper No. 84, Port Moresby.

UNICEF and HELP Resources 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG*. Draft January 05

UNICEF and NACS 2006, *Families and Children Affected by HIV/AIDS and other Vulnerable Children in PNG: A National Situation Analysis*.

⁵⁹ However, circumcision itself may have some protective value.

PART THREE: THE STRATEGIC PLAN ON GENDER AND HIV/AIDS

3.1 Introduction:

This part of the NGP describes the measures needed to fulfil its overall goal: “To reduce the HIV prevalence in the general population to below one per cent by 2010, to reduce the vulnerability of males and females (adults, youth and children) to HIV, and to improve treatment, care and support for all people infected and affected by HIV and AIDS, using a gendered and rights-based approach”.

As described in Part One, the Policy Framework, the immediate aim is to tailor the response to the specific needs and situation of males and females, with the long-term aim of transforming the gender inequalities underlying the epidemic.

Strategies are presented for each of the Focus Areas and Objectives of the NSP. Some of the strategies apply to several focus areas, for example the need for gender sensitization and skills training, the establishment of organisational infrastructures to ensure implementation of the gender strategies, the collection of information disaggregated by sex and age, and the equitable involvement of both sexes as participants and beneficiaries (gender balance). These are the essential components of gender mainstreaming, as was described in Part One.

The strategies build on the lessons learned during the last five years of the national response in PNG, as well as from international experience over more than twenty years. They incorporate numerous good practices already established by NACS and its partners, so that these can be both sustained and extended to other partners and stakeholders. As the epidemic grows, more and more stakeholders are becoming involved. It is important that all follow the same gendered and rights-based approach laid out in this NGP.

For each Focus Area, a summary of the gender issues affecting it is given. More detail on each of the issues can be found in Part Two. Since women and girls are more vulnerable to being infected with HIV, are more adversely affected by HIV and AIDS, and are less able to protect themselves than men, a gender equitable approach requires a greater strategic emphasis on reducing the disadvantages affecting women and girls.

3.2 Focus Area 1: Treatment, Counselling Care and Support

NSP Goal: To decrease morbidity and mortality from AIDS and related causes, to improve the quality of lives of people living with HIV, and to encourage access to VCT.

Gender Issues :

This Goal addresses both the bio-medical treatment and psycho-social needs of men and women living with HIV or AIDS. Strategies need to recognise the gender-related

barriers to equitable care which exist in the communities where people live as well as in the health and other services providing treatment and care. Examples are:

- * The high prevalence of wife-beating affects treatment and care for HIV and AIDS by making women afraid to:
 - ⇒ access VCT services;
 - ⇒ return for their results;
 - ⇒ reveal a diagnosis of HIV and/or an STI to their husband/partner;
 - ⇒ seek medical treatment for HIV or preventive treatment (PEP) for HIV and STIs after being raped;
 - ⇒ use medication and other evidence-based methods to prevent transmission to their unborn babies;
 - ⇒ insist on adhering to ART, once started.
- * Blaming attitudes and high stigma against women and girls by community members and health workers limit their willingness to access VCT or STI services.
- * Lack of PEP, formal medico-legal protocols and services for victims of rape.
- * Men and boys cannot easily access VCT or STI services that are attached to antenatal clinics.
- * Some STIs in women, and among men who have sex with men, are often not diagnosed until the late stages of the disease because symptoms are not visible or not well known.
- * Traditional taboos on talking about sex in mixed company limit the use of sexual health services where providers are only of one sex.
- * Women and girls access to health services (including ART, STI and VCT) are limited by gender-linked barriers: their lack of money for fees or transport, heavy domestic workload, need for male permission, and danger of rape and sexual assault when travelling.
- * Traditions of male dominance mean that men's treatment needs are often given priority over women's treatment needs, especially in conditions of poverty.
- * Gender differences in literacy, education, stigma and mobility mean that targeted methods are needed to inform men, women, youth and other vulnerable groups about options for treatment and care.
- * Women and girls are exposed to sexual harassment and exploitation in workplaces and educational institutions, attached residences and related travel.
- * The burden of caring for the sick traditionally falls disproportionately on women and girls, and is not valued or supported.
- * Overwork, child-bearing and malnutrition (linked with breast-feeding and food taboos) make women more vulnerable to HIV and opportunistic infections.
- * Men who become sick are cared for by their wives; women who become sick are more likely to be neglected, sent back to their families of origin, or abandoned.
- * Girls are often taken out of school to help with domestic tasks and care of the sick.

Some progress has been made in addressing these issues. NDOH health worker training has expanded to include some coverage of gender issues and gender violence in training for new health workers, same-sex provider service and appropriate facilities are being established throughout the country, and training is being extended to cover symptoms of oral and anal STIs. Syndromic management of STIs has been introduced to reduce reliance on specialized diagnostic tests. PEP after rape is not yet generally available, and is urgently needed.

A start has been made on developing protocols and support to address gender violence in VCT services through NACS Care and Counselling programme. Training of counsellors through this programme has included some coverage of gender issues, and has emphasised gender balance of trainers.

Objectives and Strategies:

NSP Objective 1: To make ARV treatment available and accessible to at least 10% of people currently infected with HIV and AIDS throughout PNG by 2007 and 25% by 2010.

Gender Strategies:

- 1.1.1 Set sex-specific targets for ART that ensure equal access for males and females, including women outside their reproductive role.
- 1.1.2 Monitor the progress and impact of ART to identify and address gender and age differences and barriers in adherence to treatment.
- 1.1.3 Scale-up HIV testing of pregnant mothers, prevention of parent-to-child transmission, and greater involvement of fathers in ante and post natal care.
- 1.1.4 Use sex- and age-specific targeted methods to ensure that all types of risk groups, and the health care providers who serve them, have accurate and up-to-date information about treatment options.

NSP Objective 2: To develop and implement risk management procedures to minimise exposure to HIV infection in health and non-health care settings.

Gender Strategies:

- 1.2.1 Ensure that workplace policies on HIV address the specific needs and risks of men and women, and include policies and procedures to minimise sexual harassment in workplaces, activities and residential institutions.
- 1.2.2 Make PEP available through all health facilities for rape, and all cases of accidental exposure to HIV infection whether in the workplace or not.
- 1.2.3 Ensure that all sectors of the population, and the health care providers who serve them, are informed about the local availability of PEP for rape victims.
- 1.2.4 Introduce protocols and training for addressing gender violence in the health sector.

NSP Objective 3: Establish at least two sites for VCT Services in each province that are easily accessible to people by 2010.

Gender Strategies:

- 1.3.1 Address the specific accessibility and privacy needs of men, women, adolescent boys and girls, and sex workers when locating VCT services and monitor attendance by sex and age group to ensure equitable service.
- 1.3.2 Provide same-sex service.
- 1.3.3 Include gender, human rights and gender violence in the training of all counsellors, and set targets for gender balance in counsellor training.
- 1.3.4 Actively encourage couples to be tested and receive their results together, to reduce blame and negative consequences.
- 1.3.5 Develop VCT protocols that address the risks of negative consequences to women and youth of disclosing a positive test result, particularly the risk of partner violence, and train all VCT counsellors in steps for addressing these risks systematically in post-test counselling and longer-term follow-up.

NSP Objective 4: To reduce bed occupancy rates of AIDS related patients by 50% by 2010, by strengthening of family and community care support groups.

Gender Strategies:

- 1.4.1 Actively promote greater participation of males in community and home based care as providers of care not just as supervisors of female labour, their enrolment in training and the transformation of gender norms about care-giving.
- 1.4.2 Provide support to the families of females as well as males infected or affected by HIV through community and home based care programmes, including the provision of economic assistance and appropriate technologies.
- 1.4.3 Conduct awareness and provide practical support to prevent children, particularly girls, in HIV affected families from being withdrawn from school.
- 1.4.4 Conduct research into the direct and indirect costs of community and home-based care to identify gender impacts.

NSP Objective 5: To reduce incidence and rate of STIs in risk populations to 5% and the general population to 3% by 2010.

Gender Strategies:

- 1.5.1 Provide same-sex service at all STI clinics and train staff to provide service in a non-judgemental manner, respecting privacy and confidentiality.
- 1.5.2 Consider the specific accessibility and privacy needs of men, women, adolescent boys and girls, and sex workers when locating STI services and monitor attendance by sex and age group to ensure equitable service.
- 1.5.3 Develop protocols which recognise the risk to women diagnosed with an STI in notifying their partners, and develop competence-based training for STI staff and counsellors.
- 1.5.4 Train health workers to recognise non-symptomatic STIs among women, and the symptoms of STIs associated with oral or anal sex.
- 1.5.5 Ensure all health workers are trained to administer STI prevention after rape, that supply of these drugs to health services is reliable, and that information about this is disseminated to the public.

3.3 Focus Area 2: Education and Prevention

NSP Goal: To facilitate and sustain behaviour change to minimise HIV and STI transmission in specific populations and increase awareness about prevention in the general population.

Gender Issues:

Prevention of new infections is key to controlling the epidemic. Providing appropriate information to the general population and to groups at special risk is essential, but it is not enough to create behaviour change. Women and youth, and married women in particular, usually lack the power to make decisions about safer sex (such as using condoms if the husband's fidelity is in question).

Strategies need to address attitudes and practices which increase the risk to vulnerable groups, introduce new norms of healthy, coercion-free sexuality, and work towards the long-term transformation of biased gender relations which make women dependent for their protection on choices made by men.

Various issues are relevant to the development of methods to strengthen the ability of men and women and male and female youth to protect themselves from infection:

- * Traditional gender norms about being male, which generally condone or expect men to have multiple sexual partners, drink alcohol or use drugs, demonstrate domination of women, and to appear knowledgeable about sex.

- * Traditional gender norms about being female, which generally expect women to remain faithful to one partner, to be submissive sexually even to unfaithful or abusive husbands, not to appear knowledgeable about sex, and not to initiate condom use.
- * Some interpretations of Christian scriptures, which emphasize female submissiveness and male authority.
- * Lack of control over their own lives of women and girls, especially married women, which prevents them from acting on the ABC prevention messages of Abstaining from sex or delaying first sex, or using Condoms. Being faithful does not protect women in polygamous marriages, or where the husband has other sexual partners (particularly male partners, with the increased risk through anal sex).
- * Tolerance of extreme rates of physical and sexual violence against women and girls inside and the home increases transmission risk to both partners.
- * Men's exposure to risk through working conditions which require them to be away from home, often in isolated environments.
- * Men's greater access to money, through formal employment, business, resource royalty payments and sale of cash crops, allowing them to finance sex with multiple partners and other risky behaviours, such as alcohol and drug abuse.
- * Women's economic dependence on men, and greater poverty due to lack of land rights and economic opportunities for women, contributing to transactional/survival sex.
- * High risk extends to the regular partners of people who practise high risk behaviours (e.g. village wives of mobile men, wives of men who have sex with men, and partners of sex workers).
- * Discriminatory attitudes which blame female sex workers for spreading HIV and not the men who use them, mothers and not fathers for transmitting HIV to their babies, and label women and girls who carry condoms as promiscuous.
- * Secrecy and/or stigma relating to cultural and modern male-to-male sex.
- * High rates of child sexual abuse and commercial exploitation.
- * Lesser access to information for women and girls due to lower enrolment in schools and lower literacy rates, and fear of being labelled promiscuous if they seek information.
- * Cultural taboos against talking about sex in mixed company.

NACS' national information and education campaigns have made great efforts to reach sexually active people of both sexes using messages that were developed using focus groups of males and females and designed to appeal to sex- and age-specific target groups in rural and urban settings. Drama groups have been trained in every province to avoid gender stereotyping, aim for gender balance of performers and use scenes relevant for male and female situations.

The Peer Education method has been widely used to reach groups in high risk situations (male and female sex workers, urban youth, male workforces, prisons, the defence force and the police), as well as the general population (e.g. women's groups, youth groups, sports clubs, church congregations, workplaces). Gender sensitive Behaviour Change Communication approaches are being used in high risk settings through programmes co-ordinated by NACS.

Efforts are being made to introduce curricula in schools that provide basic information about sexuality, gender discrimination and human rights, and on safer sex behaviours, though young people's access to condoms remains extremely limited and violence issues are inadequately addressed. Male condoms have been widely promoted but female condoms less so, and female sex workers have more choices for protecting themselves than non-sexworking women.

Objectives and Strategies:

NSP Objective 1: To provide 80% of the country's population with relevant, accurate and comprehensive messages about prevention of HIV transmission by 2010.

Gender Strategies:

- 2.1.1 Ensure that materials and trainings support the equal rights of women and girls to sexual and reproductive health and to make their own choices about protecting themselves from HIV.
- 2.1.2 Raise awareness about the links between GBV and HIV, and specify violence-free sex as a safer sex practice in all BCC materials and trainings for the general population (male and female).
- 2.1.3 Set criteria for awareness raising methods and materials to ensure that all funded activities, including under the Grants Scheme, are consistent with gender equality and human rights requirements.
- 2.1.4 Monitor the Grants Scheme (at national, provincial and district levels) to ensure that men, women and youth benefit equally.
- 2.1.5 Minimise stigma to women by recognizing that both parents are usually involved in transmission of HIV to babies (Parent to Child Transmission rather than Mother to Child).
- 2.1.6 Promote discussion among men and women, male and female youth, and boys and girls about transforming male and female gender norms and supporting more equal sexual relationships.

NSP Objective 2: To target interventions to groups at particular risk, using culturally acceptable methods, to keep HIV prevalence in these groups below 5% by 2010.

Gender Strategies:

- 2.2.1 Use targeted and gender-sensitive programmes for BCC relevant to specific male and female risk groups.
- 2.2.2 Address information and interventions also to the regular partners of people practicing high risk behaviours.

- 2.2.3 Raise awareness about the links between GBV and HIV, and specify violence-free sex as a safer sex behaviour in materials and trainings for groups at particular risk.
- 2.2.4 Ensure both sexes are represented in decision-making bodies for programmes addressing high risk settings, even for single-sex target groups.

NSP Objective 3: To increase safer sex practices amongst the sexually active population, in particular the youth population.

Gender Strategies:

- 2.3.1 Promote the use of female as well as male condoms among the general population, and use distribution methods that take account of the particular privacy and confidentiality needs of women and youth.
- 2.3.2 Train women and (married and unmarried) in negotiating for safer sex, using methods developed by participatory processes involving women, men and sex workers.
- 2.3.3 Target male and female in-school and out-of school youth with safer sex education that promotes gender equality, human rights and violence-free sex.
- 2.3.4 Promote more open discussion of sexuality by using mixed-sex as well as single sex groups.
- 2.3.5 Conduct awareness with adults and youth (males and females) about the risks of early marriage, age mixing in relationships, physical and sexual violence against women, sexual harassment in schools and workplaces, child sexual abuse and exploitation, incest and polygamy.
- 2.3.6 Provide life-skills training for male and female youth that supports the development of self-esteem and the creation of sustainable livelihoods.

3.4 Focus Area 3: Epidemiology and Surveillance

NSP Goal: To establish effective surveillance systems that will provide accurate measurement and understanding of the growth and other characteristics of the HIV epidemic in PNG.

Gender Issues:

In PNG, the HIV virus is mainly transmitted through sexual intercourse between men and women, with women being more easily infected than men (as was described in

Part Two). The epidemic has now spread from specific risk groups to the general population. As it progresses, it is likely that infection rates for women will be somewhat higher than rates for men, as has been found in Africa. Information about the rates and risk factors for infection as they affect males and females in different age groups is essential for tracking the epidemic and for informing gender-responsive programmes for prevention and treatment.

Constraints to the effective surveillance of the epidemic as it affects males and females exist both outside and inside the surveillance system:

- * Fears about confidentiality and of negative consequences of a positive diagnosis, and restrictions on their mobility, make it harder for women and youth, especially in rural areas, to use VCT services.
- * Routine or sentinel testing for HIV covers many pregnant mothers, but there is no comparable routine testing for their partners or men generally.
- * Surveillance reports present data on notified cases of HIV disaggregated by sex for all data sources combined, including antenatal testing, giving the false impression that young women are infected at a much greater rate than young men.
- * There is incomplete reporting by data collection staff of data on the sex, and especially the age, of persons with a positive diagnosis of HIV or STIs.
- * Data on behavioural risk factors such as male to male sex, polygamy, child sexual abuse, partner infidelity, commercial sex, and rape are not collected or linked to sero-data.

In recent years there has been considerable improvement in the accuracy of sex and age data on HIV infection, and the expansion of testing sites to all provinces. The introduction of rapid testing kits for VCT centres in both health and non-health care settings has made access easier for women and youth, so they are now more reflected in the figures. Better links with behavioural factors are still needed, and improvements in how data on sex and age are presented in surveillance reports.

Objectives and Strategies:

NSP Objective 1: To strengthen and maintain a comprehensive, efficient and well-resourced national surveillance system by establishing at least one surveillance site in all provinces by 2010.

Gender Strategies:

- 3.1.1 Improve systems and training to ensure that all data are accurately disaggregated by sex and age-group.
- 3.1.2 Provide sensitization on gender issues and training in collecting gender-sensitive data for data collection staff.

NSP Objective 2: To increase the availability of accurate data about the risk of HIV infection for particular groups and how best to reduce these risks by expanding sentinel surveillance sites to five district hospitals by 2008 and ten by 2010.

Gender Strategies:

- 3.2.1 Ensure that quarterly and annual surveillance reports present all data on HIV infection rates disaggregated by sex and age groups for each type of site separately (ANC, VCT, TB clinics and blood donors).
- 3.2.2 Expand the capacity of some sentinel VCT sites to record and report on risk factors for sex and age groups.

NSP Objective 3: To enhance the information system by establishing a well-resourced information centre by 2007 and link this up with other information systems.

Gender Strategies:

- 3.3.1 Provide training in gender analysis skills for surveillance managers.
- 3.3.2 Link with data-collection systems at clinics providing services to specific high-risk groups such as male and female sex workers, prisons and workplace clinics, whose clientele do not access public services.
- 3.3.3 Include analysis of the gender dimensions of the epidemic in periodic Consensus meetings and future projections.

3.5 Focus Area 4: Social and Behavioural Change Research

NSP Goal: To improve social behaviour research in PNG so that it complements epidemiological and other information and informs the development of strategies for behaviour change.

Gender Issues:

Sexuality and gender relations lie at the heart of the epidemic, and are affected by all the cultural, social and economic issues described in Part 2. The NSP recognised this in its recommendations, and a considerable body of information now exists and is being used for designing interventions. An ambitious social mapping exercise, documenting perceptions and behaviours affecting male and female vulnerability to HIV, was carried out for NACS in all of PNG's 79 districts between 2003 and 2005, and the resulting reports are being used by districts and provinces in their strategic planning for HIV and AIDS.⁶⁰

A similar social mapping exercise of knowledge, attitudes and behaviours was conducted for NACS in 2005 with male and female risk populations in 25 high risk sites where people negotiate for sex, along the Highlands Highway and in ports, in

⁶⁰ See NHASP 2005, Social Mapping Reports for each province, and the Summary Report on Social Mapping.

private sector industries, and among young people in NCD. The European Union Sexual Health Project also conducted gender- and age-sensitive social mapping in all provinces and with selected high risk groups, and has used the findings in designing its peer education programme. The NACS and EU studies made efforts to achieve gender balance in the selection of candidates for training as interviewers, and for supervisory positions.

National studies on sexual behaviour, sexual violence and domestic violence carried out by the PNG Institute of Medical Research (IMR) and the PNG Law Reform Commission respectively were described in Part Two. Between 2002 and 2005, the PNG IMR also conducted extensive sero and behavioural research with 3,288 males and females in eleven sites in ten provinces testing for HIV and STIs, and exploring risk perception, sexual networking and STD.⁶¹

All NHASP's national information campaigns have included extensive evaluations of their impacts on the knowledge, attitudes and behaviours of male and female adults and youth in urban and rural populations. Save the Children have conducted research with male and female sex workers, and a study funded by Caritas on masculinity and violence is currently underway.

Behaviour surveillance was begun for NACS in 2006 with certain high risk groups which will collect and analyse all data by gender, for youth (aged 15 to 24 years) and adults 25-49 years). Information is being gathered on several key behaviours and attitudes, including sex between males, which influence HIV risk in the general population. A NHASP-funded study of the links between violence against women and HIV transmission is underway in four provinces and preliminary results show a strong correlation between HIV positivity in women and the experience of physical and sexual violence, including child sexual abuse.⁶² Behavioural questions have also been included in the national Demographic and Health Survey for 2006.

Remaining gender-related gaps relevant to social and behavioural research are addressed in the strategies below.

Objectives and Strategies:

NSP Objective 1: To build capacity to strengthen social behaviour research and undertake at least two behaviour and social research works annually in collaboration with other research institutions.

Gender Strategies:

⁶¹ Hammar L. 2005, "*It's in Every Corner Now*": results from a nationwide study of HIV/AIDS, STDs and sexual health. Goroka: Operational Research Unit of the PNG IMR.

⁶² Lewis I., Maruia B., Mills D. and Walker S., 2006, *Violence Against Women and the Transmission of HIV in PNG*. Presentation at the PNG Medical Symposium.

- 4.1.1 Continue to build capacities of research designers and field teams to carry out gender focussed research (both qualitative and quantitative), and of communities/target groups to conduct participatory research.
- 4.1.2 Develop research proposal guidelines to promote gender-sensitive research design and methodologies.
- 4.1.3 Ensure that the Research Technical Advisory Committee includes expertise on gender-sensitive research.

NSP Objective 2: By 2007, to undertake collaborative research with national and international research institutions into social, cultural, economic and gender factors that shape sexual behaviour in PNG.

Gender Strategies:

- 4.2.1 Promote research on how on gender bias in customs and laws relating to marriage, divorce, custody of children, physical and sexual violence against women and children, land rights and property inheritance affect the transmission and impact of HIV and AIDS.

NSP Objective 3: To produce evidence-based information that can be used to design strategies for sustainable change in risk behaviour, by 2010.

Gender Strategies:

- 4.3.1 Carry out a gender-specific needs assessment with people of different ages and socio-economic/cultural contexts living with HIV or AIDS, and identify gaps in services.
- 4.3.2 Conduct research on the socio-economic impact of HIV and AIDS on men, women, youth and children, at household, community and societal levels.
- 4.3.3 Ensure that evaluations of programmes and interventions include an assessment of the different impacts on sex and age groups.
- 4.3.4 Share evaluation findings with relevant stakeholders.
- 4.3.5 Strengthen the capacity of NACS to build and maintain a complete collection of qualitative and quantitative research on gender relations, sexuality and HIV/AIDS in PNG.

3.6 Focus Area 5: Leadership, Partnership and Collaboration

NSP Goal: To encourage politicians and leaders at all levels of society to give a high profile to HIV and enhance co-ordination of development partners, participation and resource mobilization.

Gender Issues:

Committed leadership, strong alliances and effective mechanisms are crucial for promoting a response to the HIV epidemic that fully addresses gender-related underlying factors. Since men hold more power, motivating male leadership to take a stand for gender equality and for women's right to protect themselves against HIV will be key. Female leaders and advocates can help make this happen. The following issues affect the development of leadership capacity in a gendered response to HIV and AIDS.

- * Low representation of women in decision-making bodies at all levels, and in senior positions in the formal workforce.
- * Male-dominated decision-making structures in most government departments and private companies are gender-biased and resistant to pro-woman activities and programmes.
- * Lack of a strong and unified national women's umbrella organisation.
- * Promotion of woman-blaming attitudes and misinformation about HIV transmission by uninformed leaders of both sexes.
- * Role-modelling by many prominent males of high risk and abusive behaviours (e.g. polygamy, multiple sex partners, use of sex workers, exploitive sexual relationships with young girls, alcohol abuse, violent mistreatment of women).
- * Lack of gender mainstreaming infrastructure and capacity and in all government and non-government institutions, particularly at sub-national levels.
- * Low level of knowledge about and interest in gender and human rights.

Some progress has been made in this area. Provincial women's leaders and female agricultural extension officers have been given training through NHASP. UNDP have sponsored a leadership development programme for male and female leaders, and the development of a national coaching training manual on HIV and AIDS for leaders. To-date there are 17 certified national coaches (of which 8 are women) who are able to precipitate the Global LDP programme at sub national level. AusAID's leadership development initiative with parliamentarians and senior bureaucrats does not effectively address gender issues, but offers a component on women's leadership as one of seventeen options.

NHASP has funded Fiji-based training on gender violence and human rights for many of its male counsellors, who are now developing a network of men willing to become "champions for gender equality" through NACS. UNDP are in the process of developing a gender-sensitive guide for the development of workplace policies to promote leadership by employers in the public and private sectors. Other initiatives for male leadership on HIV and AIDS which recognise gender issues are being developed through the private sector and the defence force.

Despite the greater activity around leadership development, structures and systems for mainstreaming a gendered approach to HIV/AIDS are still largely absent. In the public sector, only the Education Department, and the Law and Justice Sector Support Programme have so far produced HIV/AIDS policies and plans that pay attention to gender issues.

Objectives and Strategies:

NSP Objective 1: To ensure annual increase in financial commitment and political involvement to the national response by fostering political and leadership commitment at all levels of society.

Gender Strategies:

- 5.1.1 Include sensitisation on gender, gender based violence and human rights in education and awareness training on HIV/AIDS for leaders at all levels.
- 5.1.2 Assist government and non-government sectors to mainstream a gendered approach to HIV and AIDS into the planning, development and implementation of the national HIV and AIDS response at all levels.
- 5.1.3 Provide training and support to women's organisations, women's leaders and opinion-makers to advocate for gender equality and the empowerment of women and girls to protect themselves from HIV/AIDS.
- 5.1.4 Encourage more young people, particularly young women, to take up leadership roles.

NSP Objective 2: To strengthen existing partnerships and establish new partners on the basis of equality and mutual respect at all levels.

Gender Strategies:

- 5.2.1 Identify and support appropriate male leaders to advocate for gender equality and the elimination of gender based violence.
- 5.2.2 Ensure that gender is integrated into all sectoral planning on HIV and AIDS at national, provincial and district levels.
- 5.2.3 Ensure that workplace policies on HIV and AIDS meet the specific needs of females as well as males, including protection against sexual harassment and other forms of gender violence.
- 5.2.4 Build capacity for advocacy of the national organisation for PLWHA (Igat Hope), and of its women's branch.

- 5.2.5 Develop partnerships with male and female leaders in all sectors to advocate for gender justice in HIV and AIDS prevention.
- 5.2.6 Include women's and youth organisations, and coverage of gender issues, in the agenda of the annual National HIV and AIDS Partnership Forum.

NSP Objective 3: To strengthen the capacity of NAC and its Secretariat to effectively co-ordinate the national response to HIV through the implementation of the NSP [and the NGP], including effective provincial co-ordination.

Gender Strategies:

- 5.3.1 Create a dedicated position of Gender Advisor in NACS and set up a Gender Technical Advisory Committee.
- 5.3.2 Set guidelines for the integration of gender into regular planning processes for NACS, PACs and DACs and for other stakeholders and partners.
- 5.3.3 Ensure that all employees and volunteers of NACS, PACs and DACs receive gender sensitization, and training in gender analysis and planning skills where appropriate.
- 5.3.4 Actively promote equal participation of females and males in employment, training, decision-making and programme implementation.
- 5.3.5 Provide guidelines for integrating gender into HIV and AIDS activities.
- 5.3.6 Ensure that the next national strategic plan on HIV and AIDS incorporates gender as a theme area from the outset.

3.7 Focus Area 6: Family and Community Support

NSP Goal: To support and sustain a social and cultural environment that will enable families and communities to care for and support people infected and affected by HIV.

Gender Issues:

The NSP acknowledges the climate of fear, stigma and discrimination that surrounds the epidemic, and the gaps in existing care and support measures for people living with HIV or AIDS. The focus is on increasing access to services, building a supportive environment, respecting human rights and supporting orphans and vulnerable children. It is estimated that there will be 77,000 AIDS orphans in PNG by

2010, and another 270,000 children living in AIDS-affected families who are at risk of being orphaned.⁶³ Relevant gender issues are as follows.

- * Women and girls are less likely to disclose their HIV+ status because they face more severe stigma, discrimination, violence and abuse due to the sexual double standard.
- * Widows of HIV+ men often face poverty and hardship because they lack rights to inherit land or property from their husbands, and (except in some matrilineal systems) to enforce land rights in their birth clans.
- * Women with HIV or AIDS may be abandoned by their husbands and be too far away to receive care from their own kin (since women usually move to their husband's place on marriage).
- * The extra burden of caring for the sick and for orphans falls on women and girls in both home based and community based care.
- * Girls are more likely than boys to be kept away from school to help with care tasks.
- * Orphans and children in families affected by AIDS, particularly girls, are at greater risk of sexual abuse and exploitation.

The training provided by NHASP for all staff and volunteers of NACS, NHASP and other stakeholders at all levels has actively addressed stigma and discrimination by including coverage of gender inequality, gender violence and human rights as a compulsory unit. NHASP training for home-based care encourages males to participate as care givers, and promotes keeping girls (and boys) in school. NHASP-funded care kits have been distributed equally to the families of AIDS affected men and women, and are effective in reducing some of the labour involved in caring for a sick person, and in maintaining the dignity of persons sick with AIDS related illness.

Over thirty community care centres now exist, run by community and faith-based groups, though caring work is still done predominantly by women. Some community organisations raise funds to pay the school fees of girls and boys from families affected by AIDS. A national organisation for people living with HIV/AIDS has been operating for several years, and is beginning to develop as a national network. A women's wing has been formed in NCD. More information is needed so that programmes to meet the needs of positive men and women in different age groups and socio-cultural contexts can be developed, and fear and stigma further reduced.

Objectives and Strategies:

NSP Objective 1: To increase access for people living with HIV throughout PNG to STI/HIV community based care and support services.

Gender Strategies:

⁶³ UNICEF and NACS 2006, *Families and Children Affected by HIV/AIDS and Other Vulnerable Children in PNG*.

- 6.1.1 Develop criteria, materials and training for gender-sensitive and age-sensitive care, based on research carried out under Focus Area 4.
- 6.1.2 Support linkages between women's and children's organisations and women and children living with HIV or AIDS.
- 6.1.3 Establish programmes for income generation and food security for infected and affected families, especially female-headed households.

NSP Objective 2: To develop a supportive environment for people living with HIV and their families through the establishment, training and support of care groups in all provinces by 2010 ,and to reduce discrimination and violence against them.

Gender Strategies:

- 6.2.1 Ensure equitable participation for people of both sexes living with HIV or AIDS in training for leadership and communication, providing additional supports to females.
- 6.2.2 Ensure equitable participation for people of both sexes living with HIV or AIDS in care programmes.

NSP Objective 3: To ensure proper full recognition of human rights, including children's rights, in addressing the HIV epidemic, including respect for confidentiality, reduction of discrimination, and increased access to care and support.

Gender Strategies:

- 6.3.1 Include information about gender discrimination, gender violence, human rights and the HAMP Act in community education programmes.
- 6.3.2 Monitor the application of the HAMP Act and the operations of Village Courts to ensure that females living with HIV or AIDS are not victimised.
- 6.3.3 Identify gender disparities in customary laws and practices relating to land and property rights, inheritance, family law and custody of children.

NSP Objective 4: To build capacity for community based organisations and groups to identify and provide support for orphans and vulnerable children.

Gender Strategies:

- 6.4.1 Ensure that criteria for identifying orphans and vulnerable children recognise the special vulnerability of girls to sexual abuse and exploitation.
- 6.4.2 Build capacity of CBOs (including women's organisations) and school teachers to identify and register OVCs in their communities, and to

address the increased risk of sexual exploitation of children, especially girls, in HIV affected families.

- 6.4.3 Promote equitable access for girls and boys to community based trust funds and education support.

3.8 Focus Area 7: Monitoring and Evaluation

NSP Goal: To effectively track the progress of the HIV epidemic in PNG through regular monitoring and evaluation mechanisms and measure the impact of the national response.

Gender Issues:

Tracking of the gender aspects of the epidemic and of the impact of the national response requires the development of sex-specific and gender-sensitive indicators for process, outputs, outcomes and impacts. Some progress on this has been made at national level through NHASP, by the introduction of sex-disaggregated data-bases on participation in training, but not yet on meetings, and committees. At provincial and district levels, there is little development of sex-disaggregated data-collection systems and indicators, but NACS newly established M&E unit has begun work on this. NACS' strategic planning manuals are also in the process of being revised to include guidance in gender-sensitive planning, monitoring and evaluation.

Objectives and Strategies:

NSP Objective 1: To develop a Monitoring and Evaluation framework to produce, collate, analyse and disseminate information on the national response to HIV, by 2006.

Gender Strategies:

- 7.1.1 Provide training on gender issues and gender-sensitive monitoring and evaluation for all personnel involved in developing monitoring and evaluation systems.
- 7.1.2 Establish gender-sensitive indicators and tools for the different levels of Monitoring and Evaluation, and ensure that these are incorporated into national and provincial data collection and analysis systems.
- 7.1.3 Incorporate training on gender issues and gender-sensitive monitoring and evaluation into consultations with all stakeholders involved in the design, implementation and analysis of monitoring and evaluation activities on HIV and AIDS.

NSP Objective 2: To accumulate and disseminate data from all sources, including provinces through the use of relevant indicators that will assist in the reporting on respective international milestones, for example UNGASS and the MDG by 2007.

Gender Strategies:

- 7.2.1 Incorporate a summary of progress on gender indicators and gender related issues into quarterly and annual monitoring and evaluation reports, and disseminate these to provinces and districts for feedback and guidance.
- 7.2.2 Create linkages with organisations representing women, youth and other vulnerable groups for the feedback of information relevant to their needs.

NSP Objective 3: To measure the effectiveness and efficiency of the national response by undertaking a review of the NSP by 2010.

Gender Strategies:

- 7.1.1 Undertake an evaluation of the NGP by 2010, in conjunction with the evaluation of the NSP.

PART FOUR: PRIORITIES

4.1 Gender Mainstreaming Framework:

The immediate priority must be to create the institutional framework for gender mainstreaming. Gender cannot be integrated unless people are tasked and trained to do this, and systems and processes developed which ensure that gender is routinely addressed at all points in the project cycle. Since gender cuts across all Focus Areas, a lead agent is necessary at senior executive level, with identified personnel in each programme area formally linked as a gender management team.

Planners at all levels and in all sectors need to be trained not only to recognise gender issues but to develop appropriate interventions, and use gender-sensitive indicators and data collection systems to monitor them. Programme managers need to understand how gender affects all aspects of their work, and how they can implement their activities in gender sensitive ways. Service providers must have skills to address the specific gender- and age-related needs of their clients, particularly in preventing and responding to gender based violence.

The above capacities need to be developed not only with NACS, but also with NDOH, which is taking over a greater share of the implementation of the NSP and the NGP, and with other key partners and stakeholders. At present, the capacity of government and civil society to implement the gender strategies of the NGP is extremely low, both in terms of personnel and systems. Creating an effective institutional framework will take long-term commitment and sustained inputs of technical and financial resources, and must be treated as an urgent priority.

4.2 Leadership:

The relevance of gender to HIV and AIDS and to national development generally is not well understood by the country's leaders. The common view is that gender is a matter just for women. Since most leaders are male, and benefit from male privilege, there is also some resistance to the concept of gender equality.

Leaders who have not been sensitised to the key role that gender inequalities play in the spread and impact of the epidemic may publicly promote gender-biased misinformation, and influence policy development, budget allocations and implementation in ways that may be harmful. Effective sensitisation of politicians, policy makers and senior executives to the importance of a gendered approach to HIV and AIDS is a matter of urgency.

4.3 Gender Based Violence:

The appalling levels of violence against women and children in this country, and the many ways in which they affect the spread of HIV, have been described in each of the previous parts of this document. Everyone recognises the importance of the problem, yet this has not resulted in widespread efforts to address it. This is because the scale of

it can seem overwhelming, or because it is accepted as inevitable, or in the case of wife-beating, seen as legitimised by custom.

The police continue to treat wife-beating as a “family matter”; male-dominated village courts offer no protection to beaten wives and treat rape as a matter for compensation to the victim’s male relatives; the Health Department has no national policy or procedures on domestic violence, rape or child abuse; there are very few support services for women and children who have been beaten, raped or sexually abused and virtually none in rural areas; “safe houses” or “shelters” where victims and their children are almost non-existent outside Port Moresby; few workplaces have policies on sexual harassment; and VCT counsellors have minimal, if any, skills or referral systems for supporting clients dealing with violence in their lives.

Government and non-government planners and implementers at all levels must begin to address gender violence through their HIV/AIDS programmes, developing partnerships with appropriate organisations where necessary. Technical and financial resources for awareness training and skills development are needed to facilitate this. At national level, strengthening of the justice and health sector responses is urgently needed.

4.4 PEP (Post Exposure Prophylaxis):

At present, medication to help prevent a person who has been raped from contracting HIV is not widely available, and few people know about it even when it is available. It is vital that PEP for rape victims be made universally available, and that the general public (especially women) are informed about what it is and where to get it. As well as helping to reduce HIV infection rates directly, this will also give raped women and girls an incentive to report the rape to authorities rather than hide it, increasing the likelihood that perpetrators will be caught and prosecuted.

4.5 VCT and PPCT:

Reduction of stigma is a crucial element in encouraging people to find out their HIV status so that they can avoid spreading the infection further. Women face more negative consequences than men if they are known to be HIV+, which has direct consequences for the rates at which babies become infected with HIV.

Fear of the consequences of a positive diagnosis prevents some pregnant women from giving birth in a health facility, and many pregnant women who are diagnosed with HIV through ANC testing do not follow through with telling their partner and accessing methods to prevent transmission to their babies, because this will mean their status becoming known. Presently, only a small proportion of pregnant mothers are tested for HIV.

It is important that capacity be developed to extend routine VCT for HIV to all ANCs, that PPCT be similarly extended, and that the public be better educated about availability and benefits. Responsibility for preventing transmission to babies must be promoted as the responsibility of both parents: PPCT (Prevention of Parent to Child

Transmission) rather than PMCT (Prevention of Mother to Child Transmission). Encouraging couples to be tested together will help with this, as well as Safe Motherhood programmes which encourage men's participation.

4.6 Involvement of Men:

Motivating men to take leadership in male behaviour change as “champions for gender equality” has already begun through a number of initiatives. These need to be strengthened and co-ordinated, with the development of a national network and the development of training programmes for men and boys similar to the one being piloted by NACS Care and Counselling component. Prevention of violence against women and children is a useful strategic entry point.

4.7 Education and Prevention with Youth:

More efforts need to be put into reaching young males and females with accurate information about safer sex, including violence-free sex, and into ensuring that they have access to age-appropriate, non-judgemental, confidential VCT services, and to male and female condoms. There is no evidence to suggest that this approach encourages young people to have sex.

School-based programmes need to address sexual harassment and other gender violence risks to pupils of both sexes, and to prevent OVCs from being withdrawn from school or resorting to selling sex to cover their school fees. Out-of-school programmes should be linked with life-skills development and income-generation opportunities that break down gender stereotypes. The leadership of girls should be strengthened, and BCC approaches with youth should promote gender equality.

PART FIVE: NGP IMPLEMENTATION ARRANGEMENTS

NPSPG GOAL: TO REDUCE THE HIV PREVALENCE IN THE GENERAL POPULATION TO BELOW ONE PERCENT BY 2010, TO REDUCE THE VULNERABILITY OF MALES AND FEMALES (ADULTS, YOUTH AND CHILDREN) TO HIV, AND TO IMPROVE TREATMENT CARE AND SUPPORT FOR ALL PEOPLE INFECTED AND AFFECTED BY HIV/AIDS, USING A GENDERED AND RIGHTS-BASED APPROACH.								
Focus Area 1: Treatment, Counselling, Care and Support								
Goal: To decrease morbidity and mortality from AIDS and related causes, to improve the quality of lives of people living with HIV, and to encourage access to VCT.								
Objective 1: To make ARV treatment available and accessible to at least 10% of people currently affected with HIV and AIDS throughout PNG by 2007 and 25% by 2010.								
Ref.	Gender Strategy	2006	2007	2008	2009	2010	Organisations Responsible	Performance Indicators
1.1.1	Set sex-specific targets for ART that ensure equal access for males and females, including women outside their reproductive role.	X					NDOH, private and FBO health services, NACS	# M, #F (pregnant), # F (non-pregnant) started on ART.
1.1.2	Monitor the progress and impact of ART to identify and address gender and age differences and barriers in adherence to treatment.	X	X	X	X	X	NDOH, private and FBO health services, NGOs trained in ART support, NACS	% of people adhering to treatment, by sex and age group. % of people receiving ART still alive at 6, 12 and 24 months, by sex and age group.
1.1.3	Scale-up HIV testing of pregnant mothers, prevention of parent-to-child transmission, and greater involvement of fathers in ante and post natal care.	X	X	X	X	X	NDOH, private and FBO health services, NACS	% pregnant mothers aged 15 –24 yrs attending ANC receiving HIV testing, by testing site, nationally. # and % of health facilities signed Safe Motherhood agreement with community
1.1.4	Use sex- and age-specific targeted methods to ensure that all types of risk groups, and the health care providers who serve them, have up-to-date information about treatment options.	X	X	X	X	X	NDOH, private and FBO health services and training colleges, NACS, CSOs, FBOs, WOs, YOs, private sector	Materials produced cover M/F issues on treatment for adults and youth. Information reaches M/F PLWHA, M/F care-givers, FSW, male clients of FSW, MSM, rural and urban youth, M/F clients and staff of STI, ANC, TB VCT and blood donor clinics .
Objective 2: To develop and implement risk management procedures to minimise exposure to HIV infection in health and non-health care settings.								
1.2.1	Ensure that workplace policies on HIV address the specific needs and risks of men and women, and include policies and procedures to minimise sexual harassment in workplaces, activities and residential	X	X	X			All govt depts, private sector, CSOs UNDP Institute of Public Admin.	# workplaces policies addressing specific needs of M/F. # workplace policies including policies and procedures on sexual harassment.

	institutions.							
1.2.2	By 2009, make PEP available through all health facilities for rape and all cases of accidental exposure to HIV infection whether in the workplace or not.	X	X	X			NDOH, private and FBO health services, NACS	# and % rape victims receiving PEP, by sex and age group. # and % of persons receiving PEP for workplace exposure, by sex. Monthly reports on drug availability, by site.
1.2.3	Ensure that all sectors of the population, and the health care providers who serve them, are informed about the local availability of PEP.	X	X	X	X	X	NDOH, private and FBO health services and training colleges, NACS, CSOs, FBOs, WOs, YOs, private sector, the media	# PACs Activity Plans which included awareness raising about PEP after rape.
1.2.4	Introduce protocols and training for addressing gender violence in the health sector.	X	X				NDOH, HSIP, CBSC, NACS	NDOH protocols on domestic violence, rape, child sexual abuse: a) approved and established b) incorporated into training curricula for all levels of health worker.
Objective 3: Establish at least two sites for VCT Services in each province that are easily accessible to people by 2010.								
1.3.1	Address the specific accessibility and privacy needs of men, women, adolescent boys and girls, and sex workers when locating VCT services and monitor attendance by sex and age group to ensure equitable service.	X	X	X	X	X	NDOH, private and FBO health services, NGOs and employers providing VCT, NACS	# VCT sites where privacy needs of M, F, youth, and sex workers are catered for, by province. # adult and # youth (under 25) VCT clients, by sex and province of site.
1.3.2	Provide same-sex service.	X	X	X	X	X	As above	# VCT sites providing same-sex service, by province.
1.3.3	Include gender, human rights and gender violence in the training of all counsellors, and set targets for gender balance in counsellor training.	X	X	X			NACS, IEA, NDOH, NGOs	% of counsellors receiving gender, human rights and gender violence training, by sex. % training courses reaching gender balance target.
1.3.4	Actively encourage couples to be tested and receive their results together, to reduce blame and negative consequences.	X	X	X	X	X	NDOH, private and FBO health services, NGOs and employers providing VCT, NACS, CSOs, the media	% clients being counselled as a couple., by type of service provider.
1.3.5	Develop VCT protocols that address the risks of negative consequences to women and youth of disclosing a positive test result, particularly the risk	X	X	X	X	X	NDOH, private and FBO health services, CSOs and employers providing VCT,	Protocol includes steps for addressing negative consequences for F, youth. Counsellors have referral networks for GBV.

	of partner violence, and train all VCT counsellors in steps for addressing these risks systematically in post-test counselling and longer term follow-up.						NACS	Counsellor training develops competence in GBV. # counsellors receiving training, by sex. # referrals made for GBV, by site. # and % of clients receiving more than one post-test session, by sex and age group.
Objective 4: To reduce bed occupancy rates of AIDS related patients by 50% by 2010 by strengthening of family and community care support groups.								
1.4.1	Actively promote greater participation of males in community and home based care as providers of care not just as supervisors of female labour, their enrolment in training and the transformation of gender norms about care-giving.	X	X	X	X	X	NACS, PACS, DACS, IEA, FBOs, CSOs, WOs, YOs , the media, Education Dept.	# and % care providers trained, by sex. Training materials and methods promote male involvement in care.
1.4.2	Provide support to the families of females as well as males infected or affected by HIV through community and home based care programmes, including the provision of economic assistance and appropriate technologies.	X	X	X	X	X	NACS, PACS, DACS, FBOs, CSOs, WOs, YOs	# and % of people attendees at Care Centres, by sex. # and % of persons receiving economic assistance, by sex. # and % of persons receiving Living With Dignity Kits, and/or HBC Kits, by sex. % hospital beds occupied by AIDS related patients, by sex and province of service.
1.4.3	Conduct awareness and provide practical support to prevent children, particularly girls, in HIV affected families from being withdrawn from school.	X	X	X	X	X	NACS, PACS, DACS, Education Dept., WOs.	# programmes conducted, by type of organisation , per province.
1.4.4	Conduct research into the direct and indirect costs of community and home-based care to identify gender impacts.	X	X				NACS, research institutions	Research report accepted by NAC.
Objective 5: To reduce incidence and rate of STIs in risk populations to 5% and the general population to 3% by 2010.								
1.5.1	Provide same-sex service at all STI clinics and train staff to provide service in a non-judgemental manner, respecting privacy and confidentiality.	X	X	X	X	X	NDOH, private and FBO health services, NACS	# clinics providing same-sex service, by province. Annual review of quality of service provided.
1.5.2	Consider the specific accessibility and privacy needs of men, women, adolescent boys and girls, and sex workers when locating STI services and monitor attendance by sex and age group to ensure equitable service.	X	X	X	X	X	NDOH, private and FBO health services, NACS	# STI sites where privacy needs of M, F, youth, and sex workers are catered for, by province. # adult and # youth (under 25) STI clients, by sex and province of site.

1.5.3	Develop protocols which recognise the risk to women diagnosed with an STI in notifying their partners, and develop competence-based training for STI staff and counsellors.	X	X	X			NDOH, private and FBO health services, NACS	Protocol includes steps for addressing negative consequences for F, youth. Counsellors have referral networks for GBV. Counsellor training develops competence in GBV. # counsellors receiving training, by sex. # referrals made for GBV, by site.
1.5.4	Train health workers to recognise non-symptomatic STIs among women, and the symptoms of STIs associated with oral or anal sex.	X	X	X	X	X	As above	# and % health workers trained, by sex.
1.5.5	Ensure all health workers are trained to administer STI prevention after rape, that supply of these drugs to health services is reliable, and that information about this is disseminated to the public.	X	X	X	X	X	As above, and PACS, DACS, CSOs, private sector, WOs, YOs, the media.	# and % health workers trained, by sex. Monthly reports on drug availability, by site. # PAC activity plans which include awareness-raising about STI prevention after rape.
Focus Area 2: Education and Prevention								
Goal: To facilitate and sustain behaviour change to minimise HIV and STI transmission in specific populations and increase awareness about prevention in the general population.								
Objective 1: To provide 80% of the country's population with relevant, accurate and comprehensive messages about prevention of HIV transmission by 2010.								
2.1.1	Ensure that materials and trainings support the equal rights of women and girls to sexual and reproductive health and to make their own choices about protecting themselves from HIV.	X	X	X	X	X	NACS, PACs, DACs, NDOH, private and FBO health services, NGOs, CSOs, Education Dept .	% materials and trainings meeting criteria for supporting female reproductive and sexual rights.
2.1.2	Raise awareness about the links between GBV and HIV, and specify violence-free sex as a safer sex practice in all BCC materials and trainings for the general population.	X	X	X	X	X	NACS, PACs, DACs, HRS, private sector, NGOs, CSOs	# programmes addressing GBV, by province. # materials and trainings specifying violence-free sex as a safer sex practice.
2.1.3	Set criteria for awareness raising methods and materials to ensure that all funded activities, including under the Grants Scheme, are consistent with gender equality and human rights requirements.	X	X				NACS, PACS	% of grants applications screened using gender and human rights criteria, by NACS, PACs and DACs.
2.1.4	Monitor the Grants Scheme (at national, provincial and district levels) to ensure that men, women and youth benefit equally.	X	X	X	X	X	NACS, PACs, DACs	# and % of beneficiaries, by sex and age group.
2.1.5	Minimise stigma to women by recognizing that both	X	X	X	X	X	NACS, PACs, DACs,	Materials produced and distributed

	parents are usually involved in transmission of HIV to babies (Parent to Child Transmission rather than Mother to Child).						NDOH, private FBO health services, CSOs, the media	# and % partners of mothers attending ANC also being tested for HIV
2.1.6	Promote discussion among men and women, male and female youth, and boys and girls about transforming male and female gender norms, and supporting more equal sexual relationships.	X	X	X	X	X	NACS, PACs, DACs, CSOs, the media, Education Dept	Reports on methods used in NACS/IEA trainings Reports of CSOs to funders
Objective 2: To target interventions to groups at particular risk, using culturally acceptable methods, to keep HIV prevalence in these groups below 5% by 2010.								
2.2.1	Use targeted and gender-sensitive programmes for BCC relevant to specific risk groups.	X	X	X	X	X	NACS, PACs, DACs, HRS, private sector, CSOs, NGOs	# programmes targeted to M and F sex workers and their clients, MSM, M and F PLWHA, urban M and F youth, rural M and F youth, mobile and at-risk occupations, prisoners, discipline forces, landholders in resource development areas.
2.2.2	Address information and interventions also to the regular partners of people practicing high risk behaviours.	X	X	X	X	X	As above	# programmes reaching village wives, urban wives, regular partners of people in high risk work-related settings, non-commercial partners of sex workers, female partners of MSM.
2.2.3	Raise awareness about the links between GBV and HIV, and specify violence-free sex as a safer sex practice in all BCC materials and trainings for groups at particular risk.	X	X	X	X	X	As above	# programmes addressing GBV, by province. # materials and trainings specifying violence-free sex as a safer sex practice.
2.2.4	Ensure both sexes are represented in decision-making bodies programmes addressing high risk settings, even for single-sex target groups.	X	X	X	X	X	As above	# Tingim Laip committees with 30% or greater female membership.
Objective 3: To increase safer sex practices amongst the sexually active population, in particular the youth population.								
2.3.1	Promote the use of female as well as male condoms among the general population, and use distribution methods that take account of the particular privacy and confidentiality needs of women and youth.	X	X	X	X	X	NACS, PACs, DACs, CSOs, NGOs, private sector, Education Dept	# and % condom machines accessibly located for M/F, by province. # women's organisations involved in distributing M condoms/F condoms, by province. # youth organisations involved in distributing M condoms/F condoms, by province.

								# M condoms distributed annually. # F condoms distributed annually.
2.3.2	Train women and (married and unmarried) in negotiating for safer sex, using methods developed by participatory processes involving women, men and sex workers.	X	X	X	X	X	NACS, CSOs, NGOs, private sector	# of married F and unmarried F trained.
2.3.3	Target male and female in-school and out-of school youth with safer sex education that promotes gender equality, human rights and violence-free sex.	X	X	X	X	X	NACS, PACs, DACs, CSOs, NGOs, Education Dept, YOs	# in-school youth reached, by sex. # out-of-school youth reached, by sex.
2.3.4	Promote more open discussion of sexuality by using mixed-sex as well as single sex groups.	X	X	X	X	X	As above	Reports from organisations involved
2.3.5	Conduct awareness with adults and youth (males and females) about the risks of early marriage, age mixing in relationships, physical and sexual violence against women, sexual harassment in schools and workplaces, child sexual abuse and exploitation, incest and polygamy.	X	X	X	X	X	As above, and the media	# PACs Activity Plans including awareness programmes on these issues. # CSOs funded through grants scheme to do awareness. # workplace policies addressing sexual harassment.
2.3.6	Provide life-skills training for male and female youth that supports the development of self-esteem and the creation of sustainable livelihoods.	X	X	X	X	X	NACS, PACs, DACs, CSOs, NGOs, Education Dept, YOs	# trainings held # and % of youth trained, by sex.
Focus Area 3: Epidemiology and Surveillance								
Goal: To establish effective surveillance systems that will provide accurate measurement and understanding of the growth and other characteristics of the HIV epidemic in PNG.								
Objective 1: To strengthen and maintain a comprehensive, efficient and well-resourced national surveillance system by establishing at least one surveillance site in all provinces by 2010.								
3.1.1	Improve systems and training to ensure that all data are accurately disaggregated by sex and age-group.	X	X				NDOH, NACS	Accuracy rates for sex and age data collection reach 100%.
3.1.2	Provide sensitization on gender issues and training in collecting gender-sensitive data for data collection staff.	X	X	X			NDOH, NACS	# trainings including gender sensitivity for data collection staff.
Objective 2: To increase the availability of accurate data about the risk of HIV infection for particular groups and how best to reduce these risks by expanding sentinel surveillance sites to five district hospitals by 2008 and ten by 2010.								
3.2.1	Ensure that quarterly and annual surveillance reports present all data on HIV infection rates disaggregated by sex and age groups for each type of site separately	X	X	X	X	X	NDOH, NACS	# and % of new infections, by sex, age group and type of site. # of notifications by sex and age group

	(ANC, VCT, TB clinics and blood donors).								present ANC notifications separately.
3.2.2	Expand the capacity of some sentinel VCT sites to record and report on risk factors for sex and age groups.	X	X	X			NDOH, NACS, CSOs and NGOs offering VCT	# VCT sites reporting data on risk factors, by sex and age group.	
Objective 3: To enhance the information system by establishing a well-resourced information centre by 2007 and link this up with other information systems.									
3.3.1	Provide training in gender analysis skills for surveillance managers.	X	X	X			NDOH, CBSC, NACS	# trainings covering gender analysis skills for surveillance managers.	
3.3.2	Link with data-collection systems at clinics providing services to specific high-risk groups such as male and female sex workers, prisons and workplace clinics, whose clientele do not access public services.	X	X				NDOH, private clinics, NGOs providing clinics, NACS	# special group services providing data to NDOH Disease Control Section.	
Focus Area 4: Social and Behavioural Change Research									
Goal: To improve social behaviour research in PNG so that it complements epidemiological and other information and informs the development of strategies for behaviour change.									
Objective 1: To build capacity to strengthen social behaviour research and undertake at least two behaviour and social research works annually in collaboration with other research institutions.									
4.1.1	Continue to build capacities of research designers and field teams to carry out gender focussed research (both qualitative and quantitative), and of communities/target groups to conduct participatory research.	X	X	X	X	X	NACS, research institutions, CBOs and NGOs	# researchers trained, by sex.	
4.1.2	Develop research proposal guidelines to promote gender-sensitive research design and methodologies.	X	X				NACS Research Advisory Committee	Guidelines on gender-sensitive design and methods used by Research Committee.	
4.1.3	Ensure that the Research Technical Advisory Committee includes expertise on gender-sensitive research.	X	X				As above	Research Committee reports specify members with gender expertise.	
Objective 2: By 2007, to undertake collaborative research with national and international research institutions into social, cultural, economic and gender factors that shape sexual behaviour in PNG.									
4.2.1	Promote research on how on gender bias in customs and laws relating to marriage, divorce, custody of children, physical and sexual violence against women and children, land rights and property inheritance affect the transmission and impact of HIV and AIDS.	X	X	X			NACS Research Advisory Committee, research institutions in PNG, overseas	Research reports.	

Objective 3: To produce evidence-based information that can be used to design strategies for sustainable change in risk behaviour, by 2010.								
4.3.1	Carry out a gender-specific needs assessment with people of different ages and socio-economic/cultural contexts living with HIV and AIDS, and identify gaps in services.	X	X				NACS, research institutions	Research reports.
4.3.2	Conduct research on the socio-economic impact of HIV and AIDS on men, women, youth and children, at household, community and societal levels.	X	X				As above	Research reports.
4.3.3	Ensure that evaluations of programmes and interventions include an assessment of the different impacts on sex and age groups.	X	X	X	X	X	NACS, PACs, DACs, CSOs, NGOs, private sector	# and % evaluations assessing impacts by sex and age group.
4.3.4	Share evaluation findings with relevant stakeholders.	X	X	X	X	X	NACS	# stakeholder briefings with women's groups, youth groups, PLWHA, sex worker and MSM advocacy groups,
4.3.5	Strengthen the capacity of NACS to build and maintain a complete collection of qualitative and quantitative research on gender relations, sexuality and HIV and AIDS in PNG.	X	X				NACS, research institutions	Database of materials on gender and HIV established and maintained.
Focus Area 5: Leadership, Partnership and Collaboration								
Goal: To encourage politicians and leaders at all levels of society to give a high profile to HIV and enhance co-ordination of development partners, participation and resource mobilization.								
Objective1: To ensure annual increase in financial commitment and political involvement to the national response by fostering political and leadership commitment at all levels of society.								
5.1.1	Include sensitization on gender, gender based violence and human rights in education and awareness training on HIV and AIDS for leaders at all levels.	X	X	X	X	X	NACS, all govt depts, Parliament, WOs, YOs, CSOs, private sector, NGOs	# of leaders trained, by level of position , organisation and sex.
5.1.2	Assist government and non-government sectors to mainstream a gendered approach to HIV and AIDS into the planning, development and implementation of the national HIV and AIDS response at all levels.	X	X	X	X	X	NACS, PACs, DACs, CSOs, NGOs, private sector,	# gender positions created. # District Strategic Plans addressing gender issues in programming and M&E. # CSOs with strategic plan/annual plan on gender and HIV. # meetings of multi-sectoral co-ordinating

								committee on gender and HIV.
5.1.3	Provide training and support to women's organisations, women's leaders and opinion-makers to advocate for gender equality and the empowerment of women and girls to protect themselves from HIV and AIDS.	X	X	X	X	X	NACS, NCW, NGOs, CSOs, Dept. Community Development	# trainings held. # women trained, by organisation and province.
5.1.4	Encourage more young people, particularly young women, to take up leadership roles.	X	X	X	X	X	NACS, PACs, DACs, YOs, Dept Community Devpt, Education Dept, CSOs, CBOs	# and % young people attending leadership trainings, by sex
Objective 2: To strengthen existing partnerships and establish new partners on the basis of equality and mutual respect at all levels.								
5.2.1	Identify and support appropriate male leaders to advocate for gender equality and the elimination of gender based violence.	X	X	X	X	X	NACS, PACs, DACs, Education Dept, Parliament, CSOs, sports orgs, NGOs, the media, private sector	# trainings held for men and boys. # and type of leaders reached. # men sent to Fiji gender training annually # members, Men's Network
5.2.2	Ensure that gender is integrated into all sectoral planning on HIV and AIDS at national, provincial and district levels..	X	X	X	X	X	NACS, Dept of Planning, PM's Dept, PACs, DACs, CSOs, private sector	Annual national planning includes appraisal of plans using gender analysis.
5.2.3	Ensure that workplace policies on HIV and AIDS meet the specific needs of females as well as males, including protection against sexual harassment and other forms of gender violence.	X	X	X	X		NACS, PACs, DACs, all govt depts, CSOs, NGOs, private sector employers	# workplace policies which include policies and procedures on sexual harassment.
5.2.4	Build capacity for advocacy of the national organisation for PLWHA (Igat Hope), and of its women's branch.	X	X	X	X	X	NACS, NCW, Dept Community Devpt	# and % of members, by sex. Advocacy activities in periodic reports to funders.
5.2.5	Develop partnerships with male and female leaders in all sectors to advocate for gender justice in HIV/AIDS prevention.	X	X	X	X		NACS, PACs, DACs, CSOs, Parliament, sports orgs, NGOs, the media, private sector	# of leaders attending one-on-one awareness sessions on HIV/AIDS and gender, by sex and organisation.
5.2.6	Include women's and youth organisations, and coverage of gender issues, in the agenda of the annual National HIV and AIDS Partnership Forum.	X	X	X	X	X	NACS	# and % of women's groups and youth groups participating Coverage of gender issues in Forum report.
Objective 3: To strengthen the capacity of NAC and its Secretariat to effectively co-ordinate the national response to HIV through the implementation of the NSP [and the								

NPSPG], including effective provincial co-ordination.								
5.3.1	Create a dedicated position of Gender Advisor in NACS and set up a Gender Technical Advisory Committee.	X	X				NACS	Position established, at Gr16 or above. Gender Technical Advisory Committee established, # meetings per quarter
5.3.2	Set guidelines for the integration of gender into regular planning processes for NACS, PACs and DACs, and other stakeholders and partners.	X	X				NACS	Guidelines created for NACS, PACs, DACs Strategic Planning Manuals and trainings integrate gender issues. District and Provincial Plans identify gender strategies
5.3.3	Ensure that all employees and volunteers of NACS, PACs and DACs receive gender sensitization, and training in gender analysis and planning skills where appropriate.	X	X	X	X	X	NACS, PACs, DACs	# and % of employees and volunteers receiving Intro. to HIV/AIDS and Gender , by sex and job category. % employees attending gender skills training, by sex and job category.
5.3.4	Actively promote equal participation of females and males in employment, training, decision-making and programme implementation.	X	X	X	X	X	NACS	Establishment of sex-disaggregated databases on employment, attendance at trainings, # of trainers trained, and membership of committees (PACs, DACs, Tingim Laip sites,etc).
5.3.5	Provide guidelines for integrating gender into HIV and AIDS activities.	X	X	X			NACS	# of copies distributed
5.3.6	Ensure that the next national strategic plan on HIV and AIDS incorporates gender as a theme area from the outset.					X	NACS	Gender expertise included in strategic planning team. Gender balance of strategic planning team.
Focus Area 6: Family and Community Support								
Goal: To support and sustain a social and cultural environment that will enable families and communities to care for and support people infected and affected by HIV.								
Objective 1: To increase access for people living with HIV throughout PNG to STI/HIV community based care and support services.								
6.1.1	Develop criteria, materials and training for gender-sensitive and age-sensitive care, based on research carried out under Focus Area 4.	X	X	X			NACS, CSOs and NGOS involved in HBC	Criteria created and circulated. Training curriculum and materials created. # and % of trainers trained, by sex # and % of persons trained, by sex.
6.1.2	Support linkages between women's and children's organisations and women and children living with HIV or AIDS.	X	X	X	X	X	NACS, PACs, DACs, NCW, Igat Hope, WOs, Dept. Comm. Devpt,	# of women's organisations reporting on activities involving HIV+ women # of children's organisations reporting on

							UNICEF	activities for HIV+ children.
6.1.3	Establish programmes for income generation and food security for infected and affected families, especially female-headed households.	X	X	X	X	X	NACS, PACs, DACs, Dept Agriculture, Dept Community Devpt donor partners	Annual funds disbursed for income generation, by sex of beneficiary and household head status. As above, for food security in affected families.
Objective 2: To develop a supportive environment for people living with HIV and their families through the establishment, training and support of care groups in all provinces by 2010 ,and to reduce discrimination and violence against them.								
6.2.1	Ensure equitable participation for people of both sexes infected and affected by HIV or AIDS in training for leadership and communication, providing additional supports to females where necessary.	X	X	X	X	X	NACS, PACs, DACs, CSOs, NGOs	# and % of persons infected and affected by HIV/AIDS receiving training, by sex. # of additional support programmes for females.
6.2.2	Ensure equitable participation for people of both sexes living with HIV or AIDS in care programmes.	X	X	X	X	X		# and % of PLWHA enrolled in care programmes, by sex.
Objective 3: To ensure proper full recognition of human rights, including children's rights, in addressing the HIV epidemic, including respect for confidentiality, reduction of discrimination, and increased access to care and support.								
6.3.1	Include information about gender discrimination, gender violence, human rights and the HAMP Act in community education programmes.	X	X	X	X	X	NACS, PACs, DACs, NDOH Health Promotion, Education Dept, Dept Community Devpt, CSOs, NGOs, HRS, private sector	Materials produced and/or screened by gender specialist. # materials distributed.
6.3.2	Monitor the application of the HAMP Act and the operations of Village Courts to ensure that females living with HIV or AIDS are not victimised.	X	X	X	X	X	NACS, Dept. Justice	# of cases relating to HIV/AIDS infection identified in review of Village Court records, conducted annually, by sex and District.
6.3.3	Identify gender disparities in customary laws and practices relating to land and property rights, inheritance, family law and custody of children.	X	X	X			NACS, NCW, Dept Community Devpt	Research commissioned. Report distributed.
Objective 4: To build capacity for community based organisations and groups to identify and provide support for orphans and vulnerable children.								
6.4.1	Ensure that criteria for identifying orphans and vulnerable children recognise the special vulnerability of girls to sexual abuse and exploitation.	X	X				NACS	Criteria created and circulated.
6.4.2	Build capacity of CBOs (including women's organisations) and school teachers to identify and	X	X	X	X	X	NACS, PACs, DACs, Education Dept, CSOs,	# and % CBOs assisted, by sex of membership.

	register OVCs in their communities, and to address the increased risk of sexual exploitation of children, especially girls, in HIV affected families.						Dept Comm Devpt, NCW, WOs	# and % individuals trained, by sex and job category/type of involvement.
6.4.3	Promote equitable access for girls and boys to community based trust funds and education support.	X	X	X	X	X	NACS, Education Dept, CSOs	# and % children receiving education support, by sex and age group.
Focus Area 7: Monitoring and Evaluation								
Goal: To effectively track the progress of the HIV epidemic in PNG through regular monitoring and evaluation mechanisms and measure the impact of the national response.								
Objective: To develop a Monitoring and Evaluation framework to produce, collate, analyse and disseminate information on the national response to HIV, by 2006.								
7.1.1	Provide training on gender issues and gender-sensitive monitoring and evaluation for all personnel involved in developing monitoring and evaluation systems.	X	X	X	X	X	NACS	# and % personnel trained in gender-sensitive M&E, by sex, job category and location.
7.1.2	Establish gender-sensitive indicators and tools for the different levels of Monitoring and Evaluation, and ensure that these are incorporated into national and provincial data collection and analysis systems.	X	X				NACS	Indicators and tools address all strategies of the NPSPG, the gender goals of UNGASS and of the MDGs.
7.1.3	Incorporate training on gender issues and gender-sensitive monitoring and evaluation into consultations with all stakeholders involved in the design, implementation and analysis of monitoring and evaluation activities on HIV and AIDS.	X	X	X	X	X	NACS, Dept of Planning, CSOs, NGOs, private sector	# and % of persons in stakeholder organisations trained in gender-sensitive M&E, by sex and organisation.
Objective 2: To accumulate and disseminate data from all sources, including provinces through the use of relevant indicators that will assist in the reporting on respective international milestones, for example UNGASS and the MDG by 2007.								
7.2.1	Incorporate a summary of progress on gender indicators and gender related issues into quarterly and annual monitoring and evaluation reports, and disseminate these to provinces and districts for feedback and guidance.	X	X	X	X	X	NACS, PACS, DACS	Summary reports on progress of gender strategies produced quarterly and annually. # agencies receiving reports, by province.
7.2.2	Create linkages with organisations representing women, youth and other vulnerable groups for the feedback of information relevant to their needs.	X	X	X			NACS, PACS, DACS	# organisations in network, by type of beneficiary and province.
Objective 3: To measure the effectiveness and efficiency of the national response by undertaking a review of the NSP by 2010.								
7.1.1	Undertake an evaluation of the NGP by 2010, in conjunction with the evaluation of the NSP.					X	NACS	Evaluation team includes gender expertise, and is gender balanced.,

ANNEX ONE
GENDER EQUALITY GOALS OF UNGASS AND THE UN MDGS

UNGASS (United Nations General Assembly Special Session on HIV and AIDS, June 2001) gender equality goals:

Article 59: By 2005, develop and implement national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to enjoy safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.

Article 60: By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework.

Article 61: By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering, and trafficking in women and girls.

MDG (United Nations Millennium Development Goals) gender equality goals:

Goal No. 2: Achieve universal primary education.

Goal No. 3: Promote gender equality and the empowerment of women.

Goal No. 5: Improve maternal health.