



UNAIDS/PCB(20)/CRP1
11 June 2007

20th Meeting of the UNAIDS Programme Coordinating Board
Geneva, Switzerland
25-27 June 2007

Provisional Agenda Item 4.2:

Conference Room Paper

**Assessing Gender Equality and Equity as Critical Elements in
National Responses to HIV:
Cambodia, Honduras and Ukraine**

Presentation of policy guidance to address gender issues

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Acknowledgements

UNAIDS Secretariat and **UNDP** wish to acknowledge the numerous people who contributed to the design and execution of the gender and HIV assessments.

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Introduction

1. In June 2006, the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS) requested *“UNAIDS, in partnership with national governments, to conduct a gender assessment of three to five national AIDS plans and in addition submit to the Programme Coordinating Board, at its 2007 meeting, technical and policy guidelines to address gender issues in a practical way for use by governments, national AIDS programmes, donors, international agencies, the UN system and nongovernmental organizations in response to the increased feminization of the epidemic.”* (Decision 7.10 of June 2006)

2. This paper presents the work that was done in response to the specific request by the Programme Coordinating Board to conduct *three to five gender assessments*. In preparation for this work, UNAIDS Secretariat and UNDP considered the fact that many gender assessments of national AIDS plans have been conducted, as inventoried and analyzed in Board paper, UNAIDS/PCB(20)/07.11. Yet, few governments have costed, budgeted and implemented a truly “gendered” national response to HIV, that is, a response that involves sufficient political, financial and programmatic commitment to gender equality and equity to fully address the HIV-related rights and needs of women and girls, men and boys.

Gender equality exists when both women and men are able to share equally in the distribution of power and influence; have equal opportunities, rights and obligations in the public and private spheres, including in terms of work or income generation; have equal access to quality education and capacity-building opportunities; have equal possibility to develop their full potential; have equal access to resources and services within families, communities and society at large; and are treated equally in laws and policies. It does not mean that women and men are the same, but that their rights, responsibilities and opportunities do not depend on their sex. Efforts to expand gender equality in national AIDS responses should be based on commitment to the realization of human rights, including non-discrimination and freedom from violence.

3. In light of this, it was decided to identify the elements of a gendered response to HIV; and based on these elements, to conduct the assessments called for by the Board, in terms of which of these elements were, or were not, part of the national response to HIV. It is intended that these assessments:

- Be useful to the countries that participated in the assessments to further expand gender equality and equity in their responses to HIV, and
- Inform the development of guidelines to help Governments, donors, the UN system and civil society to take gender equality and equity from the project to programme level in national HIV responses.

4. In conducting the gender assessments, certain general parameters were established. These were to:

- Capture and build on work already done in country on the promotion of gender equality and equity in the national response to HIV.
- Focus on the prevailing gender norms that contribute to the vulnerability of both men and women to HIV.

- Focus on gender equality in terms of the unequal power, distribution of resources and differential access between men, women, girls and boys, as well as between members of both sexes in vulnerable groups, and how these factors increase the vulnerability to HIV and its impact (See box).
- Focus on gender equity in terms of the fair distribution of resources between the sexes (See box).
- Design the assessments so that the results are useful to ongoing national processes and structures, e.g. national programming, the Three Ones, universal access, and mainstreaming HIV into sectors and programmes, and country gender equality/mainstreaming plans.
- Involve key stakeholders in the assessments, notably representatives of Government, the UN system, bilateral/multilateral agencies and non-governmental organizations in country; women, men, young people living with HIV; representatives of groups working on women, gender equality and human rights; representatives of sex workers, men having sex with men, drug users and prisoners.
- Seek, in the implementation of the work, commitment from stakeholders to follow up after the assessments to take the work forward.

Gender equity refers to the fact that, where needs of men and women are different, resources and programmatic attention should be in proportion to those needs; equal opportunities should be ensured; and if necessary, differential treatment and attention should be provided to guarantee equality of results and outcomes and redress historical and social disadvantages experienced by women.

5. This paper presents results from three gender and HIV assessments conducted in Cambodia, Honduras and Ukraine as part of the response to the request of the Programme Coordinating Board. It begins with a discussion of the methodology used, describes the analytical framework that guided the assessments, presents some general findings and observations on the gender and HIV assessment process, and discusses, by country, the primary results from the country visits, including country-specific recommendations.

Methodology

6. To fulfil the Board request to conduct three to five gender and HIV assessments, the UNAIDS Secretariat and UNDP undertook the following work between August 2006 and May 2007:

- Consulted with various partners within the UNAIDS Secretariat and UNDP to determine the capacity/budget to conduct gender and HIV assessments, possible criteria by which to select countries, and possible analytical frameworks by which to orient the assessments
- Developed a draft project description which was shared with Cosponsors, and interested governments and non-governmental organizations at various stages
- Developed criteria for selecting countries to be assessed and a shortlist of possible countries
- Consulted with UNDP and UNAIDS Secretariat staff in the possible countries
- Selected three countries
- Contacted government partners through the UNAIDS Country Coordinators for their engagement

- Conducted the three gender assessments of national HIV responses based on desk reviews and in-country visits (see more on methodology below)
- Wrote up the results
- Shared these with country counterparts.¹

7. The criteria for country selection were as follows:

- Time, budget and human resources by which to conduct the assessments
- Government interest in participating, and some ongoing work on gender equality in the context of the HIV response
- Diversity in terms of geographic and epidemiological considerations, and
- Sufficient in-country support in the form of staff of the UNAIDS Secretariat, UNDP and/or UNIFEM.

8. Based on this selection criteria, **Cambodia, Honduras and Ukraine** were selected for the gender and HIV assessments.

9. The **International Center for Research on Women** was selected as the principle consultant to assist in the conduct of the assessments.

10. **Irish Aid** kindly provided funding for the project.

11. In January and early February, relevant staff of International Center for Research on Women reviewed key documents relating to the national responses in the three countries, including national strategic and operational plans, policies and legislation relating to HIV, research reports, reports on epidemiology, project proposals, and meeting reports.

12. From 10-24 February, a team of two people, one from the International Center for Research on Women and one from the UNAIDS Secretariat, conducted the assessments in Cambodia and Ukraine. From 18-24 February, a senior staff member of the International Center for Research on Women conducted the assessment in Honduras, with support from the regional UNAIDS Office and the UNDP Gender Focal Point. The visits were supported by the office of the UNAIDS Country Coordinator, and in the case of Cambodia, by the UN HIV Theme Group Chair and the UN Gender and HIV Working Group.

13. During these visits, the team interviewed stakeholders representing Government, donors and multilateral agencies, international and national NGOs, and representatives of civil society. (See annexes for lists of groups contacted.) The missions culminated in debriefings, at which key preliminary findings were shared with representatives from Government, the Joint UN Team on AIDS, and civil society organizations.

14. The desk reviews and country visits helped identify successes and challenges in expanding attention to gender equality and equity in national AIDS programmes and processes, and resulted in recommendations for taking the work forward. In addition, the team used the three country visits as an opportunity to gauge the relevance and usefulness of gender and HIV assessments as a tool. These assessments have also informed the broader effort to develop practical guidelines on gender and HIV as requested by the Programme Coordinating Board.

¹ For more background, please see the paper under agenda item 4.2. Presentation of policy guidelines to address gender issues
UNAIDS/PCB(20)/07.11.

The Analytical Framework

15. An Analytical Framework was developed to ensure consistency in the assessments and, in general, to set the scope and parameters for the overall response to the Programme Coordinating Board's request. The Analytical Framework comprises a set of factors to assess national HIV responses from a gender perspective, and organizes findings so that they are easily lent to expanding concrete actions on gender equality in national programmes. (See Annex I for a summary version of the framework). The framework attempts to provide an outline of the components that are necessary for integrating and expanding gender equality and equity in national HIV responses. The framework is organized into four areas:

- (1) Knowing your epidemic in gender terms;
- (2) Ensuring political and financial commitment to gender equality in the national response to HIV;
- (3) Addressing the rights and needs of women, girls, men and boys in the processes of the national response (the Three Ones); and
- (4) Addressing the rights and needs of women, girls, men and boys through specific programmes.

16. The UNAIDS Secretariat, UNDP and the International Center for Research on Women developed the framework in consultation with a virtual task force composed of representatives from UNIFEM, UNFPA, Open Society Initiative for Southern Africa, governments, donors, and civil society experts on gender and HIV. The framework was shaped by UNAIDS Secretariat work in this area and a focused literature review of relevant frameworks. Key resources for the framework included existing conceptual frameworks related to gender integration, and evidence from best practices in mainstreaming gender equality in reproductive health and other programmatic areas. Thus, the framework builds on prior experience, incorporating lessons learned about what has worked and why, and how to address challenges in advancing gender equality in national responses. The framework has evolved throughout the process to incorporate better the various components of gender equality and equity in a national response to HIV. In country, the Analytical Framework was expanded into a Field Guide consisting of questions to be posed to different stakeholders (available on request). Teams conducting the assessments also looked at programmes and activities in terms of whether they were gender sensitive, empowering or transformative. For an explanation of this terminology, please see **Annex II**.

Challenges and Limitations

17. The results of the gender and HIV assessments conducted in Cambodia, Honduras and Ukraine presented in this paper should be viewed in light of a number of challenges and limitations. The assessments were conducted in a relatively short time-frame and involved only five days in each country. These short visits permitted the team to meet briefly with a limited number of people. In many cases, the team members wished there could have been sufficient time to conduct more in-depth discussions. The key informant interviews were rich in material. However, there was no time to independently verify the information received. Furthermore, since the assessments were undertaken in response to the Programme Coordinating Board's request, they also represent a somewhat "vertical" effort in that they were conducted in isolation from mainstream HIV processes in the three countries.

18. Thus, rather than providing an exhaustive overview of the epidemic's gender dimensions, the assessments should be characterized as a snap-shot of HIV programming as it relates to addressing gender inequality and inequity at the time of the review. The following reports summarize the information most relevant to a discussion of integrating and expanding gender equality and equity more effectively into the national HIV responses. Policy and programme examples are cited selectively to underscore particular points. Regrettably, space constraints do not permit a full reporting of the many programming "gems" that dot the HIV landscape in the three countries discussed.

General lessons learned concerning the gender and HIV assessment process

19. Findings from the gender and HIV assessments highlight several important contextual factors at the national level that have important implications for addressing gender concerns in the national responses to the HIV epidemic. Unless more comprehensively addressed, these factors will constrain the ability of the assessments to inspire change.

20. **Limited consideration of issues around gender equality and sexuality.** The gender and HIV assessments demonstrate overall a limited consideration of aspects of gender inequality and sexuality that act as drivers of the epidemic. While country plans may discuss the vulnerability of women and girls, they typically include much less attention to the following issues: the vulnerabilities of men and boys to HIV due to harmful gender norms; the unequal power dynamics between men and women that influence the vulnerability of both sexes, but particularly girls and women; the different experiences of sexuality as between men and women and among young people; issues of sexual violence, coercion and exploitation; and the need to promote social dialogue and debate on HIV, sexuality, sexual violence, and gender norms.

21. **Limited knowledge of 'how to' apply gendered approaches.** The gender assessments highlight that there is an insufficient practical understanding of how to apply a gendered approach in programmes and operations at the national level. During the Cambodia, Ukraine and Honduras country visits, stakeholders were candid about the need to build the capacity of government, the UN and civil society actors on the practical 'how to' of integrating gender concerns into their work.

22. **Need to identify, scale-up and mainstream promising practices.** While promising practices and projects related to gender and HIV exist, they are small in number and size and often limited to the non-governmental sector or to one or two Government ministries. They are usually not linked or coordinated with national efforts. These approaches remain an untapped resource with potential for scale-up and mainstreaming in the national response to HIV. Gender and HIV assessments would be more useful if their methodology included identification and cataloguing of promising practices and projects.

23. **Lack of attention to structural issues that underlie gender inequality.** National efforts and plans related to HIV include few measures to address the structural issues that underlie gender inequality, such as social and economic pressures on men and women, as well as in some cases, the unequal access of women to education, economic opportunities, political participation, housing and land rights. Even more commonly, programmes addressing attitudes and norms that impact on men's behaviour that put both men and their partners at an increased risk of infection or limit men's access to health care are missing from national HIV responses

This gap calls for multi-sectoral approaches and a focus on the broader enabling environment for the well-being of women and men. These elements need to be incorporated necessarily into a gender and HIV assessment exercise.

Recommendations for use of gender and HIV assessments as a tool

24. Results from the country assessments highlight several lessons learned about how gender and HIV assessments can be strengthened to improve expansion of gender equality and equity in the national response to HIV. Looking toward the future, the following is recommended:

25. Integrate gender assessments in HIV programming processes and tools.

Whenever possible, gender and HIV assessments should be an integral part of HIV programme processes and should be implemented at opportune points to ensure that they influence HIV plans and programmes. To enhance impact, gender and HIV assessments can be implemented at the beginning of the planning process, before strategy reviews, or as part of mid-term reviews, and prior to the development of national HIV strategies so that their findings inform national policy and programmes. Gender elements should also be integrated into other HIV programming tools, including the AIDS Strategy and Action Plan (ASAP), Self-Assessment Tool (SAT), and the Country Harmonization and Alignment Tool (CHAT), as relevant.

26. Ensure the gender and HIV assessment process is broadly consultative.

There should be a broad back and forth consultative process involving the participation of a broad range of stakeholders, participating in key meetings, through key informant interviews or through focus group discussions. This helps the assessment process to have a positive and real impact on the national response. In addition to government, international agencies and donors, important national actors include women's and gender equality groups, networks of women and men living with HIV, representatives of marginalised groups, traditional leaders, the private sector and the media.

27. Provide gender expertise and 'hands on' accompanied assistance. Planners and programmers commonly report that they need to know more about "how to do gender" and would like more country-specific tools. To strengthen understanding of gender and its practical application, whenever possible, the gender and HIV assessment should be an accompanied process, closely assisted by an experienced gender and HIV specialist. The gender and HIV specialist should provide capacity-building for key stakeholders to strengthen understanding of the issues concerning gender equality, gender and HIV programming, sexuality, a rights-based approach, creating an enabling environment, and stigma and discrimination related to HIV, sex and sexual orientation. Capacity-building should also focus on how to apply a gender analysis to policies and programmes, and ways to ensure accountability, such as gender audits and gender budgets. Whenever possible, capacity-building efforts should be complemented by the provision of country-specific gender tools, rather than generic gender tools.

28. Ensure gender and HIV assessment findings are pragmatic and strategic.

The outcome of the gender and HIV assessment process should be a focused, pragmatic strategy aimed at getting results, rather than an extensive list of recommendations. The strategy should aim for results in the short/medium term as well as long term, and develop a strong monitoring plan to ensure accountability. Actions should be taken to ensure findings are integrated into national plans, costed and budgeted.

29. Identify positive projects that should be expanded. Gender and HIV assessments should not only critique current practices, they should also identify positive practices and evidence of results that can be expanded and built upon in future efforts. This will help galvanize key stakeholders and advance an operational strategy that is most likely to achieve successful outcomes. The strategy will need to be informed by guidance on how to scale-up or mainstream successful small-scale interventions. Scaling-up may require partnership with other key stakeholders beyond the government and civil society, such as the private sector.

30. Provide guidance for a comprehensive, consistent approach. Given the variability in gender approaches, present efforts involving gender and HIV assessments rarely yield comparable data. Though countries will always have different objectives in conducting gender assessments, next generation gender and HIV guidance should help ensure that gender and HIV assessments analyze a comprehensive range of issues and cover all key actors in the national response at different levels. Applying a more consistent approach could also facilitate improved understanding of trends across countries and regions.

Cambodia gender and HIV assessment

Overview of the epidemic in Cambodia

31. The response to HIV in Cambodia represents one of the success stories in reversing the upward trend of HIV infections. HIV prevalence among adults has declined from 3% in 1997 to 1.9% in 2003.² The 2005 Cambodia Demographic and Health Survey and the 2006 HIV Sentinel Surveillance both indicate further declines in adult prevalence. It appears that behaviour change efforts have been particularly effective in the brothel-based sex industry, as consistent condom use rose from 53% in 1997 to 96% in 2003 among brothel based (direct) sex workers, and HIV prevalence fell from 42% in 1995 to 21% in 2003. Among non-brothel-based (indirect) sex workers, condom use rates also rose – from 30% in 1997 to 84% in 2003; while HIV prevalence declined from 20% in 1998 to 15% in 2002.³ However, the 2005 STI Sentinel Surveillance indicates 80% condom use in brothel-based sex, 34% condom use with casual partners, and 25% with “sweethearts” among indirect sex workers.

32. HIV prevalence among pregnant women attending antenatal clinics has not improved significantly between 1997 and 2003, falling only slightly from 2.3% to 2.1%. Women comprised almost half (47%) of people living with HIV in Cambodia in 2003, compared with just over one third (37%) in 1998⁴; and 43% of new infections are occurring in married women⁵, most of whom are believed to have been infected by their husbands.

33. Little data is currently available on HIV trends among men who have sex with men. In the UNAIDS 2006 Global AIDS Epidemic Update, it was reported that a survey in 2000 in Phnom Penh found that 15% of men who have sex with men were infected with HIV, while a more recent survey found that 8.7% were HIV-positive in Phnom

2 UNAIDS. (2005). Turning the tide, Cambodia's response to HIV & AIDS 1991-2005, Phnom Penh.

3 UNAIDS/WHO. (2006). AIDS epidemic update. Geneva

4 Ibid.

5 UNAIDS. (2006). "Scaling up towards universal access to HIV prevention, treatment, care and support, Cambodia country report." Geneva.

Penh⁶. The same survey found that in the cities of Battambang and Siem Reap, HIV prevalence among men who have sex with men was low (0.8%), but that condom use was rare and inconsistent, and rates of sexually transmitted infections were high. Given such behavioural trends, there is a strong likelihood that HIV could spread among men who have sex with men in cities like Battambang and Siem Reap once the virus establishes itself in those networks.⁷

Knowing the epidemic in gender terms

34. A comprehensive assessment on the situation of women in the country, *A Fair Share for Women*, which covers areas such as the labour market, education, violence, politics, health and HIV was published in 2004⁸, and there are plans to update the data in the assessment this year with UN assistance. The assessment asserted that strong, stereotypical gender norms about sexuality and sexual behaviour underpin the epidemic in Cambodia. These norms make it difficult for women to negotiate condom use with their partners, as this implies infidelity; yet for men, extramarital sex is widely accepted.⁹

35. High levels of gender based violence against women appear to create barriers to comprehensive HIV prevention. *Violence Against Women, A baseline survey*¹⁰ on violence against women conducted in 2005, found significant acceptance of domestic violence, especially by husbands against wives, and a strong belief that men are entitled to more rights than women. The study showed that there is a broad agreement that a wife challenging her husband's dominance to do as he pleases can justify the most severe violence, and more than half of respondents said this type of behaviour by a wife justifies even extreme violent acts. Less than half of respondents said that a husband's HIV infection was a justifiable reason for a wife to refuse sex with him. These attitudes appear to be prevalent also among young people, and women appear to be more accepting of violence than men. Lack of law enforcement and male peer pressure were cited as major influences on men's attitudes toward women.¹¹

36. Another factor undermining success in current prevention efforts seems to be the changing behaviour patterns among men. Men are increasingly seeking sex from women other than brothel-based sex workers – from so-called “indirect” sex workers (such as karaoke bar and massage parlour workers, and beer promoters), and from “sweetheart” relationships.¹² Recent data indicate that 86% of karaoke singers have ever received money for sex, 34% are paid by sweethearts every time they have sex, 20% currently have more than one sweetheart, and the average number of paying sex partners of karaoke singers in the last 12 months was 14.6.¹³

6 Phalkun, M et al. (2006). “HIV, sexually transmitted infections and related risk behavior among Cambodian men who have sex with men.” CDC0618.XVI International AIDS Conference. 13 -18 August Toronto.

7 Ibid.

8 UNIFEM, WB, ADB, UNDP and DFID/UK. (2004). *A Fair share for women: Cambodia gender assessment*. Phnom Penh.

9 Ibid.

10 GTZ, UNIFEM; CIDA, USAID, East West Management Institute, Kingdom of Cambodia Ministry of Women's Affairs. (2005). *Violence Against Women, A baseline survey*. Phnom Penh.

11 Ibid.

12 Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs (2005). “Cambodia Behavioral Surveillance Survey (BSS)”. Phnom Penh. PSI, Cambodia. (2003). “Knowledge, attitudes and practices regarding HIV/AIDS in Cambodia.” Phnom Penh.

13 PSI 2006 2nd Round HIV/AIDS Tracking Surveys among Two Target Populations: Karaoke Women with Sweethearts & Sexually Active Men with Sweethearts. This data confirms the findings of the 2005 STI Sentinel Surveillance.

37. Such male behaviours, their changing patterns, and their impact on male and female vulnerability to HIV, strongly suggest that there is a need to address the values and attitudes underlying these behaviours. While Cambodia's prevention programmes have clearly demonstrated success in the brothel-based sex industry, similar success for male partners of indirect sex workers, for these sex workers, and for the wives of these men will be difficult to achieve if the causes and consequences of men's risky behaviour are not confronted in the national AIDS programme.

Political and financial commitment to gender equality and equity in the context of the HIV response

38. The Government of Cambodia has shown commitment to gender equality in laws, policies and plans. Equality between men and women is enshrined in the 1993 Cambodian Constitution; legislation has been revised to safeguard gender equality in marriage, family, employment and land ownership; and gender-sensitive language has been included in numerous plans and policies.¹⁴

39. According to several informants, the promotion of gender equality and equity by key individuals within Government, with the support of the international community and national partners, has been a crucial factor in getting gender concerns acknowledged at the highest levels. The Ministry for Women's Affairs has spearheaded the establishment of gender mainstreaming working groups in a number of Ministries, although some informants suggested that many of them are not yet fully functional.

40. The UN has played an important role in engaging national leaders and ensuring their commitment to gender and HIV issues. An example of this is UNDP's Leadership and Development Programme which has brought together key actors, such as senators, representatives from several Ministries, civil society organisations, Buddhist monks and the media to identify the role that cross-cutting issues, such as gender or poverty, play in the country's HIV response.¹⁵ In September 2006, UNAIDS engaged the First Lady of Cambodia, who is also the President of the Cambodian Red Cross, as a National Champion on HIV/AIDS for the Asia Pacific Leadership Forum on HIV/AIDS and Development. As the National Champion, the First Lady has spearheaded the campaign against stigma, promoted the rights of people living with HIV, and continues to mobilise specific groups, such as young people and the private sector, in the HIV response. This work has helped to renew and re-energise the commitment by political leaders to address HIV, and has increased discussion on stigma and discrimination, especially in the media.

41. The United Nations Development Assistance Framework 2006-2010 (UNDAF) states that gender is mainstreamed in each of the areas of assistance "in order to ensure that disparities are addressed in both the social and economic sectors"¹⁶; and addressing HIV prevention and treatment as gender issues is cited as a priority in the United Nations framework for support of gender in Cambodia.¹⁷ A UN working group on Gender and HIV, chaired by UNFPA, has been established to harmonise support to the National AIDS Authority, Ministry of Women's Affairs and other partners, and coordinate UN activities on gender. The working group has supported the Ministry of Women Affairs in the development of a costed Strategic Plan on Women and Girls and HIV/AIDS 2007-2010.

14 United Nations, Cambodia Country Team. (2007). "A framework for support of gender in Cambodia." Phnom Penh.

15 UNDP. (2003). "Results: HIV/AIDS, 2001/2002." New York.

16 United Nations and Kingdom of Cambodia. (2006) "United Nations Development Assistance Framework 2006-2010." Phnom Penh.

17 Office of the United Nations Resident Coordinator in Cambodia. (2007). "United Nations, A framework for support of gender in Cambodia." Phnom Penh.

42. However, despite these achievements, some key informants expressed the view that there continues to be a degree of reluctance within some areas of Government, especially among senior male officials, to expand efforts on gender equality and women's empowerment. Also, many informants observed that, while the concepts of "gender" and "gender equality" are found in policy documents and strategic plans, it is much more difficult to change deeply embedded gender stereotypes and power differentials in practice, such as the reported high level of acceptance of violence against women in Cambodian society. Focus group discussions also indicated that sexual minorities face discrimination institutionally, in the community, and at individual levels, and there is anecdotal evidence of gang rape of transgender populations.

Legal and policy framework

43. In 2002, the Parliament passed the Law on Prevention and Control of HIV/AIDS which includes articles on the protection of the human rights of people living with HIV and on addressing all drivers of the HIV epidemic, and makes specific reference to programmes for women and girls, providing for "special education programmes on HIV/AIDS targeting teenage girls and women-headed-households to address the role of women in society and gender issues."¹⁸ Guidelines on the implementation of the law¹⁹ have been developed, although it was reported during the country visit that they are not yet fully operational.

44. In 2003, the Ministry of Women's Affairs formulated a Policy on Women, the Girl Child and STI/HIV/AIDS. Despite the fact that the policy has been in existence for four years, the Ministry has not had the required resources and capacity to implement the policy and translate it into action. With the support of the UN Gender and HIV Working Group, the Ministry of Women Affairs has now developed and finalised the Strategic Plan on Women and Girls and HIV/AIDS 2007-2010 to implement the Policy. Due to the cross-sectoral nature of the policy, the Ministry of Women's Affairs has a coordinating role in relation to the implementation of the policy, and many of the activities will have to be implemented by other Ministries. Advocacy and technical assistance are needed to ensure that relevant Ministries are willing and able to take on this work.

45. A recent national policy audit and assessment, supported by UNAIDS and the UN Joint Team on AIDS, revealed that Cambodia does not have a national policy statement on men who have sex with men and HIV. The audit recommended that one should be developed as a priority in order to address stigma and discrimination against this group and to create an enabling environment for programmes targeting men who have sex with men.²⁰ The same audit indicated that a policy is also needed on the availability of post-exposure prophylaxis for non-occupational cases, especially for rape survivors.

46. From discussions with key informants, it seems that the major challenge is to translate existing policies into good programmes. In this regard, it appears that there is need to ensure that resources are allocated so that policies can be implemented. It also appears necessary to engage all relevant Ministries who are critical to various policies. These would include the Ministries of Interior, Defence, Public Works and Transport, and Justice.

18 Kingdom of Cambodia. (2002). Law on Prevention and Control of HIV/AIDS, Article 6.

19 National Aids Authority. (2005) "Implementing Guidelines on the Law on Prevention and Control of HIV/AIDS National AIDS Authority."

20 National AIDS Authority. (2007). "Cambodia HIV/AIDS Policy Assessment and Audit, Draft Report."

Gender equality and equity in the Three Ones

47. **The National AIDS Action Framework:** Human rights, gender equality, empowerment and community involvement are among the guiding principles of *National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2006-2010* (NSP II). The national operational plan also contains some activities that are related to gender concerns (e.g. prevention activities among uniformed services and their partners), women-targeted activities (e.g. formal and informal sex workers), and tailored interventions for men who have sex with men.

48. However, several people interviewed expressed concern that the NSP II does not adequately address gender concerns. Gaps appear to be: (a) objectives, activities and indicators on reducing spousal and partner transmission, (b) addressing the underlying gender norms that fuel the epidemic, (c) better addressing stigma and discrimination and violence against women, people living with HIV and marginalised populations, and (d) increasing access to appropriate services for sexual minorities.

49. **The National AIDS Authority:** The multisectoral National AIDS Authority was established by Royal Decree in 1999 and is headed by the Prime Minister. With a relatively small secretariat staff, the National AIDS Authority seeks to coordinate the HIV-related activities of the various government sectors. Some National AIDS Authority staff have received gender training, though key informants suggested that more capacity and additional training is needed to enable the National AIDS Authority to carry out gender analysis and to coordinate a gendered response.

50. Within the National AIDS Authority, the Ministry of Women's Affairs has been charged with coordinating gender and HIV work across the various sectors. In light of the challenges of cross-department coordination and the competing priorities within the Ministry's mandate, a capacity-building plan to strengthen the Ministry's role in the AIDS response is currently being co-developed by the Ministry and the National AIDS Authority. Some gender-related issues, such as addressing the gender-based vulnerabilities of men who have sex with men and transgender communities, do not sit naturally within the mandate of the Ministry of Women's Affairs or of any other Ministry. However, work on these issues is being taken forward and coordinated by a national technical working group. This working group includes representatives of the recently established national network of men who have sex with men (Bandagn Chaktomuk), and is chaired by the National AIDS Authority.

51. It should be noted that civil society is very active in the response to HIV in Cambodia. However, some interviewees remarked that women (including women living with HIV), sexual minorities, and other marginalized groups have not been sufficiently and meaningfully engaged in national-level decision making processes. As in many countries, it appears that participation of these groups is still somewhat tokenistic with insufficient space provided for them to express their views or have an impact.

52. Efforts are currently being made by the UNAIDS Secretariat and UNIFEM to build the capacity of the Cambodian Community of Women living with HIV/AIDS. In addition, genuine attempts to involve communities and affected populations were made during the universal access consultations, and had some tangible impact (e.g. representatives of injecting drug users successfully advocated for a higher universal access target for the coverage of services for injecting drug users).

53. The National Monitoring & Evaluation Framework: Cambodia has one of the most advanced HIV surveillance systems in the developing world, which incorporates both serological and behavioural data from a range of sentinel populations across the country. A multisectoral monitoring and evaluation system is currently being developed with assistance from the UNAIDS Secretariat.

54. Most surveillance and service statistics are disaggregated by sex and age, though they are not widely available to the public and are often collapsed when reported. Data is not yet systematically analysed and used as evidence to inform the design of gender-informed programmes. However, it appears that surveillance data has helped create awareness of the issues. For example, some informants reported that surveillance data regarding sexually transmitted infections in 2005 led to increased awareness of the importance of programmes tailored for men who have sex with men, and a strategy is currently being developed to scale up such programmes for this community. It is anticipated that men who have sex with men and injecting drug users will be added to national sentinel surveillance surveys on HIV, sexually transmitted infections and behaviours.

55. From interviews with key informants, it appeared that there is a need to supplement surveillance with qualitative research, especially on how masculinity is constructed in the Cambodian context, which will help increase understanding of the underlying risk behaviours that continue to fuel the epidemic. In particular, there is a need to understand the basis for the peer pressure and cultural norms that encourage men to have multiple sexual partners, thereby increasing their risk (and that of their wives and partners) to HIV infection.

Programmatic responses

56. The 100% Condom Use Programme in commercial sex establishments has been the cornerstone of prevention efforts in Cambodia, and it is believed to be contributing significantly to control of the epidemic. In the programme, sex workers serve as peer educators within these establishments, and the cooperation of brothel owners, local governments and the police is engaged.

57. It was the opinion of some informants that the 100% Condom Use Programme is not a gendered programme in that it: (a) does not consider the power dynamics involved in sex work; (b) its outreach activities and information, education and communication materials do not seek to transform harmful gender norms, and (c) the sex workers are held accountable, but the men are not. However, peer educators interviewed noted that the programme has had many benefits, including increased access for sex workers to voluntary counselling and testing and to treatment, and decreased stigma and discrimination among sex workers against people living with HIV. The peer educators also reported that many positive sex workers have started thinking about their future, getting out of sex work, and starting small businesses.

58. However, informants also reported police harassment of sex workers and outreach workers, and violence by clients. Indeed, high levels of sexual violence against sex workers and sexual minorities, exacerbated by a culture of impunity, may undermine the success of the programme. Research carried out in 2005 revealed that approximately half of the 1000 female and transgender sex workers surveyed in Phnom Penh reported being beaten by the police, about a third reported being gang raped by police, slightly more than one third reported being gang raped by gangsters,

and about three quarters reported being gang raped by clients.²¹ Overall, over 90 per cent of the sex workers surveyed were raped, many of which were gang rapes, at least once in the previous year. It is doubtful that these rapes are counted in behavioural surveillance data reporting the proportion of sex workers using condoms with clients, and they could account for a significant increase in infections among sex workers, their clients and eventually the wives and partners of those clients.²² Also, in a survey carried out in 2005, 67% of female sex workers interviewed reported having been forced not to use condoms in the previous week.²³

59. Efforts to address violence against women in Cambodia have intensified in recent years, and a domestic violence law was passed in 2005. However, implementation of the law has been slow – an area of concern expressed among the UN, donors and civil society. It was reported that there are some small scale campaigns against violence against women but no concerted and coordinated action to tackle the problem. There appeared to be very little acknowledgement among decision-makers of the important link between gender-based violence and HIV and the need to address it.

60. There are some HIV programmes which are addressing gender issues. For example, the Ministry of Defence has implemented a peer education programme among military personnel and their families which aims at improving couples communication, decreasing violence against women, and increasing community dialogue.²⁴ Though the programme has yet to be evaluated, anecdotal evidence suggests that communication between husbands and wives has improved, condom use by military personnel and among married couples has increased, and domestic violence has decreased. The programme is currently being expanded. The Ministry of Interior has also implemented a peer education programme with the police. However, key informants reported that this programme does not include couples communication or a broader gender equality component. It was reported that other relevant Ministries, such as Labour, Public Works and Transport, and Justice, have not yet sufficiently engaged in gender issues in general, or in the context of the HIV response.

61. Within the Ministry of Interior, gender concerns have been mainstreamed into the commune-based development planning process with support from UNFPA. The National AIDS Authority is currently working with the Ministry to also mainstream HIV into the commune-based development planning. In addition, UNFPA is working with the Ministry of Interior to ensure that the decentralisation process addresses gender, and that sexual and reproductive health are programmed into Commune Investment Plans, and the ILO HIV/AIDS Workplace Education Programme has mobilized key partners in the private sector reaching 4,000 workers (80% of them women) in the garment industry. The challenge is to ensure that the *gender dynamics of the epidemic* are taken into consideration in these mainstreaming processes.

62. There is an urgent need to do more to address HIV transmission among married couples and partners. The Ministry of Women's Affairs has developed a National Action Plan on Prevention of Spousal and Partner transmission accompanied by a costed operational plan. The plan has been incorporated into the Strategic Plan on Women and Girls and HIV/AIDS 2007-1010. This provides a renewed opportunity and focus to address underlying norms, attitudes and behaviours that increase both men's and women's vulnerability to HIV.

21 Carol Jenkins, The Cambodian Prostitutes Union (CPU), Women's Network for Unity (WNU), and Candice Sainsbury. (2005). Violence and Exposure to HIV among Sex Workers in Phnom Penh, Cambodia. Phnom Penh.

22 *ibid.*

23 NCHADS, FHI, ADB and CDC GAP. Cambodian STI Survey 2005: Key Risk Behaviors and STI Prevalence.

24 Smiling Families Program. (n.d.) Phnom Penh: Kingdom of Cambodia, Ministry of Defense and FHI.

63. There also appear to be insufficient programmes tailored to the needs of sexual minorities. Although awareness about the vulnerability of men who have sex with men has increased and prevention measures targeting men who have sex with men have been included in the universal access targets²⁵, informants indicated that these groups are currently inadequately covered by appropriate information and services in both urban and rural settings. This situation is likely to improve, however. A national strategic framework and three year operational plan (costed) on HIV prevention among men who have sex with men is currently being developed, and programmes addressing the needs of these communities have been included in the Global Fund Round 7 application.

64. Another gap in programming seems to concern the reproductive rights of people living with HIV. Some interviewees suggested that many decision-makers lack knowledge about safe motherhood, reproductive rights, and positive prevention. Anecdotal evidence indicates that women living with HIV are told by doctors not to get pregnant, and positive women who do get pregnant are stigmatised. This is no doubt partly due to the low access to prevention of mother to child transmission services. However, there is a need to train health care workers in non-discrimination and referral, and to increase the awareness of positive women of their rights, reproductive issues and choices, and safe motherhood. Furthermore, many women living with HIV interviewed for this assessment felt that participation of persons living with HIV in prevention activities and outreach was limited.

65. Coverage of services to prevent mother to child transmission remains very low. At the end of 2005, it was estimated that less than 10 per cent of HIV positive pregnant women received these services.²⁶ This should be seen within a context where less than half of all pregnant women access antenatal care services. However, it is evident that coverage of prevention of mother to child transmission services is low even among antenatal care patients, only about 12% attending antenatal care received counselling and testing services in 2006.²⁷ Anecdotal evidence suggests that women may refuse offers of HIV testing in antenatal care due to lack of consent from their husbands, fear of seeking consent, and/or fear of possible recriminations if they accept testing without their husbands' consent. Knowledge of services also appears to be low, and men rarely attend antenatal care services with their partners, although recent efforts to increase partner attendance have begun to pay dividends.

66. Access to voluntary, confidential counselling and testing has increased significantly. By December 2006, there were 140 HIV counselling and testing sites, with 212,789 adults receiving services annually.²⁸ Testing guidelines emphasise confidentiality and counselling. However, several informants expressed concerns about judgemental attitudes of counsellors and the lack of confidentiality. It was reported that fears related to the implications of disclosure are central to the reluctance of women to seek testing for HIV. Marginalized groups also appear to experience stigma and discrimination when accessing these services.

67. Significant efforts have also been undertaken to expand access to anti-retroviral treatment. Over 20,131 people were on treatment by December 2006 including 1,787 children - 80% of those in need of treatment. However, no assessment has been

25 Percentage of men who have sex with men exposed to HIV prevention measures 60% by 2008, 90% by 2010.

26 National AIDS Authority of Cambodia. (2005). "United National General Assembly Special Session on HIV/AIDS, Monitoring the Declaration of Commitment, January 2004-December 2005."

27 National AIDS Authority. (2005) Mapping Cambodia's Response to HIV/AIDS. Phnom Penh.

28 Information received from UNAIDS Cambodia country office, May 2007.

carried out to date to analyse different barriers to HIV services for women and men among different population groups, and there is a need to carry out systematic quantitative and qualitative analysis of the specific needs of women and men living with HIV. It was reported by several informants that women have variable access to treatment. Some reported that men access treatment first because they support the family; others suggested that women, more often than men, are asked for money under the table in order to receive treatment. Focus group participants also reported judgemental attitudes by health care workers in the provision of treatment.

Recommendations

68. Government

- a. Use the mid-term review of National Strategic Plan II and the Annual Multi-sectoral Joint Review 2007, to assess the extent to which women, men, girls and boys, including among marginalised populations, enjoy equitable access to HIV prevention, treatment and support services and the specific barriers to such access that should be addressed. (The National AIDS Authority to lead with support from all sectors and development partners.)
- b. Ensure, together with partners, that the response includes the following:
 - Mass media and communication programmes to transform harmful gender norms, eliminate violence against women, and reduce discrimination and violence against people living with HIV and marginalized populations, using different community voices on the TV and radio (Ministry of Information to take the lead)
 - In the context of expansion of sexual and reproductive health services, expansion of prevention of mother to child transmission programmes within a comprehensive programme to address the health and treatment needs of HIV positive women, including training of health care workers in non-discriminatory attitudes. (National Centre for HIV/AIDS, Dermatology and STI Control together with the National Centre for Maternal and Child Health Ministry of Health)
 - User-friendly and non-discriminatory health services for men who have sex with men and transgender groups, including STI services, and promotion of these in a way that addresses factors that make it difficult for these communities to address services, including homophobia (Ministry of Health)
 - Review of programmes for sex workers and their clients to expand sex workers' empowerment and to address underlying norms driving clients' behaviour, including increased use of informal sex workers and violence against women (Ministry of Health, Ministry of Interior, Ministry of Justice, Ministry of Women's Affairs)
 - Peer education programmes among the police forces that include modules on gender equality, non-violence against sex workers and members of sexual minorities, and working with marginalized groups to support their access to HIV prevention, treatment and care (Ministry of the Interior)
 - Expanded services for victims of sexual violence, that, among other things, provide post-exposure prophylaxis (Ministry of Health, Ministry of Women's Affairs)
 - Condom promotion programmes targeting married men and women (Ministry of Health, Ministry of Information)

- Expanded couples counselling and testing (Ministry of Health)
 - “Know your rights” campaigns and legal support services for women, people living with HIV, and members of marginalised groups (Ministry of the Interior as part of Commune Development Programme, Ministry of Education, Ministry of Information)
- c. Continue to strengthen the capacity of the Ministry of Women’s Affairs to engage in the AIDS response and, as far as feasible, conduct a gender and HIV capacity audit in other relevant Ministries, such as Defence, Interior, Education, Finance, Public Works and Transport and Justice. Ensure that gender training and capacity-building programmes are designed so that they increase the understanding of how gender norms, gender inequality and violence drive the epidemic for both men and women in the Cambodian context. (National AIDS Authority)
 - d. Ensure that women’s groups and groups engaging men are represented and have space to express their views in national AIDS processes, such as National AIDS Authority technical working groups, the Country Coordinating mechanism, mid-term review of the national strategy, development of the next national strategic plan and national consultations on HIV. (National AIDS Authority)
 - e. Raise the importance of addressing gender equality and equity in the national HIV response through the Government-Donor Technical Working Group, and formally request donors to coordinate support and ensure sustainability of funding for programmes addressing gender equality in the context of the national response. (National AIDS Authority)
 - f. Involve the Ministry of Finance and the General Auditor’s Office to audit the Operational Plan in terms of resources dedicated to gender relevant programmes in the HIV response. (National AIDS Authority)

69. The UN system

- a. Support the Government in integrating and expanding gender issues in the national AIDS strategies, and annual HIV operational plans of different sectors, ensuring that gender issues are addressed at programmatic level within each sector and moving away from small scale gender projects.
- b. Ensure that the UN Joint Programme on AIDS Operational Plan and Budget reflect joint UN support to programmes that address harmful gender norms and gender inequality, and mobilise resources for this work
- c. Support the engagement of Ministries outside the Health Ministry and Ministry of Women’s Affairs in the expansion of gender-related programmes, e.g. Ministry of Interior and Justice in programmes to stop violence against women and against sexual minorities and other marginalized communities, such as sex workers.
- d. Support capacity-building of women’s groups and other civil society organisations in terms of skills to engage in national AIDS processes on the importance of understanding and responding to the gender dimensions of the epidemic in Cambodia, and to participate more effectively in national AIDS processes.
- e. Support operational research on gender norms and roles in the Cambodian context, with focus on indigenous entry points for transforming these norms towards gender equality.

70. Donors

- a. Increase and coordinate financial assistance to programmes that address gender equality and equity within the national HIV response and ensure sustainability of funding over time; in particular to address the present critical funding gap in programmes addressing gender-based violence.
- b. Support capacity-building of Government and civil society partners to more effectively promote and programme gender issues in the national response.
- c. Ensure funding for the operationalising the Strategic Plan on Women and Girls and HIV/AIDS 2007-2010.

71. Civil society

- a. Increase the participation of women, including women living with HIV, sex workers, men who have sex with men and members of other marginalised groups in the design of HIV programmes addressing their needs.
- b. Develop strategies to build the capacity of women's groups to better participate in the national HIV response. Increase participation of women within non-governmental organisations.
- c. Increase effort to achieve gender parity in recruitment.
- d. Build alliances and advocate jointly on the importance of reducing stigma and discrimination and addressing gender inequality and harmful gender norms in the context of the HIV response.

(For organizations contacted during the Cambodia gender and HIV assessment, see **Annex II**)

Honduras gender and HIV assessment

Overview of the epidemic in Honduras

72. With one of Latin America's highest HIV prevalence levels, Honduras has taken numerous measures to tackle the epidemic. Many of the right components are in place for an effective response to HIV: an ambitious national AIDS plan,²⁹ laws to protect the rights of people living with HIV, reproductive and sexual education for youth, community-based support groups, and free testing and treatment services. Also, the First Lady has become a prominent spokesperson on women and HIV.³⁰ Despite these laudable efforts, however, HIV infections continue to occur, and women are increasingly affected. While the epidemic is still concentrated in the country's central corridor, the Government has found cases in all municipalities, indicating that more and more areas are becoming affected.³¹

Knowing the epidemic in gender terms

73. HIV prevalence among adults is an estimated 1.5 percent, but prevalence levels are substantially higher among key populations, including men who have sex with men (13 percent); female sex workers (9.7 percent); people in prisons (6.8 percent); and the Garifunas³² (8.4 percent). Among the Garifunas, women (8.5 percent) and men

29 Government of Honduras, Sub Secretaria de Salud Dirección General de Promoción y Protección de la Salud Departamento ITS/VIH/SIDA. (2003). PENSIDA II: National HIV/AIDS strategic plan (2003-2007) (II Plan estratégico Nacional de Lucha Contra el VIH/SIDA 2003-2007). Tegucigalpa.

30 UNAIDS. (2006). 2006 Annual UNAIDS Country Report. Geneva: UNAIDS.

31 Government of Honduras. (2005). "Honduras: Follow-up report to the commitment to HIV/AIDS." Prepared for the United Nations General Assembly Special Session on HIV/AIDS. Tegucigalpa.

32 An Afro-Carib ethnic group.

(8.2 percent) have similar prevalence levels.³³ Factors influencing vulnerability among these groups include poverty, social exclusion and discrimination, violence, stigma, homophobia, low education, unemployment, alcoholism and drug use. For men who have sex with men, rates of sexually transmitted infections, including HIV, have continued to rise since 1998 due to inconsistent condom use and multiple sexual partners.³⁴ Overall in Honduras, while HIV knowledge is high, the use of condoms is still relatively low. Greater engagement on HIV among the population in general and vulnerable groups in particular has been hampered by denial and stigma, and norms associated with gender and sexuality.³⁵

74. Women now account for an estimated 26 per cent of people living with HIV.³⁶ However, women appear to be increasingly affected – 42 per cent of all recorded cases are among women, and women accounted for 61 per cent of new HIV cases in 2005. Among the factors influencing vulnerability among girls and women are early initiation of sex; low levels of knowledge related to sexual and reproductive health; high levels of taboo related to sexuality; high rates of sexually transmitted infections; and gender inequality, including sexual violence.³⁷

75. Overall coverage with antiretroviral treatment has increased. Among adults needing treatment, an estimated 48.9 per cent received antiretroviral therapy in 2005, compared to 12.6 per cent in 2002.³⁸ Coverage levels, however, remain low for prevention of mother-to-child transmission. In 2005, an estimated 12 per cent of pregnant women living with HIV received antiretroviral drugs to prevent mother-to-child transmission.³⁹

Political and financial commitment to gender equality and equity in the context of the HIV response

76. Political commitment to gender equality and equity has increased through the efforts of The First Lady of Honduras, who has emerged as a major champion for reducing the vulnerability of women to HIV. Having launched the “Coalition of First Ladies and Women of Latin America”, she is working regionally, as well as nationally, to expand services for women and girls and to support efforts to mitigate the impact of HIV on their lives. There is also a strong women's movement in Honduras, but it has not yet had significant impact on national HIV programming. The National Institute for Women, which takes the lead on most women, development and rights issues, has recently begun to work on HIV.

77. The legal and policy framework in support of gender equality in the HIV response is grounded in rights established in the Honduran Constitution and in both the Law on HIV and the Law against Domestic Violence. Exercising rights is supported by some

33 UNAIDS. (n.d.). Honduras country situation analysis. Geneva: Author. Accessed at www.unaids.org/en/Regions_Countries/Countries/honduras.asp

34 Government of Honduras, Secretaría de Salud de Honduras, Departamento de ITS/VIH/SIDA, Grupo PRISMA, Asociación Colectivo Violeta, Comunidad Gay Sampedrana y Fundación Solidaridad y Confraternidad contra el SIDA. (January 2003). “Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en Honduras.” Tegucigalpa: PASCA/USAID, University of Washington, OPS/OMS, UNAIDS, CDC y la Agencia Española de Cooperación Internacional.

35 Pan American Health Organization. (2002). The UNGASS, Gender, and Women's Vulnerability to HIV in Latin America and the Caribbean. Washington, DC.

36 UNAIDS. (n.d.). Honduras country situation analysis. Geneva: Author. Accessed at www.unaids.org/en/Regions_Countries/Countries/honduras.asp

37 UNAIDS. (2006). 2006 annual UNAIDS country report: Honduras. Tegucigalpa.

38 World Health Organization, Pan American Health Organization, and UNAIDS. (2006). Honduras epidemiological fact sheet on HIV/AIDS and sexually transmitted infections, 2006 Update. Geneva: UNAIDS/World Health Organization.

39 Ibid.

innovative institutions and interventions, such as the HIV hotline, domestic violence hotline, Fiscalía de la Mujer, the Office of Gender within the National Police and the Office for Women, and Office for HIV/AIDS within the Human Rights Commission.

78. Nevertheless, there appear to be major challenges regarding effective enforcement of the law, and there is a lack of data regarding the impact of the law and the extent to which people can and do utilize the legal system. A number of informants cited as reasons for poor utilization of the legal system: lack of awareness of individual rights and the existence of protective law; stigma and discrimination by police officers; costs and frustrations related to the legal process; and lack of confidence in the legal system.

79. The United Nations agencies have advocated for and helped finance efforts to better address gender inequality and harmful gender norms in the national response to HIV. The United Nations Resident Coordinator has recently initiated the formation of a gender theme group and UNDP, UNAIDS Secretariat, UNFPA, UNIFEM and the Pan American Health Organization (PAHO) have funded a variety of important, but small, gender-sensitive projects. Collectively, these projects make a significant contribution to moving the agenda forward on violence against women, law enforcement, sex education, women's rights, and the rights of women living with HIV. However, key informants felt strongly that more gender and HIV capacity was required within the UN system to really make an impact.

80. The bilateral agencies have also made a commitment to financing a robust national HIV response, but it appears that little funding is directed at the specific needs of men, women, boys and girls. Unfortunately, neither HIV nor a gender perspective figures prominently in the national poverty reduction strategy, which helps to set funding and programming priorities nationally.⁴⁰

81. The Global Fund proposal for 2006 is for approximately US\$ 8 million and has identified youth, sex workers, men who have sex with men, prisoners, and the Garifuna population as specific target groups for investment, along with programmes for prevention of mother-to-child transmission, voluntary counselling and testing, and treatment. Efforts to address gender equality and equity through the Global Fund could be strengthened. For instance, youth is a target group, but the same programming approaches appear to be taken for girls and boys. Whereas the goals for reducing risk among youth include "increases in condom use in first and most recent sexual experience", no indicators address gender-related drivers of vulnerability to HIV, such as decreasing levels of coerced sex or domestic violence.

Gender equality and equity in the Three Ones

82. **The National AIDS Action Framework:** While Honduras has promising policies and strategies in place, the National AIDS Plan II and III could more fully integrate gender equality and equity and involve more implementation of gender-based strategies. Though gender is defined as a cross-cutting theme in the National AIDS Plan II and is reflected in the language of the objectives, components of the national HIV plan tend to be "gender neutral" and a gendered approach is not reflected in the activities, or in the National AIDS Plan monitoring and evaluation indicators.⁴¹ That is, messages and services do not address how gender norms, expectations, and

⁴⁰ Ibid.

⁴¹ Government of Honduras, Sub Secretaría de Salud Dirección General de Promoción y Protección de la Salud Departamento ITS/VIH/SIDA. (2003). PENSIDA II: National HIV/AIDS strategic plan (2003-2007) (II Plan estratégico Nacional de Lucha Contra el VIH/SIDA 2003-2007). Tegucigalpa.

disparities shape whether people – women, men, girls, boys – can protect themselves from HIV and access services.^{42,43} Though the Global Fund proposal prioritizes strategies for pregnant women and sex workers, it does not focus on women in general, even though the epidemic is spreading among this group.⁴⁴ Efforts that do address gender-related vulnerabilities to HIV, such as initiatives on domestic violence and reproductive health rights, are small-scale and have not been recognized as part of the National AIDS Strategy.⁴⁵

83. Additionally, it is difficult to differentiate approaches that might address gender equality and equity within integrated objectives and activities. For example, one of the objectives of the Plan is to strengthen the development of the information, education, and communication activities that address reproductive health themes, including sexuality, gender, masculinity and reproductive health rights. But the indicator is that a plan is completed and implemented, with nothing about the content of the plan. Nor does the monitoring and evaluation plan include disaggregated data on outputs, such as how many women, men, boys and girls are reached by these activities.

84. The National AIDS Coordinating Authority: The National AIDS Commission, which is comprised of major government agencies and some civil society organizations, has helped strengthen national support of AIDS policy and programmes and leads the implementation of the National AIDS Plan. The coordination among the National AIDS Commission, donors, and civil society has become increasingly effective and productive.⁴⁶ Similarly, the Commission's capacity to advance gender equality has improved. Gender equality figures prominently as a cross-cutting theme in the National AIDS Plan II, and there are plans to reinforce this in the National AIDS Plan III. To strengthen this emphasis, the National AIDS Commission plans to involve agencies in the National AIDS Plan III that work on gender equality, such as the National Institute for Women and the Women's Rights and the HIV/AIDS Rights Offices of the Honduran Human Rights Commission.

85. Within the National AIDS Commission, a few individuals have worked on issues such as the integration of HIV into reproductive health services and the development of a sexual education curriculum and have tried to incorporate these programmes into the National AIDS Plan II. The National AIDS Commission does not have a dedicated gender expert or focal point to reinforce these efforts.

86. Professional men and women are well represented in all coordinating bodies and forums. Representation of women and men living with HIV, as well as men who have sex with men, is currently weak, although interest groups are strong. Representation of sex workers in national level decision-making bodies is a gap.

87. A strategy that both the Global Fund and National AIDS Commission use for addressing gender is to appoint a positive woman as a governing member. In the case of the Global Fund, their Board Chair is a positive Garifuna woman. This same

42 Government of Honduras. (2005). "Funds requested from the Global Fund (in USD)." (Worksheet from 2005 Global Fund proposal.) Tegucigalpa.

43 Government of Honduras. (2005). "Honduras: Follow-up report to the commitment to HIV/AIDS." Prepared for the UN General Assembly Special Session on HIV/AIDS. Tegucigalpa.

44 Ibid.

45 Government of Honduras, Sub Secretaria de Salud Dirección General de Promoción y Protección de la Salud Departamento ITS/VIH/SIDA. (2003). PENSIDA II: National HIV/AIDS strategic plan (2003-2007) (II Plan estratégico Nacional de Lucha Contra el VIH/SIDA 2003-2007). Tegucigalpa.

46 UNAIDS. (n.d.). Honduras country situation analysis. Geneva: Author. Accessed at www.unaids.org/en/Regions_Countries/Countries/honduras.asp

woman is a member of the National AIDS Commission. This is an important attempt to ensure that gender equality is advanced and that issues pertinent to minority women are considered within HIV programming. More effort is needed, however, to ensure that all affected populations meaningfully participate in national AIDS processes.

88. The National Monitoring and Evaluation Framework: In general, monitoring and evaluation systems are currently weak, and even more so in terms of creating baseline data or tracking progress in integrating gender into HIV programmes. It is envisaged, however, that the monitoring and evaluation system will be improved under the National AIDS Plan III. Honduras has data disaggregated by sex and for some key populations (sex workers and men who have sex with men), but these data do not tend to be used to inform gender programming or to assess impacts. In terms of reporting for the United Nations General Assembly Special Session on HIV and AIDS, missing indicators include: condom use among men who have sex with men; HIV prevalence among young women and men ages 15 to 24; and HIV prevalence among clients of sex workers.⁴⁷ A few recent studies, however, improve the understanding of the epidemic among vulnerable groups such as men having sex with men, female sex workers and the Garifunas.^{48,49,50}

Programmatic Responses

89. There are a significant number of HIV projects and activities being implemented in Honduras that recognize and respond to the different needs and constraints of individuals based on their gender and sexuality. Some of these go a step further, seeking to empower women and men in the face of harmful gender norms. Promising programmes include: reproductive and sex education for children and youth; radio and television dramas that address reproductive health and rights, sexuality, and gender roles; counselling and legal support for victims of domestic violence; development of community-based support groups that provide information and counselling to individuals and families on reproductive health and rights, HIV, sexual abuse and violence; a rehabilitation programme for perpetrators of violence against women that deals with masculinity; two model clinics that provide specialized services to men who have sex with men and youth; and programmes that inform women and people with HIV of their rights and provide legal counsel. In addition, a few programmes that address underlying vulnerabilities, such as those challenging violence against women or fostering women's access to micro-credit, are not recognized as HIV-related programming.

47 Government of Honduras. (2005) "Honduras: Follow-up report to the commitment to HIV/AIDS." Prepared for the UN General Assembly Special Session on HIV/AIDS. Tegucigalpa.

48 Government of Honduras, Secretaría de Salud de Honduras, Departamento de ITS/VIH/SIDA, Grupo PRISMA, Asociación Colectivo Violeta, Comunidad Gay Sampedrana y Fundación Solidaridad y Confraternidad contra el SIDA. (January 2003). "Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en hombres que tienen sexo con otros hombres en Honduras." Tegucigalpa: PASCA/USAID, University of Washington, OPS/OMS, UNAIDS, Centers for Disease Control and la Agencia Española de Cooperación Internacional.

49 Government of Honduras, Secretaría de Salud de Honduras, Departamento de ITS/VIH/SIDA. (2003). "Estudio multicéntrico centroamericano de prevalencia de VIH/ITS y comportamientos en poblaciones específicas en Honduras: Resumen de principales hallazgos". Tegucigalpa: PASCA/USAID, University of Washington, OPS/OMS, UNAIDS, Centers for Disease Control and la Agencia Española de Cooperación Internacional.

50 Cubas, D. (2003). "Apreciación rápida de los impactos del VIH / SIDA en la comunidad Triunfo de la Cruz, Municipio de Tela, Atlántida." Tegucigalpa: UNIFEM.

90. While promising, these projects and activities are, for the most part, not being implemented at a large enough scale to have a significant impact on the epidemic. Presently, most of these programmes are implemented by non-governmental organizations, with some by the Government. A major challenge is to shift from smaller, targeted projects to national-level programmes.

91. Like most countries, Honduras has also seen political challenges to gender-sensitive programmes.⁵¹ One of the National AIDS Plan's activities—a comprehensive sex education curriculum for public education—was a point of controversy. But, with the support of UNAIDS, the National AIDS Commission mobilized a coordinated and effective response to the controversy, engaging civil society organizations, opinion leaders, parents, and other key stakeholders. The primary gender activity supported by the Global Fund involves a life-skills based HIV education curriculum implemented at the community-level, primarily by non-governmental organizations. The curriculum emphasizes gender equality, responsible sexuality, and other topics.^{52,53} This is a promising effort, but it has also attracted political controversy.⁵⁴

92. Treatment services, with a few exceptions, could better address the unique needs of different population groups. For example, female sex workers and men having sex with men are referred to Infectious Disease Control Clinics. The focus of these services is on “controlling” disease, not on providing counselling or care that might reduce vulnerability. Those receiving the most accessible and integrated attention are pregnant women and their infants who access services through the Mother and Child Integrated Clinics. However, pregnant women are treated primarily in their reproductive role, with a focus on the mother and her newborn, and little attention is given to other affected members of the family, such as the male partner. In addition, some key informants expressed concerns that women are sometimes coerced into undergoing an HIV test.

93. The area of care and support for those affected and infected by HIV has not been fully developed in Honduras. There have been, however, a few promising, dispersed efforts to meet the nutritional and economic needs of families affected by HIV. These efforts include feeding programmes such as home delivery of groceries⁵⁵ and small-scale economic development interventions.

Recommendations

94. The National AIDS Commission

- a. As part of the process of developing National AIDS Plan III, ensure that there is a dedicated gender and HIV programming expert who leads the development of a gender strategy in the new plan so as to address the gender realities of the epidemic, e.g. that sufficient programming and funding is going to sex workers and their clients, men who have sex with men, prisoners and Garifunas and that the specific vulnerabilities, based on sex, of these groups are understood, addressed, and monitored through the development of

51 Ibid.

52 Government of Honduras. (2005). “Funds requested from the Global Fund (in USD).” (Worksheet from 2005 Global Fund proposal.) Tegucigalpa.

53 Government of Honduras. (2005). “Principal Recipient Year 3 Budget and Workplans Template.” (Worksheet from 2005 Global Fund proposal.) Tegucigalpa.

54 UNAIDS. (2006). 2006 annual UNAIDS country report: Honduras. Tegucigalpa.

55 Government of Honduras. (2005). “Honduras: Follow-up report to the commitment to HIV/AIDS.” Prepared for the UN General Assembly Special Session on HIV/AIDS. Tegucigalpa.

specific indicators. To avoid the need to revise the National AIDS Commission by-laws to incorporate a gender expert, it may be feasible for one of the National AIDS Commission member institutions to appoint a representative with the requisite skills to serve this function. Working with other National AIDS Commission members and affected populations, the gender expert would ensure that:

- Relevant data and information are reviewed by the National AIDS Commission to inform the gender strategy.
 - The objectives and activities, as well as the accompanying indicators, that are incorporated into the new monitoring and evaluation plan, are gender specific and enable the tracking of related gender outcomes.
- b. Create a gender and HIV learning agenda within National AIDS Plan III that would include operational research, as well as accompanying communication strategies, to fill the gaps in knowledge related to gender and HIV.
- c. Enable and encourage all National AIDS Commission members to become “experts” in gender and HIV by involving them in the development and monitoring of the gender strategy and the ongoing learning agenda so that they advocate within their own institutions to improve understanding and support for policies and programmes that advance gender equality and equity.
- d. As part of the process for developing National AIDS Plan III, audit relevant laws and their enforcement (e.g. the HIV Law, the Law against Domestic Violence) to better understand their impact, or lack thereof, in supporting the AIDS response.
- e. Ensure that the National AIDS Plan III includes the following:
- Moves from a “gender neutral” approach to better address the specific needs of men, women, girls, boys, and other vulnerable groups, e.g. condom promotion with messages against sexual violence, increased access to the female condom, provision of school-based life-skills education that includes teaching on gender equality.
 - Programming to better support women and girls to protect themselves against HIV through expanded programmes on sexual education, campaigns against sexual and domestic violence, integration of HIV into sexual and reproductive health, expansion of prevention of mother to child transmission programmes with components that bring male partners and husbands into services and ensure treatment for the mother.
 - Programmes that address legal and social vulnerability of key populations, e.g. know your rights campaigns for women; legal aid for victims of discrimination and violence; training of police to work successfully with sex workers, survivors of sexual violence, men who have sex with men and transgender populations; development of comprehensive programmes for prisoners.
 - Programmes for social and legal support of families and individuals living with HIV and/or caring for persons living with HIV or orphaned.
- f. Coordinate with the Global Fund to develop compatible systems that complement one another but do not duplicate efforts, e.g. data from the Global Fund monitoring and evaluation system and data on key indicators should feed into the National AIDS Plan III monitoring and evaluation plan and system.

- g. Develop a communications strategy to support leadership and advocacy by political leaders and celebrities around key gender issues and HIV, such as homophobia, violence against women, and harmful gender norms that support multiple partnerships among men and sexual ignorance among women.

95. The UN system

- a. Build the capacity of national authorities to disaggregate data by sex, age, marital status and ethnicity and use such data to inform HIV programming.
- b. Increase own capacity on gender and HIV programming, e.g. hiring a dedicated gender and HIV advisor to provide assistance to national actors for the further integration of gender into national HIV programmes.
- c. Provide assistance to national authorities to carry out a national legal and policy audit in terms of gender, human rights, and HIV, focusing on how national legislation and law enforcement impact on the ability of men and women, including those among marginalised groups, to access HIV prevention, treatment, care and support services.
- d. Advocate and promote integration of HIV and gender equality into other plans and strategies that set funding and programming priorities, including the national Strategy for Poverty Reduction, the new Global Fund proposal, the annual workplan for Universal Access, and the new national Policy on HIV.
- e. Support national mechanisms to apply for and receive funding for programmes that address specific needs of vulnerable groups, e.g. men who have sex with men, women facing sexual violence and coercion, sex workers, prisoners, Garifunas, in the context of the National AIDS Plan III gender and HIV strategy.
- f. Monitor obstacles to investment and programme implementation and support strategies that strive to overcome the obstacles.

96. Donors

- a. Ensure that support to gender-sensitive programmes is fully coordinated and sufficient to support the Government to expand these from the project to programme level.
- b. Dedicate resources for building the gender and HIV capacity of all national partners, including women's groups and other members of civil society.

(For organizations contacted during the Honduras gender and HIV assessment, see **Annex III**)

Ukraine gender and HIV assessment

Overview of the epidemic in Ukraine

97. Ukraine, together with the Russian Federation, accounts for 90 per cent of all people living with HIV in Eastern Europe and Central Asia.⁵⁶ After a gradual debut, the rate of infection began to rise rapidly in 1995 fuelled by transmission through contaminated injecting drug equipment.⁵⁷ Until recently, the principal modes of HIV transmission have been injecting drug use (60 per cent), followed by heterosexual transmission (25 per cent) and mother-to-child transmission (12 per cent)⁵⁸, but the proportion of heterosexual transmission is rapidly increasing. Injecting drug use is

⁵⁶ UNAIDS/WHO. (2006). 2006 AIDS epidemic update. Geneva.

⁵⁷ World Bank and International HIV/AIDS Alliance in Ukraine. (2006). Socioeconomic impact of HIV/AIDS in Ukraine. Washington, DC.

⁵⁸ Ibid.

most prevalent among men aged 15 to 49 years.⁵⁹ HIV prevalence is very high among injecting drug users, and ranges from 10 per cent in the city of Sumy to over 66 per cent in the city of Mykolayiv.⁶⁰ HIV prevalence among prisoners has risen from 9 per cent in 2003 to 14 per cent in mid-2006. The principal mode of transmission among incarcerated people is also injecting drug use.⁶¹

98. Presently, HIV prevalence among pregnant women is 0.31 percent, which is among the highest levels in Europe.⁶² The Government reports that transmission patterns are now shifting from populations at higher risk to the general population.⁶³ The proportion of women among adults diagnosed with HIV rose from 38.2 per cent in 2001 to 41.6 per cent in 2005⁶⁴, revealing a feminization of the epidemic with women accounting for an increasing number of newly diagnosed cases of HIV. With the epidemic gaining ground among the general population, the World Bank and the Ministry of Health of Ukraine project national HIV prevalence ranging between 1.9 per cent and 3.5 per cent by 2014.⁶⁵

99. Youth and young adults are at particular risk of exposure to HIV for four reasons: early age of sexual debut⁶⁶, unprotected sex, injecting drug use, and sex work.⁶⁷ The percentage of sexually active young people reporting condom use with non-regular sexual partners was 69 per cent in 2004. Irregular condom use accounts for high levels of unwanted pregnancy and sexually transmitted infections.⁶⁸ Injecting drug use among young people is an important social problem, with injecting drug users aged 20 to 29 years currently representing over 50 per cent of people living with HIV in Ukraine.⁶⁹

100. Many adult and adolescent women in Ukraine who enter the sex business for money, drugs or other commodities are at increased risk for HIV and sexually transmitted infections, violence and trafficking. According to the sentinel surveillance data from 2005, 21-25% and 25-30% of female sex workers are infected with syphilis and genital chlamydia, respectively.⁷⁰ Another factor contributing to the rapid increase in sexual transmission of HIV is an overlap between injecting drug use and sex work among these women. Sentinel surveillance data indicate that HIV prevalence among female sex workers who reported injecting drug use was between 8.3 per cent and 100 per cent depending upon the study site, whereas among sex workers who did not report injecting drug use, prevalence ranged between 0 and 21.1 per cent.

59 UNICEF and UNAIDS. (2005). A Review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic. Kiev.

60 UNAIDS/WHO (2006). AIDS epidemic update. Geneva.

61 Ibid.

62 UNAIDS/WHO. (2006). 2006 AIDS epidemic update. Geneva.

63 Ministry of Health of Ukraine. (2006). Ukraine: National report on the follow-up to the UNGASS declaration of commitment on HIV/AIDS – reporting period: January 2003 – December 2005. Kiev.

64 Ibid.

65 World Bank and International HIV/AIDS Alliance in Ukraine. (2006). Socioeconomic impact of HIV/AIDS in Ukraine. Washington, DC.

66 Median age for first sex is 17 years in Ukraine, with 67 per cent and 62 per cent of youth aged 15 to 24 years sexually active in urban and rural settings, respectively. Nearly a third of sexual contact is with non-regular sexual partners.

67 UNICEF and AFEW. (2006). Children and young people living or working on the streets: The Missing face of the HIV epidemic in Ukraine. Kiev.

68 Ministry of Health of Ukraine. (2006). Ukraine: National report on the follow-up to the UNGASS declaration of commitment on HIV/AIDS – reporting period: January 2003 – December 2005. Kiev.

69 UNICEF and UNAIDS. (2005). A Review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic. Kiev.

70 International HIV/AIDS Alliance, State Institute for Issues of Family and Youth, and Ukrainian Institute for Social Studies. (2005). Analytical Report on the Results of the Study, Monitoring of Behaviours of Female Sex Workers as a component of the second generation surveillance. Kiev.

101. There is limited sentinel surveillance in populations of men who have sex with men. Reports indicate that condom use among men who have sex with men is not practiced consistently with regular sexual partners, both male and female.⁷¹ Some informants also suggested that the real numbers of HIV transmission through male-to-male sex may not show up in surveillance statistics because male-to-male sex is more stigmatised in Ukraine than injecting drug use.

102. In a study of the socioeconomic impact of HIV, the World Bank and the Ministry of Health of Ukraine (2006) estimate that by 2014 the 20-34 age group will account for 75 per cent of all new HIV infections, half of which will be among women.⁷² The study projects that both men and women will have lower life expectancy, and that AIDS-related deaths will account for 60 per cent of female deaths in the 15 – 49 age group as compared to a third of all male deaths in the same age group. The report concludes that national policy makers must focus more effectively on understanding and addressing the underlying causes of vulnerability to HIV which are driven by gender inequality, harmful gender norms, and power dynamics that adversely affect women and girls, as well as men and boys.

Knowing your epidemic in gender terms

103. Gender aspects of the HIV epidemic in Ukraine are not as clear cut as in many other regions where women's unequal legal status and limited access to education, economic opportunities, and control over their sexuality make women especially vulnerable to HIV. In Ukraine, legislation provides a supportive framework for gender equality; there is gender parity in access to education and economic opportunity; and attitudes favour faithfulness to one's partner and joint decision-making in the use of contraception and family planning.⁷³ In Ukraine, many people state that gender inequality is "not a problem" in their country because the Equal Opportunities Law enshrines equal treatment of women and men under the law. Such statements understandably emphasize the important political and legal basis of gender equality that exists in Ukraine.

104. However, even where gender equality is enshrined in law, socially scripted expectations and interactions can still have a differential impact on the vulnerability of both sexes to HIV, particularly regarding the nature of engagement in sexual and risk-taking behaviours and in accessing HIV prevention, treatment and support services. In the post-Soviet transition to a market economy, a new HIV "riskycape" is emerging in Ukraine involving economic hardship, high levels of unemployment and shifting gender roles. Men appear to have been hardest hit by the deteriorating economic situation which has precipitated a psychosocial crisis for many men whose stature and authority had previously been based on economic productivity, i.e., being the breadwinner and head of household.⁷⁴ Although they too are experiencing stress, women appear to be more resilient and flexible than men in the face of social upheaval. This evolution of gender roles in Ukraine is placing considerable stress on gender relations in families and households. With their sense of autonomy and self-worth threatened, many men

71 UNICEF and UNAIDS. (2005). A Review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic. Kiev.

72 World Bank and International HIV/AIDS Alliance in Ukraine. (2006). Socioeconomic impact of HIV/AIDS in Ukraine. Washington, DC.

73 UNDP Ukraine. (2004). Gender and HIV/AIDS, A new approach to prevention and policy. Kiev.

74 Dudwick, N., Srinivasan, R., and Braithwaite, J. (2002). "Ukraine Gender Review". Washington, DC. Rhodes, T. and Simic, M. (2005).

"Transition and the HIV risk environment." *British Medical Journal*, 331: 220-223. Barnett, T., Whiteside, A., Khodakevich, L., Kruglov, Y., and Steshenko, V. (2000). "The HIV/AIDS epidemic in Ukraine: Its potential social and economic impact." *Social Science and Medicine*, 51:1387-1403.

appear to be managing economic and social dislocation by taking refuge in alcohol and drug abuse, perpetrating violence against themselves and others, and engaging in sex with multiple partners. Consequently, men's risk of exposure to HIV infection is high and is increasing, as is that of their sexual partners.⁷⁵

105. In spite of the health crisis that men in Ukraine are experiencing in part due to changing gender roles and harmful gender-based ways of coping, national leadership, as well as non-governmental and civil society actors, tend to interpret (as elsewhere in the world) gender as a code word for "women". Many policy-makers and programmers consider that they have responsibly "dealt with the gender dimensions" of the HIV epidemic by collecting and disaggregating data on women or by providing services to women. This assessment indicates that there is a need for further policy and public dialogue on what "gender" means in the Ukrainian context, and how gender norms are affecting *both* men's and women's risk-taking behaviour, their capacity to protect themselves from HIV infection, and their ability to access HIV services.

Political and financial commitment to gender equality in the context of the HIV response

106. Ukraine has demonstrated considerable political commitment to deal with the national HIV epidemic in an open and comprehensive manner. It is well acknowledged that unsafe injecting drug use is the key factor promoting the spread of the epidemic, and the increasingly supportive policy framework has allowed an evolving national response to HIV that is tailored to meet the needs of key populations. Some female parliamentarians interviewed for this assessment are taking the lead in advancing gender and HIV issues nationally. However, it appeared from interviews during the assessment that women's and men's different vulnerabilities to HIV and ability to access HIV services are not yet fully understood and recognized in Ukraine.

107. Most of the national HIV funding is allocated to epidemiological surveillance, blood safety measures, and anti-retroviral and other related treatment – with less investment in focused prevention activities among the vulnerable communities that are key to the epidemic dynamics in the country.⁷⁶ Funding to address these groups is obtained primarily from international sources, especially the Global Fund to Fight AIDS, Tuberculosis and Malaria.

108. Informants indicated that the UN has done some advocacy work on gender issues in the context of the HIV response, although it does not appear that this has been reflected in national programming. It was reported by several informants that donors have not focused particularly on addressing the gender-related aspects of the epidemic, although many of those do have programmes on either HIV or gender.

Legal and Policy Framework

109. The policy and legal environment in Ukraine is generally supportive of an effective and gendered response to HIV. The Government has ratified all major human rights instruments, including the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Political Rights of Women, the Convention on the Rights of the Child, and the Convention against Transnational Organized Crime. The Constitution of Ukraine guarantees equal rights to all Ukrainian

⁷⁵ Ibid.

⁷⁶ International HIV/AIDS Alliance. Strengthening the response to the HIV epidemic in Ukraine: positive sides of economic transition <http://www.aidsalliance.org/sw29482.asp>.

citizens and prohibits discrimination on the basis of race, sex, ethnicity, and religion; guarantees equality between men and women; and protects women's equal rights in a range of domains, including health care, legal protection, and financial and moral support to women with children.⁷⁷ In September 2005, the Verkhovna Rada (Parliament) passed an Act on the Provision of Equal Rights and Opportunities for Women and Men which seeks to secure parity for women and men in all sectors of public life. The Minister for Family, Youth and Sport is currently leading on the implementation of the Act which requires gender to be mainstreamed into all government sectors. In 2006, the State Programme on Gender Equality in Ukrainian Society was approved by the Cabinet of Ministries and in the same year the Parliament's Hearings "Equal Rights and Opportunities for Women and Men" took place.

110. As a newly independent state, Ukraine has laws that contain language that could be supportive of efforts to address the particular needs of women and men in relation to access to HIV prevention, treatment, and care services for those populations in need. The Verkhovna Rada enacted the Law of Ukraine "On Prevention of Acquired Immunodeficiency Syndrome (AIDS) and Social Protection of Population" in 1991 and later passed amendments in 1998 and 2001, all of which are reflective of European legal and public health standards. However, it does not appear that the language in the laws has translated into implementation of public policy or programmes that deal with the particular needs of women and men, that the subordinate legislation required to translate the law into practice has been put in place, or that many sectoral acts are in line with the law.⁷⁸

111. One area that has been scrutinized is the impact of law and law enforcement on access to HIV prevention and treatment services by people who inject drugs.⁷⁹ However, this scrutiny has not focused on the different needs of men and women drug-users or the differential impact of the law on them. During the assessment, several people suggested that additional research would be valuable on the intersection between gender, injecting drug use and HIV.

Gender Equality and Equity in the Three Ones

112. **The National AIDS Action Framework:** In March 2004, the Cabinet of Ministers established the Concept of the Strategy of Government Action targeting prevention of HIV, and approved the National Programme to Prevent HIV Infection, Support and Treatment of People Living with HIV for the period 2004-2008. The Programme specifies key priorities in response to the epidemic and provides a framework for attracting additional financial and technical resources.⁸⁰ However, the Programme does not explicitly address gender issues.

113. With support from DFID, UNAIDS is working to convert this programme into a comprehensive national programme. This realignment represents an opportunity to integrate gender more explicitly in the national programme. Also, evaluation of the programme this year could and should be used as an opportunity to examine how effective the programme is in reaching men and women.

77 Government of Ukraine. (1996). Constitution of the Ukraine, Chapter II, Article 24. Kiev.

78 UNAIDS. (2006). National report on universal access to HIV/AIDS Prevention, Treatment, Care and Support in Ukraine by 2010. Geneva.

79 Human Rights Watch. (2006). "Ukraine--Rhetoric and risk: Human rights abuses impeding Ukraine's fight against HIV/AIDS." Washington, DC.

80 Ibid.

114. **The National Coordinating Council for HIV/AIDS:** The Government restructured its national coordinating body in May 2005 and established the National Coordinating Council for HIV/AIDS. The Council is headed by the Deputy Prime Minister. Serving as the gender focal point to the National Coordination Council, the Ministry of Family, Youth and Sport is responsible for ensuring that the needs of women, men and youth are addressed in national policies and programmes.

115. Within the National Coordination Council, there is representation from across Government, donors, civil society and associations of people living with HIV. There did not appear to be representation of women's groups, groups representing sexual minorities, or groups with a dedicated gender focus. However, many interviewees commented that the leadership of the International HIV/AIDS Alliance and the All Ukrainian Network of People Living with HIV and AIDS had resulted in greater direct involvement of civil society in national decision-making, as well as in gender promotion on the national HIV agenda.

116. Other than these two large organizations, people interviewed generally considered that the involvement of civil society organisations, such as those working directly with injecting drug users, sex workers, orphans and vulnerable children, and prisoners, is weak in the current formulation of HIV policy and programming at the national, regional and local levels, although many people were satisfied with the three-stage consultative process adopted for the articulation of the universal access targets.

117. **The National Monitoring and Evaluation Framework:** Data collection and analysis is centralized within the Ukrainian AIDS Centre, which is housed in the Ministry of Health. Although HIV prevalence data is disaggregated at the national level, data on service use are not routinely reported as sex- and age- disaggregated. However, at the regional and site levels, point-of-service data are collected in disaggregated format by sex and age, so could be available for sex- and age-disaggregated analysis at the central level. Key informants felt that it was more problematic that data are not being used systematically for programmatic purposes. Key informants reported that there are Government plans to establish a national monitoring and evaluation unit, and that a team will soon be in place.

Programmatic Responses

118. Both the Government and civil society are actively involved in the implementation of the Ukrainian HIV response at programmatic level. The International HIV/AIDS Alliance is the main recipient of the Global Fund Programme 'Overcoming HIV/AIDS Epidemics in Ukraine', which includes some gender-related activities. These include gender-sensitive provision of voluntary testing and counselling; development of gender-sensitive information materials; peer outreach work to men who have sex with men, as well as sensitization of the police; and development of gender-sensitive services, including the provision of consultation on legal issues, reproductive health, contraception, and care, support and treatment for HIV positive women and children.⁸¹

⁸¹ National Coordinating Council for the Prevention of HIV/AIDS, Ukraine. (2005). Global Fund to fight AIDS, Tuberculosis and Malaria, Sixth Call for Proposals: "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine"

119. Injecting drug users are a priority for HIV interventions in Ukraine, and harm reduction programmes are in place in most regions, although they are still only covering less than 25 per cent of injecting drug users. Substitution therapy for injecting drug users is being scaled-up in eight pilot sites in Ukraine.⁸² Many informants believe that the programmes targeting drug users are not effectively dealing with the gender dimensions of the epidemic among people who inject drugs and their sexual partners.

120. Research carried out by the International HIV/AIDS Alliance shows that female injecting drug users are potentially more vulnerable to HIV than men.⁸³ The principal risk factor for female drug users, according to the study, is linked to “double dependency” – to drugs and to men who involve them in drug use and, in many cases, commercial sex. The research also showed that female drug users report finding it difficult to use harm reduction services because of registration requirements. Female drug users often do not want to register officially as a drug user because they suffer greater stigmatisation than male drug users, as this goes against the traditional expectation of women as “nurturers of families”. Some informants also pointed out that female injecting drug users who have children do not access services because of fear that their children will be taken away from them. Female drug users also experience discrimination in social services. Research carried out in 2005 indicates that social workers often refuse to designate child care assistance, or to provide other types of social assistance (e.g. coupons for free transportation) to unwed mothers with injecting drug user status.⁸⁴

121. Informants reported that female drug users often have an injecting drug using male partner. Because of unequal power imbalance in many of these relationships, females have greater difficulty in abstaining from drug use, and often inject drugs after their male partner, who could be HIV infected. Many female drug users also engage in high-risk sexual activities, including sex work.

122. Female drug users also have women-specific needs, such as women self-help groups, consultations with gynaecologists, and detailed information about pregnancy, childbirth and infant feeding.⁸⁵

123. Police harassment is another barrier to accessing services for both male and female injecting drug users and sex workers. The police often interfere with the delivery of harm reduction services to injecting drug users and frequently stop syringe exchange clients near, or at, syringe exchange sites.⁸⁶ Although prostitution was decriminalized in January 2006, sex workers continue to be targeted by police for prosecution, and routinely experience harassment and abuse. When sex workers are victims of physical or sexual violence, e.g., coercive sex or gang rape, the police often disregard their requests for police protection. Various reports indicate that it is not unusual for police to perpetrate physical and sexual violence on sex workers.⁸⁷

82 Ibid.

83 International HIV/AIDS Alliance, Ukraine. (2005). Introduction of gender dimension into prevention, care and support programs. Kiev.

84 Centre for Social Expertise of the Institute of Sociology at the National Academy of Science of Ukraine. (2005). A Review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic, Kiev.

85 Ibid.

86 Human Rights Watch. (2006). “Ukraine--Rhetoric and risk: Human rights abuses impeding Ukraine’s fight against HIV/AIDS.” Washington, DC.

87 O. M. Balakireva, Ph.D. in Social Science, T.V. Bondar, Yu. M. Galustyan, Ph.D. in Social Science, O. A. Ganukov, Ph.D. in Philosophy, O. G. Gorbunova, E. M. Lutsenko, Ph.D. in History, V. I. Menzhulin, Ph.D. in Philosophy, G. V. Svyatnenko, Ph.D. in History, O. O. Yaremenko, Ph.D. in Economy. Ukrainian Institute for Social Research with support of UNAIDS. (2001) “Sex business in Ukraine: an attempt of social analysis”. Kyiv.

124. Access to anti-retroviral treatment has increased considerably in recent years. Cooperation between public health care facilities, non-governmental organisations working on AIDS and communities of positive people at the national and local level were cited as the key factors that have allowed for the rapid scale-up of treatment. It is estimated that around a third of people in need of treatment are women. However, around half of all people on treatment in Ukraine are female. There has been no analysis of the reasons of this relative over-representation of women on anti-retroviral treatment, but the possible reasons are the promotion of prevention of mother to child transmission as an entry point to treatment, and the barriers in access to treatment for injecting drug users, most of whom are men.

125. It was reported, however, that prevention of mother to child transmission services are often limited to the delivery period, and many informants expressed concerns that women are treated mainly in their reproductive role rather than as individuals with rights. "PMTCT-plus", which uses the prevention of mother to child transmission as an entry point for treatment and care for the pregnant woman's whole family, is not practiced in Ukraine. There are currently efforts to increase access to prevention of mother to child transmission services for women who inject drugs and who often avoid contact with health professionals. Issues of confidentiality, informed consent and quality of counselling in the context of HIV testing remain problematic for pregnant women.

126. Some health services are linked in Ukraine. For example, many voluntary counselling and testing sites also offer family planning, antenatal and postnatal care. At the same time, each Oblast has reproductive health services that also provide HIV testing and referral to treatment. However, many informants felt that most vertical programmes are not sufficiently linked to each other. For example, during interviews, several people commented that the Ministry of Health is focused primarily on a medical response, and would be able to increase the effectiveness of its services and programmes through a more systematic consideration of the epidemic's gender dimensions. Likewise, it was felt that the Ministry of Family, Youth and Sport did excellent work on women-centred issues such as trafficking and gender-based violence, but could expand its role and influence even further by developing expertise around the gender dimensions of the HIV epidemic in Ukraine. Many respondents would like to see greater communication, coordination and collaboration between the two ministries.

127. Several non-health ministries provide a range of HIV-related programmes and services for their target populations. One example is the State Department for the Enforcement of Sentences where the medical department has been working to serve the needs of prisoners and juvenile delinquents who are HIV positive. Officials interviewed during the assessment mentioned that women prisoners living with HIV have special needs for care and support while incarcerated. Given caseloads, prison physicians do not have time to devote to individual prevention and counselling. The Department is encouraging greater involvement of non-governmental organizations in providing prevention outreach as well as care and support services to HIV-positive women prisoners in order to meet this identified need.

128. The Ministry of Defence used to have a peer education programme for armed services. However, key informants reported that the programme was currently stalled due to restructuring with the Ministry, but there are plans to restore the programme. This should be used as an opportunity to broaden the gender dimensions of the HIV prevention programme by including components on male and female gender norms, gender-based violence and homophobia. The Ministry has taken a crucial first step by appointing a gender focal point person as required under the Equal Opportunities Law.

129. There appear to be very few programmes that seek to identify entry points for social change which would transform gender roles and norms of sexuality throughout Ukrainian society and reduce vulnerability to HIV for both women and men. One positive example is the UNFPA Country Program (2006-2010) which proposes to address gender inequality – specifically the high morbidity and premature mortality of Ukrainian men – by framing traditional male gender roles and masculinity as social constructions amenable to adaptation or modification.⁸⁸

130. Although interventions targeting men who have sex with men have been included in the most recent Global Fund programme, many informants felt that there is currently not enough focus on prevention programmes for sexual minorities. Although Ukraine was the first former Soviet republic to decriminalize sexual relations between consenting adult males in 1991, men who have sex with men experience widespread stigma, discrimination, violence and abuse which serve to increase their vulnerability to HIV and complicate efforts to reach this population with a full range of prevention and treatment services.⁸⁹ Networks and associations of men who have sex with men stated during the assessment that they are advocating for greater involvement in the national HIV response so that their particular interests and needs are well represented. These groups were represented during the consultations to set the universal access targets; this is an encouraging first step.

131. Another sector of the national HIV response that would benefit from more in-depth inquiry, according to key informants, is the care economy as it relates to home- and community-based caretakers of people living with HIV, especially of children living with HIV. The All Ukrainian Network of People living with HIV has evaluated the situation of women and children affected by HIV and has collected information on social support to caretakers which could be more fully used in the context of policy and programme development.

Recommendations

132. Government

- a. Use the Programme Evaluation process this year to assess the extent to which women, men, girls and boys, including among marginalised populations, have access to HIV prevention, treatment and support services and how specific barriers to such access should be addressed.
- b. Create operational links between the different departments of Ministry of Family, Youth and Sport (departments working on HIV, gender equality, and against violence against women), and the Ministry of Health's AIDS Centre.
- c. Designate one Ministry as a formal lead on gender and HIV issues. Carry out an audit of gender and HIV capacity within that Ministry as a matter of priority and develop a capacity building plan.
- d. Give each Ministry involved in the HIV response a gender mandate and create formal links between the current gender mainstreaming efforts across Government sectors and the HIV programme.

⁸⁸ UNFPA. (2006). UNFPA Ukraine country programme gender equality component: Annual Work Plan 2006. Kiev

⁸⁹ Ministry of Health of Ukraine. (2006). Ukraine: National report on the follow-up to the UNGASS declaration of commitment on HIV/AIDS – reporting period: January 2003 – December 2005. Kiev.

- e. Initiate Parliamentary hearings on how to address the different gender aspects of the HIV epidemic in Ukraine, including male risk-taking behaviour, vulnerability of female sexual partners of injecting drug users, and specific needs of female injecting drug users.
- f. Through the DFID-funded initiative to align the Three Ones, re-formulate the national M&E protocol and calibrate key processes in the re-engineered national health information system (i.e., collection, analysis, reporting, utilization) to assure the systematic disaggregation by sex, age and marital status of relevant data.
- g. Ensure that representatives of key affected populations, such as female sexual and drug-using partners of drug users and women drug users, sex workers, men who have sex with men and male and female prisoners, are directly involved in the formulation of the new national programme.
- h. Ensure that the new national programme, as well as any future funding applications, includes the following:
 - Expanded training of key professionals, such as police, health care workers and social workers, on gender sensitization and non-discrimination
 - Development of stand-alone programmes that address the needs of female injecting drug users, as well as guidelines on how to address their needs in existing programmes
 - Operational research on stigma/discrimination and violence/rights abuse as experienced by marginalized populations, e.g., male and female injecting drug users, men who have sex with men, HIV-positive mothers
 - Peer education programmes among the defence forces and the police that include modules on gender equality, harmful gender norms, gender-based violence and homophobia.

133. The UN system

- a. Produce policy briefs for national leaders, Parliamentarians, and Government officials, synthesizing the most critical data on the gender dimensions of the Ukraine epidemic, providing examples of innovating and promising practices from across Europe and the CIS region.
- b. Advocate for the inclusion of gender and HIV expertise with a focus on relevant gender-based vulnerabilities to HIV of men and women in the Programme Evaluation this year, and in the development of a new national programme, as well as in the formulation of applications for funding from the Global Fund to Fight AIDS, TB and Malaria.
- c. Support the National Coordinating Council in designing a capacity-building strategy to provide national leaders and organizations with a solid understanding of gender concepts and their application in HIV policy formulation and programming.
- d. Build the capacity of organizations representing men who have sex with men, women's organizations, and organisations working with men to transform harmful gender norms and address gender based violence, so that they may participate more effectively in the national effort to contain HIV.

134. Donors

- a. Coordinate and expand support for gender and HIV-related programmatic responses in the context of drug use, sex work, and men's vulnerabilities.

(For organizations contacted during the Ukraine gender and HIV assessment, see **Annex IV**)

ANNEX I: Summary of action framework developed by UNAIDS, and used to review previously conducted gender assessments, and to conduct gender assessments in Cambodia, Honduras and Ukraine

SUMMARY OF ACTION FRAMEWORK	
TO ADDRESS GENDER INEQUALITY, HARMFUL GENDER NORMS, AND RIGHTS AND NEEDS OF WOMEN, MEN, BOYS AND GIRLS IN NATIONAL RESPONSES TO HIV	
Components	Key Actions
1. Know your HIV epidemic in gender terms	
Prevention	Identify why women, men, girls and boys, including among key populations at higher risk of exposure, are becoming infected.
Treatment and related services	Identify the specific barriers to use of treatment and related services experienced by women, men, boys and girls, including among populations at higher risk of exposure.
Care and Support	Identify the specific needs of women, men, girls and boys infected and affected by HIV and the roles and needs of their caretakers.
Law and enforcement	Assess the impact of laws and law enforcement on vulnerability to HIV and on access to HIV services for women, men, girls and boys, including among populations at higher risk of exposure.
2. Ensure political and financial commitment to gender equality	
International leadership (bilateral and multilateral)	Advocate for and support with funding and technical assistance national programmes and mechanisms to address gender inequality and harmful gender norms in the context of the HIV response.
National leadership	Advocate for and support with funding programmes to address gender inequality and harmful gender norms in the HIV response.
Legal and policy framework	Revise national laws and policies and their enforcement to protect and realize the rights of women, men, boys and girls and provide an enabling environment in the HIV response
3. Address the rights and needs of women, men, girls and boys in ongoing HIV processes	
National AIDS Action Framework	Develop the National AIDS Action Framework through a consultative process that ensures that gender equality and equity are mainstreamed into it, as well as supported by specific activities addressing gender inequality and harmful gender norms.
National AIDS Authority/ Partnership Forum	Ensure that the National AIDS Authority has a broad multisectoral mandate that includes addressing gender inequality and harmful gender norms and working on a consistent basis with organized groups of women/girls and men/boys. ⁹⁰
National M&E Framework	Ensure that the National M&E Framework collects, analyses and uses data disaggregated by sex, age and marital status, and evaluates the impact of HIV programmes on women, girls, men and boys.
4. Address the rights and needs of women, men, girls and boys through specific programmes and funding	
Programmatic responses	Implement specific programmes to address gender inequality, harmful gender norms and practices that drive the epidemic.
Human resources	Implement training, technical assistance and tools to support the capacity of HIV programme implementers to address gender inequality and harmful gender norms.
Financial resources	Adequately fund activities and programmes that address the different needs of men and women and/or gender inequality.
Participatory approach	Include key civil society groups and affected individuals in the design, planning and implementation of responses to gender equality and equity in HIV programmes.

⁹⁰ Including groups of women and men living with HIV, human rights organisations, organisations working on gender inequality, groups addressing male gender norms, children's organisations, groups of sex workers, men who have sex with men, people who use drugs, prisoners, refugees, and migrants.

Annex II

Gender continuum analysis

A Continuum Analysis, as introduced originally by Geeta Rao Gupta in a plenary address at the Durban Conference in 2000, gauges the nature of a strategy or approach seeking to promote and integrate gender equality into HIV services and projects.⁹¹ The continuum extends from approaches that reinforce damaging gender stereotypes to those that empower.

The following describe key elements of the typology:

Empowering approaches seek to empower and free women and men from the impact of destructive gender and sexual norms. Examples include policies that aim to decrease the gender gap in education; improve women's access to economic resources; increase women's political participation; and protect women from violence.

Transformative approaches seek to transform gender roles and create more gender-equitable relationships. Examples include efforts that: foster constructive roles for men in sexual and reproductive health; facilitate critical examination and dialogue on gender and sexuality and its impact on health and relationships; and work with couples as a unit of intervention, for example, couples counselling in HIV testing clinics.

Gender-sensitive approaches recognize and respond to the differential needs and constraints of individuals based on their gender and sexuality. These approaches tend to accommodate rather than challenge underlying drivers of gender-related vulnerabilities (e.g., harmful notions of masculinity or femininity). Efforts illustrating this approach include programs that provide women with a female condom or a microbicide. These recognize the power disparity women face in negotiating protection. Another example might be the integration of treatment for sexually transmitted infections with family planning so women may access services without fear of social censure.

Do no harm approaches fail to address the different needs of women and men. Examples of "gender neutral" efforts include prevention messages that are not targeted to a particular sex (e.g., "Be Faithful") and treatment services that make no distinction between the needs of women and men (e.g., not recognizing that men may be reluctant to use services and may deduce HIV status or even acquire drugs through female partner).

Damaging gender stereotype approaches foster a predatory, violent, and irresponsible image of male sexuality and/or depict women as powerless victims or repositories of infection. Examples include exploiting a macho image of men to sell condoms or a poster depicting a sex worker as a skeleton, bringing death and disease to her clients.

⁹¹ See also, "Integrating Gender into HIV/AIDS Programmes, A Review Paper", WHO Health Organization, in Resource pack on Gender and HIV/AIDS, prepared for the UNAIDS Interagency Task Team on Gender and HIV/AIDS, 2005

ANNEX III

Organizations Contacted during the Cambodia Gender Assessment

Government

Kingdom of Cambodia, Ministry of Health, Communicable Disease Control
Department, Office of Principal Recipient Global Fund to Fight AIDS, TB, Malaria
Kingdom of Cambodia, Ministry of Women's Affairs
Kingdom of Cambodia, National AIDS Authority
Kingdom of Cambodia, National Centre for HIV/AIDS Dermatology and STI Control

Civil society

Cambodia Network of People Living with HIV (CPN+)
Cambodian Community of Women Living with HIV (CCW)
Reproductive Health Association of Cambodia
Family Health International
Population Services International
Gender and Development for Cambodia
HIV/AIDS Coordinating Committee (HACC)
Khmer HIV/AIDS NGO Alliance (KHANA)
Khmer Youth Association
Womyn's Agenda for Change
Women's Network for Unity

The UN system

UNAIDS Secretariat
UNDP
UNESCO
UNIFEM
UNFPA
UN Gender and HIV Working Group- Members

Donors

German Technical Cooperation (GTZ)
Department for International Development, UK (DFID)
USAID Cambodia

Focus group discussions

Women's Health Net Work - Focus Group discussion with sex workers
Men who have sex with men network - Focus Group discussion with men who have sex with men
Military and married couples
Entertainment workers - Focus group discussion with beer promoters, karaoke and massage parlour workers

ANNEX IV

Organizations Contacted during the Honduras Gender Assessment

Government

National AIDS Commission
Instituto Nacional de la Mujer
Fiscalía de la Mujer
Honduran Human Rights Commission
First Lady of Honduras
National Police
Ministry of Education

Civil society

Consejo Hondureño de la Empresa Privada
Enlace de Mujeres Negras de Honduras
Centro de Estudios de la Mujer – Honduras
Centro Derecho Mujeres
Technical Unit, Infecciones de Transmisión Sexual y el VIH/SIDA
Self Help Groups, San Pedro Sula
Media (Social Communications), San Pedro Sula
Movimiento de Mujeres de la Colonia Lopez Areallano y Aledañas
PARADIGMA
Red de Jóvenes por los Derechos Sexuales y Reproductivos
Colectivo Feminista Mujeres Universitarias
Instituto Nacional de la Juventud
Liga Juventud
Foro Nacional de SIDA
Asociación Hondureña de Planificación de la Familia

The UN system

Office of the United Nations Resident Coordinator
UNFPA
UNIFEM
United Nations Gender Theme Group
United Nations HIV/AIDS Theme Group

Donors

Global Fund to Fight AIDS, Tuberculosis and Malaria

ANNEX V

Organizations contacted during the Ukrainian gender assessment

Government

AIDS Department of the Institute of Epidemiology and Infection Diseases after L.V. Gromashevsky, AMS Ukraine
Centre of Work with Women under Kiev Administration
Committee on Healthcare of the Parliament of Ukraine
Department of Family and Gender Policy (Ministry of Ukraine for Family, Youth and Sports)
Governmental Institute of the Development of Family and Youth
Parliament of Ukraine
Ministry of Defence of Ukraine
State Department of Ukraine for Enforcement of Sentences
Ukrainian Centre for HIV/AIDS Prevention and Combating at the Ministry of Health of Ukraine

Civil society

All-Ukrainian Charitable Fund: Coalition of HIV Service Non-Governmental Organizations
All-Ukrainian Network of People Living with HIV
Centre for Social and Gender Research "New Life"
Community Centre for people living with HIV and their families
Daily Centre for HIV positive children
Information-Education Center (Women Network)
International HIV/AIDS Alliance in Ukraine
International Organisation for Migration
NGO "Club "Eney"" (injecting drug users)
Regional Informational and Remedial Center for Gays and Lesbians "Our World"
Ukrainian Greek-Catholic Church
Ukrainian Institute for Social Research
Ukrainian Orthodox Church/Anti-AIDS Projects and Programme of Fighting Against Trafficking, All-Ukrainian Charity Fund "Faith. Hope. Love."

UN system

UNAIDS Secretariat
UNDP
UNFPA
United Nations High Commissioner for Refugees
UNICEF
World Bank
World Health Organization

Donors

Canadian International Development Agency