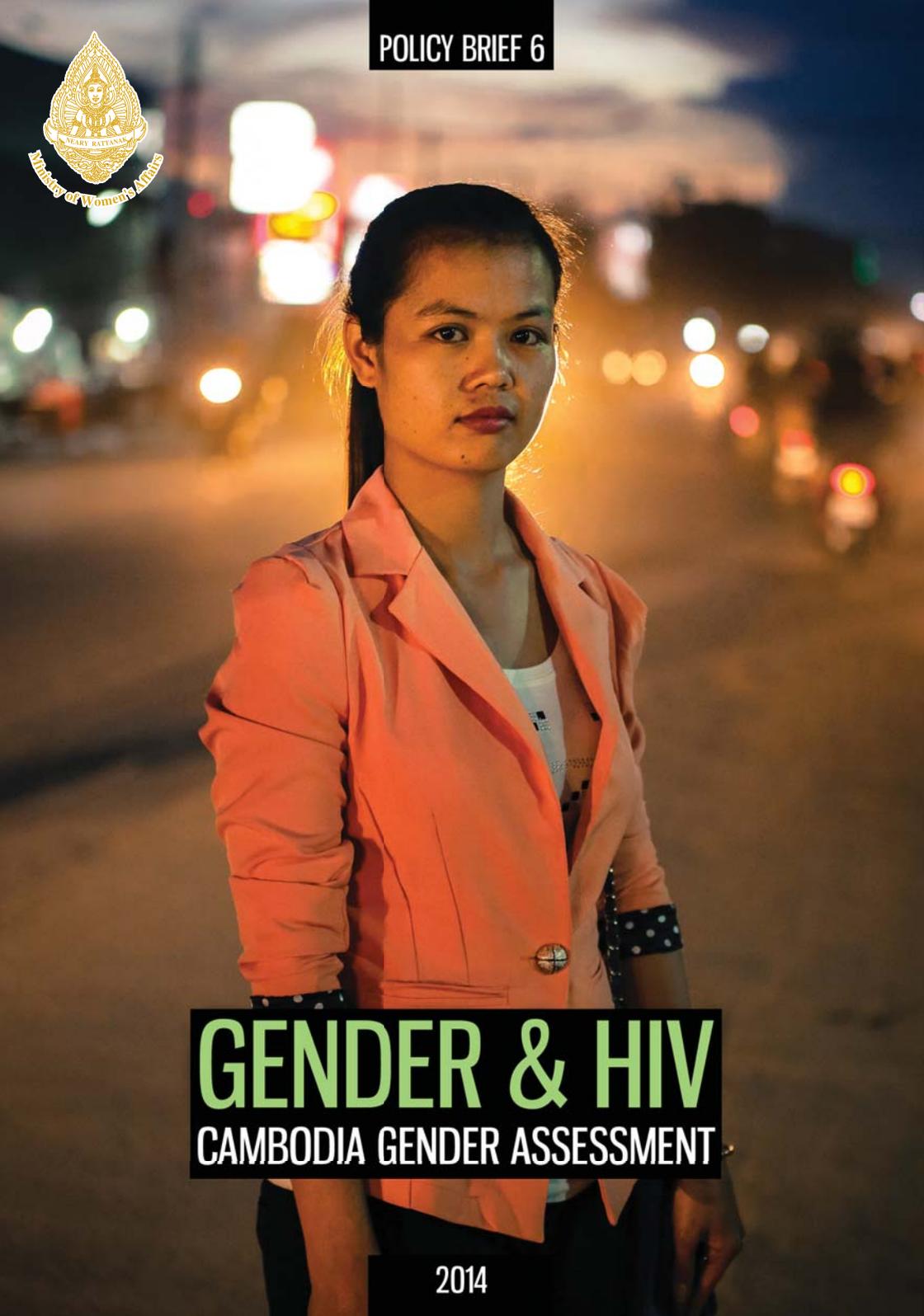




POLICY BRIEF 6



GENDER & HIV
CAMBODIA GENDER ASSESSMENT

2014

Cover photo:

Say Net, Community Health Facilitator (28) meets female workers each month to talk about HIV prevention and work place safety. She loves her job because she wants all women to have access to good health care.



6. HIV

GENDER AND HIV

POLICY CONTEXT

Article 36-42 of the Law on the Prevention and Control of HIV/AIDS (2002) prohibits all forms of discrimination against people living with HIV (PLHIV). The Law establishes the responsibility of the State to take measures to address unsafe sex and respond to the spread of HIV. The National Strategic Plan for Comprehensive and Multi-Sectoral Response to HIV/AIDS (2011-2015) established guidelines and specific activities on the prevention of HIV among high-risk groups, including drug users, and identified the need “to address the role of women in society, and gender issues”.

The Policy on Women, the Girl Child and STI/HIV/AIDS (2003) by the Ministry of Women’s Affairs (MoWA), informed by gender equality and human rights principles, places emphasis on addressing poverty, legal rights and legal protection, and on ensuring the involvement of PLHIV in the HIV response.

The Cambodia 3.0 Strategy, introduced by the Ministry of Health in 2012, has the vision of Zero new infections, Zero discrimination and Zero HIV-related deaths. National guidelines to operationalize the 3.0 Strategy include Standard Operating Procedures for Continuum of Prevention, to Care and Treatment for most-at-risk populations (MARP), HIV Testing and Counselling, Boosted Linked Response towards elimination of mother-to-child transmission, Continuum of Care for PLHIV and a Concept Note on Treatment as Prevention.

The MoWA Strategic Plan, Neary Rattanak IV (2014-2018) specifies activities to reduce HIV/AIDS under the health program, with a view to preventing further HIV infections.



The draft National Action Plan to end Violence against Women recognizes violence as a cause and consequence of HIV and identifies entry points for linking violence response services with HIV services.

▲ Testing services for HIV have been scaled up.

International Commitments

Cambodia is a signatory to the Declaration of Political Commitment on HIV/AIDS made at the 2011 Special Session of the UN General Assembly. This Declaration established ten Universal Access Targets, against which member states have committed to report on a biennial basis starting from 2014. Target 7 is that of eliminating gender inequalities, gender-based abuse and violence, and empowering women and girls to protect themselves from HIV. Cambodia has established one indicator to track progress towards this target, measuring the proportion of women who have experienced physical or sexual violence from a male intimate partner.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was ratified by Cambodia in 1992, includes provisions for the protection of women living with HIV from



discrimination, including in health care settings. In October 2013, the Royal Government of Cambodia (RGC) presented its combined fourth and fifth periodic report, in response to which the CEDAW Committee recommended that the Government “Provide free antiretroviral treatment for women and men living with HIV/AIDS, including women engaged in prostitution and pregnant women, in order to prevent MTCT” and “Combat all forms of discrimination against pregnant women living with HIV/AIDS”.

FINDINGS

HIV prevalence has declined significantly

- Prevalence among people aged 15-49 has decreased significantly, from 1.7 percent in 1998 to an estimated 0.7 percent in 2014, according to the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) report on Estimations and Projections of HIV/AIDS in Cambodia 2010-2015.
- The decline in HIV prevalence is attributed to: a decline in new infections, through targeted prevention efforts, particularly among groups at high risk of HIV infection; increased coverage of HIV testing and antiretroviral therapy (ART); and improved service delivery and links with line ministries and relevant key stakeholders.
- Cambodia has achieved its universal access target for treatment of women and men, girls and boys. Reflecting this achievement, AIDS deaths are estimated to have declined from 6,657 deaths (2,888 females) in 2004 to 2,229 deaths (1,151 females) in 2013.
- While HIV has declined significantly and Cambodia no longer has a generalized epidemic, pockets of high prevalence continue to exist among high-risk groups and Cambodia has the second highest prevalence of HIV in Asia.
- The highest rates of HIV have been reported among female entertainment workers who sell sex (13.9 percent)¹; injecting drug users (24.8 percent)² and men who have sex with men (2.14 percent)³.

¹ Ministry of Health/National Centre for HIV/AIDS, Dermatology and STIs, (2012). HIV Sentinel Surveys 2010. Report: Estimations and Projections of HIV/AIDS in Cambodia 2010-2015. Phnom Penh: Ministry of Health.

² Chhorvann, C. (2012) *People Who Use Drug Study 2012: National Population Size Estimation & HIV Prevalence and HIV Related Risk Behaviors*. Presentation at Advisory Consultative Meeting 05 March 2013. Phnom Penh; National AIDS Authority (2014) *Cambodia Country Progress Report 2014: Monitoring the Progress towards the Implementation of the Declaration of Commitment on HIV and AIDS*. (Draft prepared and submitted 05 April 2014). Phnom Penh.

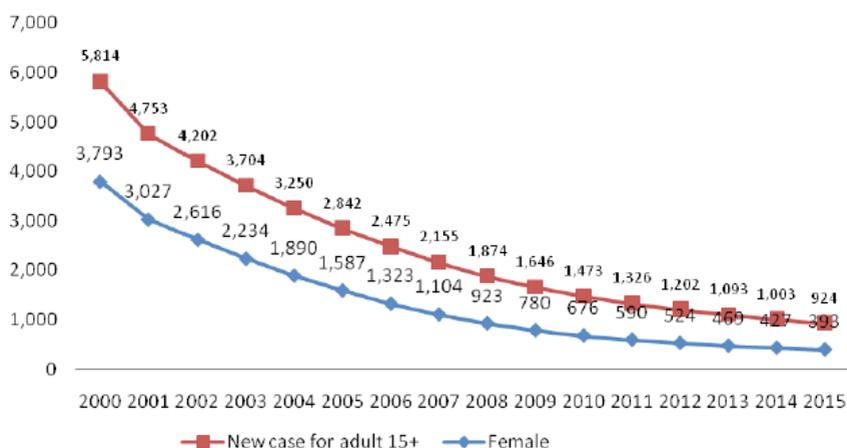
³ Liu, K. L. & Chhorvann, C. (2010). *Bros Khmer: Behavioral Risks On-site Serosurvey among At-risk Urban Men in Cambodia*. Phnom Penh: FHI 360 & National Centre for HIV/AIDS, Dermatology and STIs.

- Consistent with an overall reduction in HIV prevalence in-country, the prevalence rate among pregnant women has declined remarkably. According to the 2013 Annual Report of NCHADS, through Link-Response HIV prevalence among pregnant women is 0.1 percent, down from 0.7 percent in 2007.

Heterosexual sex is the main mode of HIV transmission; high-risk behaviours place people at risk of HIV infection

- The main mode of HIV transmission has remained the same throughout the history of the epidemic in Cambodia, namely, heterosexual sex.
- New incidents of HIV are driven by multiple and often overlapping risk behaviours, including unprotected paid sex, unprotected sex between men, and sharing contaminated injecting equipment.
- A significant proportion of new infections occur among low-risk women and men sexually linked to high-risk groups.
- Vertical transmission from mother to child has significantly decreased in recent years, and was estimated by NCHADS at 111 incidents out of a total of 1,210 incidents in 2013.

Figure 1: Number of individuals and females infected with HIV aged 15+, 2000 – 2015

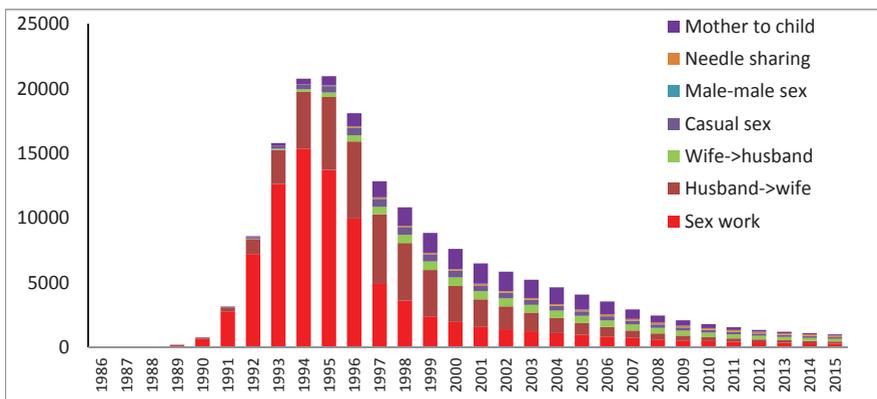


Source: NCHADS (2011) *Estimations and Projections of HIV/AIDS in Cambodia 2010-2015*

Women comprise more than half of all adults living with HIV

- The proportion of women among all adults living with HIV has increased from 38 percent in 1997 to 53 percent in 2014. This is significantly higher than the regional average of 32-35 percent⁴ and stems from women's greater biological susceptibility to infection, and their subordinate status and relative lack of power to negotiate safer sex.
- More than half (55 percent) of the cumulative HIV infection cases in Cambodia are among women. Until 2007, the percentage of women infected surpassed that of men. This trend shows signs of slowly changing. In 2014, the proportion of women infected was estimated to have decreased to 43 percent.
- Among the general population, HIV prevalence is highest among men aged 30-39 years and among women aged 25-29 years, with figures slightly higher for married women in this age group.
- Women with higher levels of education are less likely to contract HIV, while the reverse is true of men. The 2010 Cambodia Demographic and Health Survey (CDHS) revealed that risky sexual behaviour among men increased with younger age, higher education and higher income.

Figure 2: Major modes of HIV transmission in Cambodia



Source: NCHADS (2011) *Estimations and Projections of HIV/AIDS in Cambodia 2010-2015*

⁴ UNAIDS, (2013). *HIV in Asia and the Pacific*. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/2013_HIV-Asia-Pacific_en.pdf



Gender inequalities drive the HIV epidemic

▲ Young people need a range of services.

Expectations and behaviours related to gender contribute to HIV infections

- Cultural ideals and norms underscore the importance of female marital fidelity and sexual morality among women and girls, as well as attributes such as sexual innocence and submissiveness. Men are seen as having stronger sexual urges and needs than women, and sexual experience is perceived to be important in determining masculinity. These ideals and norms, together with women's overall inferior status to men, challenge women's ability to negotiate the terms of sexual activity, including condom use.
- Risky sexual behaviours are sometimes perceived as part of male identity and male bonding, increasing men's sense of masculinity. Peer pressure and social drinking play a role in risky sexual behaviours among men.

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- Risky sexual behaviours contribute to infections among men, who are more likely than women to report multiple sex partners, less likely to access health services, and have less access to sexual and reproductive health (SRH) knowledge than women.
 - Paid sex is relatively common among men; according to the CDHS 2010, more than one in ten men (11percent) aged 15-49 paid for sex in the year leading up to the survey, and 1.6 percent of men engaged in multiple sexual partnerships in the year leading up to the survey. A recent study on men frequenting entertainment venues in urban areas found an HIV prevalence of 1.6 percent among male clients of female sex workers.
 - Overall, women have limited power to negotiate safe sex and condom use in the contexts of paid sex (due to fear of violence and financial motivation) or sweetheart relationships and marriage (due to associating condom-free relationships with trust and intimacy).
 - Gender-based violence continues to place certain groups of women and girls at increased risk of physical or sexual violence and rape – and thereby HIV infection – due to their occupation (commercial sex).

Women and girls are differently affected by the HIV epidemic

- The 2010 Socio-economic Impact Study revealed that women and girls bear a disproportionate part of the epidemic's impact as caregivers and surviving spouses:
 - Care takers of family members living with HIV are forced to leave their jobs to assume care-giving responsibilities (15 percent in urban areas, 22 percent in rural areas); 55 percent of caregivers are female.
 - Women living with HIV (WLHIV) are more likely to be widowed and less likely to be married than men living with HIV; they are also more likely to be unemployed than men living with HIV.
 - In rural communities, widows in HIV-affected households are less likely to have inherited their late husband's assets (86 percent versus 96 percent of widows in rural non-affected households).
 - Ten percent of girls in HIV-affected households are employed, compared to 5.5 percent of girls in non-affected households; this has a negative impact on their school attendance.

- A study conducted by the Cambodian People Living with HIV Network (CPN+) in 2010 revealed higher levels of no education among HIV-positive women than men (31.8 percent versus 10.5 percent); and higher levels of verbal abuse, physical harassment and self-stigma among HIV-positive women than HIV-positive men, with 89 percent of all physical assaults on WLHIV reported to have been perpetrated by those living in the same household.
- Unintended pregnancies are high among WLHIV and female entertainment workers. In a 2012 regional study conducted in six countries, Cambodian WLHIV pregnant in the past 18 months (no=200) reported that 11.5 percent of their pregnancies had resulted in abortion⁵. Similarly, abortion rates are particularly high among female entertainment workers, with studies indicating around one third as having had abortions⁶.
- Lack of financial resources, fear of disclosure and negative attitudes among service providers who are not specialized in HIV present challenges to WLHIV accessing services and accurate information on family planning and paediatric care⁷.
- WLHIV face gender-related constraints in determining whether or not to have children. The majority of WLHIV rely on condoms as contraception, but men exercise more control over condom use than women. A study conducted in 2011 among 200 WLHIV pregnant in the past 18 months found that two-thirds of the participants reported that their partners made decisions regarding condom use; 50 percent reported that they made decisions regarding pregnancy together with their husband or partner; and 43.5 percent reported that their most recent pregnancy was unwanted⁸. The Behavioral Surveillance Survey (BSS) 2013 revealed that HIV-positive men were more likely than HIV-positive women to report not using a condom because they wanted to have a baby (30.1 percent vs. 26.5 percent).

⁵ Women of the Asia Pacific Network of People Living with HIV (2012). *Positive and Pregnant: How dare you, A study on access to reproductive and maternal health services for women living with HIV in Asia*, Bangkok: APN+.

⁶ See National Centre for HIV/AIDS, Dermatology and STIs, (2013). *2011 Cambodia STI Survey: Female Entertainment Workers. Presented 22 March 2013*. Available at: <http://www.nchads.org/index.php?id=16&lang=en>; Also see Morineau, G., Neilsen, G., Heng, S., et al. (2011). Falling through the cracks: Contraceptive needs of female sex workers in Cambodia and Laos. *Contraception* (84), pp. 194-198; Ministry of Education, Youth and Sport, (2012). *Examining life experiences and HIV risks of young entertainment workers in four Cambodian cities. November 2012*. Phnom Penh: Ministry of Education, Youth and Sport.

⁷ Women of the Asia Pacific Network of People Living with HIV (2012). *Positive and Pregnant: How dare you, A study on access to reproductive and maternal health services for women living with HIV in Asia*, Bangkok: APN+; Cambodian People Living With HIV Network (2010). *People living with HIV Stigma Index. HIV-related stigma & discrimination in Cambodia: Summary of recent findings*.

⁸ Women of the Asia Pacific Network of People Living with HIV (2012). *Positive and Pregnant: How dare you, A study on access to reproductive and maternal health services for women living with HIV in Asia*, Bangkok: APN+.



Some groups of women are more vulnerable to HIV infection

High-risk entertainment workers

- Domestic violence and anti-trafficking legislation has sought to penalize perpetrators of violence and criminalize sexual exploitation of women, but significant challenges remain. Following the official ‘closure’ of brothels, sex work has moved further underground, making it difficult to identify and reach vulnerable women. Many women who sell sex now operate out of entertainment establishments.
- The HIV Sentinel Surveillance (HSS) 2010 found that roughly one in ten entertainment workers sell sex to more than 14 clients per week. High rates of HIV have been documented among this group (13.9 percent), as well as among ‘low-risk’ entertainment workers with 14 or fewer clients per week (4.1 percent).
- Entertainment workers face many risks which increase their vulnerability to HIV exposure. These include sexual harassment and violence in the work place; high levels of alcohol use associated with the duty to encourage clients to buy alcohol; substance abuse; and coercion to sell sex.
- The sexual relationships that entertainment workers establish with men may include sex with husbands, sweethearts or boyfriends, clients and supporters. The nature of their relationship impacts their likelihood of using condoms consistently with their sexual partner. While condom use among entertainment workers with paid customers continues to be quite high, at 80.6 percent, use of condoms is low with non-paying sexual partners, including spouses (16.5 percent) and sweethearts (36.1 percent).

Women who use and/or inject drugs and women in prison

- Most drug users in Cambodia are male, with the proportion of female drug users observed in the 2012 Integrated Biological and Behavioural Survey (IBBS) recorded at 17.8 percent. The most recent data from IBBS 2012 estimates the number of injecting drug users at 1,300, with an HIV prevalence of 24.8 percent among this group. While only a small population, women who inject drugs have the highest chance of HIV infection of all groups of women in Cambodia.
- Awareness of HIV is high among drug users, yet condom use is low, particularly among injecting drug users (24.1 percent with regular partners



and 64.4 percent with non-regular partners). Risky behaviours exhibited by injecting drug users include sharing needles (36.7 percent) and injecting drugs that have been dissolved in someone else's blood (31.9 percent)⁹.

▲ Health facilities are providing pregnant women with HIV testing.

- Globally, women in prison are more likely than men to be victims of sexual violence before and during imprisonment, and women in prison are more likely to be HIV-positive due to their previous occupations¹⁰. Females comprise roughly 8 percent of the total prison population in Cambodia, with the majority of offences (62 percent) being drug related. In 2009, HIV prevalence rates ranged from 0.5 percent to 7 percent among detainees.

⁹ Chhorvann, C. (2012) *People Who Use Drug Study 2012: National Population Size Estimation & HIV Prevalence and HIV Related Risk Behaviors*. Presentation at Advisory Consultative Meeting 05 March 2013. Phnom Penh.

¹⁰ UNODC, (2009). *Women and HIV in Prison Settings*. Available at: http://www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf



Increased vulnerability to HIV exposure among transgender women and gay and bisexual men

- Roughly 29 percent of men who have sex with men are estimated to be at high risk of HIV infection, from unprotected sex, drug use, multiple sexual relationships and social stigma. Ostracism by family and community members increases their economic vulnerability, hindering their access to health services and influencing their decision to enter sex work, all of which contribute to their risk of HIV exposure.
- Data from the 2010 Bros Khmer Study conducted among high-risk men indicated HIV prevalence at 2.2 percent for men who have sex with both men and women, and 2.1 percent for men who have sex with men only. Men who have sex with both men and women were more likely to buy sex (29 percent vs. 23 percent), sell sex (43.8 percent vs. 36.4 percent), ever use drugs (42.4 percent vs. 19.6 percent) and report STI symptoms (51.5 percent vs. 36.6 percent) than men who have sex only with men. They were also less likely to use condoms consistently (62.0 percent vs. 68.8 percent).

Young people, male and female, continue to be exposed to HIV risks

- Young people comprise a large proportion of the population of Cambodia, as well as groups most at risk of HIV infection.
- Lack of comprehensive knowledge on HIV, risky sexual behaviours, alcohol and drug use, as well as gender-based violence, increases HIV risk in young people.
- Comprehensive knowledge of HIV among youth is low. The results of the CDHS 2010 indicate a slight decrease in young people's (15-19 years) knowledge on HIV, with only 45.1 percent able to answer all five questions on HIV transmission correctly, compared to 47.1 percent in the CDHS 2005.
- Gaps exist in access to prevention information and access to essential services among young people at high risk of HIV infection. A 2010 Ministry of Education, Youth and Sport (MoEYS) survey among most-at-risk young people aged 10-24 years revealed that 39 percent of the females surveyed had never received HIV/AIDS information. Only 42.9 percent of females and 29.1 percent of males who reported any STI symptoms had sought treatment in the past year. Almost 12 percent of females reported pregnancies in the past year, and 33.19 percent had induced abortions, with a higher rate (44.28 percent) reported among younger women (aged 10-19).

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- As demonstrated by the same study, risky behaviours among young people overlap, with 18 percent of females versus 2.3 percent of males rating themselves as drinking a lot, and drug or alcohol use being more common among those who reported ‘ever having sex’.
 - The CDHS 2005 found that HIV prevalence among women aged 15-24 is three times higher than among men in the same age group.

Access to HIV and other essential services has improved significantly, but needs to be strengthened and expanded

- Counselling and testing services have been scaled up significantly. In 2010, the percentage of females and males tested for HIV in Cambodia was 8 percent and 6 percent respectively.
- Cambodia has universal access to antiretroviral therapy (ART) treatment, and treatment coverage is high, at 89.5 percent of the total eligible population. Treatment retention is also good, with recent data recording treatment adherence at 84.2 percent and 78 percent at 24 and 60 months respectively after ART initiation.
- In 2011, 921 (92 percent) out of 997 health facilities were providing pregnant women with both antenatal care services and HIV testing and counselling. About 78 percent of pregnant women knew their HIV status in 2012, an increase from 63 percent in 2010. The percentage of pregnant women attending antenatal care whose male partner was tested during the last 12 months has also increased, standing at 17 percent in 2012.

Institutional gaps and barriers

- Coverage of antiretroviral therapy for HIV-positive pregnant women has significantly improved through the introduction of the Linked Response. However, critical gaps exist in the uptake of prevention of mother-to-child transmission (PMTCT) services, with only roughly one-third of HIV-positive women receiving the full package of interventions.
- WLHIV, female entertainment workers and young females at high risk of HIV exposure have unmet needs for counselling on sexual health and contraception.
- Rural women and girls are less likely than their urban counterparts to have access to information on HIV and SRH issues, while user fees and



transportation costs present a barrier to access to key HIV and SRH health services.

- HIV and SRH services for transgender women, men who have sex with men and young people most at risk of HIV infection are not being systematically linked to HIV and harm reduction, violence response and other services.
- As identified by a 2013 report released by the National AIDS Authority (NAA) and the UN, PLHIV and key affected populations face specific challenges in relation to social protection. PLHIV do not automatically qualify for existing social protection schemes such as the IDPoor program. Existing schemes do not cover services highly relevant to HIV-positive women, such as pap smears for cervical cancer, and while most-at-risk populations (MARPs) are concentrated in urban areas, the IDPoor program focuses on rural areas. Further, as IDPoor is based on proxy indicators of a household's poverty, this may exclude key affected populations who have been ostracized by their family.

Legal and policy gaps and barriers

- There is a lack of national clinical and policy guidelines responding to intimate partner violence and sexual violence, including provision of free post-exposure prophylaxis in cases of sexual assault, relevant especially to female MARPs. There is also a lack of legal aid and legal assistance services for PLHIV and MARPs.
- HIV testing among young people under 18 is contingent on parental consent, which may restrict access among particularly high-risk young people and young migrants.
- There are no policies or laws prohibiting the sale of alcohol to under-age young people in Cambodia.

POLICY RECOMMENDATIONS

Strengthen strategies that promote the empowerment of women through increased access to information and services

- Update and review the Policy on Women, the Girl Child and STI/HIV/AIDS 2013 of MoWA, to reflect the change in HIV transmission and policy environment.

MoWA
- Continue to promote programs that aim to increase women’s awareness of their sexual and reproductive health and rights, through multi-channel mass media campaigns incorporating messages on: women’s health issues; HIV prevention, care and support; and women’s right to make decisions regarding pregnancy and sexuality.

MoWA, MoH, MoIn
- Strengthen the implementation of national guidelines for the prevention of mother-to-child transmission.

NCHADS, NMCHC, CSOs involved in service delivery
- Strengthen the meaningful involvement of WLHIV and key affected women and girls in the HIV response, including through participation in decision-making at different levels of the response.

MoWA, NAA, PLHIV networks, CSOs
- Expand access to legal empowerment initiatives for WLHIV and MARPs, including legal literacy programs and access to legal aid.

PLHIV networks, CSOs

Ensure an effective response to harmful gender norms and practices that increase vulnerability to HIV infection

- Support and monitor behaviour-change programs for men and boys, promoting messages on equality and respect between men and women, and responsible sexual behaviours.

MoWA, MoH, CSOs

| | |
|---|---|
| <ul style="list-style-type: none"> Strengthen implementation and monitoring of the national Comprehensive HIV and Sexuality Education Curriculum in all parts of the country, prioritizing rural areas. | MoEYS |
| <p><i>Expand and strengthen access to essential HIV and SRH services among WLHIV and vulnerable groups of women and girls</i></p> | |
| <ul style="list-style-type: none"> Address barriers of transport costs that undermine the ability of rural women and girls to access SRH, maternal and child health (MCH) and antenatal care services. | CARD |
| <ul style="list-style-type: none"> Continue to strengthen the Linked Response, identifying strategies and critical gaps in uptake of services by HIV-positive pregnant women. | NMCHC |
| <ul style="list-style-type: none"> Strengthen the referral system from HIV-related services to other services including pain killing, family planning, response to violence and other social services. | NCHADs, CSOs involved in service delivery |
| <ul style="list-style-type: none"> Expand and strengthen access to youth-friendly voluntary confidential counselling and HIV testing (VCCT) and SRH services, with particular emphasis on reaching young people in vulnerable circumstances and at highest risk of HIV infection, as well as young people living with HIV. | MoH, NCHADs, CSOs |
| <ul style="list-style-type: none"> Develop and strengthen coordinated approaches to address the needs of most-at-risk young people, as well as transgender women, ensuring these are linked to key services such as violence response and harm-reduction services. | MoEYS, MoH, NACD, CSOs |
| <ul style="list-style-type: none"> Continue to expand initiatives with entertainment venues that aim to strengthen access to services for entertainment workers, building on successful approaches such as the SMART girl program and the <i>Police Community Partnership Initiative</i> (PCPI). | Mol, CSOs |
| <ul style="list-style-type: none"> Expand access to harm-reduction services and condoms to prison inmates and people in detention centres. | Mol |



Strengthen capacity of key actors to provide gender-responsive, rights-based services

- | | |
|---|------------------------------------|
| <ul style="list-style-type: none">• Raise awareness of opportunistic infection (OI)/ART nurse counsellors and clinicians, home-based care teams and PLHIV volunteers working with Mondol Mith Chuoy Mith (MMM) groups on the sexual and reproductive health and rights of WLHIV. | MoH/NCHADS, NMCHC, CPN+/DPN+, CSOs |
| <ul style="list-style-type: none">• Strengthen the capacity of healthcare workers to implement national clinical and policy guidelines for responding to intimate partner violence and sexual violence in the context of Cambodia's 3.0 Strategy. | MoH/NCHADS |
| <ul style="list-style-type: none">• Strengthen the capacity of commune committees for women and children (CCWC) to engage in the coordination of violence response and support services, including making referrals to VCCT. | MoI/NCDD, MoWA |
| <ul style="list-style-type: none">• Continue to strengthen the understanding of the Law on the Prevention and Control of HIV/AIDS among the judiciary, police and health service providers through training and information dissemination. | MoJ, MoI, MoH |
| <ul style="list-style-type: none">• Strengthen understanding of police on the Explanatory Notes on the Law on the Suppression of Human Trafficking and Sexual Exploitation, HIV/AIDS and Drug Abuse Harm Reduction Program and on the health needs and rights of HIV-positive women and men, including high-risk groups in police custody, to facilitate access to antiretrovirals. | MoI |



Strengthen the integration of HIV into broader programs, policies, official guidelines and budgets.

- Develop a component on gender equality, gender-based violence and HIV for inclusion in the 4th National Strategic Plan for Comprehensive and Multi-Sectoral Response to HIV/AIDS that is consistent with the National Action Plan to Prevent Violence against Women (NAPVAW II) and the Gender Assessment of the HIV Response (2013). NAA, MoWA, NCGHA
- Ensure national clinical and policy guidelines that respond to intimate partner violence and sexual violence are developed, including protocols for post-exposure prophylaxis (PEP) and emergency contraception. Include provisions to ensure that access to PEP and emergency contraception is free for all survivors of violence. MoH, NAA, MoWA
- Ensure women and men living with HIV and their families are covered by social protection schemes such as the Health Equity Fund. CARD
- Mainstream HIV and AIDS into the Women’s Economic Empowerment Strategic Plan currently under development. MoWA

Research, monitoring and evaluation

- Conduct research on the interconnections between sexual and physical violence and HIV/AIDS to inform the development of effective prevention and response strategies. Include in this research questions related to HIV transmission and access to essential services, including VCCT. NAA, MoWA, CSOs
- Promote research on the gender-specific vulnerabilities of women at higher risk of HIV infection (entertainment workers, and transgender sex workers, women who use or inject drugs, women in prisons and correctional centres). NAA, NCHADS, NACD



| | |
|--|-------------|
| <ul style="list-style-type: none">• Conduct research on male health seeking behaviours in the context of HIV, including factors influencing male uptake of VCCT, HIV and SRH services, and male involvement in family planning. | MoH, CSOs |
| <ul style="list-style-type: none">• Conduct research to increase understanding of effective approaches to mitigating the impact of HIV on WLHIV and key groups of women affected by HIV, including through social protection schemes. | MoSVY |
| <ul style="list-style-type: none">• Strengthen gender analysis in the context of routine monitoring and evaluation of HIV-related services and existing periodic surveys, ensuring data is consistently presented as gender-disaggregated. | NAA, NCHADS |
| <ul style="list-style-type: none">• Strengthen monitoring and evaluation on the progress of addressing harmful gender norms and behaviours in the context of the HIV response, ensuring relevant indicators are developed to track changes at the outcome and output levels. | NAA, MoWA |

| KEY INDICATORS AND TARGETS (GENDER AND HIV/AIDS) | | | | |
|--|------------|-----------|----------------|---|
| Indicator | Value | Year | 2015 Target | Achievements |
| Reduce the vulnerability of women to HIV/AIDS | | | | |
| HIV prevalence rate among adults aged 15-49 (ŸS★) | 1.0% | 2005 | <0.6%* | 0.7 (2014)‡ |
| HIV prevalence rate among pregnant women aged 15-24 visiting ANC (Ÿ) | 1.1% | 2006 HSS | n/a | 0.4% (2011)‡ |
| Condom use reported by married women who identified themselves at risk (Ÿ) | 1%Ÿ | 2000Ÿ | 10%Ÿ | 2.9% (CDHS, 2005) |
| Percentage of ever married women aged 15+ who have experienced physical or sexual violence★ | 13% & 3% | 2005 CDHS | n/a | - |
| Other indicators | | | | |
| HIV-infected pregnant women attending ANC who received antiretroviral prophylaxis to reduce the risk of MTCT (Ÿ★S) | 32.3%S | 2009 | 75%S | 65.1% (NMCHC, 2012) |
| Condom use rate among commercial sex workers during last commercial sexual intercourse (ŸS★) - EWs with 2 or less sexual clients (per day) - EWs with more than 2 sexual clients (per day)* - EWs (all) | 99% 94% | 2007 | - - 99%S | 94.8% (2010) 97.7% (2010) 94.3% (BSS, 2013) |
| Condom use at last sex by young people (15-24) (ŸS) | 82%Ÿ | 2002Ÿ | 90%S | 88% (CDHS, 2005; data on young men only) |
| NSDP indicators and targets (2009-2015)* CMDG indicators and targets(Ÿ) Revised Universal Access indicators and targets (2011)★ NSP III SINCHADS 2011. Report on Projections for HIV-AIDS in Cambodia (2010-2015, 2009-2015)‡ | | | | |



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