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HEALTHY OPTIONS PROJECT SKOPJE

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- Executive Summary -

Assessment of gender related issues and their connection to the risk of HIV/AIDS

and the barriers conditioning the equal access to adequate HIV/AIDS prevention and treatment services

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Content

- Introduction ... 07
- 1. Initial gudielines of the methodology and the assessment approach ... 09
- 2. Summary findings ... 11
- 2.1. Absence of appropriate methodological approaches and practice of systematic collection of gender-relevant strategic information ... 11
- 2.1.2 Gender vulnerability to HIV transmission among high risk groups ... 14

  Drug injecting persons ... 14

  Sex workers ... 16

  People living with HIV/AIDS ... 18
- 2.2 Absence of gender perspective in current policies/ programs ... 20
- 2.3 Insufficient gender inclusion in service for prevention and protection from HIV: overcoming barriers ... 22
- Recommendations ... 27
- Bibliography ... 29

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Introduction

This text is an executive summary of the assessment of the need for adequate inclusion of the gender perspective in the National HIV/AIDS response of R. Macedonia.[1] Starting from the initial evaluation that gender aspects are not sufficiently present in the National response[2] and that the gender dimension should become its integral part, the purpose of this study is to present and demonstrate the main premises of a gender-integrating approach to HIV/AIDS.

From the perspective of the expertise present in the study, classical approaches[3] of risk assessments and vulnerability to HIV are inappropriate for the treatment and understanding of the topic of gender vulnerability and HIV/AIDS. To understand the influence of gender and gender relations on HIV transmission, structural characteristics shaping and determining that influence should be taken into consideration, of social, economic and political nature, including analytical categories that surpass the individual approach of a behaviorist analysis.

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1 The syntagm „gender perspective" is used as a synonym for Gender Mainstreaming, the basis of which was taken to be the definition in the Economic and Social Council of the General Assembly (ECOSOC) 97: „The process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality". E.1997.L.O. Para.4. Adopted by ECOSOC 17/7/97.

2 UNDP, Request for Proposal (RFP 08/2011) Assessment of gender related vulnerabilities for HIV transmission and barriers for unequal utilization for HIV services.

3 **The distinction risk/vulnerability** is usually represented as follows: **the risk of HIV** is defined as the **probability** that the person may acquire HIV infection, and certain behavior may create, increase or perpetuate risk: unprotected sex with a partner, whose HIV status is unknown; multiple sexual partnerships involving unprotected sex; injecting drugs with contaminated needles and syringes (UNAIDS; 2008, 67). **Vulnerability** is represented as the **an outcome resulting from a multitude of factors decreasing the ability of individuals and communities to avoid the risk of HIV infection**: personal factors, such as lack of knowledge and skills required to protect oneself or others; factors related to the service quality and coverage, such as inaccessibility of services due to distance; costs and other factors; societal factors, such as human rights violations, social and cultural norms, such as practices, beliefs and laws stigmatizing and discriminating against certain populations, thereby acting as barriers of essential significance to HIV/AIDS prevention, treatment and care. These factors, alone or combined, may create or exasperate individual or collective vulnerability to HIV (UNAIDS; 2008, 67).

What is considered HIV/AIDS vulnerability from the standard social point of view, represents only an aspect of the same process from the gender perspective in this study, if we take the stance according to which **gender relations are constituted from a social process, which also affects social and biological characteristics of people, creating women/men identities set in mutually submissive and superior positions**. Put in legal terms, this would mean that discrimination, the potential for social, political and economic inequality is already contained in the categories women/men. From this perspective, HIV vulnerability of women and men are all those factors that constitute their identity as women and men in a given context, and the influence of these factors is such that they imply their exposure to HIV transmission. So, the nature of HIV vulnerability is such that its factors should not be understood solely as agents that increase/decrease HIV susceptibility through the risky behavior of individuals, but which directly influence the appearance of HIV exposure.

Hence, this study arguments the need to introduce this premise as a principle not only used in future investigations, the devising of policies and measures, but also in the structure and processes of the organization of state institutions and organizations from the civil sector operating in the field of HIV/AIDS.
Оттука, студијата ја аргументира потребата од воведување на оваа премиса како принцип не само во идни истражувања, креирање мерки и политики, туку и во структурата и процесите на организација на државните институции и организации од цивилниот сектор што дејствуваат на полето на ХИВ/СИДА.

1. Initial guidelines of the methodology and the assessment approach

In order to represent the connection of gender relations with different aspects of HIV/AIDS, to receive the needed strategic information about this connection and to transport these into national policies and programs, an analysis and assessment was performed of the gender relations as a catalyst of HIV transitivity and analysis of the national response to the HIV/AIDS epidemics.

The key research questions at the basis of this assessment are the following: What are the general and basic aspects between gender relations and HIV/AIDS vulnerability? How and to what extent does the condition of gender equality at a national level represent a factor for HIV/AIDS exposure and vulnerability? What are the gender relations within the groups assessed with HIV/AIDS risky behavior? Is the gender perspective integrated in the HIV/AIDS national response (politically and operationally)? Are there gender barriers in the accessibility and treatment of persons who are potential /current users of HIV/AIDS related services?

The assessment was performed by a combined use of analytical and empirical approaches and methodologies. Its structure is comprised of three parts. Two of them are analytical in their approach and consider the **gender based HIV/AIDS vulnerability** and **the existing HIV/AIDS national response** (policies, programs, measures), viewed from the gender perspective, and the third, empirical part of the assessment refers to the **identification of possible gender-based barriers in the approach and use of services offering care for HIV/AIDS prevention and treatment**. Although this part also contains an analysis and interpretation, it has an empirical status because it is grounded in research methods and techniques[1] which are empirical in their nature.

1 In the period from July to September 2011, field research was carried out, covering 83 interviewees from 6 target groups: (1) persons being treated for dependence on opiates. Subgroups: persons taking substitutional therapy with methadone at the Centre for prevention and treatment of misuse and addiction to drugs and other psychoactive substances, Public health organization Psychiatric Hospital – Skopje; Persons treated for addiction without the use of substitution therapy (popularly called „dry detoxification") at the Centre for prevention and treatment of misuse and addiction to drugs and other psychoactive substances Public health organization Psychiatric Hospital – Skopje; Persons taking substitution therapy with buprenorphine at the Public health organization – University Toxicology Clinic; (2) Persons injecting drugs, users of the Drug use harm reduction programs offered by HOPS – Healthy Options Project Skopje; (3) Sex workers, users of the sex workers' support program offered by HOPS – Healthy Options Project Skopje. Subgroups: Female sex workers; male sex workers offering sex services to men; transgender sex workers (men who have stated that they fell and act like women); persons living with HIV/AIDS (patients of the Public health organization – Clinic for infective diseases and febrile conditions – Skopje and members of the working group for support and self-help of persons with HIV – „Stronger together"); (4) Users of youth centers „I want to know" of H.E.R.A. – Association for health education and research. (5) Employees and activities in the offices for prevention and treatment of HIV/AIDS and representatives of organizations for marginalized communities human rights protection.

2. Summary findings

2.1. Absence of appropriate methodological approaches and practice of systematic collection of gender-relevant strategic information

The effectiveness and sustainability of the HIV/AIDS response depends to a large measure on its groundedness in quantitative and qualitative gender-sensitive data and analysis. Analytical information about trends from the aspect of the position/condition of men and women, gender relations, as well as factors affecting the risks and vulnerability of men and women in the context of HIV/AIDS in RM represent the basis for planning of key activities and evaluation of their influence on gender. Legal, social and economic inequality, gender roles and relations conditioned by different cultural contexts have significant influence on the ability of individuals and the community to protect and cope with the influence from HIV/AIDS.

The multiple analyses and studies carried out in the context of HIV in Macedonia are directed towards the identification and description of risky behaviors and the differences in the behavior of men and women, but do not provide an explanation why these differences exist and where they come from. These analyses prove rare or no consideration at all to the **structural aspects of gender vulnerability to HIV-transmission**.

Analysis of gender and gender relations should take into consideration the system of gender norms and psychological, social and political mechanisms of the power distribution processes. Those are the contexts in which the categories of „woman/women" and „man/men" are being „produced", replicating the biological and physiological difference/dichotomy into a difference/dichotomy in the social sphere. The construction of these categories via the power distribution processes works in such a way that biological, behavioral and social features and characteristics are being correlated, but only if they, as a whole, have a certain superior or subordinate position regarding another group of correlated relations. The treatment of transgender persons as „deviant" from the norm man/woman is a characteristic example of the problematic representation of these categories as objective and real socio-biological categories. The information from the field research indicates the influence of gender norms on self-identification, behavior and social relations between people.

Most of the surveyed persons held gender role attitudes based on gender stereotypes which arise out of the ideal system of social values, according to which women are subordinated to men[1]. An interesting fact is that transgender men are much more attuned to the ideal model of gender role distribution and insist on adapting their behavior to idealized female traits. However, it is noticeable that the public expression of their gender affinities irritates the wider community, due to which they are subject to ridicule and violence. That is why they must hide their gender identity and present themselves publicly in the gender role congruent to their sex, while expressing their true affinities only in a limited space and among a limited number of people. In all target groups covered by this research dominant gender stereotypes were identified, causing gender discrimination against persons from the groups from which they themselves arise and towards persons from other target groups included in the research.

Researchers and policy makers in the field of HIV prevention in R. Macedonia should take into consideration the three aspects of gender categories (biological, social and the power distribution processes) as separate aspects of one and the same process. Undertaken measures targeting biological vulnerability of women, for example, must be accompanied with measures which are at the same time socially and culturally sensitive. A similar approach should be used in situations when women and men are targeted as a group. HIV vulnerability of men and women can never be estimated and an appropriate response undertaken, if no heed is taken for the processes determining their roles and positions as well as expectations in the given social context in which we perform assessment and carry out the preventive measure.

Gender socio-economic vulnerability and social exclusion are also aspects of HIV vulnerability. Professions become characteristically male or female based on differences in income, goods distribution and social consequences of such differences. The gender factor plays an exceptional role in the processes of social exclusion, since in combination with other factors it often determines the features of groups facing the risk of marginalization and social exclusion: single mothers, victims of gender-based violence, women from rural areas, women from ethnic minorities, senior women, women under long-term care, girls outside the educational process, are only part of the population susceptible to social exclusion. Groups with high risk of HIV exposure have all the characteristics of socially excluded groups, and persons pertaining to these groups tend to turn to activities and behave with high risk of HIV exposure. In fact, their double victimization, both as a group of high risk to HIV exposure and a group susceptible to social exclusion, should represent a starting point

1 Heterosexual, strong, brave men, protectors who are the bread winners and act in the public sphere and heterosexual, emphatic weak women, spenders, whose domain is the private sphere.

for a combined approach, which joining the characteristics of HIV-preventive programs, specific for the group of interest in the program and measures inherent in social inclusion programs.

2.1.2. Gender vulnerability to HIV transmission among high risk groups

Drug injecting persons (DIP)

Generally, the assessment of gender vulnerability to HIV transmission, especially among DIP in R. Macedonia, rests upon the general regional assessment, that the stigma related to drug use is added on top of the gender related discrimination. In the case with women, stigma and discrimination are the basis for highly risky behavior for exposure to HIV transmission. There is a big probability that women or men will engage in risky sexual activities for the sake of obtaining drugs, but also for gaining basic means of sustenance, especially economically affected users. Most of DIP are sexually active and most of them have sexual behavior that increases their risk of HIV-transmission (Pinkham, S. & Malinowska-Sempruch, K.; 2007, 8). According to the mentioned study, women-drug users are exposed to discrimination and violence within networks of their closer friendships and partnerships by men and in certain cases are victims of sexual abuse from their partners, some of which may also be drug users. It is worth emphasizing that the rate of use of used injecting equipment by women, especially equipment already used by their intimate partners, is higher than that of men, which may represent a key indication and a starting position in identifying the characteristic gender relations among drug users.

Information from the field research indicates some gender relations based on stereotypical gender roles among drug users, which may result with a limited access to specific information and services and increased probability for risky behavior.

Women-drug users want to stay anonymous, get access to drugs much easier than men, acquire the confidence of dealers, always have an intimate partner providing them drugs, and when the intimate partner cannot provide them with drugs any longer, they immediately find another intimate partner. Male drug users take care of them, provide them with protection and drugs, and there are even cases in which men plead guilty instead of them for a criminal charge and let themselves be sentenced to prison in order to protect their female intimate partners.

The use of free of charge medical, social and legal services by most drug users is controlled by their intimate partners, who prevent them from using such services, financing their private treatment. If they use them, they usually do this in the presence of their partner. The conclusion that female drug users accept the dependent position for a benefit, does not mean that male users

are „the used party", because they control their female partners' movement and contacts. By having an intimate partner, men's status in the community is improved, and it is a frequent case that male drug users encourage their female intimate partners or the girls from their clique to offer sex services in order to provide drugs or the money for drugs. In a similar situation with this description are female sex workers working on the open street scene in Skopje, who almost invariably, have a pimp who protects them, but also holds them in a dependent condition.

Despite the lack of more comprehensive empirical research in R. Macedonia regarding gender aspects of the population using and injecting drugs, we can conclude that gender relation patterns replicate and constitute the gender system of distribution power within this population, as well.

A final step is identification of the specific mechanisms of gender vulnerability posited as form of characteristic conduct and behavior of women or men as drug users. To reiterate, such an assessment must be strictly contextualized because of the contextual character of gender inequality.

From the perspective of HIV prevention policies, sex work is important from the aspect of its connection to the HIV transmission vulnerability and exposure (UNAIDS; 2009). Having in mind that sex work is based on sexual activities, behaviors with high risk of HIV exposure, such as engaging in unprotected sex relations with more partners and drug use, both abroad and locally, were and are dominant points of intervention in the area of sex work.

The question of sex work and gender vulnerability to HIV transmission is a complex issue which opens numerous controversial topics including gender equality, human rights of women, moral and politics. In the field of sex work, several interests and ideologies from different protagonists are intersected, such as sex workers, the state, the authorities with their parties' ideologies, human rights activists, civil organizations providing support to sex workers[1].

The general unacceptability of sex work as a „societal evil" or „socio-pathological phenomenon" in the public and by the state determine the stigma, discrimination and violence as basic features of the vulnerability of sex workers in R. Macedonia.

The absence of human rights protection, including sexual and health rights of sex workers when they are in danger from clients, the wider community or state institutions[2], directly leads to risky behavior of sex workers, thereby increasing their risk of HIV transmission.

Sex workers' vulnerability, especially of female sex workers, is manifested via

1 According to one of the standpoints, sex work is an outcome of a vulnerable condition in which people find themselves, which can be of socio-economic nature, social status etc. According to others, sex work is work like any other, and vulnerability is considered a feature of individual nature and that, like any other job, sex work also bears its professional risks. According to this stance, stigma and discrimination in the social context is a much more important aspect of sex workers' vulnerability to HIV, than socio-economic conditions which contribute to becoming a sex worker. A third aspect, from a preventive-epidemiological perspective, considers the reasons and justification with personal motives and the societal justification for the acceptance of sex work as important if they contribute to the decrease of the risk from HIV or other STDs infection. In this context, it is only very pragmatic for this perspective to adopt the fact of the existence of sex work than to try and change social processes and conditions which have been identified as reasons for the vulnerability to entry and acceptability of sex work.

2 An example where the state is found directly involved in the increase of vulnerability of sex workers happened in 2008, when the Ministry of interior (MOI) (in cooperation with the public prosecution office and the court) carried out forceful testing of sex workers for HIV/AIDS and STDs, with the intent, according to human rights activities, to purposefully use the test results as the crown evidence proving the sex workers perpetrators of the criminal act intentional (or non-intentional) spreading of infectious diseases (Trajanoski; 2009).

forms of sexual exploitation and trafficking. According to a current information from civil organizations[3], the number of domestically trafficked women is increased, in the context of sexual exploitation, and „rescue raids" of the police of alleged trafficking victims, actually is fight against sex work. Instead of protecting them from the violence and exploitation in sex work, sex workers are represented as victims of trafficking, thereby depriving them and/or devaluating their right to identification of their activity as sex work and devaluating their capacity as subject able to make rational, autonomous and responsible decisions for their own lives.

For further actions in this context, it is urgently needed to undertake two types of activities related to HIV vulnerability in the context of sex work: to assess gender factors as instigating factors, whereby sex work is more the outcome of a vulnerable state than a professional and economic option, and to assess practices of gender based discrimination by the state and its institutions against sex workers.

3 Otvorena Porta – La Strada Macedonia, The phenomenon of domestic trafficking in people, http://www.lastrada.org.mk/content.asp?id=59.

Most HIV prevention strategies are focused on persons and populations which are not HIV positive or do not know their HIV status. They are directed towards HIV transmission risk decrease related to the internal risk potential: use of condoms in case of sexual activity, use of sterile needles and syringes for injecting in case of drug using.

Issues related to the HIV exposure risks because of lack of knowledge of their own HIV status, dilemmas regarding the disclosure/non disclosure of their HIV status to their sexual partners and the ways of changing their negative attitude and stigma towards HIV positive persons are achieved via the strategy of the so called positive prevention. It is consisted in empowering persons living with HIV/AIDS to make decisions and choices that relate to their health and wellbeing, but also to health and wellbeing of others in the context of HIV prevention.

However, the existence of such a strategy is a symptom of deep seated ambiguity and dividedness in bearing the load of responsibility for the choices and decisions of persons living with HIV/AIDS, between their needs for protection from the stigma and discrimination in the public sphere and the implications of their decisions and choices which remains in the domain of the private and personal ethics.

Vulnerability of persons living with HIV/AIDS is chiefly based on the dichotomy disclosure/nondisclosure of the HIV positive status (Suzanne Maman and Amy Medley; 2004). The assessment of vulnerability of persons living with HIV is comprised in identifying the consequences on their sexual, health and social status and on other persons in their surrounding, having in mind the disclosure/nondisclosure of their status in a certain given social context. Gender vulnerability of persons living with HIV/AIDS, in the context of their knowledge and facing their positive HIV status, is consisted of change of behavior towards closest, within their family or working environment, intimate partners, which also entails change in gender roles which they usually hold in socio-cultural contexts in which they live and exactly this deviation from what represents the matrix of gender relations makes them vulnerable to the challenges of their new health and social status. The change in gender behavior doesn't usually go „unpunished". Persons living with HIV/AIDS, especially women are exposed to gender-based violence arising from their HIV status. The fear of abandonment from their intimate partner, family, friends, may expose them to sexual behavior with risky elements. Practicing less risky sex life is also related gender inequality, especially in the case of women because

of the possible negative social implications which they would face both as a woman and as an HIV positive person (WHO; 2006).

In the context of R. Macedonia, stigma and discrimination invariably appear in HIV positive cases, accompanied with violation of rights of persons with HIV, most frequently by health institutions, where it should also be taken in consideration the fact that they have disclosed their positive status only before health workers (HERA; 2009). The question of HIV status disclosure in the closest social environment is key for the support or lack thereof for persons living with HIV/AIDS in the direction of the needed treatment and the needed care. It is to be expected that in conservative communities the disclosure of status would entail rejection and refusal of their responsibility for the needed care from their closest ones, which for women, who are particularly socially and economically vulnerable, would contribute to further victimization and social inclusion.

2.2. Absence of gender perspective in current policies/programs

For gender mainstreaming in the area of HIV/AIDS, all stakeholders should provide conditions in which roles, problems and experiences of women and men will become an integral part of planning, preparation, implementation, observation and assessment of all laws, policies and programs in the area of HIV/AIDS, in order to provide equal benefits to women and men. Consequently, gender mainstreaming in the area of HIV prevention is of key importance for all decisions and interventions in that field; gender integration in preventive programs shall positively affect the decrease of poverty, employment, procedures and culture of stakeholders and shall represent an integral part of their responsibilities.

A general conclusion from the analysis of policies[1] and programs is the absence of a systematic approach in the treatment of gender issues in the context of prevention and treatment of HIV. Namely, gender issues in strategic documents are treated on the level of principle/declarative commitment, which has not been turned into specific measures and activities.

Also noticeable is the absence of coherence / complementarity of HIV and drugs prevention, protection and treatment and a policy for improvement of gender equality, which imposes gender mainstreaming in various areas as one of the key premises for the development in the areas which are subject of cross-functional coordination, regardless of the different contexts in which these policies have been developed and the objectives they should have achieved. In this context, worth mentioning is the inconsistency in the treatment of certain marginalized groups[2] in different policies and laws which may cause decrease/annulment of the effects of policies, programs and services. Also absent are any measures and activities that would provide assessment

1 Reviewed here are the HIV/AIDS 2007-2011 Strategy, as a key national document stating political commitment, strategic spheres and priorities as well as program activities for HIV/AIDS response in RM, the National Drugs Strategy of RM 2006-2012, which formulates strategic directions and activities for the prevention and treatment from drug abuse, and which, among other things, focuses on the prevention of HIV/AIDS epidemics, as well as the treatment and strengthening of health and social services. Also considered was the manner in which HIV/AIDS is treated in the National Plan for Improvement of Gender Equality 2008-2012, as the basic strategic document which formulates the policy for improvement of gender equality and the status and position of women in different spheres of social living.

2 The most illustrative example are „sex workers (male and female)", a group still treated by the Macedonian legislation as persons engaging in „prostitution" and subject to sanctions, and sex work is not recognized nor regulated as a legitimate economic activity. „Men who have sex with men" is a priority target group of the HIV/AIDS Strategy, and explicit protection from discrimination on the basis of sexual orientation exists only in the Law on protection of the patients rights and the Labor Law. For transgender persons, according to activists for protection and promotion of sexual and health rights of marginalized communities, competent institutions refuse any discussion.

and/or impose identification of the specifics connected to gender norms and relations within the target groups which have been covered by the HIV/AIDS response interventions, creating a different degree of risky behavior and exposure, and a lacking obligation for reassessment of programs and activities in line with the different practical and strategic gender based needs of target groups. The scope of specific measures/services which treat women and girls (within the general population and the groups under highest risk) is limited. There are no measures, also, for the active promotion of gender equality and overcoming gender stereotypes, norms and damaging practices as well as stigmatization of particularly marginalized groups, present in the public and within the institutions.

From the analysis of policies it can be concluded that the sustainability of the system of services intended for the communities of interest is limited. Namely, large part of the services which should provide outreach and direct services to groups with high degrees of marginalization are realized by civil organizations[3] in conditions of dependence from external sources of financing.

Most concerning is the absence of an explicit obligation for collection and analysis gender-sensitive data, preparation of gender analysis or estimation of the effect of policies and activities from the gender perspective, which should be assessed and direct the development of an appropriate national strategic and program response, and for the sake of developing contextualized, gender sensitive indicators in the function of a comprehensive reporting on the progress of the plan for prevention and protection from HIV/AIDS, such as is, for example, towards UNGASS, the Millennium development objectives, CEDAW, the Beijing Action Platform etc.

3 It is important to mention that a significant part of the programs active in this field, are the result of their autonomous policies and priorities at the field of informing, education and direct services for different target groups, and especially research and analysis for risky behavior and vulnerability to HIV, which are possible to a large extend due to the accessibility of these organization to hardly accessible vulnerable/marginalized groups.

2.3. Insufficient gender inclusion in service for prevention and protection from HIV: overcoming barriers

In conditions of absence of provided basic premises for integration of the gender perspective in general strategic documents in which measures and activities have been formulated, a general conclusion from the assessment is that structures for HIV prevention and protection, inclusive the treatment of persons living with HIV/AIDS, are partially gender inclusive.

The usual barriers to HIV prevention, such as gender relations and norms, stereotypes, subjective and objective aspects of stigma and discrimination (both from potential clients and service providers, the state) continue to represent real obstacles in using services.

A key barrier to the access to HIV prevention related services is the absence of the gender aspect in creating programs of organizations. The lack of analysis and estimation of gender needs and analysis and estimation of the influence of programs on gender relations in the context of HIV, as a principle of programming is the key system barrier of organizational and topical nature. Not taking these two aspects into consideration will render programs and their interventions insufficiently attractive for target groups from a gender perspective.

Data analyses for the effects from efforts to respond to specific needs of men and women by services provided by state services and civil organizations working on the field of HIV prevention differ. Thus, for example, an increase is noticed in the number of newly registered women-users of the services in the part of the harm reduction programs (HOPS and the Centre for treatment of addictions "Kisela Voda"), however the number of their participation in the total number of users in both programs is 12%. It should be noted that the trend of female service users is also increased in HOPS, and for 2011 is 17,70. The question of including gender in the program for support of sex workers in the HOPS is also subject of intervention. The engagement of outreach workers with a „different gender identity" as one way of offering a more adequate response and approach to possible client, is one of the efforts for better inclusion. Despite this, the percentage of men –sex workers, contacted/assisted

clients in the program in the last four years is 131, which is 18% of the total number of program users. In regards to preventive measures directed towards the wider population, and despite the large number of campaigns, educational workshops and similar activities, we can identify a negative tendency[1], which is an indicator for a preventive barrier in the fight against HIV. Results confirm that activities should be devised towards inclusion of the gender perspective in designing public campaigns in the fight against HIV.

Part of the reasons for the limited effects of such positioned programs must be identified from the field research data. What is noticeable is the big distrust and strive for avoiding institutions/organizations. For example, interviewees forced to seek specific health care services, try to treat themselves in private practices and clinics, because they think that they would receive better care and discretion there. Only those who cannot afford, use the medical services from institutions accepting health insurance and from civil organizations offering such or similar services. Although most of the interviewees of all target groups included in the field research fail to identify appropriate examples for gender discrimination in institutions/organizations providing services for prevention and treatment of HIV/AIDS, with which they have contacted/are contacting, the conclusion is that gender stereotypes represent/ed an obstacle for accessibility to HIV/AIDS prevention and treatment services.

Females do not feel pleasant in centers for harm reduction from the use of drugs in which most clients are men. Women are better accepted from male clients when they are accompanied by a man, who is most often their intimate partner. But, female drug users avoid these centers also because they don't want to be recognized as drug users, as a consequence of the widely present attitude that using drugs does not become women well. Contrary circumstances exist in the program for support of sex workers, in which male clients do not feel comfortable among the majority of female and transgender clients. Some transgender sex workers even state examples in which they were offended or discriminated by sex workers who identify with their biological female gender, but luckily, this has not prevented them from seeking help from the Program.

Persons pertaining to the groups which are most vulnerable to HIV/AIDS continue to demonstrate biggest trust in civil organizations and see them as

1 Among the student population, only 3,8 of the total number of surveyed (10.256) took an HIV-test, of which 235, or 4% are female, and 158, or 3,6% are male. But, of biggest concern is that only 7,3% (2,8% male, 4,4% female) are informed where they can take an HIV test. http://hera.org.mk/webcontent/file_library/section_images/hiv_testiranje.jpg.

protectors of their interests. This attitude is mostly due to the discriminatory experiences in state institutions and does not refer only to institutions which are directly involved in the prevention and treatment of HIV/AIDS, but to the overall health system, and the police and social work and policies institutions. Transgender and gay sex workers give numerous examples of physical and sexual abuse to which they have been exposed because of their sexual affinities and gender identity, but the police has not undertaken anything to protect or punish the perpetrators. Examples are provided for cruelty on transgender and gay man by policemen as well, which contributes to the increase of fear from the police and the mistrust from institutions of the system. Transgender persons face many more institutional barriers compared to other target groups covered by this research.

As opposed to the police and the social services, there is less criticism for the health workers, but the numerous examples indicate the reasons for mistrust towards public health institutions. Indicative are the examples for different treatment of male and female service users for the treatment with methadone therapy by health institutions. According to the experiences from some of the users of this service, professionals are more tolerant towards male users attempting to take their therapy outside because of injecting, and in certain cases for resale. Persons living with HIV/AIDS witness the existence of health workers who have publicly disclosed their HIV-status and from the gender perspective, such cases discourage HIV positive women to seek health services from a gynecologist, especially limiting them in their considerations for children. Some of the interviewed, especially drug users and HIV positive persons, witness resistance from health workers to provide certain services. Thus, for these persons, the selection of a family doctor and the provision of basic health services is limited because of their health status and these services must be preapproved. For women an additional problem is the selection of personal gynecologist, regular gynecological controls and tests. An alleviating circumstance is the fact that employees at the Public health institution Clinic for infective diseases and febrile conditions– Skopje (medical personnel – doctors and medical nurses, and a social worker), outside of their regular working tasks, help people living with HIV/AIDS to find a trustworthy personal physician and gynecologist. Similar experiences have been witnessed by representatives of other target groups included in the field research.

The lack of confidence towards health institutions urges people from target groups included in the field research to use health services provided by civil organizations working in the field of HIV/AIDS prevention. These health services, which can be gender dimensioned, do not intend to grow into a parallel health system, but to develop habits for health hygiene among their clients. Still, it seems that sex workers show greater confidence in the gyne-

cologist cooperating with HOPS – healthy options project Skopje, than in the whole health system. Even more confidence in this gynecologist demonstrate transgender and male sex workers, who are more keen to be checked by a trustworthy gynecologist than an indiscrete urologist or gastro-entero-hepatology specialist. But, the popularity of the youth centers „I want to know" of H.E.R.A. – Association for health education and research, especially the centre in Shuto Orizari, which offer medical and social services, confirms that young people trust civil organizations more than state institutions.

In addition to the struggle for the number and scope of new service users, a starting point towards an effective HIV response surely represents the organizational positioning of organizations working in the field of HIV prevention. Gender aspects in the work of these organizations are included above all in the identification of problems and needs of their clients, which refer to the daily problems encountered by the target population in the social sphere. Organizations are trying to reach sensitization to gender issues by involving persons from a specific sex/gender, as the „natural" way of attracting potential users of their services, for a population which they consider insufficiently covered by their interventions. On the other hand, it can be concluded that there are policies for gender representation in the bodies of organizations as a way of integrating the gender principle in their managing structures.

Among all the organizations covered by this research, HIV prevention represents one of the main objectives of their programs and activities. Starting from the fact that target populations (drug users, sex workers) or specific areas of operation (sexual and reproductive health) „coincide" with the HIV/AIDS issue, the need for increased efforts in both spheres of interest appears. Gender aspects of the work of these organizations are above all present in the form of identification of issues and practical needs of their clients, which refer to daily problems from the social sphere. Facts indicating to conditions of lesser accessibility to services for women/men are taken in sight, but in such a way that the program should adapt to conditions in which the immediate needs of women and men have appeared, without taking them in consideration. This manner of programming and functioning is dominant in our state as well, whereby it is considered that in that way the gender aspect has already been integrated in the provision of services and the organizational aspect of the services. This manner of operation may be deemed acceptable from the point of need for urgent acting. However, gender-responsible programming presupposes undertaking steps for answering strategic needs, i.e. the interests of women and men and the societal interest of elimination of those processes that produce gender inequality, promotion of human rights and creation of conditions for free development of individual capacities. The issue of gender integration is an issue of understanding, management and

programming social consequences from the operation of the services on gender equality. This means that philosophies and policies behind the service provides in the area of HIV/AIDS cannot take neutral stances regarding gender interests in their target groups and users. Neutrality in the context of struggle for gender equality means gender-blind policy and thus contributes to the maintenance of gender inequality.

¶ A permanent assessment of the institutional framework in the field of HIV prevention in R. Macedonia is needed, which would be founded on the principles of coherence and consistence in its functioning, the connectivity and the performances of its parts, which would identify its weaknesses and strengths in the context of the Macedonian model of gender mainstreaming and would propose directions towards its improvement. In the contrary, the institutional environment, policies and activities undertaken in the field of HIV prevention shall produce a fragmentary and local effect on gender relations, thereby degrading the sense of the existence of an institutional gender equality framework.

¶ Directing the attention towards gender issues in policies, projects and programs of service providers in the HIV prevention field, via analysis of the roles, problems and experiences of women and men as a routine part of the planning, and based on the results, drawing and follow-up of these policies, projects or programs' effects.

¶ Inclusion of concerned communities – DUs, SWs, PLWHIV in creating and implementing HIV/AIDS related policies and programs.

¶ Development and support not only of „female" only (or „male" only) projects and programs for dealing with specific aspects of gender vulnerability to HIV, but also programs which would encompass gender relations in the field of intervention in order to positively transform them.

¶ Ensuring complementarity in gender equality by improving policies and HIV/AIDS related policies. This coordination is needed at all levels and among all policy makers, but is especially significant between the two referent ministries making these specific policies – the Ministry of labor and social policy and the Ministry of Health. Above all, this means coordination, i.e. exchange of strategic information in the process of planning and programming, implementation and outcome assessment.

¶ Creating systems for systematic collection, analysis and exchange of gender-sensitive strategic information for the needs of planning, monitoring and evaluating policies, programs and activities on all levels. This specifically refers to collection and analysis of gender-differentiating statistical data for assessing trends of range, scope, frequency and effects of services provided to different target groups.

¶ Monitoring changes in attitudes, habits and behavior of groups relevant from the gender perspective and accommodating policies and activities for the prevention of and protection from HIV.

¶ Introducing systems for integration of the gender perspective in the managing processes of institutions /organizations included in the prevention and protection of HIV.

¶ Developing specialized programs for sensitization as to the connection and effect of gender on the risks from HIV transmission and establishing a continuing education of professional structures providing services in the formal and informal sector.

¶ Introducing education on gender, sexual and reproductive health and rights as part of formal educational system, including the teaching staff.

¶ Identification and development of policies for overcoming discriminating /damaging practices in the provisioning of health and social services.

¶ Increasing the variety of services and their accommodation to different cultural and social groups in line with the commitments arising out of strategic documents.

¶ Extending the accessibility of the HIV prevention and treatment service network.

¶ Developing innovative tools for informing about the risks and consequences, appropriately adapted to different target groups.

¶ Developing specialized programs for re-socialization of marginalized groups.

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