Baseline Assessment - Honduras

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV Services

November 2018
Geneva, Switzerland

The Global Fund

DISCLAIMER

Towards the operationalisation of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics*, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working document for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV services and implementing a comprehensive programmatic response to such barriers in Honduras. The views expressed in the paper do not necessarily reflect the views of the Global Fund.

ACKNOWLEDGEMENTS

With regard to the research and writing of this report, the Global Fund would like to acknowledge the work of the International Center for Research on Women (Authors: Jeff Edmeades, Katie McDowell and Anne Stangl; and in-country team –Gabriela Flores, Antonio Barahona, Maricela Barahona, and Orlando Torres) as well as country and technical partners and the many others who have contributed to the report.

Acronym List

ART	Antiretroviral Therapy
ARV	Antiretrovirals
ASONAPVSIDAH	Asociación Nacional de Personas que Viven con VIH/Sida en Honduras / National Association of People Living with HIV/AIDS
CAI	Centro de Atención Integral / Integrated Treatment Centers
CCM	Country Coordinating Mechanism
CDO	Chief District Officer
CEPROSAF	Centro de Promoción en Salud y Asistencia Familiar / Center of Promotion in Health and Family Assistance
CIPRODEH	Centro de Investigación y Promoción de los Derechos Humanos de Honduras / Center of Research and Promotion of Human Rights in Honduras
CONADEH	Comisionado Nacional de los Derechos Humanos
CONASIDAH	La Comisión Nacional de Sida
CSO	Civil Society Organization
DOTS	Directly observed therapy, short course
FCHV	Female Community Health Volunteer
FGD	Focus group discussion
FHI 360	Family Health International
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IACHR	Inter-American Commission on Human Rights
ILO	International Labour Organization
MoH	Ministry of Health
NCASC	National Centre for AIDS and STD Control
NCPI	National Commitments and Policies Instrument
SAI	Servicios de Atención Integral / Integrated Treatment Services
STI	Sexually Transmitted Infection
ONUSIDA	Organización Nacional SIDA / United Nations Commission on AIDS
PENSIDA	Plan Estragético Nacional de Respuesta al VIH y SIDA / National Strategic Plan in Response to HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VICIT	Vigilancia Centinela de las Infecciones de Transmisión Sexual
WHO	World Health Organization

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Executive Summary

Introduction

Since the adoption of its strategy, Investing to End Epidemics, 2017-2022, the Global Fund to Fight AIDS, Tuberculosis and Malaria has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria[1]. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

In addition to including attention to breaking down human rights-related barriers to health in all of its allocations to countries, the Global Fund is providing intensive support over the next five years to a set of 20 priority countries to enable them to put in place comprehensive programs aimed at significantly reducing these barriers[2]. Programs are considered "comprehensive" when the right programs are implemented for the right people in the right combination at the right level of investment to remove human rights-related barriers and increase access to HIV and TB services.[3] Based on criteria involving needs, opportunities, capacities and partnerships in country, Honduras has been selected as one of the countries to receive intensive support. This baseline assessment is the first component of the package of support to Honduras and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV services. This assessment: (a) establishes a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) sets out a costed comprehensive program aimed at reducing these barriers; and (c) recommends next steps in putting this comprehensive program in place.

The comprehensive programs proposed are based on the seven key Program Areas for HIV programs identified by UNAIDS and the Global Fund. These are set out in the respective program sections below.

Methodology

In September 2017 a literature review of formal and informal literature on the HIV response in Honduras was conducted, followed by an in-country assessment. This assessment involved a total of 22 in-person and telephone interviews with key informants (See Annex 6) engaged in research and/or activism related to key and populations in vulnerable situations, and 5 focus group discussions with individuals from the key populations of people living with HIV, female sex workers, and men who have sex with men. The interviews and focus group discussions were carried out in Tegucigalpa, San Pedro Sula and La Ceiba. A standard assessment protocol, developed to be used across the twenty country assessments and standard tools for the key informant interviews and focus groups discussions were used. An Inception Workshop was held with key stakeholders at the beginning of the data collection process to inform them of the assessment process and to consult with them on focus areas and key informants. This meeting was also used to fill any gaps in

[1] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

[2] *Ibid*, Key Performance Indicator 9.

[3] This definition of "comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

the literature review. Following the fieldwork, a prioritization meeting will be held with the same key stakeholders to capture feedback on the proposed activities, including prioritization and implementation suggestions. Lastly, a validation meeting will be held with the CCM to confirm the activities proposed for the comprehensive response.

Summary of baseline findings: HIV

Key populations and populations in vulnerable situations

The key populations and populations in vulnerable situations most affected by HIV in Honduras include: people with HIV, sex workers (particularly female and transgender), members of ethnic minorities (particularly the Garifuna), men who have sex with men, and transgender people/transvestites/transsexuals. It should be noted that while drug trafficking is an important underlying issue in Honduras, it is not considered a concern specific to HIV. Drug users are not listed in PENSIDA IV as a key population or populations in vulnerable situations, nor were they identified as such in this study. Other populations in vulnerable situations include male labor migrants and their partners, vulnerable children, including orphans and street children, and women and girls. This assessment is in general agreement with the key populations identified in the most recent version of Honduras' Strategic National Plan in Response to HIV and AIDS ("el Plan Estratégico Nacional de Respuesta al VIH y SIDA" (PENSIDA IV[4]), though the national plan also identifies Afro-Hondurans and incarcerated people as key populations.

Barriers to HIV services

The most significant human rights-related barriers identified in the desk review and confirmed by key populations and populations in vulnerable situations and the people who work with them were the following:

a) Stigma and discrimination against key populations and populations in vulnerable situations, including people living with HIV, is pervasive and includes continued stigma and discrimination in relation to HIV generally, specific stigma related to belonging to certain populations, and significant self-stigma.
b) The lack of effective implementation operationalization of legal protections and the existence of punitive regulations affecting people living with HIV and/or key populations represents a persistent barrier to access to HIV services for key populations, particularly female sex workers, men who have sex with men, and transgender people/transvestites/transsexuals.
c) Gender inequalities and power dynamics create vulnerabilities for women and adolescent girls, particularly in the context of intimate relationships. Related to this is the very high incidence of gender-based violence (GBV) in Honduras, which both increases the vulnerability of women to HIV infection and acts a barrier to seeking and accessing health services.
d) Sociocultural, physical and economic barriers – including the inability to pay for health care (despite care being nominally free in many cases), transportation to health centers with specialized HIV services and laboratory tests for monitoring treatment – is a salient barrier for people living with HIV to access, enroll, and remain in services.

[4]Seehttp://www.salud.gob.hn/noticias/15links/pensidaiv.pdf

e) Inconsistent quality of service in the health care settings, including stigmatizing and discriminatory treatment and a lack of empathetic and holistic approaches to care represents a significant barrier to effective use of available services.

The ways that these barriers affect the key populations and populations in vulnerable situations are set out in detail in the findings section of this report.

Programs to address barriers to HIV services – from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Honduras to remove human rights-related barriers to services and provides a summary of the proposed elements of a comprehensive program[5], based on the seven Program Areas set out in the Global Fund HIV, Human Rights and Gender Equality Technical Brief.[6]

The seven program areas are:

PA 1: Reduce HIV-related stigma and discrimination

PA 2: Train health care workers on human rights and ethics related to HIV

PA 3: Sensitize lawmakers and law enforcement agents

PA 4: Provide legal literacy ("know your rights")

PA 5: Provide HIV-related legal services

PA 6: Monitor and reform laws, regulations, and policies related to HIV

PA 7: Reduce discrimination against women and girls in the context of HIV

Overall several non-government and community-based organizations, as well as government entities, are currently working to some extent to address human rights-related barriers to HIV. However, the programs they implement do not fully cover each Program Area and lack the resources to be implemented at scale. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these interventions, in order to determine which ones would be appropriate to take to scale.

Summary of existing/recent programs and proposed elements of a comprehensive program

In order to comprehensively address human rights-related barriers to access and use of HIV-services, the following existing interventions should be refined in some cases and taken to greater scale in others. These interventions were identified as being particularly successful or promising during fieldwork with key population members and Civil Society Organizations (CSOs) that work with them, in addition to insights gained from the desk review and successful activities in other settings.

[5]Programs to remove human rights-related barriers to services are defined to be *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.

[6] Technical *Brief HIV, Human Rights and Gender Equality,* Global Fund to Fight AIDS, TB and Malaria (April 2017)

PA 1: Reduce HIV-related stigma and discrimination

Current and recent initiatives to reduce HIV-related stigma and discrimination included: (1) Peer or face-to-face education, which seek to reach members of key populations with information and services that may reduce both stigma and discrimination; (2). Community outreach/mobilization activities, such as street theatre or mass communication campaigns that aim to change attitudes towards HIV in the general population; (3) implementation and dissemination of the PLHIV Stigma Index, which quantifies the level of stigma experienced by people living with HIV and was used to attempt to motivate change in policy and practice; (4) self-help group-based support for people living with HIV and key populations, which was viewed as key to improving self-esteem and reducing self-stigma and stigmatizing attitudes within key populations themselves; and (5) the sensitization and/or capacity-building of key stakeholder groups, through providing training on the specific needs of HIV-affected populations.

To comprehensively address HIV-related stigma and discrimination, these interventions are recommended:

- Update existing stigma-reduction curricula for CSOs and duty bearers to include information on HIV, non-discrimination, and violence, and promote supportive, accepting, responsive services. Where possible, curricula should be standardized and based on the USAID/HP+ model, build on experience gained from implementing the curricula in Honduras to date and be developed in partnership with people living with HIV and CSOs that represent them. Both pre-service and in-service trainings are recommended.
- Develop and implement a national reporting and monitoring system to capture experiences of stigma, discrimination and violence and link affected populations to relevant services and link these to relevant information systems for monitoring related human rights violations. Where possible, this should be conducted in conjunction with efforts to strengthen government response to human rights violations.
- Institutionalize training on reducing stigma, discrimination and violence related to HIV in basic training, as well as continuing in-service training, for teachers, law enforcement and judiciary, and medical education. Where possible, this should be integrated into existing training mechanisms focused on human rights and be a mandatory requirement for ongoing employment. Key populations, populations in vulnerable situations (as outlined above) and the CSOs that work with them should be involved in developing training materials.
- Support mass media or public campaigns to reduce stigma and discrimination based on real or perceived HIV status or belonging to a key population and associated rights. These should both target HIV directly and link to broader barriers such as gender inequality. A variety of approaches should be used to reach different populations, developed in partnership with people living with HIV, key populations and CSOs that work with them.
- Address gender inequalities and sexual orientation discrimination. Support the implementation of a comprehensive sexuality education curriculum in schools and routinely monitor the implementation of the program. Sections of the curriculum dealing with sexuality, that are currently available from the Educational Secretary, should be developed and improved in partnership with key population groups and CSOs that represent them and draw from examples of comprehensive sexuality education from the region. Emphasis should be placed on extending the curricula to include components related specifically to HIV-related stigma.

PA 2: Train health care workers on human rights and medical ethics

The formal training of health care workers in both human rights and medical ethics is led primarily by the Ministry of Health, which develops policies and regulations that guide practice. While there are training manuals that are designed to inform staff about these issues, it is unclear how consistently staff members are trained on these or how the guidelines are applied in practice. CSOs do work closely with individual clinics and doctors to help build capacity, often through the cultivation of personal connections, but this remains somewhat inconsistent in both its application and impact. There remain few programs designed to train healthcare staff on medical ethics, both generally and specifically related to HIV.

- To comprehensively address capacity building and sensitization of health workers to issues related to human rights and ethics as these relate to HIV, these interventions are recommended: Support the development of a curriculum, in partnership with key populations and CSOs working with them, for pre-service training of medical personnel on human rights through medical colleges. Ensure that this includes training on stigma, discrimination and human rights specifically for HIV. This must be implemented as a core aspect of medical training and fully institutionalized within medical system.
- Support development/revision of curriculum, in partnership with key populations and CSOs working with them, for routine in-service trainings on HIV and key population-related stigma reduction, non-discrimination, gender equality and medical ethics for current health facility staff; engage administrators and identify champions within the health sector/or facilities for sustainability and follow-up. Make this a requirement for all existing health care staff, but initially start with those directly servicing KPs with regard to HIV. This should be supported by a tracking system, ideally located within existing human resources systems.
- Support routine assessments of knowledge, attitudes and practices of health care workers towards people living with HIV and other key populations to support health facility administrators to identify and address any issues. Measurement should be conducted annually or every other year using the MERG-approved, validated short survey developed by HP+ to inform the need for re-training or other action by health facility administrators. Results should be made publicly available as soon as possible to foster greater accountability.

PA 3: Sensitize lawmakers and law enforcement agents

The efforts to sensitize lawmakers and law enforcement agents to the needs of HIV-affected groups have primarily taken three forms: (1) Partnerships with law enforcement. A number of CSOs have sought to establish ongoing partnerships with local law enforcement where they share information and conduct training sessions. (2) Strategic working alliances between CSOs and government agents. These have typically taken the form of ongoing information sharing with the goal of influencing policy within the government agencies. CSOs also form alliances to allow for a more coordinated and influential approach to government and other actors; (3) Advocacy efforts aimed at sensitizing lawmakers to the issues faced by key populations in terms of HIV and developing support for policies to address these issues. These have typically involved the sharing of information and generation of dialogue through forums or similar events.

To comprehensively address legal and policy barriers, and abusive law enforcement in a consistent manner, these interventions are recommended:

- Institutionalize pre-service training on reducing stigma, discrimination and violence, including gender-based violence, within existing training processes for anyone involved in law enforcement (including legal training, police academy, within the prison system and military). Existing curricula need to be updated – input from CSOs working in this area and key populations should be incorporated into the design of the curriculum.
- Support in-service trainings for current police, judges, prison staff on HIV policies, legal rights of citizens (particularly key populations); responsible and supportive policing in the context of HIV; reduction of illegal police practices as they specifically relate to their interaction with key populations (such as commercial sex workers) and encouragement to fulfill their duties to protect these populations. This should be linked to content included in professional training and regularly assessed in terms of effect on knowledge and attitudes (see above in "Stigma and Discrimination Reduction" section).
- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and other key populations and support administrators to identify and address any issues. Results should be made public on an ongoing basis to foster accountability. Community-based monitoring of human rights violations perpetrated by police should be in place as another accountability mechanism.
- Continue and expand community-based advocacy and joint activities with law enforcement to address key challenges affecting key population groups (particularly those with more regular interaction with law enforcement agents, such as sex workers). A number of CSOs already conduct outreach and capacity-building activities with police and other law enforcement agents. These activities should be coordinated and expanded.

PA 4: Legal literacy ("know your rights")

Efforts to improve knowledge of the legal rights of key populations and populations in vulnerable situations have typically taken the following forms: (1) Face-to-face/peer education, where information is shared through one-on-one discussions between trained peer educators and members of key populations and/or populations in vulnerable situations; (2) General capacity building in terms of knowledge of human rights. These are programs that focus more broadly on human rights education that may include HIV-related content or touch on key populations and populations in vulnerable situations (such as women's rights).

To comprehensively address the need to increase legal literacy around the rights of key populations, the interventions above should continue but be supplemented by additional activities designed to increase legal literacy, as follows:

- Support legal literacy in human rights and patients' rights education through conducting awareness campaigns and workshops among people living with HIV and other key populations in high-prevalence departments with the goal of creating social and political pressure at the local level to ensure the realization of the right to health (i.e. universal, non-discriminatory access to good-quality services) and uphold other human rights in context of the HIV response. This should be coordinated with training of health care providers and law enforcement (see above) and a streamlining of complaint resolution systems (see below) to ensure adequate attention is paid to human rights concerns and violations.

PA 5: HIV-related legal services

There are relatively few programs that aim to provide legal services to key populations and populations in vulnerable situations. Those that do include: (1) Facilitation of the process of submitting human rights complaints. CSOs do this in a number of ways, ranging from having CSO staff with experience navigating the complaint procedure, accompany complainants when filing and processing their complaint, to more directly linking individuals to legal services such as the public prosecutor's office, the national police and CONADEH; and (2) Provision of staff at medical centers who are dedicated to resolving human rights-related complaints. These individuals are located in some of the Integrated Treatment Services (SAIs) and are available to assist with cases of potential abuses of rights. Furthermore, a pilot program was established in the Hospital Escuela Universitario de Tegucigalpa in 2017 where an office of human rights was set up to allow for formal complaints, though it is not clear at this stage what effect this has had.

To comprehensively address the needs of people living with HIV and key population groups for specialized legal services related to HIV rights violations, the interventions above should continue, but be supplemented by additional activities designed to increase access to legal services, as follows:

- Provide CSOs with continual access to professional legal services dedicated to prosecution and resolution of human rights abuses. Alternatives would be to identify a network of legal professionals willing to provide pro bono services, train them and link these to CSOs.
- Train and support paralegals to provide legal advice, awareness raising and "know your rights" campaigns in high-prevalence departments among key populations, people living with HIV and/or in health care facilities. Effective links to full legal services must be put in place, particularly for formal complaints regarding human rights violations.
- Provide direct support to non-governmental organizations/CSOs who are currently focused on human rights issues, but without a clear mandate to focus on HIV-related human rights questions. Support should be directed towards building capacity in these organizations (or networks of organizations) around the rights of key populations and towards building systems for adding a focus on HIV-related rights to their portfolios of work. This capacity building exercise must include key population groups.

PA 6: Monitor and reform laws, regulations and policies related to HIV

While virtually all CSOs are closely monitoring changes in laws, regulations and policies related to HIV and some are actively proposing legal change, there is no systematic monitoring system in place for this. Until very recently, the National Commission for Human Rights (CONADEH) was the primary independent government entity charged with overseeing the monitoring of human rights in Honduras, including of HIV. Their principal responsibility is the reception and investigation of complaints/reports and human rights advocacy/education. To develop the task of receiving complaints, the National Commissioner is authorized to carry out investigations, inspections, verifications, or any other action necessary in order to verify the complaint. In addition, they have access to all the documentation that they consider necessary for consultation in the Public Administration offices for further clarification. The Human Rights Secretariat (SEDH) was created by the PCM-055-2017 decree on September 12th, 2017. The SEDH acts as director and coordinator of the Implementation of Public Policy and the National Action Plan on Human Rights, and is responsible for the design, monitoring and coordination of public policies in the area of human rights, especially for all people and groups in vulnerable situations, who require special advocacy in and protection of their human rights. It is unclear, at the time of publication of this study, how the new secretary will coordinate with CONADEH or whether it will take on part of the responsibilities CONADEH has historically

assumed. While CONADEH does track and report on human rights cases related to HIV, the very low number of cases resolved provides clear indication of the challenges individuals face when attempting to address violations. At this point it is unclear what monitoring or reporting system that SEDH will have.

To comprehensively address capacity building and sensitization of health workers to issues related to human rights and ethics as these relate to HIV, these interventions should continue, but be expanded substantially by additional activities designed to improve accountability and accelerate legal reform, as follows:

- Support for advocacy and lobbying for law and regulatory reform related to human rights protections generally. Increase funding for advocacy groups to support the legal reform process and advocate for the operationalization or development of supportive policies and laws as they relate to different key populations (see below for examples specific to sex worker and transgender people/transvestites/transsexuals). Given Honduras' generally progressive legal frameworks, a great deal of the effort for this should be directed toward actual implementation/operationalization and enforcement of existing laws.
- Increased monitoring of HIV-related human rights cases currently being processed by human rights agencies and within legal processes. Fund the development of national-level system tracking the progress of human rights-related complaints and their resolution. This would include counting the number of cases presented, the number proceeding to a formal resolution process, and the eventual resolution of the complaint. The information will increase accountability through providing clear information on both how many cases are being taken up by these entities and what proportion are resolved in a reasonable period of time. This should be closely linked to efforts to improve the access to legal remedies available to CSOs and key populations.
- Streamlining of complaint mechanisms within health care settings. As noted above, there are some systems for managing complaints, including related to human rights violations, within the health care system itself, though these are generally considered to be ineffective. Providing technical and financial assistance to the Ministry of Health to develop a more robust and responsive complaint system, building on models successfully adopted in other countries and in consultation with key population groups, will provide an important avenue for rapid identification and resolution of complaints that currently does not exist in many cases.
- As per UNAIDS guidelines, a comprehensive program includes advocacy for decriminalization of sex work, which should be increased. Fund advocacy groups to support the development of draft legislation providing formal legal status for sex workers (most of whom are women). Emphasis should be placed on how the unstable legal status of sex workers is placing them and the population at greater risk and increasing hardship for sex workers. All efforts should be led by key population representatives.
- As per UNAIDS guidelines, a comprehensive program includes advocacy to allow transgender people/transvestites/transsexuals to change their names to match their gender and this should be increased. Fund advocacy groups to support the development of draft legislation providing for the right of individuals to change their name legally without restriction. Additional efforts should focus on the ability of individuals to change the biological sex listed on official documentation and identification papers. All efforts should be led by key population representatives.
- A comprehensive program should also include advocacy for reforming non-HIV specific laws to preclude their application for overly broad criminalization of transmission, exposure and non-disclosure of HIV.

PA 7: Reduce discrimination against women and girls in the context of HIV

The broader context of gender relations in Honduras is one that is very unfavourable to women. According to IUDPAS at least 3,967 women in Honduras were murdered between 2009 and 2016, and a recent study carried out by FOROSIDA-INIGES found that 40 percent of women in the most populated areas of the country (also with the highest concentration of people with HIV) had been victims of gender-based violence. This study also highlighted the lack of research on GBV in Honduras, though research in other settings has established a clear link between experience with GBV and heightened risk of HIV infection. While there are a number of programs focused on gender-based discrimination in Honduras more broadly, there are very few that focus on the intersection this has with HIV specifically.

To comprehensively address the risks that discrimination against women and girls poses both in general terms and as these relate specifically to HIV, these interventions should continue, but be expanded substantially as follows:

- Mobilize women's groups and support networks to combat violence and support survivors to seek redress and services. This should aim to use community-based advocacy and mobilization to reduce GBV and support redress for survivors of violence. Where possible, this should build on existing platforms established by groups focused on GBV prevention, with content added that is HIV-specific.
- Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence. Integration of human rights and gender programming into schools is key to achieving long-term changes in norms around both in Honduras, including specific to HIV.
- Mass media campaigns aimed at reducing GBV broadly through gender transformative messaging should be considered, potentially using increased risk of HIV transmission as one of many reasons for the need for change. All advocacy activities must be developed in partnership with key population groups and women and girls living with HIV, or representatives and groups working on GBV prevention.
- Train girls and women in the field of International Human Rights Law, especially with regard to the International Convention against All Forms of Discrimination against Women (CEDAW) and the Inter-American Convention to Prevent, Punish and Eradicate Violence against Women.

2015 - 2016 investments and proposed comprehensive program costs - HIV

Funding source	**2015 allocation (USD)**
The Global Fund	119,118.60
Total	**USD 119,118.60**

Funding source	**2016 allocation (USD)**
The Global Fund	6,024.37
Total	**USD 6,024.37**

HIV Human Rights Program Area	2015	2016
PA 1: Stigma and discrimination reduction	51,180.00	6,024.37
PA 2: Training for health care workers on human rights and medical ethics related to HIV	11,748.36	0
PA 3: Sensitization of law-makers and law enforcement agents	36,748.36	0
PA 4: Legal literacy ("know your rights")	11,441.88	0
PA 5: HIV-related legal services	0	0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	8,000.00	0
PA 7: Reducing discrimination against women in the context of HIV	0	0
Total	**119,118.60**	**6,024.37**

The costing for the 5-year comprehensive program is set out in the following table:

HIV Human Rights Program Area	Total
PA 1: Stigma and discrimination reduction	1,869,671.12
PA 2: Training for health care workers on human rights and medical ethics related to HIV	322,225.43
PA 3: Sensitization of law-makers and law enforcement agents	262,024.57
PA 4: Legal literacy ("know your rights")	651,546.08
PA 5: HIV-related legal services	736,570.19
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	385,618.24
PA 7: Reducing discrimination against women in the context of HIV	540,539.15
Total	**4,768,194.78**

Priorities for scaling up towards comprehensive programs to reduce barriers to HIV services

The full list of programs and activities in the comprehensive response are summarized in Annex 1. A significant amount of work has already been done in Honduras to address specific barriers, and the legal system on paper provides significant protections. However, there is poor coordination and a lack of systematic application of the lessons learned through these years of implementation. Programs focused specifically on human rights do not cover each of the seven priority programmatic areas for human rights, are being implemented at a small scale, and are significantly underfunded. Honduras has institutions, protective laws and civil society that can all be strengthened and engaged to significantly reduce such barriers. Such an effort will require increased and sustained investment in interventions and activities that provide important human rights-related knowledge and skills to officials and to the populations of those

affected by HIV and that change harmful attitudes and practices. Furthermore, fundamentally changing the landscape for HIV services in Honduras will require efforts to address the impunity of human rights violators and a systematic effort to reduce stigma and discrimination towards HIV-affected groups.

Given the nature of the human rights-related barriers to access and use of services in Honduras, it is recommended that the early focus be on activities to update or develop curricula on stigma reduction and human rights for key duty bearers and the integration of these curricula into the appropriate professional training schools and colleges. In all cases, the development of curricula should be led by key population members or CSOs who work with them. These curricula should be tailored to the needs of particular duty bearers, such as health care professionals, teachers and law enforcement agents, as the needs of each group are somewhat different. It is critical that this training be designed in a manner that will allow for it to be institutionalized effectively, ideally through making the training a required component of both pre-service education and through developing in-service opportunities for training. Negotiating the inclusion of the curricula in existing training systems and, if necessary, developing new training mechanisms should begin immediately to avoid implementation delays. This should be accompanied by the development of various systems to capture experiences of stigma and discrimination and support redress. This should include both improved national-level monitoring systems that track human rights violations, complaints and how these were resolved in a consistent way and direct support for the provision of legal aid. A key component of this will be providing more direct support to CONADEH and/or the newly formed Ministry of Human Rights, which should be preceded by a needs assessment to identify key gaps in their capacity and to develop a plan to address these sustainably. In particular, the Human Rights Secretariat should coordinate closely with all relevant State institutions who are responsible for the implementation of the actions laid out in the Public Policy and National Action Plan on Human Rights, so as to fulfill all its functions. They should also coordinate actions with independent institutions such as the Public Ministry, the Supreme Court of Justice, the Attorney General's office and the National Commissioner for Human Rights.

It is also recommended that concerted efforts be made to identify opportunities for increased collaboration with existing CSOs that are focused on addressing human-rights issues in Honduras more broadly but that do not include HIV-related discrimination as an integral part of their efforts, with a focus on building towards a broader partnership that would build their capacity for including HIV in the future. A similar focus should target those CSOs that are currently working to address issues related to gender discrimination and gender-based violence (GBV), again with the goal of enhancing their capacity for developing interventions that include a focus on the intersection of HIV and gender discrimination. Finally, the development/updating of advocacy and tools for legal literacy in human rights and campaigns should be prioritized to ensure that networks and advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation.

Following the completion of these initial activities, the next stage should focus on the training of trainers and/or professors/instructors, followed by the systematic rollout of both pre- and in-service routine training/retraining of key duty bearers. Linked to this scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty bearers with clear accountability mechanisms in place to ensure that the information collected is acted on. These should include routine assessments of knowledge, attitudes and behavior to assess change over time. This phase of the response should also involve direct support to CSOs working on human rights and gender discrimination to integrate HIV-related issues into their programmatic efforts and develop broader

strategic alliances with those CSOs focused more specifically on key populations and populations in vulnerable situations with regard to HIV. Linked to this, outreach and engagement with the legal community, including provision of training to lawyers and paralegals on HIV, discrimination, KP and women's rights and the engagement with *pro bono* legal support for the resolution of complaints or violations identified by CSOs and to build a cadre of lawyers familiar with the issues, and support legal-literacy efforts. Mass media and advocacy campaigns would also start full implementation during this phase. Finally, the PLHIV Stigma Index should be implemented in year 3 or 4, with additional funding support to PLHIV networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

Next steps

This baseline assessment will be used by the government, civil society, other stakeholders, technical partners and donors in Honduras to develop a five-year, comprehensive program to remove human rights-related barriers to services. Data from the baseline assessment will be used to inform the matching fund application of Honduras to the Global Fund and will inform its grant-making and implementation. Finally, the data will be used as a baseline for subsequent reviews at mid-term and end-term during the period of the Global Fund strategy to assess the impact of scaled up programs in reducing human rights-related barriers to services.

1. Introduction

1.1 Overview of the Global Fund Assessment Initiative

This report comprises the baseline assessment conducted in Honduras to support scaling up of programs to remove human rights-related barriers to HIV services. Since the adoption of its strategy, *Investing to End Epidemics,* 2017-2022, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service";* and, to *"scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities*."[7]

The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

1.2 Background and Rationale for Baseline Assessment in Honduras

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – «Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation". This KPI measures "the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries".[8] Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Honduras as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV, is the first component of the package of support the country will receive.

1.3 Purpose, Objectives and Expected Outcomes of the Assessment

The outcomes of this assessment in Honduras are to: (a) establish a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) set out a costed, comprehensive program aimed at reducing these barriers; and (c) recommend next steps in putting this comprehensive program in place.

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[7] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

[8] 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

The programs recognized by UNAIDS and other technical partners as effective in removing human rights-related barriers to HIV services are: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy in human rights ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV.[9]

The findings of this baseline assessment will be used by the Honduran government, the Global Fund, civil society organizations, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to services in Honduras. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

2. Methodology

2.1 Conceptual Framework

The conceptual framework for the baseline assessments (and Global Fund Strategic Objective 3) is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV, TB and malaria services; (b) These human rights-related barriers are experienced by certain key populations and populations in vulnerable situations who are most affected by HIV, TB and malaria; (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers; (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country, they will remove or at least significantly reduce these barriers; (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV, TB and the malaria; and, (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Honduras has identified:

a) Human rights-related barriers to HIV services
b) Key populations and populations in vulnerable situations most affected by these barriers;
c) Existing programs to address these barriers; and
d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and, poverty and economic and social inequality.

Key populations have been defined as follows by the Global Fund:

a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to HIV – due to a combination of biological, socioeconomic and structural factors;

[9]See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also Technical *Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and

The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.[10] In Honduras, key populations include: men who have sex with men, transgender people/transvestites/transsexuals, and female sex workers.

Populations in vulnerable situations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable to HIV and its impact.[11] In Honduras, Populations in vulnerable situations include: incarcerated populations and the afro-Honduran population, an ethnic minority in Honduras.

The design, outcomes and costs of existing programs to reduce these barriers were analyzed and a set of initiatives have been proposed in order to make up a comprehensive program to address human rights-related barriers at scale.

2.2 Steps in the assessment process

Desk Review - A comprehensive search to assess human rights-related barriers to HIV and TB services in Honduras, key populations and populations in vulnerable situations affected by these barriers and programs to address them, was conducted using PubMed, Embase, and Web of Science to identify peer-reviewed literature. Searches were conducted in both English and Spanish. Eleven relevant articles were identified. The publications section of local NGOs and CBOs working in Honduras in the HIV sector were also searched for relevant publications, yielding 22 additional resources. Emails seeking additional information on programs were sent to several non-government organizations (NGOs) working on HIV in Honduras to achieve a greater understanding of issues faced by their target population.

a) *Preparation for in-country work* - From the Desk Review, a list of key informants and types of focus groups was developed to guide data collection in country. Instruments developed for these forms of data collection were adapted to the circumstances of Honduras. Researchers (nationals of Honduras) were trained in the use of these instruments and were assigned tasks. The Ministry of Health of Honduras was contacted about the need for ethics approval, and the research team was informed by the relevant officer that ethics approval was not required for this assessment.
b) *In-country work* - An inception meeting introduced the project to national stakeholders, explained the role of the baseline assessment and data collection procedures, and summarized the findings of the Desk Review. This was followed by key informant interviews and focus group discussions with members of key and affected populations in Tegucigalpa, San Pedro Sula and La Ceiba (areas of Honduras with particularly high incidence of HIV). A total of 21 face-to-face interviews were carried out with 23 key informants; and 5 focus groups (including between 7 and 15 individuals) were conducted with key population members.
c) *Data collection* - Through the desk review and in-country work, data were collected on the following areas:
    - Human rights-related barriers to HIV services
    - Key populations and populations in vulnerable situations most affected by these barriers
    - Programs carried out presently or in the past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers

[10] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations: A Definition 2015.*

[11] Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017;95:159-161.

- Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
- Funding of all such programs (for 2016 financial year); and
- Costing of effective[12] programs carried out presently or in the past.

d) *Data analysis* - The in-country data were analyzed to explore agreement with or divergence from the Desk Review findings and to add data on barriers and affected populations missing from the Desk Review. This information, together with data on funding in 2016, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights-related barriers to HIV services in Honduras and propose a set of indicators to measure the impact of the comprehensive programs, using where possible those also suggested in *Plan Estratégico Nacional de Sida* (PENSIDA IV).

e) The proposed comprehensive response will be updated, costed and draft indicators to measure the impact of the comprehensive programs will be developed.

f) *Finalization and next steps*–Upon finalization, this assessment will be provided to the Global Fund Secretariat for use as background in preparation of an in-country multi-stakeholder meeting to develop a 5 year plan to reduce human rights-related barriers to HIV services in Honduras.

2.3 Costing methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who were discovered to have financed any activities in the seven human rights program areas for HIV were asked to supply details of the amount of funding provided and the program areas in which funding was provided; and, if possible, to state the type of activities and reach or coverage of funded activities.

Second, specific implementers were approached and information gathered on costs involved in carrying out specific interventions. This process will follow the Costing Guidelines (available from Global Fund on request). The expenditure lists and donors for HIV will be summarized in Annex 2. Individual costing sheets for programs and activities implemented by each of the organizations will be prepared.

Third, a prospective costing of the comprehensive program was carried out. This process will follow the Costing Guidelines (available from Global Fund on request). The results of this process are provided in Annex 3. For each type of intervention, an intervention-level cost was assembled.

Information was collected through visits to each participating organization and interviews with technical and administrative personnel at all levels. Information gathered from operational plans, proposals, settlements, and other documents provided the required costing information.

The information compiled during interviews centered on activities that the organizations implemented in each program related to human rights. The human rights-related activities in the context of HIV for which information was solicited were activities that occurred during the years 2015 and 2016.

The unit costs for activities included in the prospective costing of the 5-year comprehensive response were premised on the retrospective costs as well as on analysis of similar activities and other related elements such as geographic coverage and population reached per activity. These costs were used to construct calculation tables (see HIV calculation table in Annex 3). In these calculations, the number of services to be

[12] Effectiveness is determined either by evaluation or by broad agreement among key informants that a program is/was effective.

provided/people to be reached/trained will be multiplied by the intervention-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every few years, such as the PLHIV Stigma Index, and others require capacity building or other activities in the first year that are not needed in later years. Comment boxes to the right of each activity in these calculation tables show where the data came from to construct the calculation. These calculation tables were used to provide overall Program Area and Activity sub-activity budgets (see Annex 3), for each of five years as well as a five-year total. To account for the underestimation of the costing of activities by program area due to underreporting of some program-related costs, we have added a percentage share of program management (15%)costs to the total prospective costing calculation for each of the seven program areas (applying the assumptions GF uses for the reporting on the share of its investments in key populations services and programs to address human rights-related barriers, as mandated by KPI 9b), as well as specific activities of monitoring and evaluating and investigating to measure stigma and discrimination in HIV and key populations. These budgets were used to construct the five-year totals provided at the end of the HIV section of this report.

Furthermore, the rate of inflation was utilized and other elements were considered, such as previous costing estimates and average unit costs for necessary supplies for activities, all with the objective of unifying and standardizing unit costs.

Limitations

With regards to the retrospective costing, it should be noted that the tool for data collection was sent to a wide range of organizations, including key population networks, UN agencies (notably WHO, UNFPA UNAIDS), and INGOs involved in the response to HIV. This often involved visiting these organizations repeatedly for orientations on the tool and follow-up, as well as telephone conversations. Many organizations were not comfortable providing financial information, so the cost estimate of existing programs is likely an underestimate. Though unit costs for many outputs have been calculated, it was not possible for a number of activities, as it was extremely difficult to separate out the expenditures incurred for each of these activities because many headings including salary, utilities, transportations, and communications were shared by other interventions also. Moreover, many interventions also have multiple outputs at the same time. Further costing considerations are described in detail in Annex 4.

3. Findings: HIV

3.1 Overview of epidemiological context and key populations and populations in vulnerable situations

According to estimates and epidemiological projections by the Secretary of Health and UNAIDS in 2015, the adult prevalence of HIV for Hondurans ages 15-49 is 0.4%. While the registration system in Honduras has a breadth of challenges that make it difficult to know the actual numbers of all people living with HIV in Honduras, Honduras registered an accumulated 34,258 cases of people living with HIV between 1984 and 2016.[13] In 2016, 755 new infections were reported, 65% male and 35% female, with the most advanced infections occurring in the regions of Cortes, Francisco Morazan, and Atlantida.[14] Sexual transmission is the

[13]Secretaría de Salud, Gobierno de la República de Honduras. (2016). Plan de Sostenibilidad de las Subvenciones de Malaria, Tuberculosis y VIH/SIDA, Propuesta.

[14] Secretaría de Salud, Gobierno de la República de Honduras. (2016). Plan de Sostenibilidad de las Subvenciones de Malaria, Tuberculosis y VIH/SIDA, Propuesta.

most common path by which transmission takes place in Honduras.[15] In recent years, according to one study of Honduras in 2015, over 90% of new HIV infections are transmitted through heterosexual intercourse, with women accounting for a majority of these new infections.[16] At the end of 2016, there were 10,848 people taking antiretroviral therapy, which is estimated to be about half of those living with HIV.[17]

Honduras has a concentrated HIV epidemic among the following key populations: men who have sex with men, transgender people/transvestites/transsexuals, and female sex workers. Populations in vulnerable situations also report higher prevalence. These groups include incarcerated populations, as well as in the afro-Hondur population, an ethnic minority in Honduras.18The Inter-American Commission on Human Rights notes in a 2015 report that the dramatic increases in the prison population in the past decade have contributed to "serious structural deficiencies…in which the fundamental rights of prisoners are systematically violated"19. The majority of prison facilities rely on a "self-governance" system authorities have limited control over many day-to-day functions within prisons. As a consequence, Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersexed people are often particularly discriminated against. This is exacerbated by the failure of some prison facilities fail to effectively segregate male and female inmates or effectively classify the prison population, increasing the chances of sexual assault discrimination on the basis of sexual identity20. The provision of health services, especially for populations in vulnerable situations, is extremely poor in the prison system – a 2013 report found that the average number of inmates per physician was 1,446, with one large prison having a medical doctor visit only for three hours a day21. In this context, where even basic health care needs are not met, inmates with HIV-specific health concerns are especially unlikely to have their needs met, despite the presence of Integrated Attention Centers (CAI) in some prisons. The PENSIDA IV report notes that there continue to be difficulties in providing condoms to inmates in some prisons due to concerns that these be used for violence or suicide attempts.

In 2012, the HIV prevalence among sex workers was 3.3% in Tegucigalpa, 6.7% in San Pedro Sula, and 15.3% in La Ceiba. For men who have sex with men, the prevalence was 6.9% in Tegucigalpa, 10.7% in San Pedro Sula, and 11.7% in La Ceiba. In the urban Garifuna population, men had an HIV prevalence of 4.4%, and women had a prevalence of 4.6%. As for rural Garifuna, men's prevalence was 1.6%, and women's was 4.9%.[22] In terms of geographic distribution, reported prevalence is highest in the departments on the

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[15] CONASIDA, Gobierno de la República Honduras, ONUSIDA. (2015). *Resultados del Informe Nacional de Progreso de la Respuesta contra el VIH y el Sida.*

[16] Gandhi AD; Pettifro A; Barrington C; Marshall SW; Behets F; Guardado ME; Farach N; Ardon E; Paz-Bailey G. (2015). *Migration, Multiple Sexual Partners, and Sexual Concurrency in the Garifuna population in Honduras.* AIDS Behavior 19(9), 1559-1570.

[17] Secretaría de Salud, Gobierno de la República de Honduras. (2016). Plan de Sostenibilidad de las Subvenciones de Malaria, Tuberculosis y VIH/SIDA, Propuesta.

[18] USAID (AIDSTAR-One). (2009). Diagnóstico de los servicios de VIH/SIDA ofrecidos en los centros de atención integral en Honduras.

[19]Organization of American States Inter-American Commission on Human Rights. (2013), Report of the Inter-American Commission on Human Rights on the Situation of Persons Deprived of Liberty in Honduras. http://www.oas.org/en/iachr/pdl/docs/pdf/honduras-ppl-2013eng.pdf

[20]Organization of American States Inter-American Commission on Human Rights. (2015). Situation of Human Rights in Honduras. http://www.oas.org/en/iachr/reports/pdfs/honduras-en-2015.pdf

[21]Organization of American States Inter-American Commission on Human Rights. (2013). Report of the Inter-American Commission on Human Rights on the Situation of Persons Deprived of Liberty in Honduras. http://www.oas.org/en/iachr/pdl/docs/pdf/HONDURAS-PPL-2013ENG.pdf

[22] CONASIDA, Gobierno de la República Honduras, ONUSIDA. (2015). *Resultados del Informe Nacional de Progreso de la Respuesta contra el VIH y el Sida.*

Atlantic coast and in the Sula Valley, though the highest numbers of people living with HIV are in the urban areas of Tegucigalpa, San Pedro Sula and La Ceiba. The PENSIDA IV report noted an alarming increase in HIV incidence between 2006 and 2012 in HIV prevalence among key populations,[23] though the reasons for these increases are not entirely clear.

3.2 Overview of the policy, political and social context relevant to human rights-related barriers to HIV services

3.2.1 Protective laws (with challenges of enforcement)

Honduras has a relatively progressive legal framework with regards to the rights of people living with HIV, though overall protections of human rights are less developed.

The Optional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (Protocol of San Salvador) was ratified by Honduras on November 10th, 2011. The State presented the National Reports corresponding to the First and Second Groups of Rights in June 2017, in accordance with its international commitments, a process that was carried out in coordination with the relevant institutions from the Special Response Group on Human Rights. These reports were evaluated by the Protocol of San Salvador Working Group, who commended the State for having included the majority of the indicators in their reports and urged for compliance on the missing indicators in time for the next State report.

In 1999, a "Special Law about HIV/AIDS" (*Ley Especial sobre VIH/Sida (Decree No. 147-99)* was approved, with the main objectives of establishing mechanisms for inter-institutional coordination of efforts, assigning duties to government entities and roles for civil society in the context of HIV, and to solidify the rights and duties of people living with HIV. The law explicitly acknowledged the right of people living with HIV, including those who are incarcerated, to access timely and appropriate health care, and established anti-discrimination regulations for health care professionals, employers, and within educational settings. The law also formally led to the formation of the National Council on HIV/AIDS, known as CONASIDA (La Comisión Nacional de Sida), which is responsible for coordinating the national response to HIV and integrating it into the government institutions in which it is relevant.[24] This was followed by the development of the *Plan Estratégico Nacional de Sida (PENSIDA)*, with the goal of developing a coordinated, national-level governmental response to the epidemic. At this time, PENSIDA IV is the most current version of this plan. The response advocates not only for prevention, but also treatment and support for people living with HIV. The enforcement of the human rights components of these laws is enforced through the National Commission of Human Rights (CONADEH – *Comisionado Nacional de los Derechos Humanos*).

As of 2013, the reform of the Penal Code, Article 321, prohibits discrimination based on sex, gender, age, sexual orientation, gender identity, party membership or political views, marital status, being a member of an indigenous or Afro-descendant group, language, nationality, religion, family status, economic or social status, different abilities or disability, health conditions, physical appearance or any other factor that

[23]Comisión Nacional de SIDA, República de Honduras. (2015). Plan Estratégico Nacional de Respuesta al VIH y SIDA en Honduras (PENSIDA IV) 2015-2019.
[24] UNAIDS. (2014). National Commitments and Policies Instrument (NCPI) Honduras Report.

violates the human dignity of the victim and establishes such discrimination as a potentially aggravating factor in a range of crimes,[25] in reality, however, it does not seem to afford much protection.

At the sub-national level, individual cities and municipalities have considered legislation to protect the rights of people living with HIV and other key populations. In 2014, San Pedro Sula was the first city in Honduras to put in place a policy that would increase the rights and dignity of people living with HIV with relation to workplace policy. The act recognizes the response to the epidemic as a corporate social responsibility, meaning that the dismissal of employees living with HIV, hiring discrimination, and mandatory HIV testing are violations that are prohibited in the workplace. Further, status confidentiality between employer and employee was stressed. However, since 2014, no other cities have moved forward significantly on employees' rights in the context of HIV.[26]

In 2017, the Government of Honduras Secretary of Health set out a proposal plan for an integrated and sustainable health system plan, known as the Plan de Sostenibilidad. This plan focuses on TB, Malaria, and HIV, and the integration of a national system that encompasses health and social problems associated with them. This includes implementing an integrated information system of health (SIIS) for HIV, malaria, and TB, and to develop an advocacy resource to assure sustainable reporting of the diseases and contribute to an analysis in risk reduction. Specifically for HIV, the focus is in lowering cases and transmission rates, and making an emphasis on key populations, human rights, and gender equity. This plan has yet to be finalized.[27] How the punitive legal environment acts as a barrier to HIV services in Honduras will be examined in section 2.5.

Challenges of enforcement and other gaps:

While this legal framework provides a robust system for the protection of the human rights of people living with HIV, enforcement and implementation of these legal protections remain poor. The failure to operationalize legislative protection in part reflects broader challenges within the Honduran legal system, including more broadly around human rights, though there are a number of particular features related to HIV. Generally, research participants reported that these laws provided little in the way of direct protection, with a general culture of impunity regarding violations of the rights of key populations (KII1, KII3, KII12, FGD1,3). This is supported by evidence of prosecutions or resolutions of reported cases of human rights abuses. In 2016, CONADEH reported 58 complaints related to HIV and AIDS received nationally which corresponded to the following issues: 10 on the right to personal integrity, 11 regarding the right to work, 1 regarding the right to life, 3 regarding the right to due process, twenty-seven regarding the right to health, and 5 regarding the right to personal security and privacy.

Although CONADEH has attended a considerable number of cases, the focus group informants have mentioned that the actual incidence of discrimination would be much higher if there were more effective

[25]Articles 321 and 321-A of the Penal Code (as amended by Decree No. 23-2013); see also Carroll A, Ramón Mendos L. State-sponsored homophobia: A world survey of sexual orientation laws. Geneva: IGLA, 2017.
[26]IDLO. (2016). Honduras: First city adopts policy on HIV in the workplace. http://www.idlo.int/news/highlights/honduras-first-city-adopts-policy-hiv-workplace
[27]Secretaría de Salud, Gobierno de la República de Honduras. (2016). Plan de Sostenibilidad de las Subvenciones de Malaria, Tuberculosis y VIH/SIDA, Propuesta.

implementation mechanisms in place. The relative impunity that arises due to the ineffective mechanisms enabled was broadly acknowledged by virtually all research participants as a point of frustration (e.g. KII1, KII3, KII12, KII16), though many also viewed this as part of a general challenge with the implementation of laws regarding human rights and law enforcement generally. Finally, the Special Law itself includes no specific protections for Lesbian, Gay, Bisexual, transgender people/transvestites/transsexuals and Intersexed people, including their broader right to treatment or health care– the exception being for HIV (KII6, KII18).
The age of consent to HIV testing and other health services is 18, limiting the ability of adolescents and children to access services without parental consent.

3.3 Human rights-related barriers to access, uptake and retention in HIV services

The major barriers to the full realization of human rights identified through the Desk Review and confirmed by the key informants and focus groups were:

- Stigma and discrimination against key populations and populations in vulnerable situations, including people living with HIV, is pervasive and includes continued stigma and discrimination in relation to HIV generally, specific stigma related to belonging to certain populations, and significant self-stigma.
- The lack of effective implementation of legal protections and punitive regulations for people living with HIV represents a persistent barrier to access for key populations, particularly female sex workers, men who have sex with men, transgender people/transvestites/transsexuals, and people who use drugs.
- Gender inequalities and power dynamics create vulnerabilities for women and adolescent girls, particularly in the context of intimate relationships.
- Sociocultural, physical and economic barriers – including the inability to pay for health insurance, transportation and physical travel to ART centers and laboratory tests for monitoring treatment – is a salient barrier for people living with HIV to access, enroll, and remain in services.
- Inconsistent quality of service in the health care settings, including stigmatizing and discriminatory treatment and a lack of empathetic and holistic approaches to care represents a significant barrier to effective use of available services.

It is important to also note that many other barriers to services were identified - including a lack of facilities for assessing viral load, leaving people uncertain about effective treatment options; and limited HIV and/or ART centers, which mean people living with HIV may have to travel on difficult roads and/or long distances for treatment (especially in rural areas). While these barriers do not fit squarely under any of the headings below, they all affect standards of availability, accessibility, acceptability, and quality of services, and thus the realization of the right to health. Furthermore, there are a number of broader contextual factors related to human rights that impede access to services that are beyond the scope of this assessment but merit discussion. These include the extremely high rates of violence in Honduras; high rates of poverty, especially in rural areas; unequal gender norms and practices, which in turn influence the very high rates of gender-based violence in the country; corruption; and the impunity that results from a legal system that is unable to cope with the level of criminal behavior.

3.4 Stigma and discrimination

Despite the right to live free from discrimination being an immediate legal obligation in all human rights instruments to which Honduras is a party, participants in interviews and focus groups described stigma and discrimination against key populations and populations in vulnerable situations, including people with HIV generally, as pervasive, confirming findings from the desk review. Low level of knowledge, attitudes, and social norms negatively contribute to the formation and resiliency of stigma in all levels of society. In the country's Global AIDS Monitoring progress report[28,29], it was reported that only half of respondents in a survey would buy fresh fruits from a vendor with HIV. One recent report stated that the level of stigma experienced is higher among the following groups: older people, transgender people/transvestites/transsexuals, those with lower levels of education; people who have migrated to another country, bisexuals, and those whose self-perception of their health is particularly low.[30] High levels of discriminatory attitudes were also found in a public opinion survey conducted by USAID in 2016, with 35.5% of Hondurans believing that God punishes sex workers and gay men with HIV for their way of life; 33.3% agreeing that employers should have the right to test prospective employees for HIV; only 41% agreeing that women living with HIV have the right to become pregnant; almost 70% agreeing that children living with HIV should have to receive a separate education from the general population of children; and only 85.6% of respondents agreeing that people living with HIV should have access to public spaces.[31] Overall, 40.3% of people living with HIV said they had encountered forms of stigma and discrimination, and only 15% of people living with HIV felt they could comfortably disclose their HIV status beyond their close friends and families. Even within the healthcare settings, issues with confidentiality, stigma and discrimination are relatively commonplace for people living with HIV in Honduras.[32].

The high level of stigma experienced by people living HIV has a number of negative impacts on the utilization of services, rapid diagnosis and treatment, adherence to treatment, and the realization of the rights to quality care that Hondurans are entitled to.[33] Because of actual and feared stigmatization by the community as well as service providers and the fear associated with being diagnosed as HIV-positive, individuals are often reluctant to get tested. As a result, many people living with HIV are not aware of their HIV status and less than half of people living with HIV in Honduras are receiving antiretroviral treatment.[34] In one report, 11.8% of those interviewed reported mistreatment in health services, and 20.5% considered it necessary to hide their diagnosis of HIV from health providers.[35] Not only do stigma and discrimination violate the human rights of those who suffer, they also obstruct the efforts of public health in the prevention

[28] UNAIDS. Global AIDS Monitoring.http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting

[29]UNAIDS. (2017) Global AIDS Monitoring 2018: Indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf

[30]REDCA+. (2017). Perfil de Riesgo de Personas con VIH de los paises beneficiarios del Programa Regional REDCA+ 2016-2017, Informe Final de la Encuesta Realizada en Honduras.

[31] PEPFAR, USAID, PASCA. (2016). *Estigma y discriminación en relación al VIH y sida en Honduras: Encuesta de opinión pública 2013-2016*.

[32] Elías CDV, Ortega YG. (2014). *Cuidado de Enfermería en Pacientes con VIH: Estigma y Discrimación.* Revista Científica de Enfermería, 16(11), 24-36.

[33] Ciudad, JM, González RA, LLAVES. (2014). Informe Ejecutivo: Índice de Estigma en Personas que Viven con VIH.

[34] Comisión Nacional del SIDA, República de Honduras. (2015.) Plan Estratégico Nacional de Respuesta al VIH y SIDA en Honduras (PENSIDA IV) 2015-2019.

[35]REDCA+. (2017). Perfil de Riesgo de Personas con VIH de los paises beneficiarios del Programa Regional REDCA+ 2016-2017, Informe Final de la Encuesta Realizada en Honduras.

of new HIV infections and the reduction of impact of the epidemic on individuals, families, and communities.[36] This is true within the health-care system itself, where experience with stigmatizing attitudes and behaviors can have strong effects on a person's likelihood to search out testing, participate in treatment, and become adherent to treatment[37], a pattern confirmed by respondents in both the KIIS and FGDs (e.g. KII1, KII2, KII3, KII8, KII11, KII15, FGD1,FGD4).

There was strong consensus among research participants regarding the importance of HIV-related stigma and discrimination as a barrier to the realization of the rights of individuals. For example, fear of a positive diagnosis and the resulting stigmatization was listed by multiple respondents as resulting in avoidance of testing (KII1; KII3); others mentioned the risk of being recognized while attending specialized services and then being labelled as being HIV-positive as a barrier to seeking care (KII2, KII11; FGD1); and others reported that employers commonly require individuals to undergo HIV-testing (often disguised as part of a general health check) prior to being considered for employment (KII10, KII11, FGD1, FGD2).

Stigma related to key populations and populations in vulnerable situations

Key populations and populations in vulnerable situations often encounter multi-layered forms of stigma and discrimination that are based both on their identification as members of these populations and because of the assumed relationship this identity has with HIV, as exemplified by a focus group participant who said:

> "*if they [health system personnel] see a trans girl who was stabbed, they don't even want to touch her because of the stigmatization, that all the homosexual people and trans have HIV…so what do they do? They wait to have her tested to see if she has HIV or not…they won't attend to her because there might be contact and the medical staff might get infected*" (FGD1)

Research participants reported high levels of stigmatization and discrimination based on sexual orientation, with both **men who have sex with men** and **transgender people/transvestites/transsexuals** being particularly vulnerable in this regard (KII18, FDG1). As in other settings, non-hetero-normative sexual orientations are considered by many in Honduras to be immoral and sinful, creating psychosocial pressures that are particularly acute when paired with a positive HIV diagnosis (KII18, FDG3). The consequences of this can be severe - in some cases, participants reported cases where individuals were denied the right to basic health care due to suspicion of their HIV status (KII18), as recounted by an FGD participant in San Pedro Sula:

A similar dynamic is true for **female sex workers**, who occupy an uncertain legal position in Honduras. They simultaneously experience the stigma and discrimination associated with being women in a society where women are very disadvantaged and being a sex worker. Women in their profession are often viewed as promotors of immorality and are assumed to be HIV-positive (KII2). While not mentioned as often by research participants, other populations such as **incarcerated people** and **people who inject drugs**

[36] ONUSIDA, UNODC. (2007). Manual sobre el VIH y los Derechos Humanos para las Instituciones Nacionales de Derechos Humanos.
[37] USAID (AIDSTAR-One). (2009). Diagnóstico de los servicios de VIH/SIDA ofrecidos en los centros de atención integral en Honduras.

also faced multiple forms of stigma and discrimination, again often because of the assumed links these groups have to HIV.

Direct impacts of stigma on accessing services

Fear of disclosure of HIV-status

Research participants reported the fear of disclosure of HIV-status (or the assumption of being HIV-positive) as being a significant barrier to the use of HIV services for all key population groups. In particular, participants reported that being seen using services would effectively 'label' them as someone living with HIV (KII, FDG1). This fear was particularly acute when referring to centers dedicated to or specializing in providing HIV care, such as the VICITS (Vigilancia Centinela de las Infecciones de Transmisión Sexual) and SAI (Servicios Atención Integral) centers, where research participants described how being seen resulted in assumptions and gossip about their HIV status (FDG1). This fear was also true in more integrated or mixed health settings, however – several research participants noted that the lack of confidentiality within the medical system allowed access to medical information to a wide range of staff members and increased the chances that others also being attended would assume HIV status based on the types of medication or treatments being prescribed, or the particular doctor who was attending them (KII1, KII2, KII3, KII8, KII11, KII16, FDG1). As one FGD participant described it *"that is why they won't want to go to a VICIT clinic, because of fear of 'signaling', the signal that because she goes there, she has an infection"* (FGD1).

Poor quality service in health-care settings

Research participants reported wide variations in the quality of the service in health care settings, particularly as this relates to stigmatizing behaviors, confirming findings from the desk review.[38][39] Often, participants discussed individual doctors or groups of staff members who were trusted and viewed as creating safe and comfortable environments, but the system as a whole was not viewed as being empathetic to the needs of patients or respectful of their needs (KII, FDG). Several participants noted that doctors viewed them solely as HIV patients, often largely ignoring other health needs and failing to provide holistic and comprehensive care (KII, FDG). As one FGD participant described her visit to the clinic, *"on one occasion I went with stomach pain and problems with hemorrhoids and the first things she [the doctor] did was check if I needed an HIV test…in the end she didn't do anything, she made me waste my time because she checked my throat and pelvis, but nothing for the stomach"* (FGD1). Participants reported feeling labelled solely as HIV patients rather than being treated as an individual with particular health needs – as one female sex worker described it, the health staff only considered her "from the waist down" (KII2), echoing the findings of earlier studies.[40]

These issues with treatment were often compounded by explicit experience with stigma in the health setting itself. Focus group participants discussed experiences with health care providers, including a counsellor, where the providers explicitly blamed clients' immoral behavior for their infection and suggested religious conversions or treatments (FGD4). In some cases, participants reported medical staff enquiring about

[38] RedTraSex, Akahata, Global Initiatives for Human Rights, Human Rights Committee. (2017). Human Rights Situation of Women Sex Workers in Honduras- Additional information submitted to the Working Group.
[39] Key Informant Interview with Mirta Leticia Valle at CEPROSAF, Oct 13, 2017.
[40] RedTraSex, Akahata, Global Initiatives for Human Rights, Human Rights Committee. (2017). Human Rights Situation of Women Sex Workers in Honduras- Additional information submitted to the Working Group.

future plans to have children and suggesting women living with HIV not have children (KII12, KII18, FGD2). Even more common was a disregard for confidentiality and privacy, with health records commonly shared among staff and medical students routinely attending or conducting examinations without the prior consent of the patient (FDG1, FGD4). In more extreme cases, as described above, respondents reported knowing of cases where patients suspected of being HIV-positive were refused prompt treatment (KII18, FDG1).

Overall, there was general consensus among participants that the medical system in its current form was failing to treat people living with HIV with any significant degree of empathy or humanity, creating an environment where patients have little choice in their treatment and are often treated in a judgmental fashion (KII6, KII9, KI11, FDG3). This lack of empathy and the dehumanization of people living with HIV and other key populations was reported as taking multiple forms. In addition to feeling largely viewed from the perspective of their status as members of key populations and their serostatus, respondents reported numerous indignities they experienced within the medical setting. This ranged from the violations of confidentiality and privacy described above to open discrimination from medical personnel. One example of the latter was an insistence of many medical staff on calling transgender people/transvestites/transsexuals by their male or 'birth' name rather than their preferred 'assumed' name and continuing to refer to them using male pronouns (KII18, FDG1). Multiple respondents reported being asked to be at the clinic early in the morning, only to wait hours for treatment, while others reported punitive practices related to inflexible application of clinical guidelines. One key informant described missing her appointment by a day as the result of a scheduling mistake, which led to her being given only one week of medication and required to consult with a psychologist before returning for another appointment where she was given her medication (KII6). This pattern was confirmed by the accounts other people living HIV in focus groups, who also viewed this process as representing a punishment rather than as a safeguard against discontinuation (FGD3).

The failure of the medical system to provide services in a humane manner was viewed as a major barrier to the effective use of these services, dissuading individuals from continued use of services (KII4, KII8, KII9, KII11, KII18, FDG3). These barriers are especially problematic for those for whom accessing services is already difficult – for example, potentially having to return twice in the space of a week is especially difficult for people from rural areas who have to travel long distances, navigate dangerous and unfamiliar neighborhoods, and for whom cost is a major factor (KII11). Other practices, such as setting up appointments in the early morning, pose problems for key populations, such as sex workers, who often are working at night (KII1,2, FDG1). Unfortunately, respondents reported that in many regards the lack of humane treatment has worsened in recent years, despite efforts to sensitize medical staff. When asked why this is the case, numerous respondents pointed to recent changes to the health system that have increased the rotation of staff, meaning that efforts to sensitize individual doctors or staff members to the needs of specific populations are often wasted when the individual is required to move to another center (KII3, KII5, KII7, KII8, KII12, KII13, FDG1).

3.5 Punitive policies, laws and practices

Criminal laws

The legal environment surrounding HIV in Honduras carries both positive and negative laws and policies that affect people living with HIV, including key populations and populations in vulnerable situations affected by the disease. Throughout the legal framework in Honduras, there is a strong emphasis on wording in the language that describes not only the "rights" of people living with HIV defined and pushed as necessary to be protected, but also their "duties." With regard to HIV, these 'duties' are often linked to punitive laws or policies that potentially represent barriers to the access individuals and groups have to health services and the level to which these services are used.

One prominent example of this is Articles 180, 184 and 186 of the Criminal Code of Honduras (Decree No. 144-83), which require compulsory disclosure of serostatus to intimate partners and criminalize intentional transmission. Article 180 declares that: to anyone who intentionally spreads a dangerous illness or causes an epidemic through the spread of pathogens, there will be imposed an imprisonment for 3 to 6 years. Article 184 states: If the configured crimes from the preceding articles prove the death of a person, they are liable to be punished with a sentence of homicide, depending on the circumstances of the incident. And finally, article 186 declares that anyone who violates the provisioned measures may be punished with imprisonment of six months to two years in order to prevent the introduction or spreading of an epidemic.[41]

While both key informants and key population groups interviewed as part of FDGs were aware of the broad legal framework, including the more punitive aspects, few mentioned them as very significant barriers to their use of HIV services specifically– rather, as described above, most simply viewed the laws and policies designed to protect their rights as poorly implemented and enforced (KII1, KII3, KII5, KII6, KII10, KII11), or in the context of broader stigmatization or discrimination against particular key populations. A general lack of knowledge about these laws, both in the general population and within key population groups, was also seen as contributing to an acceptance of violations of rights, even when these were linked to lower use of services by key population groups (e.g. KII2, KII3, KII15). Among the key populations research participants mentioned as having particularly fewer legal protections, on paper or in practice, were female or transgender sex workers, transgender people/transvestites/transsexuals and Lesbian, Gay, Bisexual, Transgender/Transvestites/Transsexual and Intersexed people.

The concerns of **female sex workers** and, to a lesser extent, **transgender people/transvestites/ transsexuals sex workers**, centered primarily on the ambiguity of the legal status of sex work in Honduras. While sex work is not penalized, the law of Citizenship Coexistence prohibits the presence of sex workers in the night-time hours, creating situations where sex workers are particularly vulnerable to police harassment (KII2). This ambiguity also makes it much more difficult to seek protection from police in the event of abuse on the parts of clients, street gangs and others – as both key informants and focus group participants described it, the only applicable rules for much of their work is the 'law of the streets' (KII2, FGD1). Furthermore, because sex work is not officially recognized as a legal profession, sex workers cannot take advantage of legal protections in the workplace, contribute to pension plans, or use their employment as justification for bank loans, all of which contribute to the economic vulnerability many commercial sex workers face (KII2, FGD1).

The reforms to the Penal Code (Article 321), enacted in 2013, prohibit discrimination based on sexual orientation and establishes such discrimination as a potentially aggravating factor in a range of

[41] Código Penal de Honduras. Decreto 144-83 de 26 septiembre de 1983.

crimes,[42] but in reality it has not seemed to afford much protection for the Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed population. Numerous observers in the baseline assessment noted high levels of violence and hate crimes against Lesbian, Gay, Bisexual and Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed people, which has also been documented by the Inter-American Commission on Human Rights, among others.[43] While violence, included gang violence and violence perpetrated by organized crime networks, is generally among the highest in the world per capita in Honduras, Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed people are particularly targeted because of widespread stereotyping and discriminatory attitudes.[44] Efforts to address the violence (including stronger language in the proposed Law of Gender Identity) have encountered particularly strong opposition from religious and cultural groups – these discriminatory views have even led civil society organizations to avoid using the terms 'gay' or 'LGBTI' in their names or statutes, as this is viewed as attracting greater opposition (KII18). When asked about specific vulnerabilities faced by different groups, however, a number of focus group discussants spoke of the specific difficulties the **transgender population** faced, in part because they are unable to 'hide' their identity in the way that a gay man, for example, may be able to (FDG4).

Health policies and practices

In addition to specific components of the legal framework that pose human rights-related barriers to the access and use of services by key populations and populations in vulnerable situations, research participants also pointed to specific policies and practices within the health sector as being significant obstacles to their use of health services. As noted above, everyday practices within clinics may contribute significantly to the stigma patients may feel and to the quality of the care they feel they receive. In particular, respondents reported specific practices (some described in more detail above) that they viewed as especially problematic:

- A lack of empathy and understanding of the constraints faced in accessing health care. While this was particularly clearly described in terms of the policies around missed appointments for ART monitoring, as described above, this was a consistent concern for all groups included in the research.
- In some cases, respondents reported feeling that care was at times driven by core indicators that the health system or service provider was being assessed by (such as the number of new cases identified). As one FGD participant described *"they are just numbers, what matters to them is numbers…the human being becomes dehumanized to turn them into numbers, and that is where there is a lack of focus on human rights"* (FGD4). This was true also for civil society organizations – for example, respondents in two different locations reported that a civil society organization that they worked with had a policy of providing them with only 17 condoms and seven lubricants per year, numbers that were clearly insufficient for many of them. While commercial sex workers were provided with larger quantities (130 condoms per year), this also was much less than required, meaning that a visit to a health center was required in order to

[42]Articles 321 and 321-A of the Penal Code (as amended by Decree No. 23-2013); see also Carroll A, Ramón Mendos L. State-sponsored homophobia: A world survey of sexual orientation laws. Geneva: IGLA, 2017.
[43]Inter-American Commission on Human Rights. Situation of human rights in Honduras. Washington, DC, 2016.
[44] Ibid.

access affordable condoms. Respondents reported suspecting that this was because the organization had committed to a target number of individuals to whom condoms and lubricants would be distributed, rather than a genuine attempt to appropriately provide for their needs (KII9, FGD1, FGD4).

- As noted above, the persistent use of 'birth names' for transgender people/transvestites/transsexual individuals in the medical setting, even when it was requested that the social name be used, was of particular concern to this group, particularly as the law does not provide the option of easily changing names or gender on formal identification documentation
- While medical services for people living with HIV are by law provided free of cost, it is clear that in some cases people living with HIV face pressure to pay for services or medication – this is particularly the case for more specialized treatments (KII14)
- A further policy mentioned by both key informants and focus group participants related to how the needs of youth were catered for within the health system, including by civil society organizations (KII6, KII18, KII13, FGD1). According to these accounts, minors, including those separated from their families, require parental permission to access most services, and civil society organizations are unable to provide them with any form of service. This means that even street children or children victims of sexual exploitation have few options to access critical components of prevention services, such as access to harm reduction, condoms or lubricants, or testing and treatment.
- Finally, there was virtually complete consensus among research participants that recent changes to the health system, particularly in shorter term contracting of health workers and much more frequent rotation of staff, were problematic (KII3, KII5, KII7, KII8, KII12, KII13). From the perspective of individual clients, these policy changes have disrupted established relationships with individual doctors and staff members who are viewed as particularly sensitive to the needs of key populations. From the perspective of civil society and government organizations that focus on capacity building and sensitization of medical personnel, this means that significant investments in building relationships and understanding with staff must effectively start over once individuals are rotated out and new staff is introduced. In the absence of standardized and institutionalized capacity-building programs for health staff, this creates considerable variations in the quality of the service experienced at health centers and may lead to lower utilization of services. This is particularly an issue because doctors and nurses in the SAIs do not have to be HIV specialists or even necessarily receive specialized training in HIV treatment, especially outside of the major urban centers.
- The organization of healthcare facilities can be confusing and frustrating for patients.[45] In particular, the fragmentation of services, which requires that patients sometimes have to move between sections of hospitals or attend different facilities for different types of services, such as testing and counselling or laboratory analyses. While respondents did feel that the integrated systems were easier to navigate, this challenge remained for some (FGD1).

[45] USAID (AIDSTAR-One). (2009). Diagnóstico de los servicios de VIH/SIDA ofrecidos en los centros de atención integral en Honduras.

3.6 Gender inequality and gender-based violence

Gender inequalities exacerbate women's risk of acquiring HIV around the world, making it a key component of commitments to end the epidemic. Gender inequality in the context of HIV shapes the health and well-being of women with HIV through harmful gender norms and violence, stigma and discrimination, lack of decision-making power and control over economic resources, and limitations of sexual and reproductive freedoms.[46] Honduras also has one of the highest murder rates in the world, as well as one of the highest femicide rates.[47]USAID reports that violence and crime, including gender-based violence, is the most destructive social problem in Honduras. Data presented by the National Observatory of Violence in 2017 reported that between 2009 and 2016, 3,962 women were murdered. In 2016 there were 463 cases of femicide and 388 in 2017, with impunity in the resolution of cases as high as 95%[48]. An estimated average of 3077 reports of sexual crimes against women and girls have been made over the past five years, with only 25% reaching the courts. Prior research found that in 60% of cases where women were murdered, the alleged aggressors were partners, ex-partners, or relatives, suggesting a high level of intimate partner violence.[49] Recent research in Honduras found a direct relationship between HIV infection and accounts of power inequality, physical abuse, psychological, sexual, and verbal abuse, as well as the inability to decline sexual relations with their partner, or negotiate for safe sex for one-third of women[50]. This reality was noted by research participants as well, who noted both that women in abusive relationships were less likely to be able to take steps to protect themselves from infection or seek effective treatment (often the result of fear of stigma associated with the husband's status being disclosed) and that women living with HIV were also subject to higher rates of violence as a result of their condition (KII, FGD).

Women living with HIV also face specific violations of their reproductive rights. Women living with HIV in Honduras have experiences of forced or coerced sterilization, often a feature of the HIV experience in Latin America,[51] with the Inter-American Commission on Human Rights (IACHR) expressing concern for the consequences of limitations on sexual and reproductive rights in the country.[52] This was also the experience of some of the research participants – as one FGD participant described, *"when they [women living with HIV] have found they are pregnant, they have the right to be mothers, so what has happened is that the doctor that is on duty doesn't want to attend to her and the clinic closes, and he doesn't attend to her"* (FGD2). Others reported that it was more challenging for women living with HIV to get gynecological services (KII12).

Finally, the role of social norms of masculinity and femininity in shaping broader debates around HIV and sexuality in ways that contributed to other barriers, particularly stigma and discrimination, was raised by a

[46]Amin, Avni. (2015). Addressing gender inequalities to improve the sexual and reproductive health and wellbeing of women living with HIV. Journal of the International AIDS Society 18(5).
[47] Guillen Soto MS, USAID. (2013). Gender Analysis USAID/Honduras 2013.
[48]Boletín Muerte Violenta de Mujeres y Femicidios, del Observatorio de la Violencia del Instituto Universitario de Democracia, Paz y Seguridad (IUDPAS) de la Universidad Nacional Autónoma de Honduras (UNAH) https://iudpas.unah.edu.hn/observatorio-de-la-violencia/boletines-del-observatorio-2/unidad-de-genero/
[49]UNDP. (2013). Conservatorio Nacional de Honduras: Hoja Informativa.
[50]Serna, R. (2016). Violencia de género, vulnerabilidad a infectarse con VIH y estrategias de afrontamiento en mujeres. *Iniges-Forosida.*
[51] Kendall T, Albert C. (2015). *Experiences of coercion to sterilize and forced sterilization among women living with HIV in Latin America*. Journal of International AIDS Society 18(1).
[52]Inter-American Commission on Human Rights, Organization of American States. (2015). Situation of Human Rights in Honduras.

number of the respondents. These were seen as contributing to bias against the LGTBI population in particular, but also as placing women at particular risk, as these norms disempower women, make it challenging to negotiate safe sex in relationships, and create situations where actions by their male partners, such as having multiple sexual partners, place women at particular vulnerability (KII10). These norms were also seen as contributing to the stigmatization of women living with HIV, who are often assumed to have been infected through immoral sexual behavior and therefore experience what one key informant termed a "double stigma" (KII10). Finally, women bear the burden of caring for family members living with HIV and often make up the majority of volunteers for HIV-related activities, roles that are often overlooked in the national debate on HIV (KII10).

3.7 Sociocultural, economic, and physical barriers to health services

In addition to the barriers described above, many of the participants also made reference to more macro-level factors that are barriers to access or use of services. In particular, economic costs, lack of access to services in rural areas, cultural/religious opposition, migration patterns, and the marginalization of the Garifuna population were raised in multiple conversations.

In economic terms, there was broad consensus among research participants about the importance of poverty and geographical isolation as barriers to accessing services. While HIV services are provided free of charge in most cases, many respondents described in detail the economic challenges associated with having to travel long distances to services, which typically required taking a day away from employment, significant transportation costs, and often costs associated with accommodation (KII1, KII6). As a result, poverty remains a major barrier for many. The economic challenges rural residents face also contribute to high rates of migration, both within Honduras and internationally – contributing to new infections through separating families and exposing migrants to environments where infection may be more likely. As most of these migrants are men, the increased exposure to potential infection via migration is something that places women at higher risk as migrant men return to Honduras (KII10). Further, evidence suggests that people living with HIV in Honduras typically have a low education level and limited job opportunities.

Cultural and religious values, particularly conservative religious values within the Catholic and evangelical churches, were also raised in a number of interviews and discussions. These were seen as underlying many of the broader values that lead to the stigmatization of people living with HIV and Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed populations, inequitable gender norms, and the lack of the development or implementation of further legal protections of the human rights of key populations (e.g. KII4, KII18, FGD1, FGD4). The political influence of these religious bodies is significant, posing significant challenges to the passage of legislation protecting key population groups or the extension of comprehensive sexuality education to youth.

Finally, as described in the desk review, the Garifuna population is affected by economic, social, and physical barriers to services. The rural locations where the majority of the Garifuna live make access to services particularly challenging, as do the higher rates of poverty in the population. Social norms within the Garifuna, particularly a high acceptance of multiple sexual partnerships and very low levels of condom

use,[53] also were seen as representing unique challenges, particularly in terms of developing effective programmatic interventions (KII11). Multiple respondents also reported discrimination against the Garifuna population, creating a situation of dual discrimination for Garifuna living with HIV (KII6, KII11).

The geography of Garifuna populations can also be a contributor to the experience and risk of HIV. One research study determined that, after adjusting for other variables and confounders, poor Garifuna in urban areas had higher rates of HIV infection than those in rural areas. A key informant at CEPROSAF stated that medical services were not typically available in rural areas, and people living with HIV who live in rural areas are forced to spend money and time to travel for services.[54] Further, violence and sexual abuse continue to be major problems, which limits the ability of Garifuna women to protect themselves against HIV, other STIs, and unwanted pregnancy. [55]

3.8 Description of the main interventions used to address barriers and recommendations for a comprehensive approach

Overview

The importance of human rights in achieving Honduras' 'three zero' goals for HIV (zero new HIV infections, zero discrimination, and zero AIDS-related deaths) is clear in PENSIDA IV, underpinning the first of the four national-level proposed strategies for combatting the epidemic in the country. This strategy ("public policy and social action with a focus on human rights and gender equity") focuses on the importance of following international guidelines in response to HIV, and carrying out work through all sectors of society, such as nongovernmental organizations, government offices and ministries, and civil society. While the implementation of the recommendations included in PENSIDA IV has been uneven, Honduras does have a relatively robust public health infrastructure and range of services available through both governmental and non-governmental and community-based entities.

As Honduras has increased the services available to key populations and populations in vulnerable situations and those living with HIV, the budget allocated to these has generally increased over time, though recent strains on the health system have also impacted budgets available for HIV. In 2016, USD$32.3 million was spent on HIV programming, representing the equivalent of 5.49% of the national health budget. At that point, over 25%of the overall AIDS resources came from foreign donors.[56] As a part of this, the Global Fund has disbursed $122,777,370 for HIV-related work in Honduras, some of which supported the seven human rights program areas, either directly or as a part of broader programmatic efforts.[57]

Many key informants referred to the important role that NGOs have played in working with key populations, especially in advocacy for the reduction of human rights-related barriers to services. Many of

[53] Paz-Bailey, G., S. Morales-Miranda, J. Jacobson, S. Gupta, K. Sabin, S. Mendoza, M. Paredes,; B. Alvarez; and E. Monterroso. 2009. High Rates of STD and Sexual Risk Behaviors Among Garífunas in Honduras. *Journal of Acquired Immune Deficiency Syndrome*, Vol. 51, p. S26-S34.

[54]Key Informant Interview with Mirta Leticia Valle at CEPROSAF, Oct 13, 2017.

[55] Comisión Nacional del SIDA, República de Honduras. (2015). Plan Estratégico Nacional de Respuesta al VIH y SIDA en Honduras (PENSIDA IV) 2015-2019.

[56]CONASIDA. (2016). Estudio de Medición del Gasto en Sida, (MEGAS). Honduras, 2016.

[57]The Global Fund. Honduras Overview. https://www.theglobalfund.org/en/portfolio/country/?loc=HND&k=38565614-b542-4558-96f5-6c0ab3e36f97

the interventions described empower and engage key population representatives to be strong advocates for increased access to services and support among law enforcement and health care providers for this access. A summary description of existing or recent interventions to address human rights-related barriers to HIV services for each Program Area is presented below.

PA 1: Stigma and discrimination reduction

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon in the text that follows the table.

Stigma and discrimination reduction for people living with HIV and other key populations and populations in vulnerable situations					
Program	***Description***				***Limitations***
'Face-to-face' education using peer educators	Provides information on HIV-related issues, including human rights, risk reduction counselling and referrals to services; discusses stigma and discrimination (including internalized stigma). The degree to which stigma reduction is central to the peer education program varies by implementer.				Lack of clarity around the centrality of human rights, stigma and discrimination in these programs – very often they are primarily directed at providing information and dispersing condoms and lubricants; lack of standardized models for peer education or trainings for peer educators; may be less effective for sub-populations for whom less peers are available; rely heavily on volunteers; safeguarding the safety of peer educators is extremely difficult.
Implementer	***Population(s) Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Asociacion Somos CDC	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed population, including key groups such as Garifuna and disabled people	Data not available	Tegucigalpa	Currently ongoing	This approach is a staple of HIV interventions in Honduras and is regarded as being very effective, with the use of peer educators making it easier to recruit participants and reach them in a non-judgmental manner. However, variations in the level of training that peer educators receive regarding human rights and the level to which stigma reduction is explicitly part of the 'package' provided needs to be considered carefully. A standardized training curriculum, tailored to different sub-populations, should be developed and used in a much broader way across all organizations.
Red de Trabajadoras Sexuales de Honduras	Sex Workers	Data not available	Tegucigalpa, Choluteca, San Pedro Sula	Currently ongoing	
Asociacion Kukulcan	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed	Data not available	43 municipalities	Currently ongoing	
CEPRES	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed, General Population	Data not available	Tela, Potrerillos, Omoa, Puerto Cortes, San Pedro Sula	Currently ongoing	
Colectivo Unidad Color Rosa	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed	Data not available	San Pedro Sula	Currently ongoing	

Humanos en Accion	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed	Data not available	La Ceiba, Atlantida	Currently ongoing	
Program	***Description***				***Limitations***
Community outreach/mobilization	These programs typically include a variety of activities that combine anti-stigma activities and HIV prevention efforts. Activities varied by implementer, but may include education on HIV-specific rights, HIV stigma reduction programming, mobilization activities aimed at encouraging the protection and monitoring of rights of people living with HIV in communities. This may also take the form of larger communication campaigns, including theatre and art displays – one example of this is the 'Todas Somos Positivas', implemented by the Centro de Estudios de la Mujer.				Lack of clarity of the centrality of human rights and HIV stigma reduction in the different interventions. Training curricula were not available for all of the programs described.
Implementer	***Population Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
La Liga de la Lactancia Materna	General Population; Key Populations; Youth, particularly those not in school	18,000	Data not available	Data not available	While developing a supportive environment for the protection of human rights at the community level is an important long-term goal, there is not very much evidence about how effective these types of interventions are in helping individuals overcome the human rights-related barriers to care in the Honduran context. If taken to scale, mass communication approaches might be considered as a complement to or replacement for these types of interventions, and possibly prove more cost-effective.
CONADEH	General Population and Key Populations	7109 people from key populations reached	39 municipalities	2011 - present	
Centro de Estudios de la Mujer – Honduras	General population	Data not available	Data not available	Currently ongoing	
La Fundacion Llaves	Media, general population	Data not available	Data not available	Data not available	
USAID, AIDSTAIR ASONAPVSIDAH	General population, people with HIV	Data not available	Data not available	Data not available	
Asociacion Kukulcan	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed, people with HIV	Data not available	Data not available	Data not available	
CIADES	People with HIV	Data not available	Data not available	Data not available	
Program	***Description***				***Limitations***
PLHIV Stigma Index	A process led by and for people living with HIV to gather data on the experiences of PLHIV in Honduras, including stigma and discrimination in the community and health care settings. The data generated are used to inform advocacy efforts by civil society.				Only one survey has been conducted to date (though an updated version is planned), making it hard to determine how the situation is changing in terms of stigma or how stigma might be related to other changes.
Implementer	***Population(s) Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Llanto, Valor y Esfuerzo (LLAVES) as part of a broader consortium	People with HIV aged 19 and over and representative sub-samples of key populations with HIV	N/A	National (17 selected cities)	April – November 2013 2018: Currently ongoing	Repeat national PLHIV stigma index on a 3-5-year basis to provide updated data for assessing impact of programs to remove human rights-related barriers to HIV services. This is currently in the process of being implemented.

					Future efforts should consider including youth and a selection of rural areas. Including representative subsamples of key populations living with HIV should also be considered.
Program	***Description***				***Limitations***
Group-based support for people with HIV and key populations to overcome stigma and discrimination	Group-based interventions and programs typically support people living with HIV and key populations by providing a safe-space for people to come together, discuss challenges, seek support and build community. These interventions range in structure significantly by implementer.				Lack of standardization in the type of support provided across different NGOs; minimal structure to sessions, not necessarily based on a curriculum.
Program	***Description***				***Limitations***
Sensitization and capacity building of key stakeholder groups	This includes interventions with key stakeholder groups, such as the police, members of the judiciary (such as lawyers, judges), lawmakers and medical personnel. This can be administered by the government or by civil society organizations, and in some cases formal agreements/alliances are developed. The content of the training sessions vary considerably by implementer, as does the degree to which HIV-specific stigma (as opposed to stigma related to specific key populations) reduction is a central feature of the intervention (note that this activity should include broader training on HIV and human rights and is a cross-cutting intervention, influencing a number of program areas).				There is little standardization in the approaches taken to build capacity with these groups, with personal relationships between individuals. It is unclear how much emphasis is placed on the role of stigma in these trainings. While indications are that this can be a successful approach, it has been done at such a small scale that it is difficult to assess impact more broadly.
Implementer	***Population(s) Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Asociacion Somos CDC	Police	Data not available	Tegucigalpa	Currently ongoing	Develop a standardized training toolkit, building on existing good practices in Honduras and beyond. Aim to have trainings institutionalized in as broad an area as possible, and integrate more formal sensitization exercises into pre-service training (where applicable).
Red de Trabajadoras Sexuales de Honduras	Police, health care providers, judicial system	Data not available	Tegucigalpa, Choluteca, San Pedro Sula	Currently ongoing	
Secretaria de Salud	Health workers (particularly in SAI)	Data not available	Data not available	Data not available	
Asociacion Kukulcan	Data not available	Data not available	Data not available	Data not available	
Secretaria de Derechos Humanos	Data not available	Data not available	Data not available	Data not available	

Current programs

Stigma and discrimination are widely recognized as key barriers to the access of HIV care in Honduras. As a result, almost all the organizations working with key populations and populations in vulnerable situations include some component of programming that is aimed at reducing them. The most common approach used was peer-based, self-support systems to provide education and resources to protect against stigma (including self-stigma), referrals to friendly health and legal services, and ensure people living with HIV are appropriately linked to and enrolled in HIV care and treatment. As described below, most of these activities have been embedded in programs with broader programmatic aims and/or part of larger initiatives, but in conversations with research participants, it was evident that, while insufficient on their own, these particular programs all play a crucial role in reducing self-stigma as well as facilitating access to non-stigmatizing services. Efforts to address stigma on the part of the government, particularly in the context of health service provision, have also been underway for a considerable period, though with mixed success.

Peer or Face-to-Face education

The most common interventions with key populations in Honduras rely on peer education and outreach. This approach is especially successful in reaching more marginalized sub-populations and has proved a compelling and effective way to reach a wide range of groups with training on stigma reduction. Respondents noted that this approach has a number of advantages, not least of which that key populations themselves are at the center of the model. Members of key populations are better connected to the social networks of other, more individuals in vulnerable situations, and are ideally situated to share experiences and knowledge. Peer networks also proved a powerful tool in linking key populations to health care, both through the direct provision of condoms and lubricants and direct referral systems (including sometimes accompanying individuals to health centers/clinics).

Limitations/Challenges

There is considerable variation in how implementers utilize peer or face-to-face programs with regard to stigma. This variability makes it difficult to draw clear conclusions about how effective this approach is for addressing stigma specifically, as the emphasis placed on stigma reduction programming is not consistent across all partners. There is a need for better coordination around stigma-reduction and human rights training, which would allow implementing organizations to more effectively learn from each other and develop more standardized approaches that can more easily be evaluated. In a similar vein there is a need to develop standardized approaches to training of peer educators to ensure consistent and high-quality provision of services. This training needs to be reinforced by ongoing refresher sessions. Some respondents, particularly in FGDs, mentioned that peer educators (and CSOs more generally) were too focused on conducting activities that contributed towards the measurable indicators that the CSO was being assessed by – as a result, there was sometimes too much focus on the provision of specific types of information or the distribution of very limited numbers of condoms and lubricants rather than other factors such as psychological support.

Furthermore, the peer education approach may have limited reach, both in terms of the types of people reached and in terms of its effect on stigmatizing attitudes more broadly. With regard to the first point,

peer education is most effective when peer networks are well established and clearly defined, yet this is not always the case. For example, both sex workers and Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersex participants discussed the challenges of reaching 'closeted' individuals, who do not self-identify as being Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersex, or being a sex workers, and are therefore not part of the broader peer network. In the case of sex workers, 'closeted' communities may include groups such as escorts or masseuses who would not necessarily consider themselves to be sex workers). With regard to the second point, while this approach may be quite effective at reducing internalized or self-stigma, its effect on stigma experienced more broadly is less likely to be significant, as by definition peer education focuses primarily on information transfers within the peer network, focusing less on reaching other community members. There are also questions about the consistency of delivery of content, fidelity to a clear package of intervention content, and challenges with staff turnover over the longer term. Finally, the peer education model is labor intensive, making scale-up of the approach challenging.

Community outreach/mobilization

On the other hand, the peer education approach may have a limited scope, both in terms of the types of people reached, and in terms of the effect this may have on stigma on a wider scale. Regarding the former, peer education is more effective when peer networks are well established and clearly defined, this, however, is not always the case. For example, both participating sex workers and Lesbians, Gays, Bisexuals, Transgender/Transvestites/Transsexuals and Intersexuals discussed the challenges of reaching people who are 'in the closet' or 'who have not come out', who do not identify as Lesbians, Gays, Bisexual, Transgender/Transvestite/Transsexual, or Intersex, or sex workers, who are not part of a wider peer network (in the case of sex workers, communities in the "closet" can include people from other groups such as escorts or massage therapists who would not necessarily consider themselves to be sex workers). With respect to the second point, although this approach can be quite effective in reducing internalized stigma or self-stigma, its effect on stigma experienced in general is less likely to be significant, since peer education focuses mainly on the transfer of information within the peer network and less on reaching other members of the community. There are also questions about the consistency of content delivery, adherence to a clear package of content and interventions, and challenges with long-term staff turnover. Finally, the peer education model requires a lot of manpower, meaning that scaling up the approach can be challenging.

Social norms play a critical role in determining the degree to which stigma and discrimination around HIV is both present and expressed. Recognizing this, a number of CSOs have implemented activities directed towards both the general population and key population groups. These include mass media communications or other public communication methods (public theatre, etc.), described as being particularly effective for reaching the Garifuna population, and more narrowly focused education campaigns aimed at bolstering knowledge and support in the community for people living with HIV. These include efforts to inform the broader community of the rights of key populations and populations in vulnerable situations in the context of HIV.

Limitations/Challenges

While the appeal of community outreach was acknowledged by most respondents, and many CSOs engage in some form or another of outreach, the impact of this on the everyday lives key populations and populations in vulnerable situations is unclear. Mobilizing communities is challenging and labor

intensive, requiring significant investment in terms of both time and finances. However, mass communication materials may, in some cases, prove to be quite cost-effective in terms of reaching large numbers of people. Current evidence on stigma-reduction programming suggests that mass media campaigns should be combined with other interventions, including contact strategies where people with HIV meet and engage with youth or community members and/or involvement of community leaders in sharing anti-stigma messaging in their communities to enhance the ultimate impact on shifting the harmful beliefs and attitudes that underpin stigma and discrimination at the individual level (Stangl, et al 2013).

PLHIV Stigma Index

The PLHIV Stigma Index is a critical component of efforts to combat stigma and discrimination, providing the most detailed information on experienced stigma and discrimination among people with HIV. While the most recently available Stigma Index is somewhat outdated (2014), this is being updated in 2018 and promises to provide significant insights into the lives of people with HIV.

Limitations/Challenges

Outside of the PLHIV Stigma Index, there is currently no mechanism to capture experiences of stigma and discrimination and facilitate redress in Honduras (though smaller studies provide some information). Overall however, very little data on stigma, discrimination and rights violations is being collected routinely from people living with HIV and key populations, which makes it difficult to assess the impact of the stigma and discrimination reduction efforts that have been implemented over the last 15 years. Investments in routine data collection efforts, like conducting the PLHIV Stigma Index every 3-5 years are needed to support national goals of achieving the 90-90-90 and 0-0-0 targets.

Group-based support for people living with HIV and key populations

Group-based interventions and programs have been a key component of the HIV response in Honduras, with local NGOs and key population networks both using the approach as a vehicle for trainings and capacity building. A number of key informants pointed to these groups, which can include self-support components as well as group instruction, as particularly effective in creating supporting peer networks that facilitate access to and use of information about services and other components of HIV care.

Limitations/Challenges

The lack of structure with many of the current support groups makes it difficult to assess their effect on people living with HIV and key populations and demonstrate their importance, which may make it difficult to secure continued funding for these activities. While support groups have been found to successfully combat the multidimensional effects of stigma and discrimination in previous research, additional support services could be offered, particularly to women living with HIV and their children, including economic and income-generation skill development, educational programs, transitional economic and housing support, and counseling and referral services. Furthermore, this approach relies on individuals being comfortable with, and able to, gathering with other members of key populations, and therefore is less likely to effectively reach marginalized groups or those with particular constraints on time of ability to travel.

Sensitization and capacity building of key stakeholder groups

A number of research respondents, both in the key informant interviews and the FGDs, pointed to the level of sensitivity of key stakeholder groups, particularly the police, in either limiting or enhancing their experiences with stigma and discrimination. While some pointed to successful cooperative agreements with police and other groups that helped ensure safety, others pointed to the general inability of law enforcement agents to enforce existing laws protecting key populations. Building understanding within these groups for the needs of key populations is, therefore, seen as an important priority for many CSOs and other implementers. This is usually achieved through agreements that allow implementation organizations and/or representatives of key populations to conduct sensitization trainings with staff, with the goal of ensuring a greater level of sensitivity and engagement in the future.

Limitations/Challenges

To date engagement with stakeholders has been somewhat *ad hoc*, with relatively little standardization of content or of how the trainings are delivered. Therefore, it is unclear how much emphasis is placed on the role of HIV stigma and discrimination (as opposed to discrimination against specific subgroups, such as sex workers, more generally). The lack of this type of training in pre-service and in-service training curricula makes building and maintaining capacity within stakeholder groups challenging, particularly if individuals are rotated on a relatively frequent basis, necessitating retraining.

Training of health care workers on HIV-related stigma and discrimination

While there are a number of protocols in place designed to ensure that service in health care settings is provided in a manner that is free of stigma and discrimination, as the accounts above in the barriers section of the report indicate, this remains a significant barrier to use of health services. Key informants working within the health system indicated that these trainings were conducted irregularly, a pattern that has worsened following recent changes to the health system that has increased rotation of staff and decentralized control over policies and their implementation. Nonetheless, there are a number of training curricula available that aim to reduce stigma and discrimination in the health care setting, including the recently released "Guide for Service Provision Free of Discrimination Towards People Living with HIV", developed in partnership between the Secretaria de Salud and USAID.

Limitations/Challenges

As noted, the implementation of training materials and protocols with health staff is not consistent, meaning that both the government and CSO key informants felt the impact of these was limited. More often, CSOs find themselves advocating with individual doctors to establish welcoming and humane environments within health care facilities, suggesting a role for standardized approaches to building capacity during pre-service training.

Recommendations to reach comprehensive programming

- Update existing stigma-reduction curricula to include information on HIV, non-discrimination, violence, and promote supportive, accepting, responsive services. Where possible, curricula should be standardized and based on the FHI/USAID/UNICEF/HPP models. These standardized curricula should be generalized where possible, which helps in minimizing stigma and discrimination in all KP, though retaining information on issues specific to unique KPs so they can be used in a variety of

situations. Efforts should be made to collectively learn from the experience gained from implementing the curricula and adaptations to local context made.

- Develop and implement a national monitoring system to capture experiences of stigma, discrimination and violence and link affected populations to relevant services. This monitoring should be linked to relevant information systems for monitoring related human rights violations (see HIV-related legal services below) and to referral for legal services and redress mechanisms. Global examples of similar programs include FHI SMS system, BDS-Sahara Project, Right to Health for Women program. It is recommended that this be conducted initially by an independent organization (for the sake of transparency) that then passes information and recommendations to relevant government partners, then transitioned into a strengthened human rights protection system (e.g. CONADEH).
- Institutionalize training on reducing stigma, discrimination and violence related to HIV in basic training for teachers, law enforcement, and medical education (for a more detailed description of this type of effort in the health setting, see 'Training for health care providers on human rights and medical ethics" below). Where possible, this should be integrated into existing training mechanisms focused on human rights (linking to efforts to enhance legal literacy in the general population and training in bio-ethics for medical personnel, both described below) and be a mandatory requirement for ongoing employment. Tracking the effectiveness of training on a regular basis will be critical to ensuring success.
- Support local leaders to develop a comprehensive sexuality education curriculum (CSE) for implementation in schools that includes content on basic sexuality (including diversity of sexual identities), understanding of gender as a social construct, and basic reproductive health knowledge (including HIV). Train teachers to implement curriculum and monitor its implementation. Where possible, this should build on existing sex education programming in schools, though aiming to extend those further and involving key population groups in development of material. The goal of this is both to increase knowledge around sexuality and challenge existing norms around gender roles, gender-based violence, and alternative sexual identities. While the effects of this are likely to be seen mainly in the longer term, monitoring implementation of the program will be important in order to ensure that curriculum content and implementation are consistent with the principles of CSE.
- Mass media campaigns to reduce stigma and discrimination based on HIV status and associated rights should also be considered– e.g. raising awareness on laws and policies protecting the rights of people living with HIV, reducing fears and ignorance about transmission or the realities of living with HIV, combatting existing myths around HIV (including around efficacy of faith-based or 'natural' treatments). This could also focus on areas like gender-based violence and gender norms.

PA 2: Training of health care providers on human rights and medical ethics related to HIV

The table below provides an overview of current programmatic efforts on training healthcare providers on human rights and medical ethics related to HIV. The content of the table is then further elaborated up upon.

Training for health care workers on human rights and medical ethics related to HIV					
Program	***Description***				***Limitations***
Capacity-building/sensitization training for all health care workers	Delivery of IEC materials via a training package to improve the medical environment for people living with HIV and key populations seeking HIV-related care. Training materials are designed for in-service trainings in the medical facility and are delivered by the government. Facilitators are meant to deliver education on HIV stigma, appropriate and sufficient care, and enhanced knowledge about HIV. These trainings should also be made available to staff or volunteers of civil society organizations, particularly those who provide direct services to key populations (such as testing).				While the Secretaria de Salud has training manuals around HIV that staff are required to review, it is unclear how updated or operationalized the materials are. As a result, this approach has not been as successful as hoped. While some civil society organizations do deliver content in health care settings, the scope of this and long-term impact is uncertain. There is no standardized, integrated training used across the sector to train health care workers. It is also unclear what level of training civil society facilitators or volunteers receive.
Implementer	***Population Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Secretaria de Salud	Medical personnel, including in SAI and VICIT clinics	Data not available		Ongoing	Manuals need to be updated to include a fuller understanding of human rights competences, medical ethics and a more robust stigma and discrimination reduction component. A standardized approach that builds on the lessons learned from current sensitization efforts should be developed to ensure quality delivery of effective, evidence-based training approaches. There currently is no standardized pre-service training provided to those training for a career in medical care provision. This is critical to developing a culture within the medical system that is more respectful of human rights and can provide empathetic and effective high- quality treatment to patients. This should be supported by refresher in-service courses, which can be based on material used to capacitate
Universidad del Valle de Guatemala (UVG)	Medical staff in VICITS clinics	Data not available	La Ceiba, Atlantida, San Pedro Sula, Tegucigalpa	Ongoing	

					current staff who would not have benefitted from the pre-service training.
Program	***Description***				***Limitations***
Training of health care workers on HIV-related stigma and discrimination	The most recent version of the "Guide for Service Provision Free of Discrimination Towards People Living with HIV", developed in partnership between the Secretaria de Salud and USAID, aims to provide health care providers with information to assist them in reducing stigma and discrimination towards people living with HIV.				This guide has been released relatively recently, so assessing its impact is not possible. Nor is the extent to which the guide will be used clear.
Implementer	***Population(s) Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Secretaria de Salud	Health care workers	Data not available	Data not available	Currently ongoing	Roll out trainings based on the new curriculum in health facilities across the country.

Current programs

Capacity-building/sensitization training for all healthcare workers

While the importance of respect for human rights when treating patients for HIV-related concerns has been a point of emphasis in strategic plans and in various forms of guidelines within the health system, there remain relatively few formalized systems through which healthcare staff members receive training on these issues. Because even staff members in the Centers for Integrated Attention (CAI) are not required to be HIV specialists, many do not have detailed training on the specific needs and concerns of key or vulnerable populations, and overall recognition of health care-related rights remain relatively poor in health care settings. While there are efforts underway to 'normalize' existing procedures and regulations for the protection of human rights more generally in the Honduran health systems and at higher levels, CSOs are working directly with the Secretary of Health at local levels to sensitize healthcare workers, though this is largely ad hoc and reliant on personal relationships.

There currently is very limited systematic training for medical staff on human rights and medical ethics in Honduras, and effectively none that is specific to HIV. As the section on barriers demonstrates clearly, the lack of ethical and humane treatment within the health system is a significant deterrent to use of HIV services, particularly outside of the contexts of health centers dedicated to HIV (i.e. SAI, VICITS, CAI). While the Secretary of Health does require that clinics follow WHO guidelines for HIV care, including using related manuals for training, the implementation of these policies remains inconsistent. As a result, much of the capacity-building and/or sensitization around ethical treatment of HIV patients is conducted by CSOs and is often informal in nature. Key informants reported that the establishment of close relationships with individual doctors or staff members was the most effective way to ensure humane treatment that included ethical treatment, such as requesting consent prior to treatment or respecting the confidentiality of medical records.

Limitations/Challenges

While the Secretaria de Salud has training manuals around HIV that staff are required to review, it is unclear how up-to-date or operationalized this review is. While some CSOs do deliver content to health care settings, the scope of this and long-term impact is uncertain. There is no standardized training used across the sector to training healthcare workers. It is also unclear what level of training civil society staff members or volunteers receive.

Recommendations to reach comprehensive programming

- Support the development of a curriculum for pre-service training of medical personnel on human rights through medical colleges. Ensure that this includes training on stigma, discrimination and human rights specifically for HIV. This must be implemented as a core aspect of medical training and fully institutionalized within medical system. Students must be tested and required to pass in order to continue with other studies. Human rights issues should be taught both as a stand-alone issue and in conjunction with other topics, where relevant.
- Provide in-service 'refresher' trainings at all health care facilities on human rights and medical ethics related to HIV. Support development/revision of curriculum for routine in-service trainings on HIV and key population-related stigma reduction, nondiscrimination and medical ethics for current health facility staff; engage administrators and identify champions within the health sector/or facilities for

sustainability and follow-up. Make this a requirement for all existing health care staff, but initially start with those directly providing HIV services to KPs. Ensure that the period between trainings is sufficient to ensure that new staff do not have extended periods without training.

- Support routine assessments of knowledge, attitudes and practices of health care towards people living with HIV and other key populations to support health facility administrators to identify and address any issues. Measurement should be conducted regularly using the MERG-approved, validated short survey developed by HP+ to inform the need for re-training or other action by health facility administrators. Heath care setting-based surveys must be done among providers and exit interviews with key patients throughout the country with the help of proper guidelines for ethical data collection. These routine assessments can be integrated into existing quality assurance mechanisms, where available and feasible, and coordinated with other data collection mechanisms on related topics.

PA 3: Sensitization of law-makers and law enforcement agents

- The table below provides an overview of current programmatic efforts to sensitize law-makers and law enforcement agents as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Sensitization of law-makers and law enforcement agents				
Program	***Description***			***Limitations***
Partnerships with law enforcement	CSOs and other representatives of key populations have agreements with law enforcement where they have the opportunity to provide trainings, initiate discussions, etc. that allow for the development of a greater understanding of the particular needs and concerns that HIV-affected populations face. No established training or advocacy approach is in place, with individual CSOs or groups negotiating opportunities to have training sessions with receptive law enforcement agents.			To date these partnerships have functioned largely at relatively local levels, drawing on personal relationships with receptive individuals within law enforcement. There is very little standardization in the approaches taken or used.
Implementer	***Population Targeted***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Red de Trabajadoras Sexuales de Honduras	Local police	Tegucigalpa	Ongoing	In order to be scaled up, more standardized approaches based on a mutual understanding of the goals of the intervention will be required.
Program	***Description***			***Limitations***
Strategic working alliances between CSOs and agents of the state	These alliances include both formal and informal attempts by CSOs representing key populations (such as sex workers) to establish relationships with local law enforcement representatives in a manner which creates opportunities to conduct more formal sensitization interventions, including specific training sessions or simply a greater level of understanding within the law enforcement community about the needs and situation of key populations. This includes networks focused specifically on the defense of human rights.			While these alliances are promising, there is no set coordination mechanism to ensure that efforts of all parties complement and learn from each other.
Implementer	***Population Targeted***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Foro Nacional de SIDA, ONUSIDA, PASMO, Fundacion Llaves, UNFPA, CONADEH, Red de Trabajadores Sexuales de Honduras, HUMAC, Secretaria de Salud, ICW Honduras, Asociacion Kukulkan	Various	Data not available	Ongoing	Create more formal mechanisms for coordination and learning within working groups. It is important that these strategic alliances develop clear goals for the alliance and develop mechanisms to share experiences, training materials and approaches with the goal of increasing the efficacy of programming through discontinuing ineffective approaches.
Program	***Description***			***Limitations***
Advocacy efforts aimed at building support for changing policy (incidencia politica)	These efforts typically involve the use of forum events that allow for CSOs to share experiences and learning with government stakeholders and decision-makers with the goal of creating the momentum for policy or legal change.			This approach is critical to generating support for both new legislation/policy and the implementation of existing laws and policies, but in order to be fully effective, advocacy efforts must be part of a carefully coordinated campaign, which is not always the case.
Implementer	***Population Targeted***		***Timeframe***	***Recommended Scale-Up***

Global Communities, ASONAPVSIDAH, Colectivo Unidad Color Rosa, HUMAC	Law-makers and decision-makers within government	ongoing	There is a need for an effective coordinating mechanism to ensure that these advocacy efforts area as effective as possible. As above, in order to ensure that concrete products and results emerge from these discussions, different implementers should coordinate their goals and activities as much as possible, and ensure that different members are not working at cross-purposes.

Current programs

Partnerships with law enforcement

A number of CSOs, particularly those such as sex worker groups who interact with law enforcement on a more regular basis, have established ongoing partnerships with local police where they provide information sessions on the issues faced by their population. While these were broadly seen as being successful, most of these efforts are relatively small in scale and rely on personal relationships with receptive members of local police administration rather than a systematic approach to building greater understanding and respect for the needs of the key populations. Furthermore, the training approaches and content provided varied significantly, and it was unclear how much formal training there was in terms of human rights, particularly within the specific context of HIV (as opposed to efforts to reduce harassment of sex workers for example). In addition to working with police, some CSOs reported working more directly with other important players in the judicial system, such as judges and lawyers, to help facilitate the prosecution of human rights abuses. As with the efforts to work with the police, however, there seemed to be little standardization in the approaches used and it was unclear how effective these approaches were.

Limitations/Challenges
To date these partnerships have functioned largely at relatively local levels, drawing on personal relationships with receptive individuals within law enforcement. There is very little standardization in the approaches taken or used.

Strategic working alliances between CSOs and government agents

A number of strategic alliances have been developed by CSOs with government agents, including in some cases law enforcement. These alliances have for the most part been focused at higher levels of the government and often are primarily directed at ensuring that information generated on the status of HIV-affected populations is shared with government decision-makers. In many cases, alliances between CSOs also exist, providing the opportunity to speak with a broader voice when engaging with the government. However, while this may have led to greater awareness of the issues facing these populations, it is unclear to what extent this has resulted in fundamental changes in law enforcement practice.

Limitations/Challenges
While these alliances are promising, there is no set coordination mechanism to ensure that efforts of all parties complement and learn from each other.

Advocacy efforts aimed at changing policy

A few CSOs, including Global Communities, ASONAPVSIDAH, Colectivo Unidad Color Rosa, and HUMAC have been engaging in advocacy efforts aimed at changing harmful policies or calling for the implementation of protective policies and laws. These efforts typically involved the use of forum events that allowed for CSOs to share experiences and learning with government stakeholders and decision-makers with the goal of creating the momentum for policy or legal change.

Limitations/Challenges

This approach is critical to generating support for both new legislation/policy and the implementation of existing laws and policies, but in order to be fully effective, advocacy efforts must be part of a carefully coordinated campaign, which is not always the case.

Recommendations to reach comprehensive programming

- Institutionalize pre-service training on human rights with a focus on reducing HIV-related stigma, discrimination and violence within existing training process for anyone involved in law enforcement (including legal training, police academy, within the prison system and military). Existing curricula need to be updated – input from CSOs working in this area already and key population members should be incorporated into the design of the curriculum. The importance of human rights, both generally and specifically related to HIV, must be emphasized and reinforced by government actors and representatives. Require a specific test with a minimum passing score. Integrate into existing training on legal obligations and human rights.
- Support in-service trainings for current police, judges, prison staff on HIV policies, legal rights of citizens (particularly key populations); responsible and supportive policing in the context of HIV; duty to protect; reduction of illegal police practices. This should be linked to content included in professional training and regularly assessed (see above in "Stigma and Discrimination Reduction" section). As noted above, a number of CSOs already conduct capacity building activities with local police forces. This may provide a good basis for developing a standardized curriculum that can be implemented more broadly. Tracking the effectiveness of training on a regular basis will be critical to ensuring success.
- Support routine assessments of law enforcement agents' knowledge, attitudes, practices and behaviors (KAPB) towards people living with HIV and other key populations and support police administrators to identify and address any issues. Monitoring and evaluation must be done in police academy and police headquarters so that these KAPB can be monitored more effectively biannually or annually.
- Continue and expand community-based advocacy and joint activities with law enforcement to address key challenges affecting communities. A number of CSOs already conduct outreach and capacity-building activities with police and other law enforcement agents. These activities should be coordinated and expanded. These efforts will be more effective if a coordinated strategy is used based on evidence of successful programs used by CSOs currently. Care must be taken to fully learn the lessons from earlier experience.

PA 4: Legal literacy in human rights ("know your rights")

The table below provides an overview of current programmatic efforts to improve the knowledge of legal rights of people living with HIV and other key populations and populations in vulnerable situations, as well as recommendations for scale-up. The content of the table is elaborated upon below.

HIV Legal Literacy					
Program	***Description***				***Limitations***
Face-to-face/peer educator training on legal rights	These programs use a face-to-face approach to inform key populations of their legal rights as they relate to HIV, including how to process complaints about the system itself.				There is little standardization of the information conveyed via peers or though face-to-face trainings, nor is it clear how relevant or accurate this information is. This work is currently largely small-scale and fragmented.
Implementer	***Population Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Asociacion Somos CDC	LGTBI	Data not available	Not identified	Data not available	Develop standardized curricula based on experience of CSOs in providing this content. Linkages to supportive professional legal services would enhance the impact of these programs.
Red de Trabajadoras Seuxales de Honduras	Sex workers	Data not available	Tegucigalpa, Choluteca y San Pedro Sula	Data not available	
Program	***Description***				***Limitations***
Capacity building in human rights	Programming aimed at building capacity among key populations to understand and advocate for protection of human rights.				
Implementer	***Population Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
International Coalition of Women – Honduras	Women (general population)	Data not available	Tegucigalpa, Choluteca, San Pedro Sula, La Ceiba	Data not available	Develop standard training package for working with key populations to build knowledge and capacity for engaging in direct advocacy around their rights at local and national levels. Work more directly with human rights organizations working at a larger scale (but who currently don't include a clear focus on HIV-related rights issues). Extend this programming to include all key populations.

Current programs

Face-to-face/peer education

As described above in the section describing programming targeting stigma and discrimination, peer education is an approached used by a significant number of CSOs to provide key populations and populations in vulnerable situations with information both on HIV generally and, on occasion, on their specific rights. The extent to which this approach is effective in terms of providing accurate and actionable information is unclear, particularly as the focus of many peer education approaches is on prevention or service provision. Questions remain about the quality of training received and while there have been efforts to focus specifically on legal rights using the peer education model, this is typically a smaller component of a larger training package, potentially diluting its impact.

Limitations/Challenges
There is little standardization of the information conveyed via peers or though face-to-face trainings, nor is it clear how relevant or accurate this information is. This work is currently largely small-scale and fragmented.

General capacity building in terms of knowledge of human rights

While not necessarily focused exclusively on human rights as they relate to HIV, some programming aimed at improving knowledge of human rights also addresses HIV. For example, the International Coalition of Women – Honduras offers programming aimed at building women's capacity to advocate for their rights more broadly (such as in the case of violence against women) and includes programming that address HIV specifically. Another example of this is the National Network of Defenders of Human Rights in Honduras, which while focused on the myriad human rights challenges the general population faces in Honduras, also works with CSOs around issues related to HIV.

Recommendations to reach comprehensive programming

- Support legal literacy in human rights and patients' rights education through conducting awareness campaigns and workshops among people living with HIV and other key populations in high-prevalence departments. This should be coordinated with training of health care providers and law enforcement (see above) and a streamlining of complaint resolution systems to ensure adequate attention is paid to human rights concerns and violations. These efforts should be linked to mass communication programming and other efforts being led by CSOs to highlight human rights more broadly if feasible. Building the capacity of organizations focused on human rights questions more broadly to incorporate HIV-related issues will be important to expanding the reach of this type of programming. Empower CSOs with strong connections with key populations to provide information and linkages to legal services and violation resolution mechanisms.

PA 5: HIV-related legal services

The table below provides an overview of current programmatic efforts designed to increase the access of individuals to HIV-related legal services as well as recommendations for scale-up. The content of the table is elaborated upon below.

HIV-related legal services				
Program	***Description***			***Limitations***
Facilitation of the process of human rights complaints through accompanying individuals as they lay complaints or providing references to services	This often consists of having a CSO staff member accompany and guide individuals through the process of lodging a complaint or providing references to more comprehensive services. In some cases, this may take the form of direct provision of lower level legal services in health care settings, such as the SAI.			At the moment, these efforts are extremely small scale, involving very few cases. In many cases, the person accompanying the client will moderate a solution to the concern rather than engage in the formal legal system.
Implementer	***Population Targeted***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Asociacion Somos CDC	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed	Tegucigalpa	Currently ongoing	A much more robust approach is required if this is to be taken to scale that links more directly to existing legal systems for prosecuting human rights violations. Developing a cadre of trained community paralegals to provide basic legal counseling, guide complainants through the complaint system, and link to formal legal services would greatly increase the access of individuals to the legal system
Asociacion Kukulkan	Lesbian, Gay, Bisexual, Transgender people/Transvestites/Transsexuals and Intersexed	Data not available	Currently ongoing	
Red de Trabajadoras Seuxales de Honduras	Sex workers	Tegucigalpa, Choluteca y San Pedro Sula	Data not available	
Program	***Description***			***Limitations***
Provide staff for defending human rights in medical centers	Make a person specializing in human rights law available as a defender of human rights in the medical centers (SAI in particular)			This approach, and others that are similar, were not considered particularly effective due to the lack of responsiveness of the legal system. There were some signs that this approach could be effective within individual health clinics, but this depended a lot on context (i.e. how engaged the human rights defender was, etc.).
Implementer	***Population Targeted***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
Human Rights Secretariat and CONADEH	Not identified	Data not available	Currently ongoing	This is very resource-intensive – a more effective system might have a more flexible referral-model approach, combined with robust investigation of complaints. At the same time

				coordination with the work of CONADEH will be key.

Current programs

Facilitation of process of laying human rights complaints

While virtually all key informants reported considerable frustration with the process of attempting to have violations of human rights in the context of HIV addressed by the state, a number of CSOs have ongoing programs aimed at facilitating the prosecution of complaints. These take a number of forms, ranging from having CSO staff with experience navigating the complaint procedure accompany complainants when filing and processing their complaint to more directly linking individuals to legal services. The complexity and lack of responsiveness of the systems for legal redress of human rights violations, widely viewed as a major barrier to access and use of health services, mean that very few of these complaints have even been heard and these programs remain relatively small-scale and at best loosely coordinated.

Limitations/Challenges
At the moment, these efforts are extremely small-scale, involving very few cases. In many cases, the person accompanying the client will assist in negotiating a solution with individuals concerned (e.g. approaching a senior doctor who the community regards as friendly) rather than engage in the formal legal system.

Provision of staff at medical centers dedicated to resolving human rights complaints

It was reported that the Secretary of Health had, in some cases at least, placed individuals in the SAI to act as a defender of human rights. The efficacy of this approach is difficult to assess, as it was not something that a significant number of key informants or focus group participants reported being aware of or having utilized. However, this approach has some promise, potentially preventing cases of violations of human rights and, if these occur, resolving them quickly.

Limitations/Challenges
This approach, and others that are similar, were not considered particularly effective due to the lack of responsiveness of the legal system. There were some signs that this approach could be effective within individual health clinics, but this depended a lot of context (how engaged the human rights defender was, etc.).

Recommendations to reach comprehensive programming

- Provide CSOs with continual access to professional legal services dedicated to prosecution and resolution of human rights abuses. CSOs could refer individuals to these services or use them themselves. Alternatives would be to identify a network of legal professionals willing to provide *pro bono* services and link these to CSOs. This service should be made available to all CSOs working with KPs on questions of HIV and is relevant to all KPs.
- Train and support paralegals to provide legal advice, awareness raising and “know your rights” campaigns in departments with high prevalence among key populations and/or in health care facilities. Effective links to full legal services must be put in place, particularly for formal human rights complaints. Other resources, such as a national hotline linking to free legal advice, could supplement this. A national hotline may prove to be particularly effective in promoting legal literacy in human rights and should be

considered when developing interventions in that area as well. Ideally, these types of interventions would reinforce each other.

- Provide direct financial and technical support to non-governmental organizations and CSOs already working to enhance human rights in Honduras but that currently do not include an explicit focus on HIV-related human rights in their programming.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

The table below provides an overview of current programmatic efforts to monitor and reform laws, regulations and policies relevant to HIV as well as recommendations for scale-up. The content of the table is elaborated upon below.

Monitoring and reforming laws, regulations, and policies relevant to HIV				
Program	***Description***			***Limitations***
Tracking of HIV-related human rights violations	Maintain a count of the human rights cases taken on by CONADEH that are specifically related to HIV.			Although there is a record of 58 reports addressed by CONADEH in 2016, it's possible that does not represent the full number of cases reported due to the lack of reporting and trust in the country's judicial system.
Implementer	***Population Targeted***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
CONADEH	People living with HIV and key populations	Data not available	Currently ongoing	This system is considered largely unresponsive and is poorly funded. Scale-up efforts will have to focus on extending both monitoring capacity and the responsiveness of CONADEH to human rights complaints.

Current programs

Tracking of HIV-related human rights violations

CONADEH is the primary entity charged with overseeing the monitoring of human rights in Honduras, including of HIV. Its principal work is in receiving and investigating complaints/reports and advocacy/ education in human rights. As part of its work in receiving complaints, the National Commissioner is authorized to carry out investigations, inspections, verifications, or any other action aimed at determining the truth of the reports. In addition, they have access to all documentation from the Public Administration that they consider necessary for further clarification. The Human Rights Secretariat (SEDH) was created by Decree PCM-055-2017 on September 12, 2017. The SEDH is the director and coordinator of the Implementation of Public Policy and the National Action Plan on Human Rights, as well as being responsible for the design, monitoring and coordination of public policies on human rights, particularly regarding all people and groups in vulnerable situations, who require special advocacy and protection of their human rights. As of the date of publication it was not clear how the new Secretariat plans to coordinate with CONADEH or whether it will assume part of the role that CONADEH has historically played. While CONADEH does track and report on human rights cases related to HIV, the very low number of cases addressed provides clear indication of the challenges individuals face when attempting to address violations. While a number of other entities, including both state-administered groups such as ASONAPVSIDAH or CONASIDAH or virtually all CSOs, pay close attention to the laws, regulations, and policies relevant to HIV and actively are seeking their reform or effective implementation, they are not tasked with systematically monitoring progress on these.

Limitations/Challenges
Although CONADH responded to 58 reports of complaints in 2016, it is possible that the number of complaints registered is below the actual number of cases reported, due to a lack of reporting and distrust in the effectiveness of the country's judicial system.

Recommendations to reach comprehensive programming

- Advocacy and lobbying for law and regulatory reform related to human rights protections generally. Increase funding for advocacy groups to support the legal reform process and advocate for the implementation or development of supportive policies and laws as they relate to different key populations (see below for examples specific to sex workers and transgender people/transvestites/transsexuals). Given Honduras' generally progressive legal frameworks, a great deal of the effort for this should be directed toward actual implementation and enforcement of existing laws. This will require coordination with interventions aimed at improving the capacity of the legal system (through training, improved staffing, better knowledge of human rights legal protections, etc.). It is important to both engage with groups that have a proven track record in influencing policy and to simultaneously ensure that CSOs are engaged from the outset in developing a strategy for this process (including helping identify key laws and policies to focus on). Coordination with training approaches and other interventions will be critical to the success of this effort.
- Increased monitoring of number of HIV-related human rights cases currently being processed by human rights agencies and legal process. Fund the development of national-level system tracking the progress of human rights-related complaints and their resolution. This would include counting the

number of cases presented, the number proceeding to a formal resolution process, and the eventual resolution of the complaint. This would require CONADEH and the judicial system to more effectively track cases and assess the responsiveness of the system to citizen complaints. Data should also be collected from CSOs about the number of cases of human rights-related abuses they referred for legal action and the status of these. This should be closely linked to efforts to improve the access to legal remedies available to CSOs and key populations. While data will be collected through CONADEH and other relevant organizations, an independent entity should be tasked with analysis of the data and reporting. This should be done nationally, focusing specifically on HIV-related complaints. It will be key to understanding the impact of legal literacy in human rights and legal/policy reform efforts.

- Increase advocacy for legal recognition of sex work. Fund advocacy groups to support the development of draft legislation providing formal legal status for Sex workers (most of whom are women). Emphasis should be placed on how the unstable legal status of Sex workers is placing them and the population at greater risk and increasing hardship for Sex workers.
- Increase advocacy to allow for transgender people/transvestites/transsexuals to change their names to match their gender. Fund advocacy groups to support the development of draft legislation providing for the right of individuals to change their name legally without restriction. Additional efforts should focus on the ability of individuals to change the biological sex listed on official documentation and identification papers. The key population that this would benefit is transgender people/transvestites/transsexuals, though the law would apply to all citizens. Consult closely with CSOs representing trans populations to determine most effective form of developing lobbying messages.
- Provide financial and technical assistance to Ministry of Health to develop robust rights-based complaints management and resolution system within health care settings. Where possible, this should build on existing mechanisms/systems. Should be developed in conjunction with the Ministry of Health to ensure feasibility, accountability, and sustainability and with key populations to ensure the system is respectful of their concerns.
- A comprehensive program should also include advocacy for reforming non-HIV specific laws to preclude their application for overly broad criminalization of transmission, exposure and non-disclosure of HIV.

PA 7: Reducing discrimination against women in the context of HIV

The table below provides an overview of current programmatic efforts to reduce discrimination against women in the context of HIV. The content of the table is then further elaborated upon.

Reducing HIV-related gender discrimination, harmful norms and violence against women and girls					
Program	***Description***				***Limitations***
Capacity building in human rights	Programming aimed at building capacity among key populations to understand and advocate for protection of human rights around HIV, sexual and reproductive health and gender-based violence.				These programs have typically focused on broader human-rights issues, including gender discrimination, but very few have specifically focused on the intersection between these core areas and HIV-related discrimination.
Implementer	***Population Targeted***	***# trained***	***Regions Covered***	***Timeframe***	***Recommended Scale-Up***
International Coalition of Women – Honduras	Women (general population)	Data not available	Tegucigalpa, Choluteca, San Pedro Sula, La Ceiba	Data not available	Efforts should be made to build capacity within organizations (such as the International Coalition of Women – Honduras) on HIV-related rights and the intersection with other human rights. Alliances should be formed with organizations with regional or national reach so that HIV-related rights issues become more 'mainstreamed' in discussions around human rights at the national level.

Current programs

While gender-based violence is very common in Honduras and existing gender norms were acknowledged by a range of research participants to be an important factor in both increasing vulnerability to HIV infection and reducing women's access to health care, we found very few programs that focused specifically on the intersection between HIV and gender in this sense. This is partly because women are not categorized as a key population by PENSIDA IV (which only includes Sex workers, transgender people/transvestites/transsexuals, and Garifuna and Afro-Honduran women) and because gender inequality remains such a pervasive feature of the environment in Honduras. Of the programs working on HIV that were reviewed, only the International Coalition of Women – Honduras directed programming towards women on gender-based violence specifically. Other organizations in Honduras have focused on gender norms and discrimination against women and girls, though these have not focused on HIV specifically.

Recommendations to reach comprehensive programming

- Mobilize women's groups and support networks to combat gender-based violence and support survivors to seek redress and services. This should aim to use community-based advocacy and mobilization to reduce GBV and support redress for survivors of violence. Health staff will need training and sensitization regarding how to support clients who seek services for experiences of stigma and discrimination in addition to GBV.
- Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence. Integration of human rights and gender programming into schools is key to achieving long-term changes in norms around both in Honduras, including specific to HIV. Where possible, efforts should be made to support existing organizations that are working on eliminating GBV and addressing discriminatory gender norms to integrate content around HIV in their work, both because they have experience working with these issues in a more general manner and because they have potentially broader reach.
- Mass media campaigns should be considered, aimed at reducing GBV broadly through messaging designed to transform gender norms,, potentially using increased risk of HIV transmission as one of many reasons for the need for change. This approach would apply to multiple key populations in Honduras (Sex workers, Garifuna, women more broadly). To be effective, must be linked to more effective systems of reporting and prosecuting GBV.

3.9 Investments to date and costs for a comprehensive program

In 2015, a total of USD $119,118.60 was invested in Honduras to reduce human rights-related barriers to HIV services. In 2016 a total of USD $6,024.37 was invested in Honduras to reduce human rights-related barriers to HIV services.

Major funders and allocated amounts for reduction of human rights-related barriers to HIV services in 2016 were as follows:

Funding source	2015 allocation (USD)
The Global Fund	119,118.60
Total	**USD 119,118.60**

Funding source	2016 allocation (USD)
The Global Fund	6,024.37
Total	**USD 6,024.37**

Although funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services[58]:

HIV Human Rights Program Area	2015	2016
PA 1: Stigma and discrimination reduction for key populations	51,180.00	6,024.37
PA 2: Training for health care workers on human rights and medical ethics related to HIV	11,748.36	0
PA 3: Sensitization of law-makers and law enforcement agents	36,748.36	0
PA 4: Legal literacy (“know your rights”)	11,441.88	0
PA 5: HIV-related legal services	0	0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	8,000.00	0
PA 7: Reducing discrimination against women in the context of HIV	0	0
Total	**119,118.60**	**6,024.37**

[58]Some program areas have no activities and are labeled as $0

4. Costing for 5-year comprehensive program—HIV

HIV Human Rights Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total (USD)
PA 1: Stigma and discrimination reduction	367,668.56	340,077.74	357,081.63	374,935.71	429,907.49	**1,869,671.12**
PA 2: Training for health care workers on human rights and medical ethics related to HIV	58,314.68	61,230.42	64,291.94	67,506.53	70,881.86	**322,225.43**
PA 3: Sensitization of law-makers and law enforcement agents	47,419.84	49,790.84	52,280.38	54,894.40	57,639.12	**262,024.57**
PA 4: Legal literacy ("know your rights")	117,913.42	123,809.09	129,999.55	136,499.52	143,324.50	**651,546.08**
PA 5: HIV-related legal services	133,300.64	139,965.67	146,963.96	154,312.16	162,027.76	**736,570.19**
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	88,362.67	68,966.81	72,415.15	76,035.91	79,837.70	**385,618.24**
PA 7: Reducing discrimination against women in the context of HIV	108,677.20	96,250.56	101,063.09	106,116.24	128,432.06	**540,539.15**
Total (USD)	**921,657.02**	**880,091.12**	**924,095.68**	**970,300.47**	**1,072,050.49**	**4,768,194.78**

5. Limitations and Measurement Approach

Limitations

Given the rapid nature of this assessment, it is possible that some programs or interventions that have been conducted to address the human rights-related barriers to HIV services in Honduras have been missed. However, the inclusion of the stakeholder meetings at inception allowed for an opportunity for program implementers and funding agencies to share documentation about programs that were missing from the review. This report will inform the multi-stakeholder meeting for the development of a 5-year plan to reduce human rights-related barriers; stakeholders will have the opportunity to validate the findings or complement them as necessary.

In addition, it was not possible to gather information on the perspectives of a full range of stakeholders and key populations and populations in vulnerable situations. Among the perspectives not included are those of traditional and religious leaders, the incarcerated population, and political figures/lawmakers. Limited inputs were received from some key populations, particularly the Garifuna. Moreover, the geographic coverage of the assessment (with interviews conducted only in Tegucigalpa, San Pedro Sula and La Ceiba) means that the perspectives of people and organizations focused on rural areas may not be fully represented. The research team was also not able to meet with all stakeholders and organizations involved in HIV programming in Honduras.

It was not possible to assess the effectiveness of the program approaches identified, primarily because so few were evaluated in a manner that would enable such assessment. However, rich details on the programs identified were gathered, including implementer perceptions of what worked well and what could be improved, which informed the comprehensive response proposed.

Measurement approach for assessing impact of scaled up programs to remove human rights-related barriers to services

Qualitative Assessment

In order to understand how the comprehensive response is influencing human rights-related barriers to HIV services, it will be critical to conduct midline and end-line qualitative assessments. Such assessments will provide more nuanced understanding of the various approaches being implemented and will help to understand the combined influence of the structural, community-level and individual-level interventions being proposed. Qualitative assessments could also shed light on new programs that have not been previously implemented in Honduras.

Quantitative Assessment

While it may not be possible to quantitatively evaluate all of the programs implemented as part of the comprehensive response, Honduras should consider strategically evaluating some of the interventions. For example, it will be important to determine if the stigma and human rights training for police leads to fewer criminal charges brought against sex workers or a lower proportion of sex workers reporting police harassment. Likewise, it would be important to evaluate the influence of the provision of legal services to HIV-affected populations on the number of cases of human rights abuses being brought to court, or the levels of stigmatizing attitudes and beliefs among medical personnel. In addition to evaluations of specific programs, the impact of the comprehensive response can be assessed with several outcome and impact level indicators, most of which are already being collected in Honduras as part of the national monitoring systems for HIV. The indicators, baseline values (where possible), data sources and proposed level of disaggregation are described in Annex 5.Data sources included: UNAIDS Global AIDS Monitoring (2016), PLHIV Stigma Index Honduras (2014) and Honduras Demographic and Health Survey (2011). Outcome indicators are proposed for people living with HIV, key populations, the general population, healthcare workers, institutions and financing.

Measurement Limitations

It will not be possible to directly link the activities supported under the comprehensive response with key outcomes and impacts, however, comparison of baseline values with values collected at midline and end-line, and examination of the findings of the repeated qualitative assessments, will provide a sense of how the addition or expansion of efforts to remove human rights-related barriers to HIV services has influenced Honduras' progress towards reaching the 90-90-90 targets for HIV.

5. Costing limitations

The costing component of the baseline assessment was a rapid investment analysis, therefore it should not be viewed as a full-fledged resource need estimation. The retrospective costing has informed the estimation of intervention-level costs, hence the limited data collected through the baseline assessment inherently affected the prospective costing.

The baseline assessment encountered certain limitations in the costing component both as pertaining to HIV and TB programs aimed at removing human rights-related barriers:

- Certain key stakeholders were not able to take part in the data collection due to competing priorities. As a result, an important viewpoint on human rights barriers and on the effectiveness of current efforts to address them may be missing from the analysis. Stakeholders that could not participate also included a number of bilateral partners and, as a result, the description of current efforts to address and remove barriers may not include what these entities are currently funding or undertaking directly.

More specific limitations and challenges to the collection of financial data included:

- It appeared that a number or organisations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymised at the implementer level.
- Some organisations appeared to take the position that the benefit of completing the exercise was not worth the level of effort required, given other pressures on them.
- Most funders and intermediaries appeared to be unable to disaggregate their investments in combination prevention interventions to the level where funding for programmes addressing human rights barriers could be identified.
- Finally, as the analysis has noted there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

6. Gaps, challenges and opportunities

The research suggests that there is broad consensus around the role of human rights in shaping access to services by HIV-affected populations and, when access is available, how these are used. In particular, virtually every group included in the study highlighted the role of stigma and discrimination in underpinning many of the other barriers to use, suggesting that efforts focusing in this area will be particularly impactful.

Despite the widespread recognition of the human rights challenges key populations and populations in vulnerable situations face in Honduras, including in the law, it is clear that many individuals continue to violate the basic rights of these groups with virtual impunity. If there is to be any significant change, it is essential that the system for monitoring for human rights violations and for successful prosecution of violators be strengthened significantly. While changing the entire landscape of human rights enforcement in Honduras is a daunting task, funding and empowering CSOs to raise questions of these violations more vociferously is more feasible. Developing a monitoring system that accurately captures the scale of human rights violations is a critical first step in this process, providing the evidence that advocacy can then be based on. It should be noted that any system that is put in place for reporting also be complemented by referral to support services (legal, psychological, etc.).

It is clear that a number of systemic issues also have an influence on these barriers, including the poor security situation in the country, the general challenge the country faces in providing health care to its citizens in a geographically and culturally diverse setting, and financial challenges. While these are challenges that extend beyond HIV, there are a number of specific changes at a smaller scale that may prove particularly effective. First, it is critical that the culture of the medical establishment as it relates to HIV treatment be changed to one that focuses more on providing care in a humane and respectful manner that is as free of stigma and discrimination as possible. The suggested changes to the training system would greatly assist in this regard, providing a standardized understanding of institutional expectations that CSOs can use to hold the system accountable. This would be bolstered by a revision of the ways in which HIV programs, within both the government and CSO sectors, are monitored and evaluated – the emphasis on targets and specific indicators has resulted in service delivery incentives that do not always prioritize the needs of patients. Development and use of additional indicators oriented around client satisfaction would be preferable and would provide incentives geared towards improved service.

Furthermore, despite very similar program models across CSOs, there seems to be relatively little coordination and sharing of knowledge. As a result, there is little standardization of approaches, meaning that assessing what specific approaches are proving particularly successful and which are not is very difficult. Nor is there much coordination between the CSO and government sectors, despite there being obvious synergies in their approaches. Developing more effective systems for the sharing of knowledge and incentivizing cooperation will be essential to capitalizing on the excellent work that these groups are doing while learning from mistakes.

Finally, developing effective approaches that are specifically oriented towards supporting the strategies laid out in PENSIDA IV may be an effective approach to developing broader synergies. PENSIDA IV's strategies display the aim of diminishing HIV through a variety of efforts in the form of strategy areas. The strategy area of "political publicity and social management with a focus on human rights and gender equity," focuses on the importance of following international guidelines in response to HIV, and carrying out work through all sectors of society, such as nongovernmental organizations, government offices and ministries, and civil society. The "promotion of health for the prevention of HIV" is a strategy area that involves the increase of access, availability, and successful utilization of services by key populations and populations in vulnerable situations. The strategy area "integral attention" is advocated through the special law on HIV/AIDS that was implemented in 1999 (Decreto no. 147-99), which states that a focus on rights and duties of people living with HIV is necessary in the education and protection of the general population.[59] Each of these are highly relevant to the barriers identified in this report and should be pursued in a more coordinated way.

[59] Comisión Nacional del SIDA, República de Honduras. (2014). Plan Estratégico Nacional de Respuesta al VIH y Sida en Honduras (PENSIDA IV) 2015-2019.

More specifically, it is recommended that the early focus be on activities to update or develop curricula on stigma reduction and human rights for key duty bearers and the integration of these curricula into the appropriate professional training schools and colleges. In all cases, the development of curricula should be led by key population members or CSOs who work with them. These curricula should be tailored to the needs of particular duty bearers, such as health care professionals, teachers and law enforcement agents, as the needs of each group are somewhat different. It is critical that this training be designed in a manner that will allow for it to be institutionalized effectively, ideally through making the training a required component of both pre-service education and in-service training opportunities. Negotiating the inclusion of the curricula in existing training systems and, if necessary, developing new training mechanisms should begin immediately to avoid implementation delays. This should be accompanied by the development of various systems to capture experiences of stigma and discrimination and support redress. This should include both improved national-level monitoring systems that track human rights violations, complaints and their resolution in a consistent way and direct support for the provision of legal aid. A key component of this will be providing more direct support to CONADEH and/or the newly formed Ministry of Human Rights, which should be preceded by a needs assessment to identify key gaps in their capacity and to develop a plan to address these sustainably.

It is also recommended that concerted efforts be made to identify opportunities for increased collaboration with existing CSOs that are focused on addressing human-rights issues in Honduras more broadly but that do not include HIV-related discrimination as an integral part of their efforts, with a focus on building towards a broader partnership that would build their capacity for including HIV in the future. A similar focus should target those CSOs that are currently working to address issues related to gender discrimination and gender-based violence (GBV), again with the goal of enhancing their capacity for developing interventions that include a focus on the intersection of HIV and gender discrimination. Finally, the development/ updating of advocacy and tools for legal literacy in human rights and campaigns should be prioritized to ensure that networks and advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation.

Following the completion of these initial activities, the next stage should focus on the training of trainers and/or professors/instructors, followed by the systematic rollout of both pre- and in-service routine training/retraining of key duty bearers. Linked to this scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty bearers with clear accountability mechanisms in place to ensure that the information collected is acted on. These should include routine assessments of knowledge, attitudes and behavior to assess change over time. This phase of response should also involve direct support to CSOs working on human rights and gender discrimination to integrate HIV-related issues into their programmatic efforts and develop broader strategic alliances with those CSOs focused more specifically on key populations and

populations in vulnerable situations with regard to HIV. Linked to this, there should be outreach and engagement with *pro bono* legal support for the resolution of complaints or violations identified by CSOs and to support legal-literacy in human rights efforts. Mass media and advocacy campaigns would also start full implementation during this phase. Finally, the PLHIV Stigma Index should be implemented in year 3 or 4, with additional funding support to PLHIV networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

The research suggests that there is broad consensus around the role of human rights in shaping access to services by HIV-affected populations and, when access is available, how these are used. In particular, virtually every group included in the study highlighted the role of stigma and discrimination in underpinning many of the other barriers to use, suggesting that efforts focusing in this area will be particularly impactful.

Despite the widespread recognition of the human rights challenges key populations and populations in vulnerable situations face in Honduras, including in the law, it is clear that many individuals continue to violate the basic rights of these groups with virtual impunity. If there is to be any significant change, it is essential that the system for monitoring for human rights violations and for successful prosecution of violators be strengthened significantly. While changing the entire landscape of human rights enforcement in Honduras is a daunting task, funding and empowering CSOs to raise questions of these violations more vociferously is more feasible. Developing a monitoring system that accurately captures the scale of human rights violations is a critical first step in this process, providing the evidence that advocacy can then be based on. It should be noted that any system that is put in place for reporting also be complemented by referral to support services (legal, psychological, etc.).

It is clear that a number of systemic issues also have an influence on these barriers, including the poor security situation in the country, the general challenge the country faces in providing health care to its citizens in a geographically and culturally diverse setting, and financial challenges. While these are challenges that extend beyond HIV, there are a number of specific changes at a smaller scale that may prove particularly effective. First, it is critical that the culture of the medical establishment as it relates to HIV treatment be changed to one that focuses more on providing care in a humane and respectful manner that is as free of stigma and discrimination as possible. The suggested changes to the training system would greatly assist in this regard, providing a standardized understanding of institutional expectations that CSOs can use to hold the system accountable. This would be bolstered by a revision of the ways in which HIV programs, within both the government and CSO sectors, are monitored and evaluated – the emphasis on targets and specific indicators has resulted in service delivery incentives that do not always prioritize the needs of patients.

Development and use of additional indicators oriented around client satisfaction would be preferable and would provide incentives geared towards improved service.

Furthermore, despite very similar program models across CSOs, there seems to be relatively little coordination and sharing of knowledge. As a result, there is little standardization of approaches, meaning that assessing what specific approaches are proving particularly successful and which are not is very difficult. Nor is there much coordination between the CSO and government sectors, despite there being obvious synergies in their approaches. Developing more effective systems for the sharing of knowledge and incentivizing cooperation will be essential to capitalizing on the excellent work that these groups are doing while learning from mistakes.

Finally, developing effective approaches that are specifically oriented towards supporting the strategies laid out in PENSIDA IV may be an effective approach to developing broader synergies. PENSIDA IV's strategies display the aim of diminishing HIV through a variety of efforts in the form of strategy areas. The strategy area of "political publicity and social management with a focus on human rights and gender equity," focuses on the importance of following international guidelines in response to HIV, and carrying out work through all sectors of society, such as nongovernmental organizations, government offices and ministries, and civil society. The "promotion of health for the prevention of HIV" is a strategy area that involves the increase of access, availability, and successful utilization of services by key populations and populations in vulnerable situations. The strategy area "integral attention" is advocated through the special law on HIV/AIDS that was implemented in 1999 (Decreto no. 147-99), which states that a focus on rights and duties of people living with HIV is necessary in the education and protection of the general population.[60] Each of these are highly relevant to the barriers identified in this report and should be pursued in a more coordinated way.

More specifically, it is recommended that the early focus be on activities to update or develop curricula on stigma reduction and human rights for key duty bearers and the integration of these curricula into the appropriate professional training schools and colleges. In all cases, the development of curricula should be led by key population members or CSOs who work with them. These curricula should be tailored to the needs of particular duty bearers, such as health care professionals, teachers and law enforcement agents, as the needs of each group are somewhat different. It is critical that this training be designed in a manner that will allow for it to be institutionalized effectively, ideally through making the training a required component of both pre-service education and in-service training opportunities. Negotiating the inclusion of the curricula in existing training systems and, if necessary, developing new training mechanisms should begin immediately to avoid implementation delays. This should be accompanied by the

[60] Comisión Nacional del SIDA, República de Honduras. (2014). Plan Estratégico Nacional de Respuesta al VIH y Sida en Honduras (PENSIDA IV) 2015-2019.

development of various systems to capture experiences of stigma and discrimination and support redress. This should include both improved national-level monitoring systems that track human rights violations, complaints and their resolution in a consistent way and direct support for the provision of legal aid. A key component of this will be providing more direct support to CONADEH and/or the newly formed Ministry of Human Rights, which should be preceded by a needs assessment to identify key gaps in their capacity and to develop a plan to address these sustainably.

It is also recommended that concerted efforts be made to identify opportunities for increased collaboration with existing CSOs that are focused on addressing human-rights issues in Honduras more broadly but that do not include HIV-related discrimination as an integral part of their efforts, with a focus on building towards a broader partnership that would build their capacity for including HIV in the future. A similar focus should target those CSOs that are currently working to address issues related to gender discrimination and gender-based violence (GBV), again with the goal of enhancing their capacity for developing interventions that include a focus on the intersection of HIV and gender discrimination. Finally, the development/ updating of advocacy and tools for legal literacy in human rights and campaigns should be prioritized to ensure that networks and advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation.

Following the completion of these initial activities, the next stage should focus on the training of trainers and/or professors/instructors, followed by the systematic rollout of both pre- and in-service routine training/retraining of key duty bearers. Linked to this scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty bearers with clear accountability mechanisms in place to ensure that the information collected is acted on. These should include routine assessments of knowledge, attitudes and behavior to assess change over time. This phase of response should also involve direct support to CSOs working on human rights and gender discrimination to integrate HIV-related issues into their programmatic efforts and develop broader strategic alliances with those CSOs focused more specifically on key populations and populations in vulnerable situations with regard to HIV. Linked to this, there should be outreach and engagement with *pro bono* legal support for the resolution of complaints or violations identified by CSOs and to support legal-literacy in human rights efforts. Mass media and advocacy campaigns would also start full implementation during this phase. Finally, the PLHIV Stigma Index should be implemented in year 3 or 4, with additional funding support to PLHIV networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

7. Annexes

Annex 1: Comprehensive Response to Remove Human Rights-related Barriers to HIV services in Honduras

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 1: Stigma and Discrimination Reduction				
Stigma-reduction curricula updated and rolled out to key population networks and NGOs	Update existing stigma-reduction curricula (FHI/USAID/UNICEF/HPP) to include information on HIV, non-discrimination, violence, and promote supportive, accepting, responsive services.	Revised and finalized integrated curricula on HIV stigma; training of trainers rolled out among key populations and NGOs.	FHI 360 toolkits are being used now; they must be updated and reviewed. This must be generalized where possible, which helps in minimizing stigma and discrimination in all KP, though retaining information on issues specific to unique KPs.	This will be a standardized tool with specific sections as needed for various populations (i.e. police, health workers, teachers, community member, etc.).
Mass media campaigns, advocacy, and engagement of key populations to reduce stigma and discrimination related to HIV	Mass media campaigns to reduce stigma and discrimination based on HIV status and associated rights– e.g. raising awareness on laws and policies protecting the rights of people living with HIV, reducing fears and ignorance about transmission or the realities of living with HIV, combatting existing myths around HIV (including around efficacy of faith-based or 'natural' treatments).	Increase awareness on laws and policies protecting the rights of people living with HIV; Reduced fear of infection for HIV; Improved knowledge of HIV transmission mechanisms and how life continues after diagnosis; Decreased avoidance behavior towards people living with HIV; Increased acceptance and support.	Use a mixture of both general messages and targeted campaigns for KPs. Utilize a variety of approaches (mass visual and audio, such as radio and/or television), social media; public theatre; radio/telenovelas, etc.). This seems to be particularly effective in the context of the Garifuna population, though must be carefully vetted with the community and conducted in local language.	Social media may provide a more direct and effective way to reach KPs in urban areas, though care must be given to carefully target the messages. Would strongly suggest this be carried out in partnership with an organization familiar with health-based marketing or social and behavioral change communication (SBCC) in Honduras or similar settings. This should be linked and coordinated with 'legal literacy' interventions (see below).

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
Mechanisms to monitor stigma, discrimination and violence related to HIV and linkages to redress	Develop and implement national monitoring system to capture experiences of stigma, discrimination and violence and link affected populations to relevant services. This should be linked to relevant information systems for monitoring related HR violations (see HIV-related legal services below).	Experiences of stigma, discrimination and violence monitored on a regular basis and those affected linked to services and legal redress systems.	All the key populations must be involved and CBOs and outreach workers must be involved in supporting the stigma and discrimination cases in related areas. Information must be collected through these networks in Central level and through these grass root organization rapid response must be done. Monitoring and review must be done at national level as national monitoring system with proper strategies and guidelines. Must be conducted in combination with efforts to strengthen government response to HR violations (see HIV-related legal services below)	All data must be recorded, stored, and organized in a way that generates evidence to show the national body and law enforcement both the level of stigma and discrimination and where they are taking place. Monitoring should be done routinely (e.g. every 4 months) by a joint committee of appropriate national bodies and action must be taken. We strongly recommend that this be conducted initially by an independent organization that then passes information and recommendations to relevant government partners, then transitioned into a strengthened HR protection system (e.g. CONADEH).
Human rights training as part of education curriculum for teachers, law enforcement, and medical professionals	Institutionalize training on reducing stigma, discrimination and violence related to HIV in basic training for teachers, law enforcement, and medical education (for a more detailed description of this type of effort in the health setting, see 'Training for health care providers on human rights and medical ethics' below). Where possible, this should be integrated into existing training mechanisms focused on HR (linking to efforts to enhance legal literacy in the general population and	Greater understanding of and respect for HR both broadly and in terms of HIV; greater consistency application of best-practice systems and behavior in health and legal settings.	Updated curricula noted above could be utilized; Recommend making this a required course for all teachers, law enforcement personnel, and medical students (i.e. need a certain (passing) mark on human rights exam to receive certification.)	Establishing a broad and shared understanding of relevant rights and obligations related to HR, including specific to HR, in the general population is a key step in combatting the lack of responsiveness to HR violations currently in place in Honduras. In the medical system, HR protections and respect vary dramatically depending on individuals, meaning that respect for the HR of patients can shift rapidly as individuals are rotated in and out of positions. CSOs and KPs invest significant efforts into building capacity of individuals at

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
	training in bio-ethics for medical personnel, both described below).			the moment, often only to see them rotated to another location and a new, often less sensitized individual replace them. Tracking the effectiveness of training on a regular basis will be critical to ensuring success.

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 2: Training for health care providers on human rights and medical ethics related to HIV and TB				
Development and implementation of curricula for bio-ethics within medical training system	Support development of curriculum for training of medical personnel on human rights through medical colleges. Ensure that this includes training on stigma, discrimination and human rights specifically for HIV.	Greater consistency in skills and knowledge regarding HR and ethical concerns throughout medical system. Increased recognition of HR issues as critical component of medical service.	Must be implemented as core aspect of medical training and fully institutionalized within medical system. Students must be tested and required to pass in order to continue with other studies. HR issues should be taught both as a stand-alone issue and in conjunction with other topics, where relevant.	Institutionalizing knowledge of and respect for bio-ethics is a key part of both improving service quality generally and for HIV KPs, for whom questions of confidentiality, equity and empathy in the health setting are particularly important.
Refresher training at health care facilities on human rights and medical ethics related to HIV	Support development/revision of curriculum for routine in-service training on HIV and key population-related stigma reduction, nondiscrimination and medical ethics for current health facility staff; engage administrators and identify champions within the health sector/ or facilities for the sustainability and follow-up.	Updated curricula routinely offered (e.g. on an annual basis) in health facilities for new staff, etc. Will contribute to greater consistency in the application of human rights within health settings.	Make this a requirement for all existing health care staff, but initially start with those directly servicing KPS with regard to HIV. Ensure that period between trainings is sufficient to ensure that new staff do not have extended periods without training.	Stigma, discrimination and human rights training sessions must be provided to all staff working in health provider settings (including non-medical staff such as receptionists and security staff). Initially, this should be intended to bridge the gap between the current situation and when all new staff have been training through the medical training system (see above).
Measurement of stigma and discrimination and	Support routine assessments of knowledge, attitudes and practices of health care towards PLHIV and	Measurement conducted annually or every other year using MERG-approved, validated short survey	Health Care Setting based surveys must be done among providers and exit interview with key	Data collection must be conducted and monitored rigorously. SMS systems could be included in this intervention

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
human rights violations in healthcare settings	other key populations to support health facility administrators to identify and address any issues.	to inform need for re-training or other action by health facility administrators.	patients throughout the country with the help of proper guidelines for ethical data collection. This can be integrated into existing quality assurance mechanism, where available and feasible, and coordinated with other data collection mechanisms on related topics.	because it measures stigma and discrimination among both KPs and health care workers.

Intervention	Specific activities	Expected Results/ Comments	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 3: Sensitization of lawmakers and law enforcement agents				
Training on human rights for lawmakers and law enforcement officers; Development and implementation of curricula on HIV-related human rights issues	Institutionalize training on reducing stigma, discrimination and violence within existing training process for anyone involved in law enforcement (including legal training, police academy, within the prison system and military).	Improved attitudes and treatment of PLHIV and key populations by police. Increase knowledge of current protective laws. Reduction in illegal police practices and increase in supportive policing.	Institutionalize the curricula for all components of law enforcement (including military) as a part of basic training. Require a specific test with a minimum passing score. Integrate into existing training on legal obligations and human rights.	Existing curricula needs to be updated – input from CSOs working in this area already should be incorporated into the design of the curriculum. The importance of human rights, both generally and specifically related to HIV, must be emphasized and reinforced by government actors and representatives.
On-going training on human rights for law enforcement officers	Support in-service trainings for current police, judges, prison staff on HIV policies, legal rights of citizens (particularly key populations); responsible and supportive policing in the context of HIV; reduction of illegal	Improved attitudes and treatment of PLHIV and key populations by police, judges, and prison staff. Increased knowledge and enforcement of current protective laws. Reduction in		A number of CSOs already conduct capacity building activities with local police forces. This may provide a good basis for the development of a more standardized curriculum that can be implemented more broadly.

Intervention	Specific activities	Expected Results/ Comments	Implementation suggestions (coverage, location, key populations, etc.)	Observations
	police practices. This should be linked to content included in professional training and regularly assessed (see above and in "Stigma and Discrimination Reduction" section above).	illegal police practices and increase in supportive policing and judicial decisions.		Tracking the effectiveness of training on a regular basis will be critical to ensuring success.
Routine measurement of knowledge attitudes and behaviors of police and follow-up trainings	Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards PLHIV and/or with TB and other key populations and support police administrators to identify and address any issues.	Annual or bi-annual measurement using MERG-approved, validated short survey to inform need for re-training or other action by law enforcement administrators.	Monitoring and evaluation should be done in police academy and police headquarters so that these KAPB can be monitored more effectively biannually or annually.	Police are often the first level of interaction PLHIV or KPs have with the legal system, so tailored training is key for this group. MERG-approved tool for health settings needs to be expanded to be adapted for use with police.
Continue and expand community-based advocacy and joint activities with law enforcement to address key challenges affecting communities	Support key population networks to engage with law enforcement to prevent harmful policing practices, such as arresting sex workers.	Improved attitudes and behaviors of law enforcement; empowerment of key populations; reduced arrests and detention of key populations.	A number of CSOs already conduct outreach and capacity-building activities with police and other law enforcement agents. These activities should be coordinated and expanded.	These efforts will be more effective if a coordinated strategy is used based on evidence of successful programs used by CSOs currently. Care must be taken to fully learn the lessons from earlier experience.

Intervention, priority	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 4: Legal literacy ("know your rights")				
Legal literacy 'know-your-rights'	Support legal literacy and patients' rights education through conducting awareness campaigns	Greater awareness of rights and laws, including patient rights, and greater ability to organize	Link to mass communication programs and other local efforts being conducted by	Knowledge of rights in the context of HIV is poor in Honduras generally and there is considerable cynicism about the efficacy of

Intervention, priority	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
and patients' rights campaigns	and workshops among PLHIV and other key populations in each state/district towards mobilizing around health rights and needs. This should be coordinated with training of health care providers and law enforcement (see above) and a streamlining of complaint resolution systems to ensure adequate attention is paid to HR concerns and violations. Link to mass communication programming and broader efforts to highlight human rights wherever possible.	communities around advocacy for specific needs.	CSOs. Empower CSOs with strong connections with KPs to provide information and linkages to violation resolution mechanisms.	existing methods of resolving HR violations, reflecting the very poor record of government institutions in responding to HR violations to date. Improving responsiveness to complaints will be key to building a sense of the value of human rights.

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 5: HIV-related legal services				
Building community-based legal support for HR abuses	Train and support paralegals to provide legal advice, awareness raising and "know your rights" campaigns to each state/district among key populations and/or in health care facilities.	Community-based legal support in present in CBOs or network of key populations, greater awareness of rights and better ability to get redress.	This should be implemented at the national level. Effective links to full legal services must be put in place, particularly for formal HR complaints. This could be supplemented by other resources, such as a national hotline linking to free legal advice.	This type of intervention may prove to be particularly effective in promoting legal literacy and should be considered when developing interventions in that area as well. Ideally, these types of interventions would reinforce each other.
Professional legal support to HIV CSOs	Provide CSOs with continual access to professional legal services dedicated to prosecution and resolution of HR abuses. CSOs could refer individuals to these	Improved access to legal representation when HR violations take place. Increased attention paid to HR complaints	This service should be made available to all CSOs working with KPs on questions of HIV and is relevant to all KPs.	CSOs struggle to navigate the legal system when attempting to pursue cases of HR violations, partly due to lack of access to professional legal aid. This would allow them to continue focusing on their core missions

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
	services or use them themselves. Alternatives would be able to identify a network of legal professionals willing to provide pro bono services and link these CSOs.	as more are passed through the formal legal system.		while ensuring access. Involving CSOs who have already been working to link individuals to legal services should be included in developing legal strategies.
Direct support to strengthen the institutions tasked with protecting HR in Honduras	Provide direct support to CONADEH or another institution within the government to more effectively provide rapid resolution to HIV-related HR cases. In particular, this could be directed to cover the costs of placing individuals within CONADEH field office who are tasked specifically with addressing HIV-related HR issues.	Improved access to CONADEH personnel who are dedicated to issues specific to KPs; greater ability of CONADEH staff to address HR violations immediately; greater awareness of legal rights and services in local areas.	The need for more CONADEH staff in local areas is clear, particularly for those focused on HIV specifically. Placing more staff in more accessible offices, particularly if that staff is dedicated to HIV-specific HR abuses, will provide local CSOs an immediate contact for rapid resolution of complaints.	Currently a relatively small portion of the Global Fund's investments are passed to CONADEH directly. This may be because of concerns with working with a government ministry directly, but there is a real need for additional resources in this area as CONADEH to date has been largely ineffective at managing HR abuses, both generally and in the HIV context.

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 6: Monitoring and reforming policies, regulations and laws				
Advocacy and lobbying for law and regulatory reform related to HR protections generally	Funding for advocacy groups to support the legal reform process and advocate for the implementation or development of supportive policies and laws as they relate to different KPs (see below for examples specific to CSWs and transgender individuals). Given Honduras' generally progressive legal frameworks, a great deal of the effort for this should be directed	Updated laws; existing protections implemented more effectively; reduced legal barriers to accessing HIV services.	It is important to both engage with groups that have a proven track record in influencing policy and to simultaneously ensure that CSOs are engaged from the outset in developing a strategy for this process (including helping identify key laws and policies to focus on). This will be a national level effort and benefit all	Support for the enforcement of human rights laws and policies will benefit KPs especially – but it may be more effective to frame this within a broader effort to improve the responsiveness of the Honduran legal system to human rights abuses in general. This has been classed as a 'Medium' priority not because it is not critical to the protection of HIV-related HRs, but because more targeted interventions may be more feasible.

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
	toward actual implementation and enforcement of existing laws. This will require coordination with interventions aimed at improving the capacity of the legal system (through training, improved staffing, better knowledge of HR legal protections, etc.).		KPs to differing degrees. Coordination with training approaches and other interventions will be critical to the success of this effort.	
Increase advocacy for legal recognition of commercial sex work	Fund advocacy groups to support the development of draft legislation providing formal legal status for CSWs (most of whom are women).	Increased support for the legal recognition of CSW as a form of employment; increased formal protections for CSW; potential.	Emphasis should be placed on how the unstable legal status of CSWs is placing them and the population at greater risk and increasing hardship for CSWs. Key population is CSWs.	CSWs at the moment have no clearly defined legal status in Honduras. As a result, they cannot use income as collateral for loans, enjoy employment protection benefits, and are placed at greater vulnerability (including to HIV infection). Care must be taken to proceed carefully with legislation so as to not create a backlash where CSWs are further marginalized legally.
Increase advocacy to allow for transgender individuals to change their names to match their gender	Fund advocacy groups to support the development of draft legislation providing for the right of individuals to change their name legally without restriction. Additional efforts should focus on the ability of individuals to change the biological sex listed on official documentation and identification papers.	Increased support for individuals to take the name they feel is most appropriate; systems put in place to facilitate change of name on official documents; potentially increased support for the self-definition of sex on official documents.	Key population is transgender individuals, though the law would apply to all citizens. Consult closely with CSOs representing transgender population to determine most effective form of developing lobbying messages.	This is a critical question of human dignity for many in the transgender community, and one that is directly related to their comfort in accessing health care. As for CSWs, care must be taken to not create backlash.
Increased monitoring of number of HIV-related HR cases currently being processed by HR agencies and legal process	Fund the development of national-level system tracking the progress of HR complaints and their resolution. This would include counting the number of cases presented, the number proceeding to a formal resolution process, and the eventual	Increased accountability and transparency in the process of the resolution of HR complaints.	This should be done nationally, focusing specifically on HIV-related complaints. It will be key to understanding the impact of legal literacy and legal/policy reform efforts.	The current system for resolving HIV-related HR complaints is widely regarded as ineffective, with complaints taking years to work through the process. Tracking this will highlight the problems with the current system and provide incentives to improve the system itself. It will be important that the organization tasked with analysis be

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
	resolution of the complaint. This would require CONADEH and the judicial system to more effectively track cases and assess the responsiveness of the system to citizen complaints. Data should also be collected from CSOs about the number of cases of HR abuses they referred for legal action and the status of these. This should be closely linked to efforts to improve the access to legal remedies available to CSOs and KPs. While data will be collected through CONADEH and other relevant organizations, an independent entity should be tasked with analysis of the data and reporting.			independent and that KPs and CSOs have input into which indicators are tracked.

Intervention	Intervention activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
PA 7: Reducing discrimination against women in the context of HIV				
Increase awareness of gender-based violence (GBV) as key risk factor for HIV	Conduct mass media campaign aimed at reducing GBV broadly through gender transformative messaging, using increased risk of HIV transmission as one of many reasons for the need for change.	Less GBV; improved ability of women to make choices free of fear; lower risk of HIV transmission for women.	Applies to multiple KPs in Honduras (CSWs, Garifuna, women more broadly). To be effective, must be linked to more effective systems of reporting and prosecuting GBV.	
Community-based advocacy and mobilization to	Mobilize women's groups and support networks to combat	Link survivors of violence to existing systems and CSOs for support services. Increase	Health staff will need training and sensitization regarding how to support clients who seek services	GBV is currently a largely ignored issue in terms of risk factors for HIV in Honduras. As a result, there is little or

Intervention	Intervention activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Observations
reduce GBV and support redress for survivors of violence	violence and support survivors to seek redress and services.	awareness of GBV and its consequences at both community and national level.	for experiences of stigma and discrimination in addition to GBV.	no specific attention to this issue in the context of HIV.
Reduction of harmful gender norms and gender based violence	Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender based violence.	Shift harmful gender norms and increase equality among women and men. Reduced violence against and mistreatment of women and girls.	Integration of human rights and gender programming into schools is key to achieving long-term changes in norms around both in Honduras.	While inequitable gender norms in Honduras are an important factor in the 'feminization' of the epidemic and the increased vulnerability of women to HIV, this needs to be part of a broader discussion around gender norms and how to change them.

Intervention	Specific activities	Expected Results/Comments	Implementation suggestions (coverage, location, key populations, etc.)	Observations
Other programs that fall outside the purview of the human rights funding, but are necessary to support the comprehensive response				
Address gender inequalities and sexual orientation discrimination	Support local leaders to train teachers to implement comprehensive sexuality education curriculum and routinely monitor quality of CSE classes. Consider updating curriculum to include lessons on gender norms, violence and stigma.	Updated curriculum that includes lessons on gender norms, stigma and violence		

Annex 2: Baseline indicators and values for comprehensive response

Indicator	Baseline value (national)/N	Source	Suggested level of disaggregation
Outcome indicators: People living with HIV			
Percentage of people living with HIV who know their status	61% N= 13,000	UNAIDS (2016)	Region; gender; age
Percentage of people living with HIV who report any internalized (self) stigma	21.8% N= not shown	Stigma Index (2014)	Region; gender; age
Percentage of adults and children living with HIV currently receiving ART	51% N= 11,000	UNAIDS (2016)	Region; gender; age; key population
Percentage of people living with HIV who report experiencing social exclusion, exclusion from places of worship, or family exclusion	Social exclusion: 10.9% Religious exclusion: 9.1% Familial exclusion: 8.4%	Stigma Index (2014)	Region; gender; age
Percentage of people living with HIV who report and experience human rights violations	9.2% N= 64	Stigma Index (2014)	Region; gender; age
Percentage of people who attempted to seek legal redress among those who experienced a human rights violation	25.0% of the above 64 N=16	Stigma Index (2014)	Region; gender; age
Percentage of people living with HIV who report experiences of HIV-related stigma and discrimination in healthcare settings	Data not available		Region; gender; age
Percentage of women living with HIV who were coerced into sterilization by health care workers.	11.9%	Stigma Index (2014)	Region; age
Percentage of people living with HIV who confronted, challenged or educated someone who was discriminating against or stigmatizing them	25.8% N= not shown	Stigma Index (2014)	Region; gender; age
Percentage of people living with HIV who have heard of the Declaration of UNGASS and the Special Law on HIV in Honduras, which protects the rights of people living with HIV	51.0% N= not shown	Stigma Index (2014)	Region; gender; age
Outcome indicators: Key populations			
Coverage of prevention programs among key populations	MSM: TG: SWs:		Region/district; sex; age
Percentage of key populations who received an HIV test in the past 12 months and know the result?	MSM: TG:		Region; age

	SWs:		
Percentage of key populations who are aware of their legal rights	MSM: TG: SWs:		Region; age
Percentage of key populations who report any internalized stigma in the past 12 months	Data not available		Region; gender; age
Percentage of key populations who report any experienced stigma	TG: 27.3% N=12	Stigma index (2014)	Region; gender; age
Percentage of key populations who reported being treated unfairly because of their sexual orientation in the past 12 months	MSM: TG: SWs:		
Percentage of key populations who have experienced forced sex acts or rape in the past 12 months	MSM: TG: SWs:		Region; gender; age
Outcome indicators: General population			
Percentage of women aged 15-49 who have ever tested for HIV	Data not available		Region; age
Percentage of men aged 15-49 who have ever tested for HIV	Data not available		Region; age
Percentage of men and women who report discriminatory attitudes towards people living with HIV (new, 2-item composite) Note: as the most recent DHS survey was conducted in 2011, the percentages listed here reflect disagreement with only one statement: 'Would you buy fresh vegetables from a shopkeeper with AIDS'	Women: 48.7% N=22,757 Men: 48.8% N=7,120	DHS 2011	Region; age
Percentage of adults who report fear HIV infection due to contact with saliva of a person living with HIV	Data not available		Region; gender; age
Percentage of adults who would be ashamed if a person in their family was living with HIV	Data not available		Region; gender; age
Outcome indicators: Healthcare workers			
Percent of health facility staff who worry about getting HIV when providing care or services to patients living with HIV	Data not available		n/a

Percent of health facility staff that hold stigmatizing views about people living with HIV	Data not available		n/a
Percent of health facility staff who report that their facility has written guidelines to protect patients living with HIV from discrimination.	Data not available		n/a
Outcome indicators: Institutions			
Stigma and discrimination-reduction (i.e. HIV, TB and human rights) course institutionalized in degree programs for duty bearers	Medicine: no Nursing: no Social Work: no Law enforcement: no Law: no		Type of profession (i.e. medical, nursing, social work, police, law)
Number of harmful laws impeding access to HIV services removed or replaced	0		Note specific laws removed or replaced
Outcome indicator: Financing			
Total spent on programs to reduce human rights barriers to HIV services	For 2015: Total:	Retrospective costing for baseline assessment	Source of funding (i.e. public resources; international funding); type of implementer
Impact indicators			
HIV prevalence in people aged 15-49	0.3 (~22,000 PLHIV)	UNAIDS (2017)	Region, key population, gender
HIV incidence rate per 1,000 population (15-49)	0.16	UNAIDS (2017)	Region, key population, gender; age

8. References

AIDS Education & Training Center Program (AETC) National Coordinating Resource Center. (2013). Information for Providers Assisting HIV Patients Returning to Honduras. https://aidsetc.org/resource/information-providers-assisting-hiv-patients-returning-honduras

Álvarez JM, Ramos J. (2012). *Guide to Legal Research in Honduras*. GlobaLex. http://www.nyulawglobal.org/globalex/Honduras1.html

Amin, Avni. (2015). *Addressing gender inequalities to improve the sexual and reproductive health and wellbeing of women living with HIV*. Journal of the International AIDS Society 18(5).

Auceda, R. (1999). Impacto de los mensajes VIH/SIDA en la población hondureña. *Tegucigalpa: PROGRAFIP 124 p.*

Casa Renacer. (2010). Quienes somos? http://casarenacer.blogspot.com/
Cicatelli Associates Inc., UNDP, The Global Fund. Adherence and Leadership for PLWHA Trainings. http://www.caiglobal.org/index.php?Itemid=628

Ciudad, JM, González RA, LLAVES. (2014). Informe Ejecutivo: Índice de Estigma en Personas que Viven con VIH.

Código Penal de Honduras. Decreto 144-83 de 26 septiembre de 1983.

CONASIDA, Gobierno de la República Honduras, ONUSIDA. (2015). Resultados del Informe Nacional de Progreso de la Respuesta contra el VIH y el Sida.

CONASIDA. (2016). Estudio de Medición del Gasto en Sida, (MEGAS). Honduras, 2016.

Comisión Nacional del SIDA, República de Honduras. (2014). Plan Estratégico Nacional de Respuesta al VIH y Sida en Honduras (PENSIDA IV) 2015-2019.

Comisionado Nacional de los Derechos Humanos, Gestión Institucional. Programa Especial Derechos Humanos y VIH/Sida. http://app.conadeh.hn/Anual2012/pe_pcvih.html

Corte Suprema de Justicia, República de Honduras (1999). Ley Especial Sobre VIH/SIDA. Decreto: No. 147-99.

Drug Law Reform in Latin America. (2016). Honduras – Criminalisation. http://druglawreform.info/en/country-information/central-america/honduras/item/4739-honduras

ElÍas CDV, Ortega YG. (2014). *Cuidado de EnfermerÍa en Pacientes con VIH: Estigma y Discrimación*. Revista CientÍfica de EnfermerÍa, 16(11), 24-36.

Family Health International (FHI), Implementing AIDS Prevention and Care Project (IMPACT). (2007). Honduras final report, September 1997 – September 2005. USAID's Implementing AIDS Prevention and Care (IMPACT) project.

Frautschi, S. (2010). Understanding HIV-Specific Laws in Central America. *International Journal of Legal Information* 38(1), 6.

Fundación Llaves, ONUSIDA. Communication Strategies. http://www.comminit.com/global/content/fundaci%C3%B3n-llaves-honduras

Gandhi AD, Pettifro A, Barrington C, Marshall SW, Behets F, Guardado ME, Farach N, Ardon E, Paz-Bailey G. (2015). *Migration, Multiple Sexual Partners, and Sexual Concurrency in the Garifuna population in Honduras*. AIDS Behavior 19(9), 1559-1570.

Global Communities: Partners for Good, the Global Fund. Fortalecimiento de la respuesta nacional para la protección y la promoción de la salud en el área del VIH/SIDA. http://www.chfhonduras.org/acerca-chf/mensaje-del-director/programas-anteriores/fortalecimiento-salud-vihsida/

Global Database. (2010). Honduras – Regulations on Entry, Stay and Residence for PLHIV.

Gobierno de Honduras. (1982). La Constitución de la República de Honduras.

Guillen Soto MS, USAID. (2013). Gender Analysis USAID/Honduras 2013.

Human Rights Watch. (2017). Human Rights Watch Country Profiles: Sexual Orientation and Gender Identity. https://www.hrw.org/news/2017/06/23/human-rights-watch-country-profiles-sexual-orientation-and-gender-identity

IDLO. (2016). Honduras: First city adopts policy on HIV in the workplace. http://www.idlo.int/news/highlights/honduras-first-city-adopts-policy-hiv-workplace

ILO-OFID. (2012). Conocimientos, actitudes, y practicas sobre el VIH y el Sida en la población trabajadora de la maquila en Honduras.

Inter-American Commission on Human Rights, Organization of American States. (2015). Situation of Human Rights in Honduras

Kendall T, Albert C. (2015). *Experiences of coercion to sterilize and forced sterilization among women living with HIV in Latin America*. Journal of International AIDS Society 18(1).

La Liga de la Lactancia Materna. Orientación sobre VIH a comunidades postergadas.
Mekay, E. (2003). Trade: U.S.-Central America Deal Could Block Cheap AIDS Drugs. Economy & Trade, Headlines, Latin America & the Caribbean, North America.

Observatorio de la Violencia del Instituto Universitario de Democracia, Paz y Seguridad (IUDPAS) de la Universidad Nacional Autónoma de Honduras (UNAH). *Boletín Muerte Violenta de Mujeres y Femicidios*. https://iudpas.unah.edu.hn/observatorio-de-la-violencia/boletines-del-observatorio-2/unidad-de-genero/. Accessed January 5, 2018.

ONUSIDA, UNODC. (2007). Manual sobre el VIH y los Derechos Humanos para las Instituciones Nacionales de Derechos Humanos.

ONUSIDA, UNODC. (2009). Análisis comprador sobre VIH/Sida en los Sistemas Penitenciarios de El Salvador, Honduras, Nicaragua y Panamá: Proyecto sobre estrategias nacionales y diagnósticos sobre VIH y Sida en medios penitenciarios de Centroamérica.

Organization of American States Inter-American Commission on Human Rights. (2013), Report of the Inter-American Commission on Human Rights on the Situation of Persons Deprived of Liberty in Honduras. http://www.oas.org/en/iachr/pdl/docs/pdf/honduras-ppl-2013eng.pdf

Organization of American States Inter-American Commission on Human Rights. (2015). Situation of Human Rights in Honduras. http://www.oas.org/en/iachr/reports/pdfs/honduras-en-2015.pdf

Organization of American States Inter-American Commission on Human Rights. (2013). Report of the Inter-American Commission on Human Rights on the Situation of Persons Deprived of Liberty in Honduras. http://www.oas.org/en/iachr/pdl/docs/pdf/HONDURAS-PPL-2013ENG.pdf

Paz-Bailey G, Morales-Miranda S, Jacobson JO, Gupta SK, Sabin K, Mendoza S, Paredes M, Alvarez B, Monterroso E. (2009). *High rates of STD and sexual risk behaviors among Garifunas in Honduras*. Journal of Acquired Immune Deficiency Syndrome, 51(1), 26-34.

Paz-Bailey G, Istern Fernandez V, Morales Miranda S, Jacobson JO, Mendoza S, Paredes MA, Danaval DC, Mabey D, Monterroso E. (2012). *Unsafe sexual behaviors among HIV-positive men and women in Honduras: the role of discrimination, condom access, and gender*. Sexually Transmitted Diseases 39(1), 35-41.

PEPFAR, USAID, PASCA. (2016). Estigma y discriminación en relación al VIH y sida en Honduras: Encuesta de opinion pública 2013-2016.

Population Services International. (2012). PSI/Honduras. http://psi.hfwebdev.com/honduras

Project HOPE. Honduras. http://www.projecthope.org/where-we work/americas/honduras.html?referrer=https://www.google.com/

RedTraSex, Akahata, Global Initiatives for Human Rights, Human Rights Committee. (2017). Human Rights Situation of Women Sex Workers in Honduras- Additional information submitted to the Working Group.

Sabin M, Luber G, Sabin K, Paredes M, Monterroso E. (2008). *Rapid ethnographic assessment of HIV/AIDS among Garifuna communities in Honduras: informing HIV surveillance among Garifuna women*. Journal of Human Behavior in the Social Environment 17, 237-257.

Sandoval EA, Chavarria YY, Bustillo KR. (2009). *Características clínicas y epidemiológicas de los pacientes adultos con VIH en el instituto hondureño de seguridad social.* Revista Médica Hondureña, 77(4), 153-192.

Secretaria de Salud, ONUSIDA, Fondo Mundial (2016). Medición del Porcentaje de Estigma y Discriminación en Personas con VIH de Honduras, basado en el informe de Fundación Llaves y revisión documental.

Secretaria de Salud, CONASIDA, ONUSIDA. (2016). Estimación del tamaño de las poblaciones clave con mayor riesgo de exposición al VIH en Honduras mediante la metodología de mapeo programático.

Serna, R. (2016). Violencia de género, vulnerabilidad a infectarse con VIH y estrategias de afrontamiento en mujeres. *Iniges-Forosida*.

Siempre Unidos. (2015). Home. http://www.siempreunidos.org/

Stangl AL, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *Journal of the International AIDS Society*. 2013;16(3Suppl 2):18734. doi:10.7448/IAS.16.3.18734.

Stansbury JP, Sierra M. (2004). Risks, stigma and Honduran Garifuna conceptions of HIV/AIDS. Social Science & Medicine 59, 457-471.

The Global Fund. Honduras Overview. https://www.theglobalfund.org/en/portfolio/country/?loc=HND&k=38565614-b542-4558-96f5-6c0ab3e36f97

UNAIDS. (2014). National Commitments and Policies Instrument (NCPI) Honduras Report.

UNAIDS. Global AIDS Monitoring.http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting

UNAIDS. (2017) Global AIDS Monitoring 2018: Indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf

UNICEF, UNAIDS. (2008). 4th Global Partners Forum on Children affected by HIV and AIDS.

UNDP. (2013). Conservatorio Nacional de Honduras: Hoja Informativa.

U.S. Department of State. (2016). Country Reports on Human Rights Practices – Honduras. https://www.state.gov/j/drl/rls/hrrpt/2016/wha/265596.htm#section6women

U.S. Library of Congress. Honduras – Family. http://countrystudies.us/honduras/51.htm

USAID (AIDSTAR-One). (2009). Diagnóstico de los servicios de VIH/SIDA ofrecidos en los centros de atención integral en Honduras.

USAID. (2010). Diagnóstico de los servicios ofrecidos por la associación nacional de personas viviendo con VIH/Sida en Honduras (ASONAPVSIDAH).

USAID, PASCA. (2012). Estigma y Discriminación asociados al VIH: Encuesta de opinión pública. Informe regional. Centroamérica, 2011.

USAID. (2016). Leadership, Management & Governance Project Honduras. End of Project Report January 1, 2013 – January 31, 2016. www.LMGforHealth.org