

WHY IS ACCESS TO TREATMENT A CRITICAL ISSUE FOR KEY AFFECTED WOMEN AND GIRLS?

Women and girls face complex experiences accessing treatment; violence and discrimination from family, community members and healthcare professionals act as barriers or enablers to ART access. Across Asia and the Pacific, there is an urgent need for women and girls-centered care that acknowledges and addresses these and other gendered barriers to HIV treatment and care for key affected women and girls. Removing these barriers will help countries to achieve global development goals, including the 10 targets for 2020 under the UNAIDS 2016 -2021 Strategy, shown below.

Current understandings of 'access to treatment' in the region often focus on health system service delivery, overlooking how social, cultural, economic and environmental factors all influence access to treatment for women and girls. Consequently, women living with HIV in the region have called for an expanded definition of access that includes and addresses gender-related and structural barriers to starting and staying on treatment.

Barriers to accessing HIV treatment

Gender inequalities, stigma, discrimination and human rights violations are constraining women's and girls' access to, and uptake of, health services, including their access to antiretroviral therapy (ART).

Targets for 2020		
<p>90% of people (children, adolescents and adults) living with HIV know their status</p>	<p>90% of people living with HIV who know their status are receiving treatment</p>	<p>90% of people on treatment have suppressed viral loads</p>
<p>Target 2 Zero new HIV infections among children, and mothers are alive and well</p>	<p>Target 3 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV</p>	<p>Target 4 90% of women and men, especially young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services</p>
<p>Target 5 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated SRH services for men</p>	<p>Target 6 90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners, as well as migrants have access to HIV combination prevention services</p>	<p>Target 7 90% of women and girls live free from gender inequality and gender-based violence to mitigate risk and impact of HIV</p>
<p>Target 8 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings</p>	<p>Target 9 Overall financial investments for the AIDS response in low- and middle-income countries reach at least USD 30 billion, with continued increase from the current levels of domestic public sources</p>	<p>Target 10 75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection</p>

To ensure that key affected women and girls benefit equitably from investments in ART, greater attention must be paid to the structural and individual barriers they face when accessing health services and the regular supply of antiretroviral drugs.

According to WHO Consolidated Guidelines on HIV Testing Services (July 2015), any assessment of barriers to HIV testing services should include an analysis of "social, cultural and geographical factors, psychosocial, behavioural factors, stigma and discrimination, gender and legal factors (including age of consent requirements) and structural and health system factors that may impede access".

Barriers affecting access to HIV treatment for key affected women and girls include:

- **Social and cultural norms and taboos.** In Asia and the Pacific, gender and social norms, together with cultural taboos, can create barriers to sexual and reproductive health (SRH) and HIV services;
- **Experiences of stigma and discrimination.** Key affected women and girls in the region are often stigmatised as a result of dominant social and cultural norms. For those who are also HIV-positive, the effects of HIV-related stigma can present further barriers to starting and staying on treatment. Stigmatising behaviours and attitudes expressed by health care providers, as well as within the wider community, pose some of the most significant barriers to treatment for key affected women and girls;

- **Lack of integration between HIV testing with primary health care, TB, STI, drug treatment and sexual and reproductive health (SRH) services.** This continues to compromise access to antiretroviral therapy among different communities of key affected women and girls;
- **Eligibility criteria for antiretroviral therapy (ART).** In September 2015, WHO released its *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*. According to this guideline, anyone infected with HIV should begin ART as soon after diagnosis as possible, removing all limitations on eligibility for ART among people living with HIV; all populations and age groups should be eligible for treatment. Ensuring fair and equal access to HIV treatment means updating national ART guidelines to reflect this latest WHO guideline and removing any previous discriminatory eligibility rules (where these exist);
- **Fears about confidentiality and disclosure of HIV status.** The possibility that their status will be made public without their consent – whether by health workers or family members – can strongly discourage key affected women and girls from obtaining an HIV test, seeking necessary treatment or being open about their HIV status. Barriers to disclosure include fear of discrimination, violence, accusations of infidelity, and abandonment;
- **Transport difficulties.** This can include prohibitive cost of transportation to clinics and the ability to travel to appointments at certain times of the day owing to family responsibilities and/or work commitments;
- **Care burden.** For people living with HIV in a poor household, family members often provide the primary source of day-to-day care. It is estimated that between 70-90% of care in developing nations takes place in the home. This work is particularly taxing in terms of time ('time tax') for women and girls, especially from poor households. For women and girls who are caregivers, the challenges become even greater when they are themselves ill. The lack of social support combined with HIV can turn this unpaid care burden for women and girls living with HIV into a crisis with far reaching health, economic and social consequences, including their own ability to access and stay on treatment;
- **Cost of medications;**
- **Food insecurity,** particularly when medication has to be taken with food;
- **Language barriers** which can be a significant obstacle for female migrant workers and those from ethnic minorities;
- **Lack of HIV treatment programmes in prisons.** Women have less access to health care services in prisons than imprisoned men. Access to HIV treatment, support and care, including the provision of ART, is often more limited in women's prisons than in prisons for men.
- **Criminalization of HIV transmission and exposure.** Since women generally have more contact with health services than men do, they are more likely to be the first in a sexual relationship to be tested for HIV and thus more likely to be blamed by health staff, their intimate partners, their partners' families and their communities, for both sexual and vertical transmission. The fear of an HIV positive diagnosis and the potential of subsequent prosecution generates additional obstacles to HIV treatment for key affected women and girls, discouraging them from accessing services out of fear that they will be exposed to abuse. This is especially true insofar as apportionment of blame is still an important part of both customary and formal legal systems in relation to divorce and inheritance.

"Most of us live in the far village, which takes one hour to two and a half hours by public transport, which is really costly.... So, some months we don't visit the hospital to take ART, sometimes we manage to get money from a neighbour if we don't have our own"

Woman living with HIV, Nepal

Ensuring equitable access to antiretroviral treatment

To address gender-based inequities in HIV treatment, care and prevention, it is crucial to consider the different needs and constraints of women and girls and men and boys when accessing HIV services in different settings – and design interventions accordingly. For example, women and girls' access is more likely to be affected by restricted mobility, difficulties in accessing transport and childcare and lack of treatment literacy, as compared to men's. In other cases, insufficient funds or lack of control over household resources prevents women and girls from accessing ART. For example, user fees may discourage women and girls living with HIV from accessing treatment more than other groups because they are often disproportionately disadvantaged in their access to resources, including money. In addition, women and girls have specific reproductive health concerns which need to be addressed by HIV treatment and care providers. As gender intersects with age, ethnicity, social and economic status and other social categories, these barriers can vary across settings and within populations, often creating different sets of issues for adolescent girls and boys, and for women and men in different situations (e.g. migrant workers, sex workers, housewives, others).

Entry points for ART beyond antenatal services

Whilst antenatal services remain the principal entry point for identifying women of reproductive age in need of ART, entry points for non-pregnant women and girls to HIV testing and counselling needs to be much more accessible. This is critical for key affected women and girls who often find themselves in difficult situations, with limited access to health care services. ART needs to be made available through a much wider range of health services to ensure access wherever different groups of key affected women and girls are in contact with the health system. This can be achieved by linking ART programmes with primary health care, SRH/family planning, TB, STI, and women-centered harm reduction programmes.

Nothing about us, without us: achieving universal access to treatment

The active involvement of key affected women and girls in all aspects of planning and implementing HIV treatment programmes can ensure that efforts to scale up access to ART respond adequately to their needs and rights. This includes embracing and investing in innovative strategies, particularly those implemented by community-based organisations, to reach key affected women and girls with ART.

Sources: UN Women, ATHENA, AVAC, Salamander Trust, (2015) *Key Barriers to women's access to HIV treatment: Making 'Fast-Track' a reality*; UNODC and UNAIDS, (2008) *Women and HIV in Prison Settings*, Vienna. Available at: <http://www.unodc.org/documents/hiv-aids/Women%20and%20HIV%20in%20prison%20settings.pdf>
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