

Analysis of the gender dimension in the scale-up of antiretroviral therapy and the extent to which free treatment at point of delivery ensures equitable access for women

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Abbreviations

ART	Antiretroviral therapy
CHANGE	Center for Health and Gender Equity
GFATM	The Global Fund to fight AIDS, TB and Malaria
ICW	International Community of Women Living with HIV/AIDS
NGO	Non-governmental organisation
PMTCT	Prevention of mother to child transmission
STD/STI	Sexually transmitted disease / sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary counselling and testing
WHO	World Health Organisation
WOFAK	Women Fighting AIDS in Kenya

Summary of organisations referred to in case studies:

Lighthouse, Lilongwe, Malawi, is a charitable trust in Lilongwe, Malawi, providing a continuum of care for people affected by and infected with HIV/AIDS, including an ART clinic.

The International Community of Women Living with HIV/AIDS (ICW), a registered UK charity, is an international network run for and by HIV positive women. It has an official membership of more than 5000 HIV positive women from over 130 countries (and many more unofficial members)

TASO (The AIDS Support Organisation) in Uganda is the largest indigenous NGO providing HIV/AIDS services in Uganda and the region. 22,000 people living with HIV/AIDS directly receive care and support from TASO

Sangram, is an NGO working to empower HIV-positive sex workers, rural women and adolescents in Sangli, Maharashtra, India

SAHAS is an NGO based in Surat, Gujarat, India, working on HIV/AIDS prevention and care since 1997.

Liverpool VCT and Care (LVCT) is a Kenyan NGO that provides technical assistance to the Government of Kenya and others in the scale up of quality assured Voluntary Counselling and Testing and HIV care.

Kenya Network of Women with AIDS (KENWA) is a community-based organisation formed and run by women living with HIV/AIDS. It is currently reaching approximately 470,000 people through a country-wide membership of 2,430 women.

Women Fighting AIDS in Kenya (WOFAK) is a non-governmental AIDS support organization, established to support and empower affected and infected Women and Children to live positively with HIV/AIDS

EXECUTIVE SUMMARY

This report was developed in preparation for the international meeting “Ensuring universal access: user fee and free care policies in the context of HIV treatment”, sponsored by UNAIDS Secretariat, World Health Organization and the World Bank on 21-23 March 2005 in Geneva.

The report considers aspects of gender dimension in access to treatment and the extent to which free care or co-payment at the point of service delivery intersect with gender equity in access to treatment within the context of scaling up. It provides a strategic analysis to enable the development of guidance for policy options.

Method

The report presents a review of published literature relating to equity of access to prevention and treatment services for HIV/AIDS and draws on existing evidence from gender equity analyses of access to services for other diseases such as tuberculosis. It also utilises evidence from a case study and key informant interviews.

An Internet literature search was conducted using Pub Med, additional grey literature and published literature was sourced from individuals in the Gender and Health group.

Four countries (Uganda, Kenya, Malawi, India) were selected for researching case studies and conducting key informant interviews. Selection was on the basis of:

- Experience of provision of free antiretroviral drugs through public, private or NGO services
- Representation of various stages in progression of the epidemic
- Existing personal contacts through the Gender and Health Group and the International Community of Women Living with HIV

A case study of free antiretroviral provision in Malawi was conducted by Research for Equity and Community Health Trust (REACH) using secondary health utilisation data from a service provision NGO and an existing qualitative study of the factors influencing access to these services.

Key informant interviews were conducted with women living with HIV/AIDS, representatives of NGOs, representatives of public health services including programmers and policy makers. Most interviews were conducted either face to face or by telephone, but some informants preferred to answer questions through written correspondence. This is not a representative sample of key informants, but was purposively selected to indicate a range of experiences and perspectives from these groups. Analysis of these interviews was carried out using a framework approach.

1. Why is gender important in antiretroviral therapy (ART) provision?

Globally, young women are 1.6 times more likely to be living with HIV/AIDS than young men, a figure that rises to three times more likely in sub Saharan Africa. In 2003, 13 million adult (15-49) women in sub Saharan Africa were living with the virus compared to just under 10 million adult men.

Rates of ART usage are extremely low in resource poor settings. Only 2% of the total number of people receiving treatment live in Africa and less than 8% of people in the South who need ART are receiving drug treatment. Many international donors have focused efforts on scaling up ART. “3 by 5” is the global target of the World Health Organisation (WHO) and UNAIDS to get three million people living with HIV/AIDS in the South on ART by the end of 2005.

There is little published information disaggregated by gender, age or socio-economic status to indicate who is accessing ART in resource poor contexts. However, where data is available, it

suggests that access to ART is often most common amongst educated men living in urban areas. Evidence suggests that poor women appear to be at particular disadvantage in accessing HIV treatment. Furthermore there are some groups of women who appear excluded from mainstream HIV services, such as commercial sex workers, intravenous drug abusers, HIV positive women who are pregnant or have children. These inequities in access are likely to continue or worsen when ART is made more widely available unless specific measures are taken to address this in scale-up.

2. Why is there gender inequity in access to ART?

There are many factors that shape the inequitable access to services by women and men:

Where there are **direct costs** for ART, both poor women and men have limited ability to access ART. However, women often do not have equal access to those resources available within households, where a male head will often decide how financial resources are allocated. Where a household has only sufficient resources for one member to receive ART when more are in need, it will usually be the male head who takes priority. Where women have some independent access to financial resources, they may forgo food or other essentials to pay for health care, or alternatively not seek health care. Where women care for children, they will often put providing for the child before their own health care needs.

Even if treatment is free, other **indirect costs** that are incurred can prevent women's access to treatment. Frequent journeys to and from health facilities for drugs and monitoring can be both expensive and difficult to access. Many poor women are unable to access services due to the need to earn, or produce food for their families. Even without these financial constraints, women's domestic responsibilities mean they find it difficult to leave their families to travel to a clinic. Many types of ART require certain amounts and types of food. In situations where poverty limits the amount of food available and where women are the last to eat, it can be almost impossible for them to take ART effectively without additional support.

The **stigma** of living with HIV/AIDS, although affecting both sexes, is often more extensively directed against women than against men. Social stigma often perpetuates the belief that HIV infection is a result of promiscuity or prostitution, labels which may lead to blame or violence for women, preventing them from accessing treatment. Many women fear being abandoned by their partners or families, on whom they are often dependent, which discourages them from discovering or admitting their HIV status.

The **poor quality of healthcare services** can act as a barrier to access and utilisation. Attitudes of health care staff can prevent poor and vulnerable women from using health services. Lack of privacy and confidentiality in services can mean that fear of stigma, discrimination and violence due to their HIV status prevents women from accessing care. Where corruption within the health system can result in exemption from user fees being overlooked or misinterpreted women find it difficult to negotiate their treatment. Gendered norms and stereotypes within the health system can affect what treatment women and men receive and how quickly.

The shortage in human resources, lack of training in providing ART, and poor distribution logistics mean that even if women try to access treatment, the **clinical quality of services is poor**.

Women frequently do not have **sufficient information** with which to make effective decisions about healthcare, such as information regarding where to find and how to access appropriate services. They do not have sufficient knowledge about how to treat symptoms and may be misinformed about the risks of ART.

Women may also have **limited control over their mobility and time**. A woman may not be able to access health services because society restricts her movements or a woman's husband may prevent her from obtaining treatment.

Women's status in the household and in society often means that they are not used to expressing their own needs. They may find it particularly difficult to discuss sexual health problems. Some women do not want to worry their families or be a financial burden.

3. Will free provision improve gender equity?

As indicated in the previous section, cost is a critical issue in women's access to ART. There is evidence that even when costs of ART are drastically reduced, it still remains out of reach for many poor women. There is very little published analysis on the impact of free ART on gender equity. However, key informant interviews and a case study reveal that free provision of ART can improve access to services by women. Free access should improve access for women in the following ways:

- Women are not dependent on their husbands or partners for purchasing treatment
- Stigma will be reduced as more people access ART and thus look healthy and are able to work
- Poor women who are divorced, separated, widowed or unmarried will particularly benefit as their income is unlikely to be sufficient to purchase ART and because they may not have anyone to support them if they lose their source of income once they become ill

4. How can we ensure free ART delivers gender equity in access to ART?

As there are many factors, including cost, that influence women's access to ART, it is necessary to devise a package of free access that would help ensure gender equity in access to the services. An examination of WHO's minimum set of requirements for making ART available through a gendered lens provides an entry point into developing this package. Additional recommendations will further improve gender equity.

Engendering the WHO minimum requirements for ART provision

- Reducing or eliminating costs of HIV tests, other laboratory tests and consultations in order that women can gain access to them
- VCT services should develop and follow a set of best practice guidelines, which take into account the specific needs and priorities of different groups of women
- Taking measures to reduce stigma in the provision of all services
- Training for staff to raise awareness of gender issues and the effects of discriminatory and unethical practices, and disciplinary measures to prevent these practices
- Training for staff to improve the quality of information given to clients, including messages to dispel common myths discouraging women from accessing treatment
- Training for staff in clinical issues relating to women with HIV
- Initiating or working with formal and informal support and advocacy networks of women living with HIV/AIDS at local, regional, national and international levels
- Developing a formal network of HIV service providers, both clinical and non-clinical, to improve linkages between public, private and NGO providers, building on their strengths in meeting the needs of different groups of women.
- Developing, disseminating and following eligibility criteria that address disparities in access to services by different groups of women

Monitoring and evaluation

- Develop and implement a monitoring and evaluation strategy which includes gender and equity indicators, such as the disaggregation of indicators of service use and factors affecting this by gender, age and socio-economic group

- Indicators should be regularly reviewed and the programme revised accordingly
- This strategy should monitor each of the different aspects of ART provision

Community involvement in developing interventions

- Ensure the involvement of different groups of community members when developing ART interventions. This will require an enabling environment which allows all groups to be able to participate.
- This involvement should include both the different groups of women for whom the measures address, as well as the people who exert an influence over those groups, such as men and senior family members.

Addressing geographical barriers

- Explore different options for minimising the number of journeys and travel time required to access ART
- Tailor service options to the needs of different groups of women who access ART
- Monitor the effects of innovative service provision on utilisation of services by different groups of women (e.g. in terms of age, socio-economic status, or marital status)

Health promotion/behaviour change interventions

- Develop and implement a health promotion strategy which addresses different groups of women using media accessible to these groups and non-judgemental messages
- This strategy should be developed in collaboration with relevant groups
- Promotional materials should aim to destigmatise HIV
- Health information should cover all aspects of HIV and ART including symptoms, treatment, where and how to access treatment and addressing common myths

Food and nutrition

- Provide nutritional supplements or appropriate economic support with ART
- To ensure that support is not diverted from women to other family members, it should be provided to the whole family

1. Introduction

This report was developed in preparation of the international meeting “Ensuring universal access: User fee and free care policies in the context of HIV treatment”, sponsored by UNAIDS Secretariat, World Health Organization and the World Bank on 21-23 March 2005 in Geneva. The meeting will analyse the importance of the importance and impact of policy on free access to HIV care and treatment versus user fees, with the specific intention of identifying enabling mechanisms and steps to guide countries and partners in their policy decision-making process.

The report considers aspects of gender dimension in access to treatment and the extent to which free care or co-payment at the point of service delivery intersect with gender equity in access to treatment within the context of scaling up. It contributes to the meeting by presenting a review of published literature relating to equity of access to prevention and treatment services for HIV/AIDS and draws on existing evidence from gender equity analyses of access to services for other diseases such as tuberculosis. The report provides a strategic analysis to enable the development of guidance for policy options. It uses case studies and key informant interviews from countries at various stages in their HIV epidemic and at various stages of experience with antiretroviral therapy (ART) provision to allow the voices of women, policy makers and programmers affected and infected by HIV to be heard directly.

An Internet literature search was conducted using Pub Med and additional grey literature and published literature was sourced from individuals in the Gender and Health group.

Four countries (Uganda, Kenya, Malawi, India) were selected for researching case studies and conducting key informant interviews. Selection was on the basis of:

- Experience of provision of free antiretroviral drugs through public, private or NGO services
- Representation of various stages in progression of the epidemic from Uganda, with an established epidemic to India with an emerging epidemic
- Existing personal contacts through the Gender and Health Group and the International Community of Women Living with HIV

A case study of free antiretroviral provision in Malawi was conducted by Research for Equity and Community Health Trust (REACH) using secondary health utilisation data from a service provision NGO and an existing qualitative study of the factors influencing access to these services. Key informant interviews were conducted with women living with HIV/AIDS, representatives of NGOs, representatives of public health services including programmers and policy makers. Most interviews were conducted either face to face or by telephone, but some informants preferred to answer questions through written correspondence. Informants were identified through personal contacts, introductions by ICW and ‘snowballing’ (asking existing informants to identify others with experience of anti-retroviral provision). This is not a representative sample of key informants, but was purposively selected to indicate a range of experiences and perspectives from these groups. Analysis of these interviews was carried out using a framework approach, whereby the broad questions asked in the interviews are used as a framework for grouping responses and identifying themes in the data.

The report begins with an introduction of the gender dimensions of the HIV/AIDS epidemic and goes on to discuss the broad challenges and opportunities posed by the increasing availability of anti-retroviral therapies. We then present existing evidence of gender inequities in access to and utilisation of diagnosis, treatment and care for HIV/AIDS and other infectious diseases, and discuss the factors shaping these inequities. This evidence and the perspectives of key informants are then used to present the rationale for free provision of ART as a means of ensuring women’s access. Finally, a framework for a ‘package’ of services for the delivery of

free ART is suggested, with a focus on ensuring that this package is accessible to and meets the needs of different groups of women.

1.1. Scale of epidemic and its gender dimension

HIV/AIDS is having a devastating global impact with approximately 40 million people living with HIV worldwide in 2004¹. The overwhelming majority of HIV infected people live in resource poor settings, putting enormous strain on already hard-pressed healthcare resources.

Rates of HIV infection among women are troublingly higher than those of men. Globally, young women (aged 15-24) are 1.6 times more likely to be living with HIV/AIDS than young men, a figure that rises to three times more likely in sub-Saharan Africa². In 2003, 13 million adult (15-49) women in sub-Saharan Africa were living with the virus compared to just under 10 million adult men; the relative number has increased every year since 1985 when approximately half a million of both sexes were infected³. Even in countries, such as India, where rates of HIV amongst men still appear to be higher than amongst women there are significant inequities in access to HIV services, and vulnerable groups, such as female sex workers, face major barriers in accessing care. These disparities are coupled with the increased workload that is taken on by women as a result of the HIV epidemic – caring for children orphaned by AIDS, people sick with AIDS-related illnesses and their families.

At the centre of this increased burden on women is the issue of gender inequity. Factors influencing gender disparities in HIV rates include exploitative sexual norms, societal tolerance of men's multiple partners, women's (limited) control over their bodies and violence against women within relationships⁴. Further, limited financial resources increase women's dependence upon men and hence their vulnerability to exploitation. Violence, poverty, inequality and lack of rights are all aspects of the battle to control HIV/AIDS⁵.

Alongside the WHO and UNAIDS, many international organisations, including the Global Fund to Fight AIDS, TB and Malaria have highlighted the gender dimensions of the HIV/AIDS epidemic. In June 2001, the UN General Assembly Special Session on HIV/AIDS (UNGASS) specifically identified the empowerment of women and increasing gender equality as central to decreasing females' vulnerability to HIV/AIDS. The International Community of Women Living with HIV/AIDS (ICW), founded in response to the lack of support, information and services available to women living with HIV worldwide, have produced a number of documents specifically addressing the gender dimension of vulnerability to HIV/AIDS^{6, 7, 8}

Local women's organisations are already addressing the challenges faced by women who are infected with or affected by HIV. Positive women from many different backgrounds have worked together to support each other, build self esteem, challenge stigma and cultures of gender based violence and negotiate advances in women's position in the household and in society. The subsequent growth of HIV support groups has provided a framework for women to learn about HIV and related health issues and in many cases to become more assertive of their rights^{9, 10}.

1.2. Opportunities and challenges posed by antiretroviral therapy

The introduction of highly active antiretroviral therapy (ART) in industrialised countries has led to dramatic improvements in mortality and morbidity amongst HIV-infected individuals. Although ART drugs do not cure HIV, they dramatically improve quality of life and prolong survival. Six years after the introduction of ART in Europe and the US, deaths from AIDS-related illness were cut by more than 70 per cent¹¹. If available on a large scale in the South, ART would give affected communities and societies the ability to cope and live with HIV/AIDS in ways that have not previously been possible. However, rates of ART usage in resource poor settings are extremely low. Only 2% of the total number of people receiving treatment live in Africa¹², and

less than 8% of people in the South who need ART are receiving drug treatment¹³. For this reason, many international donors have focused efforts on scaling up ART. “3 by 5” is the global target of the World Health Organization and UNAIDS to get three million people living with HIV/AIDS in the South on ART by the end of 2005. It is a step towards the goal of providing universal access as a human right.

However, there are a number of significant challenges to meeting this goal. Firstly current ART scale-up programmes need to draw on lessons learnt from the scale-up of other services, such as voluntary counselling and testing (VCT) including priority setting for scale-up and the incorporation of quality assurance and monitoring and evaluation at the outset. Secondly ART provision poses unique programming challenges. Even in well-resourced HIV clinics the need for life-long therapy, increasing resistance rates, problems with adherence and high levels of toxicity impose significant challenges for specialist health care providers. Thirdly, ‘3 by 5’ will not be able to provide services to all those who need them in the immediate future, requiring difficult decisions about prioritisation of need. A UNAIDS and WHO sponsored consultation on ethics and equitable access to treatment and care for HIV/AIDS has been produced to raise awareness of the ethical issues and to help with the planning and implementation of the scaling-up of ART in a way that is ethically acceptable, fair, and benefits health systems in general. The guidance document includes a set of measures that can be taken in countries and communities to promote fairness in scaling up HIV care¹⁴.

There is evidence that access to existing HIV/AIDS prevention and treatment services is inequitable and this is likely to continue or worsen when ART is made more widely available unless specific measures are taken to address this in scale-up¹⁵. Small-scale programmes have more flexibility to address gender equity in their initial treatment programmes but their efforts are likely to be jeopardised by scale-up. Efforts are therefore needed to mainstream a gender equity focus in scale-up¹⁶. The Global Coalition on Women and AIDS has therefore called for half the recipients of ART through the ‘3 by 5’ campaign to be women¹⁷. The WHO’s ‘3 by 5’ campaign has noted that “special attention will be given to protecting and serving vulnerable groups”¹⁸, but there remains a question mark over how this can be achieved in practice and who the most vulnerable groups are.

2. Gender equity dimensions in accessing ART

This section presents the existing evidence of inequities in access to prevention and treatment for HIV/AIDS and other communicable disease. It explores some of the underlying factors influencing these and highlights lessons learnt for ART programming. In this paper the term ‘equity’ will be used to describe differences between social groups that are judged to be avoidable and unfair, in contrast to ‘inequalities’ which refers simply to differences, without any judgement of their fairness¹⁹.

2.1. Evidence of inequality of access in the HIV prevention-care continuum

There is a paucity of published information disaggregated by gender, age or socio-economic status to indicate who is accessing ART in resource poor contexts. However, where data is available, it suggests that access to ART is often most common amongst educated men living in urban areas²⁰, despite more women than men living with HIV/AIDS.

Poor, rural women often appear to be at a particular disadvantage in accessing HIV treatment. In Zambia an estimated 70% of the 2 million people living with HIV/AIDS are women, and despite the government’s recent focus on making ART available (at the subsidised price of US \$8 a month), only 10% of the people accessing it are women²¹. This inequality appears to be more pronounced in rural than in urban areas, where women are more often not in formal employment or in control of household budgets²². Where women’s social status is lower than

men's and they live in a culture of obedience to husbands, fathers, brothers and other male relatives, women are often prevented from accessing health services^{23, 24}.

In addition, women who do not conform to social norms feel (and often are) excluded from mainstream HIV services^{25, 26}, including commercial sex workers, intravenous drug users and HIV positive women who are pregnant or have children.

Sometimes failure to access services is self-selecting in the context of women's low bargaining power to protect themselves against infection. In Thika district in Kenya, only 25% of healthcare workers choosing to access post exposure prophylaxes (PEP) following a needle injury were female, despite women constituting 72% of the workforce²⁷. Qualitative research revealed that they chose not to access PEP as they considered themselves constantly at risk from contracting HIV by having unprotected sex with their husbands.

Key Informant interview: HIV positive woman, KENWA (Kenya Network of Women Living with HIV/AIDS)

"Most of our women and those requiring ART are not in any form of employment, or [have an] income and most of them rely on their husbands or other men to provide for the basic need. So if they are not able to provide for the basic needs, accessing the ART is secondary, it's not even considered as important. If they are not supported they cannot access the medicines."

Key informant interview: Meena Seshu of Sangram, Maharashtra, India

"Sangram works with rural women because when people in rural areas are ill, chances are if they are men they will come and access the government health services, but if they are women they won't. The problem is that most women do not access services. The men get information; they also go to see the doctor much faster when they are ill compared with women who are ill. So the people who get referred to even have an HIV test are basically the men in the family. The women, if they are getting tested first it is only through the antenatal clinics who are compulsorily testing everyone who comes in the first trimester. So women actually getting tested is very little. And the women who are going for testing are only going because their men are positive and the doctor has suggested that the sexual partner should also be tested. We have seen very few women whose male partners are not infected actually going in for the test."

2.2. Evidence of inequality of access to services in other diseases

Evidence of gender inequities in access to healthcare services can be found in the context of other diseases.

Tuberculosis: Globally there is evidence to suggest that poor women experience gender-specific barriers to accessing TB diagnostic and treatment services, which are often greater than those faced by their male counterparts^{28, 29, 30, 31, 32}. For example in India, TB case fatality rates were found to be 27-41% higher amongst young women and children aged 5 -24 years compared with males in the same age group³³. This can be partly explained by delays in seeking care. The low status of women, their limited decision making ability and access to health resources place them at particular disadvantages in comparison to men who have TB. Similarly a survey estimating the gender specific prevalence of TB in a district of Vietnam³⁴, suggests that women ran a significant risk of under-detection. Although prevalence was similar for men and women, case detection was 39% amongst men and 12% in women. Under-detection of female tuberculosis patients was explained by stigma and fear of social consequences, which led to women preferring to use private providers or drug sellers, who offered greater privacy as well as being more easily accessible.

Malaria: There is also evidence of lower utilisation of formal health services to treat malaria by women than men in some contexts. For example, in a study of access to malaria services in Thailand, men attending malaria clinics outnumbered women by six to one, despite no evidence of significant differences in prevalence between the sexes³⁵. Similarly, in India women between the ages of 25 and 39 years were severely under-represented in malaria cases recorded at 39 Primary Health Centres, and a study in Ethiopia found that women utilised CHW services for malaria less frequently than expected given their proportion in the population.^{36,37}

Leishmaniasis: When leishmaniasis was investigated through active case finding in Columbia it was found to be equally prevalent among men and women. Previously it had always been considered twice as common in men because so many more men than women attended for treatment³⁸.

Onchocerciasis: In a study of treatment of onchocerciasis in Sierra Leone it was found that women who were excluded from having the treatment ivermectin because of pregnancy or breastfeeding infants, did not seek treatment once they became eligible for it. Reasons for not accessing treatment included the high cost of transport and not knowing where to seek treatment³⁹.

Leprosy: There is evidence that women delay identifying skin changes as symptoms of leprosy for longer than men and then depend on non-medical treatment for longer periods⁴⁰. A study in Nigeria estimated this time delay as being twice as long in women than in men, resulting in a higher proportion of disabilities among women. Social stigma was a major factor for women in delaying accessing treatment⁴¹. This is supported by a study in central India, where women with leprosy were found to suffer more from rejection within their families and society⁴². When quality of care amongst people with leprosy was explored in Nepal, it was found that women received poorer quality of care, including attitudes of health workers, lack of information sharing and inadequate referrals. This affected their adherence to treatment⁴³.

2.3. Reasons for inequity of access

This section explores evidence for the factors shaping inequitable access to services by women and men, drawing on studies of access to diagnosis, treatment and care services for HIV/AIDS and other communicable diseases.

2.3.1. Costs

2.3.1.1 Direct costs of treatment

Many poor people simply do not have the funds to pay for treatment. This means that, where user fees are charged, they will be unable to obtain ART, will get into debt by borrowing or will be forced to make trade-offs in forgoing food or other essentials in order to pay for healthcare⁴⁴. Both poor women and men have limited ability to access to ART where doing so incurs costs. However, the 'feminisation of poverty' – that poverty is "hitting increasing numbers of women, and is hitting them harder"⁴⁵ – indicates that women are likely to have particularly low financial access.

Research in many settings has found that women are particularly unlikely to access general healthcare services where payment at point of access is required⁴⁶. When user charges were introduced in Nigeria, maternal deaths in the Zaria region rose by 56% and the number of deliveries in hospitals declined by 46%⁴⁷. In Zimbabwe use of maternal and child health services declined when user charges were enforced⁴⁸ and in South Africa antenatal care improved after charges were withdrawn⁴⁹.

Women often do not have equal access to those resources available within households, where a male head will often decide how financial resources are allocated⁵⁰. When resources are scarce, expenditure on men and boys often takes priority over women and girls^{51, 52, 53}. Thus if a household has only sufficient resources for one family member to receive ART when more are in need, it will usually be the male head who takes priority^{54, 55}. This finding is supported by research into the intra-household allocation of resources for healthcare for other infectious diseases. For example, in a study of TB in Pakistan, the unwillingness of families to pay for women's treatment was found to be a major reason that women have greater difficulty accessing treatment than men⁵⁶. Similarly in Bangladesh, it was found that households prioritised TB treatment for men⁵⁷.

Where women have some independent access to financial resources, they may be forced to forgo food or other essentials to pay for healthcare, or alternatively not seek healthcare in order to afford these basics⁵⁸. Where women care for children, they will often put providing for the child before their own healthcare needs.

The case study and key informant interviews undertaken for this paper illustrate the effects of paying for treatment on poor families:

The Lighthouse, Lilongwe, Malawi

The Lighthouse is a charitable trust in Lilongwe, Malawi, providing a continuum of care for people affected by and infected with HIV/AIDS, including an ART clinic.

Qualitative research was undertaken at the Lighthouse to explore barriers to accessing ART at the time when drugs were provided 'at cost'¹. At the current exchange rate ART cost US \$24 per month per person during this period. In a context of limited resources and costly drugs, individuals and families had to make very difficult decisions about who should access ART. There was some evidence that where men are the breadwinners they are likely to prioritise access to ART drugs for themselves. For example from one focus group discussion one man explained: *'So the problem is that we men are selfish, selfish in the way that we are only buying medicines for ourselves and denying our partners the medicine as well. May be if it were halved but K2500... how much money do we get'*. Male participant at focus group discussion

Beatrice W, ICW Uganda, activist and mother

"Women's incomes tend to be very low, so much so that we can only afford basics really, like food, shelter. Those who remain in the rural areas you find that they cannot even find money, there is no gainful employment apart from really working the land and looking after children. You find that in most cases, women do not have money... The other priorities like food, clothing, looking after the children, eat up most of what they make - from hand to mouth. So as long as health care has a price tag added to it in Uganda, you will find that more and more women will be cut off."

2.3.1.2 Indirect costs of treatment

Even if treatment is free, other costs can prevent women's access to treatment. **Transportation costs** are a significant barrier to treatment for many women^{59, 60}. Patients usually need to make a considerable number of journeys to visit several different health units to receive a diagnosis for many communicable diseases, including HIV/AIDS. Receiving a course of treatment can mean regular and possibly long journeys to obtain drugs. A study in Rwanda reported that many women living with HIV receiving medication for opportunistic diseases could not afford transportation to the hospital⁶¹. In Mnini in South Africa, where the government has introduced a

¹ ART are now provided by the Lighthouse free of charge

free ART programme, transport is an insurmountable barrier to accessing the services for many. It has been next to impossible for those with AIDS-related illnesses to enrol on the free treatment programme, because participating in the programme requires regular visits to the treatment site to receive the drugs and undergo monitoring and health check-ups⁶².

Evidence from other diseases corroborates this. Research on access to TB services in China found that when patients were referred to TB specialist services that offered free treatment, it was often difficult for them to attend these services for diagnosis and treatment due to travelling expenses, geographical distance and time constraints. This resulted in an average of only 20% of TB suspects being successfully referred to the 'free' services⁶³.

The **cost of time** spent accessing treatment services can also act as a barrier to access. This includes both the time spent at the health unit and the time required for travel, which is time not spent in productive or reproductive labour. Many poor women are not able to access services due to the need to earn, or produce food for their families. Even without financial constraints, women's domestic responsibilities often mean they find it difficult to leave their families to travel to a clinic. Facilities' hours of operation do not account for women's domestic schedules and responsibilities and lack of access to transportation⁶⁴. The time costs of travel is particularly problematic for single women (divorced, separated, widows and unmarried women) as they are likely to have only one source of income (their own). Time away from work means they have no income at all.

For many types of ART medicines to be effective they need to be taken with a certain amount of **food and water** twice a day. The need to eat twice a day with medicines or plan meals carefully around drug regimens may require more food than usual for a poor family for whom financial constraints may mean they would otherwise eat only once a day. Further, the *types* of food an individual consumes may need to change in order for ART to be effective, which can be very difficult for a poor woman surviving at around subsistence level to afford. In situations where poverty limits the amount of food available and where women are the last to eat, it can be almost impossible for them to take ART effectively without additional support⁶⁵.

2.3.2. Other factors

It is not only the direct and indirect costs of treatment that prevent women from accessing ART. A variety of other reasons interact to affect gender inequity in access to the health system and ART.

2.3.2.1 Stigma, discrimination, blame and violence

The stigma of living with HIV/AIDS is recognised to be an enormous obstacle in the fight against the disease. Individuals can be discriminated against and ostracised by families and communities, as well as institutionally, politically and legally.

Where stigma exists, people often prefer to ignore their real or possible HIV status⁶⁶, which prevents them from accessing HIV services. Although stigmatisation affects both sexes, it is often more extensively directed against women than against men⁶⁷. For example, social stigma often perpetuates the belief that HIV infection is a result of "promiscuity" or "prostitution", or is associated with witchcraft; labels which may lead to blame or violence for women, preventing them from accessing treatment^{68, 69}. Even many middle class women who can afford to purchase ART will not do so for fear of being seen and people learning about their status.

Evidence from India has suggested that sex workers can face particular difficulty in accessing HIV services⁷⁰. Many women fear being abandoned by their partners or families, on whom they are often dependent, which discourages them from discovering or disclosing their HIV status⁷¹. They may be accused of "promiscuity" or extra-marital sexual relations, of infecting their

partners or children, or of bringing shame to the families. Alternatively they may be denied access to ART by their families who do not want others to know of their HIV status⁷².

Key informant interviews from Uganda illustrate the impact of stigma on access to care, even in a context where relative to many African countries there is a culture of openness to recognising HIV/AIDS.

Male HIV worker in ART, TASO, Uganda

“If a woman would go and disclose to their husband that they are HIV positive... that would imply that the blame would lie on the woman and that might disturb the social dynamics. It could lead to separation or divorce. So the issue of disclosure is affecting access to care”

Beatrice W, ICW Uganda, activist and mother

“Because society still looks at women as subordinate, women are easily judged when they do something ... they are the powerless sex in the community and the family. When the woman walks into an AIDS clinic that is an opportunity for people to stigmatise her, blame her, name her and shame her. You find that most women would rather keep silent or keep away from the services because of fear of being named ... and even being thrown out of her family, household or community”.

2.3.2.2 Quality of healthcare delivery

The poor quality of public healthcare services can act as a barrier to access and utilisation, particularly for the poor and vulnerable. One of many studies of poverty and healthcare identifies obstacles for the poorest presented by the low quality of health care in the public health system in Malawi ; the poor ‘wait longer, receive fewer drugs and pay more in comparison with the wealthy’⁷³. Poor quality and discriminatory service delivery can pose specific barriers to utilisation by vulnerable women⁷⁴: For example, a study of access to TB services found women to be more sensitive than men to poor health service conditions and poor staff attitudes⁷⁵. The poor quality of services is often exacerbated by discrimination against women living with HIV/AIDS.

Attitudes of healthcare staff can prevent poor and vulnerable women, particularly HIV positive women, from using health services. For example, pregnant women have been turned away from health units at delivery as a result of healthcare professionals’ fears of exposure to the virus⁷⁶ and doctors have refused to touch women with HIV⁷⁷. In some situations, women who have been identified as HIV positive through antenatal services have been pressurised into having abortions or sterilisations⁷⁸. Reports have emerged from Southern Africa and Asia that women are only allowed to access ART if they are using long term contraceptives such as the injectable contraceptive or the coil⁷⁹. Such experiences of discrimination by health professionals against people living with HIV further discourage women from accessing services.

Key informant interview, Meena Seshu of Sangram, Maharashtra, India

“The doctors themselves tend to treat you badly. For fear of catching the infection, the doctors will not treat anyone who is positive. Also, the entire health infrastructure has the attitude that you are going to die in any case, so why should they treat you? Why should they invest money in this particular cause when there are so many other patients who are not HIV positive who should get it? There is such a tremendous negative attitude that exists from the top doctor to the nurses and whoever the carers are in the hospital setting. As a result people who go there come back with such a negative attitude that they are going to die anyway they don’t even want to access services later. When men encounter this, they have a voice so they fight it out, and there is some kind of negotiation. With women they just keep quiet and return home. That is the problem they are facing. How do you give women a voice, how do you teach them about their rights, how do you tell them that they should go and access the services because it is meant for them? I think is the major problem.”

Privacy and confidentiality are key determinants of access to HIV treatment and care; the lack of confidentiality of services can mean that fear of stigma, discrimination and violence due to their HIV status prevents women from accessing care⁸⁰. In some cases adolescent girls are refused testing or treatment unless a family member gives permission⁸¹. A case study in India identified a patient whose doctor told her employer about her HIV status. She was subsequently humiliated in front of co-workers, fired, and left without a livelihood⁸². This finding is supported by evidence from other stigmatised infectious diseases: in Bangladesh, women with TB identified lack of confidentiality associated with formal health services as a reason for preferring traditional healers⁸³.

Gendered norms and stereotypes within the health system can affect what treatment women and men receive and how quickly. A study in Vietnam found that women received a TB diagnosis on average two weeks later than men who entered the health system at the same time⁸⁴. This may be partly due to gender bias by physicians, who are less likely to recognise the symptoms of what they see as a ‘male disease’ in a female patient, as found in studies of ischaemic heart disease in industrialised countries⁸⁵. In areas where ART is available, many doctors assume that women will have more difficulty adhering to complicated medication regimens and may be less likely to offer treatment, even though research has shown that women are just as likely as men to adhere to treatment^{86,87}.

‘Women friendly’ services: In order to increase women’s access, HIV services are often delivered via services that are used more regularly by women, such as reproductive health services. These services are considered to be more ‘women friendly’ because many women feel more at ease in these services due to their regular use, and it is socially accepted that women visit them. However, they are often not attractive to women who do not conform to the expectations of society or of staff – for example commercial sex workers, intravenous drug users, women considered too young to need these services, women who aren’t pregnant, women past child-bearing age and HIV positive women who are pregnant or have children. These women who ‘do not conform’ can receive very poor or inappropriate services or none at all. Pregnant women with HIV who access health services report being forced into having abortions or sterilisations or turned away altogether^{88, 89}.

The inaccessibility and ‘unfriendliness’ of public sector services can result in women seeking care from private practitioners as the first, or only, site of service access. Although private practitioners charge for services, it is reported that they often adopt more caring and respectful attitudes towards clients in addition to being more accessible in terms of time and transportation costs, and offering more flexible payment options, such as spreading payment over a period of time and working on credit (particularly the case in small towns and villages)⁹⁰. However, little is

known about the quality of clinical care of these private services, and supervision or regulation is limited, which may mean women pay to receive substandard care.

2.3.2.3 Quality of clinical care

Failures in the health system, including lack of adequate staff or facilities, or poor distribution logistics mean that even if women try to access treatment the clinical quality of services is poor; for example, drugs are not available or inappropriate: “everyone gets paracetamol”⁹¹. This may prevent women from spending the time, effort and money in accessing services.

Clinical staff need to be aware of the specific clinical needs of women in relation to HIV/AIDS. These include clinical issues which relate to pregnant women and women’s reproductive health, the differences between women and men with HIV, for example, an increased risk of certain infections, and also differences in gynaecological problems between women with HIV compared with those without. Such awareness of women’s specific needs can increase their access to HIV services.

2.3.2.4 Lack of access to information

The poor frequently do not have sufficient information with which to make effective decisions about healthcare, such as information regarding where to find and how to access appropriate services⁹². A study in China found that the poor had a lower level of knowledge about the free treatment programme for TB, whilst women in particular were being missed by health promotion programmes and consequently had lower levels of knowledge and awareness of TB symptoms⁹³. The health system often takes a passive attitude towards those who are unaware of their services or are not accessing them. The Acting National Director of the Zambian National AIDS Council says: “*the drugs are available to both men and women – I don’t know why women are not accessing them.*”⁹⁴

Poor people frequently do not have sufficient knowledge about how to treat or manage symptoms, and may be misinformed about ART risks. In Botswana, Kenya and Zambia, women have reported returning drugs they have been given for treatment due to opposition from their husbands or mistaken belief (in the case of pregnant women) that they would harm the foetus⁹⁵. Women have reported a belief that “drugs are not good for women”⁹⁶.

2.3.2.5 Women’s lack of control in decision making

In addition to a lack of control of financial decision-making, women may have limited control over their own mobility and time. A woman may not be allowed to access health services because society restricts her movements, or a woman’s husband may prevent her from obtaining treatment⁹⁷. For example, in Pakistan, restrictions placed on women’s movements were found to be a key reason that women have greater difficulty accessing treatment than men⁹⁸. Women’s – particularly younger women’s – ascribed domestic and childcare responsibilities may mean that their husbands or families do not allow them to visit health services.

2.3.2.6 Women’s status in the household and in society

Women’s position in the household and in society often means that they are not used to expressing their own needs. This can be particularly true for younger women. They will often hope that a health problem will go away on its own, meaning they will ignore signs and symptoms of an illness rather than go for treatment⁹⁹. Some women do not want to worry their families with their own health problems, or to be a financial burden. In China, women with TB would delay care seeking so as not to use scarce resources on themselves¹⁰⁰ and in Nepal, women with TB were found to wait twice as long as men before seeking treatment¹⁰¹.

There may also be additional barriers to women expressing sexual health problems. Evidence from India has indicated that in some situations it is difficult for a women to talk to her husband about sex and sexually transmitted infections, either because it is a taboo subject or because she would not want to be thought to be questioning her husband and his sexual behaviour, so she will just 'grin and bear it'¹⁰².

Women's legal rights such as widespread inequity in property and inheritance rights also influence women's ability to access ART. Although women often have equal legal rights in law, in practice this is rarely observed. Where women do not inherit land or property, their wellbeing is considered less important than male family members as a result of this low status¹⁰³.

3. Rationale for free access to ART

Women's widespread lack of access to financial resources, both independently and within households, is a strong argument for providing free access to ART. Since women are less likely than men to access healthcare services which require them to pay, ART will remain inaccessible to poor if user fees are charged¹⁰⁴. CHANGE therefore identifies free access as important to ensure equity in access to ART.

Even when the costs of treatment are drastically reduced, they can remain out of reach financially for many poor women. In Zambia, for example, GFATM funding enabled the monthly cost of ART to be reduced from \$64 to \$8 per month. Some reports indicate that as many as 70% of HIV positive people in Zambia are women, so a majority of women were expected to access ART. Instead, men began presenting for treatment in much greater numbers. Despite treatment becoming much cheaper, Zambian women reported that they still lacked sufficient funds to pay for the monthly medication, or their families chose to pay for medication for the men in the household rather than the women¹⁰⁵.

The WHO identifies minimising costs to make ART more affordable as a crucial element of providing ART¹⁰⁶. Women living with HIV/AIDS have specifically identified economic support and accessible and affordable healthcare for positive women to help improve their situation¹⁰⁷.

The provision of ART can also help reduce stigma. In India, the Society for the Protection of Youth and the Masses identified less stigmatising behaviour following a pilot project that trained health professionals to provide care as well as education around HIV¹⁰⁸. In Haiti, the highly visible fact that participants receiving ART appeared healthy and were able to work reduced stigma dramatically¹⁰⁹.

Providing ART drugs free at the point of access will have different impacts on different groups of women. Poor women who are single (divorced, separated, widows and unmarried women) will particularly benefit, both because their income is unlikely to be sufficient to purchase ART and because they may not have anyone to support them if they lose their source of livelihood once they become ill, further reducing their ability to pay for drugs^{110, 111}. Women without children may benefit from free ART where having children is an important social and cultural norm: young women with HIV may not be able to afford ART, and therefore run the risk of having a baby with HIV or decide not to have children. Free ART will give these young women opportunities to have healthy families¹¹².

Testimonies from people living with HIV/AIDS provide a strong case for making ART free:

The Lighthouse, Malawi

“Most of the money is going to buy medicine so that to feed your family then there are also some children in school and it means they will to have enough money for school even in your family you cannot even eat decently [eat three food groups] so that because of the medicine other things do not go well so this in future could make some one to say it is better I just stop taking the medicine and die”

“Some of us are failing to have our partners at home get the medicine as it is expensive and I cannot pay K5000², and then make sure we are eating and paying rent from the same amount. I can't manage, so it would help if the cost was lowered”

Lillian M, ICW East African Regional Coordinator, Uganda

“On their (women) own it is very, very difficult. Very few can afford to buy drugs on their own. Even if you look at the number of people who are taking drugs in this country, you realise that the majority of those who are paying for themselves are men, and then you have women infected with HIV accessing free treatment”

Male HIV/AIDS worker, TASO, Uganda

“Costing is a factor influencing access because majority of those who access barely afford travel costs let alone service charge”

In summary free ART should improve access for women in the following ways:

- Women are not dependent on their husbands or partners for purchasing treatment
- Stigma will be reduced as more people access ART and other HIV services
- Poor women who are divorced, separated, widowed or unmarried will particularly benefit as their income is unlikely to be sufficient to purchase ART and because they may not have anyone to support them if they lose their source of income once they become ill

The next section presents existing evidence of the extent to which the free provision of ART has improved access to services by different groups of women.

4. Evidence for the extent to which free access improves gender equity in access to ART

There is very little published analysis of the impact on gender equity of free ART at the point of access. The evidence presented in this section was obtained from the case studies and key informant interviews undertaken for this paper in Malawi, Uganda, India and Kenya. It presents the experiences of free ART on people living with HIV/AIDS and different service providers.

² At the current exchange rate of 106MK:US \$1, ART costs US \$24 per person per month.

The Lighthouse, Lilongwe, Malawi

The Lighthouse in Lilongwe, Malawi, provides a continuum of care for people affected by and infected with HIV/AIDS. The Lighthouse, under the umbrella of the Ministry of Health, has operated the ART clinic for Lilongwe Central Hospital since July 2002. Up until June 2004, patients paid for ART drugs at the subsidised cost of MK2500 per month. From June 2004, through financial support from the Global Fund for Tuberculosis, AIDS and Malaria, ART drugs are free of charge for all of those who are deemed clinically eligible.

Using a proxy measure of poverty¹¹³ it was found that during the period when patients had to pay for drugs (up to June 2004), they were mostly middle class. Since June 2004, informal observations have revealed that the portfolio of people coming to the Lighthouse for ART has shifted. As well as being more women, there are more people who are less well off economically.

In qualitative research undertaken with users of the Lighthouse, costs clearly emerged as the main barrier for patients to access and adhere to ART. This was the case for both female and male patients. The cost of accessing ART has implications for individuals, family units and the broader extended family networks.

Bureau Chief, AIDS Healthcare Foundation, India

“Provision of free ART has come as a boon for many women and it improves women access to treatment who under normal circumstance would not readily come forward either for testing or for care and support services for people living with HIV/AIDS.

Many women from lower socio-economic groups ask to receive free ART over others things. In one case a very poor lady with two young daughters kept on asking for ART medications, she wanted ART to live longer and see her daughters grow up. She could not afford it and ultimately succumbed to AIDS without having the chance to use ART.”

SAHAS, Gujarat, India

SAHAS is an NGO based in Gujarat working on HIV/AIDS prevention and care since 1997. They currently run a private initiative providing ART subsidised by 50% to women.

“Even when a cost subsidy is available, many women find it difficult to pay ... Our experience is that free ART provision to women will definitely increase access to women as most depend on their family (often the income of their spouse) for payment of their own treatment. Most do not have any other employment.

Of the 23 women attending our programme who are on ART (a programme that subsidises ART), seven have a spouse on ART and in four cases the husband started ART before the wife. The usual response from such couples is that men are the breadwinners and need to remain healthy, hence, when family income is not enough, priority is for the male to begin treatment first. If ART were free the women would be able to access treatment at the same time as the husbands”

Liverpool VCT and Care, Nairobi, Kenya and WOFAK (Women Fighting AIDS in Kenya)

Primary research undertaken in Kenya indicated that in some situations more women than men are seeking HIV care than men. The director of Liverpool VCT and Care in Nairobi noted that in centres where there are charges more men are accessing ART as women do not have the finances to buy. A HIV positive woman accessing services provided by **WOFAK** (Women Fighting AIDS in Kenya) commented that before the 3 by 5 initiative the challenge to women accessing ART has been the cost. The introduction of free treatment allowed many women to access ART.

An employee of Liverpool VCT and Care stated *“My experience is that when people are being given free services they seek the services. Especially women, they are really coming when the services are free. Before I came to LVCT I was working at Riruta where we were giving free services and there are so many people who are coming. Here in Liverpool [VCT and Care in Nairobi] when I compare there are still people coming, but when it comes to the cost, most of the people are feeling it is quite high.*

TASO, Uganda

TASO provides free HIV/AIDS services, including ART, and more women than men access their services. A male HIV/AIDS worker reported:

“Close to 65% of our clients are women, and this is because women are dependent. The majority of them are widowed - lost their spouses and they did not have source of livelihood. Because TASO provides free HIV/AIDS care we have more females accessing ART and accessing HIV/AIDS care from TASO than males... and actually 72.7% of our patients accessing ART through TASO are female”

This shows that free treatment is benefiting women who otherwise wouldn't be able to afford it. However, it is not clear whether or where men are seeking care and this needs further investigation.

Lillian M, ICW East African Regional Coordinator, Uganda

“In the first few months of the government starting to provide services providing free ART we have seen an increase of the number of people that come out to access the HIV services. This is a clear indication that probably people who are not coming out because they don't know what is going to happen next, probably they knew that they could not afford. But now, with the provision of free ART people are coming out first of all to know their status and also to take from the services that are available, to come for care and support”

Due to the paucity of published information on the impact of free ART provision, the following section presents evidence from studies which illustrate the impact of user fees or free treatment provision on women's access to general health services or services for other infectious diseases.

5. Evidence for the extent to which free access influences gender equity in access to curative services for other diseases

There is little documented evidence on the extent to which free access improves gender equity in access to curative services. However evidence indicates that the reverse is true; i.e. that fees for treatment make access to care more difficult for women.

In Kenya, the introduction of user fees in government outpatient facilities led to a dramatic reduction in utilisation of sexually transmitted illnesses services by men and women. Once the charges were revoked, attendance by women increased to 22% above the pre-user charge level.¹¹⁴ Government hospitals of three districts in Tanzania saw a 53% decline in the utilisation rates of antenatal care services when user fees were introduced¹¹⁵. In the Zaria region of Nigeria, after the introduction of user fees, not only was there a decline 46% in the number of deliveries conducted in the main hospital, maternal deaths increased by 56%¹¹⁶. In South Africa, when charges were revoked antenatal clinic attendance increased.

Free care should be seen as one of several measures which may help to increase access to health services¹¹⁷. In studies of access to TB treatment, although free or subsidised treatment was considered an important factor in improving access to tuberculosis care, women also cited stigma and fear of social isolation from family and community^{118, 119}. A study in rural China revealed important perceptions of gender roles and status in rural society. Women's status and economic dependency were perceived to constrain their decision making power regarding their own health and health care seeking behaviour¹²⁰ (Xu et al 2004).

In Vietnam, a study of perspectives on health seeking behaviour for TB amongst men and women in Vietnam revealed that amongst women, the main contributing factor to delay in seeking care was the fear of social isolation from family and community. Whilst in men the main factor was the fear of individual costs of diagnosis and treatment. This is despite the drugs for tuberculosis being free; there are other considerable costs including visits to the health facilities and one to two month hospitalisation which is the recommendation for TB treatment in Vietnam¹²¹. In Gambia, although cost of transport was a major issue for all participants, more men cited this as factor influencing their access to tuberculosis treatment. More women recognised stigma as the main issue¹²².

6. Suggested 'package' of 'free' access to ART

The previous two sections demonstrate the importance of providing ART free at the point of access to increase access by women. However, cost is only one of a number of factors that will result in increased use by women. Having earlier examined other factors that influence women's access to HIV services, the following section uses these to develop a 'package' of free access to ART that would ensure gender equity in access to services. This includes priority-setting by policy-makers, engendering the WHO minimum criteria for ART provision, and other necessary enabling measures.

6.1. Priority setting by policy makers

Improving access for women should be an urgent priority for policy makers. This needs to be expressed in government documents and used as a reference point by stakeholders and programmers. Improving access will require considering the different and inequitable barriers faced by women and men across the various services supporting ART provision, including geographical barriers to access and unequal access to information. Gender and age disaggregated monitoring and evaluation, the involvement of HIV positive women and men in developing and managing interventions are key strategies to mainstream gender considerations.

6.1.1. Monitoring and evaluation

A key lesson that has been learnt in mainstreaming gender is the importance of **gender and equity indicators** in monitoring and evaluation strategies¹²³. This helps ensure that gender awareness remains built-in to development programmes and is not forgotten as a programme or intervention progresses. This is particularly important in the context of scaling up, where an emphasis on the “3 by 5” target can mean that a focus on equity is lost. Therefore programmes should monitor and evaluate which social and economic groups in the population are accessing ART and continue to identify and address barriers that reduce the access of different groups. The ongoing collection of data disaggregated by gender and age can allow gender disparities to be identified and further explored¹²⁴. The WHO has committed to collecting data disaggregated by gender and age for monitoring and evaluation of its ART programmes. These guidelines should be regularly reviewed to respond to changing circumstances or changes in the dynamic of the epidemic¹²⁵.

Qualitative research in India identified a need for such monitoring and evaluation when providing ART free at the point of access. An employee of Sangram, an NGO in Maharashtra, India, working to empower HIV-positive females indicated that without a target for the proportion of women accessing ART and regular reviewing of gender disaggregated data, then access to ART would not be equitable.

Recommendations:

- ***Develop and implement a monitoring and evaluation strategy which includes gender and equity indicators, such as the disaggregation of indicators of service use and factors affecting this by gender, age and socio-economic group.***
- ***Indicators should be regularly reviewed and explored and the programme revised accordingly***
- ***This strategy should be used to monitor each of the different aspects of ART provision***

6.1.2. Community involvement in developing interventions

Women living with HIV/AIDS have identified developments that would improve their situation. This has included **decision-making power and consultation** at all levels of policy making¹²⁶. The WHO has identified that involving communities and family members when planning responses to HIV/AIDS is critical¹²⁷. Such consultation allows an understanding of the health seeking behaviour of specific groups and the barriers they face, such as their experiences of denial, stigma and discrimination. Where HIV activities have explicitly involved community members, including them on the programme advisory boards, they have often resulted in successful programmes and improved participation by these groups in the programme’s activities¹²⁸. Involving community members in all levels of decision-making is also cited as a successful way to challenge stigma and discrimination and promote solidarity with people living with HIV/AIDS¹²⁹.

Involvement of community groups in decision-making and programme design also includes the **involvement of men** as a means to increasing access to HIV services by women. Including men in a programme can help to break down barriers between the sexes¹³⁰ and can impact on the behaviour of both men and women. On the one hand the support of male partners can greatly influence a woman’s care seeking behaviour and adherence, which presents a clear argument for male involvement in ART promotion. On the other hand, men’s behaviour can also be addressed. Men may choose not to seek care for reasons of stigmatisation, which in turn impacts on women’s care seeking behaviour. Also men’s behaviour can place a greater burden on women and impact on their care seeking. For example, spending household income on alcohol means less disposable income for ART, and the ascription of domestic burdens solely to women can mean they do not have the time or resources to seek healthcare¹³¹.

Other groups can also influence women's care seeking behaviour and their involvement should also be included, for example other members of a woman's family and community. Qualitative research in Kenya found that it was considered important for **community leaders** to endorse HIV services in order to encourage others to attend¹³².

Recommendations:

- **Ensure the involvement of different groups of community members when developing ART interventions at all levels: local, national and international. This will require an enabling environment which allows all groups to be able to participate.**
- **This involvement should include both the different groups of women for whom the measures are addressed, as well as the people who exert an influence over those groups, such as men and senior family members.**

6.1.3. Addressing geographical barriers

We have analysed how the need to make regular visits to geographically distant health centres to obtain diagnosis or services can present problems for women in terms of both direct costs of travel and the opportunity costs of doing so. Health services can use a variety of measures to reach women, such as providing mobile health centres, providing child care at health centres and offering care to everyone in a family so that no one member is being treated at the expense of others^{133, 134}. Mobile units, patient transportation for collection of drugs, 24-hour help lines and support to home based care can reduce the problem of transport or restricted mobility. Key informants in India have indicated the need for adequately qualified staff at the village level to provide more geographically accessible services. Currently the lowest level provider of ART is often the district level, which is a significant distance to travel and limits accessibility for a large number of villagers¹³⁵.

Recommendations:

- **Explore different options for minimising the number of journeys and travel time required to access ART**
- **Tailor service options to the needs of different groups of women who access ART**
- **Monitor the effects of innovative service provision on utilisation of services by different groups of women (e.g. in terms of age, socio-economic status, or marital status)**

6.1.4. Health promotion/behaviour change interventions

A major obstacle preventing women from accessing ART and other health services is lack of information. This includes lack of information about disease symptoms, treatment options, how or where to access treatment or that treatment may be available for free. There is a clear need to develop health promotion and behaviour change strategies that address groups identified as not accessing treatment. An employee of LVCT in Nairobi indicated that an increase in clients could be associated with media campaigns about ART.

Women are often targeted through their care-giving or reproductive role, being identified at reproductive health centres or when bringing their sick children to clinics. While this strategy is a common way to seek out positive women, it should not be the only method used as it excludes women who do not have children, or are not pregnant, including younger and older women too.

However when addressing certain groups with information on ART, care must be taken not to imply that this is available only for the specific groups to the exclusion of others. For example, a

woman in Zambia reported that an ART campaign shaped for sex workers with sexually transmitted diseases left many people assuming the drugs were only available for that group¹³⁶.

As well as awareness, health promotion campaigns also play an important role in **destigmatisation and acceptance** of HIV and ART. Such campaigns can also address myths about ART that can be prevalent within a community and prevent people from accessing treatment. Women also need to be able to relate to role models used in promotional campaigns – in Kenya where promotions used well dressed city dwellers, rural women could not identify with them and were not encouraged to access the services they were promoting¹³⁷.

Recommendations:

- **Develop and implement a health promotion strategy which addresses different groups of women using media accessible to these groups and non-judgemental messages**
- **This strategy should be developed in collaboration with the relevant groups**
- **Promotional materials should aim to destigmatise HIV and attending HIV services**
- **Health information should cover all aspects of HIV and ART including symptoms, treatment, where and how to access treatment and addressing common myths**

6.2. Engendering the WHO minimum requirements for ART provision

The WHO has identified the following minimum requirements for making ART available:

- Reliable and inexpensive HIV tests
- Access to voluntary and confidential counselling and testing
- Adequate management of opportunistic infections
- Functional laboratories to monitor adverse reactions to ART
- Training for clinicians and nurses
- Functional social support network to improve adherence
- Strengthening continuum of care
- Reliable, long-term and regular supply of drugs for palliative care and opportunistic infections.
- Joint decision making between doctor and patient on ART

An examination of these requirements through a gendered lens provides us with an entry point into developing a 'package' of free access to ART which increases equity.

6.2.1. Reliable and inexpensive HIV tests

One study in Senegal, where ART is provided free, found that when the cost of drugs for opportunistic infections, laboratory examinations, consultations and hospitalisation fees are calculated, patients on ART pay an additional \$130 a year¹³⁸. Even if ART is provided free at the point of access, patients are often required to pay for tests to identify whether they are eligible to receive free drugs, as well as ongoing blood tests to monitor CD4 count.

This paper has analysed how women are often less able to access financial resources and may face gendered bias and discrimination from healthcare providers. The provision of reliable, free HIV testing is a pre-requisite to enable women to enter the prevention and treatment continuum and register on free ART programmes, and free monitoring blood tests are required to keep them there.

Recommendations:

- **Reduce or eliminate costs of HIV tests, other laboratory tests, consultations, hospital fees and drugs for opportunistic infections to ensure that women are able to gain access to them**
- **Monitor and evaluate the effects of free test provision on indicators of entry into the prevention-care continuum and adherence to treatment**

6.2.2. Access to voluntary and confidential counselling and testing

Voluntary counselling and testing (VCT) is a vital element of the response to HIV/AIDS, often serving as the gateway to the continuum of prevention and care. VCT services can provide people who are infected with or affected by HIV with information, advice and support that they require to deal with their status. Counselling individuals in how to care for themselves and others helps prevent the further spread of HIV. Counselling can assist those wishing to learn their status to be psychologically prepared for the result, whether positive or negative, and to understand the implications for behaviour of either result.

Evidence has indicated that combining testing and treatment services can help to reduce fear and stigma surrounding HIV as well as increasing the numbers of people accessing services and reinforcing prevention efforts. Where treatment is also available significant differences in the number of people being tested have been seen. For example, in Haiti, 4,000 people were tested in a nine month period at sites offering testing *and* treatment, compared to only 43 people at a site that only provided testing¹³⁹. It has also been found that attending counselling helps clients adhere to treatment regimens. For couples, the mutual support of having men and women in treatment together often increases the chances for both of succeeding¹⁴⁰.

However, discovering one's HIV status through VCT services comes with risks of blame from family members and stigmatisation by the community and health workers¹⁴¹. As women are often particularly at risk of HIV-related stigmatisation and violence it is important that VCT services take careful measures to prevent this. In the Liverpool VCT Project in Kenya this has been specifically addressed through appropriate training of counsellors, the use of best practice guidelines and through service modification following client exit interviews and other quality assurance tools¹⁴².

Recommendations:

- **Ensure VCT services, which combine testing and treatment, are available.**
- **The services should develop and follow a set of best practice guidelines, which take into account the specific needs and priorities of different groups of women.**
- **Measures to eliminate the stigma of accessing VCT services should be included, with a particular awareness of the interaction between gender and stigmatisation.**

6.2.3. Training for clinicians and nurses to improve quality of care

We have discussed how poor quality clinical care and attitudes can pose barriers to women's access to services. Recruiting, training and retaining healthcare staff is essential in order to have the resources to provide quality HIV/AIDS services. Training for clinicians and nurses needs to include a consideration of the specific needs and priorities of different groups of women, both in terms of clinical services and social welfare. Political will is required to sustain non discriminatory attitudes and practices.

6.2.4. Adequate clinical knowledge

Healthcare staff with adequate clinical knowledge are essential to ensure that appropriate treatment is provided to clients. Sufficient numbers and grades of staff are required for the number of patients a health unit serves. Confidence in the quality of care provided will

encourage people to spend time and effort accessing healthcare. Staff need to be trained to fully inform women and men of the availability of ART and its role in treatment, as well as giving correct and clear information regarding its usage. This should include **joint decision making between doctor and patient on ART** so that the treatment provided meets the needs of and are appropriate for the patient.

Equipping healthcare staff with adequate clinical knowledge should enable them to dispel gender-specific myths surrounding ART, for example beliefs that ‘drugs are not good for women’¹⁴³ or that drugs will harm a pregnant women’s foetus, when in fact they have been passed as safe for pregnant women to use¹⁴⁴. These beliefs can be perpetuated by health units, preventing women from accessing services. For example women have also reported being wrongly told by healthcare staff that they would die from HIV/AIDS very quickly – in a matter of days¹⁴⁵. This information would very likely prevent many people from considering ART as a viable or worthwhile course of action.

Recommendations:

- **Ensure there are sufficient numbers of appropriately trained staff available to deliver comprehensive ART services. Staff should be specifically trained in clinical issues relating to women with HIV.**
- **Guidelines should be developed and followed for discussing the use of ART drugs with all patients, including patients who do not proactively request information.**
- **Confidential treatment is essential, including confidentiality between partners or within families.**
- **Regular monitoring and evaluation of clinical care include indicators of women’s specific needs and the information should be used in a quality assurance cycle to improve provision.**

6.2.5. High quality service delivery

Improving the **attitudes and behaviour of healthcare staff** can contribute to reducing stigmatisation, which is key to increasing access for women. Judgemental attitudes, discrimination and unethical practices by health workers infringe the human rights of people living with HIV/AIDS and discourage use of health services. Training healthcare staff to ensure they understand the implications of such behaviour and the impact upon people living with HIV is an important step in addressing these issues. Political will is also required to discipline staff engaged in discriminatory or unethical practices.

A strategy used by WOFAK in Kenya is to deliberately **employ people living with HIV/AIDS** (90% of total workforce, of which the majority are women) to promote positive role models to the women that they work with. This also has the benefits of drawing on the knowledge and experiences of the positive female staff, as well as creating a supportive working environment for positive staff.

The development of a set of **standard considerations, guidelines or questions** to apply to ART services can ensure that gender equity concerns are built into treatment access schemes. These guidelines can be used to ensure that patients receive appropriate treatment from healthcare staff. For example, when scaling up VCT services in Kenya, LVCT analysed qualitative and quantitative gender indicators and used the results to re-examine its VCT structure and delivery to ensure gender equity in VCT scale-up. Counsellors are trained to discuss women’s experience of sexual power relations and to provide clients with strategies for sexual negotiations¹⁴⁶.

Women can be discouraged by the bureaucracy surrounding the delivery of drugs, including understanding and signing documents if they cannot read and write, or not wanting to ask basic

questions for explanation or clarification of their treatment (how to take it, how often to take it, how long to take it for)¹⁴⁷. Staff should be trained to **fully inform patients** about their treatment and to identify whether patients have a clear understanding of their situation, using local languages where necessary, both verbally and through leaflets which they can refer again to later.

Recommendations:

- **Train healthcare staff and counsellors in non-discriminatory and gender equitable HIV care and treatment and raise their awareness of the different needs and priorities of different groups of women.**
- **Involve women living with HIV/AIDS in providing HIV-related services.**
- **Discipline staff involved in unethical and discriminatory practices**
- **Monitor and evaluate care provision with gender indicators to ensure that gender and age equity concerns are built into treatment scale-up**

6.2.6. Functional social support network

Access to a social support network not only improves adherence but has been found to be extremely effective in reducing the negative effects of stigmatisation experienced by women and in providing women with a platform to voice their views and needs. Women living with HIV/AIDS have called for more support through self help groups and networks when identifying developments that would improve their situation¹⁴⁸. These networks can be formal or informal, and exist both at the local level and also at the regional, national or international levels in the form of support provided by committees, networks and umbrella organisations.

Where women face stigma and discrimination from family and the community, as well as from the healthcare, political and legal systems, **formal networks** can provide immense support and solace for women with no other source of support. The experience of an HIV positive woman working as a programme co-ordinator for WOFAK (Women Fighting AIDS in Kenya) illustrates the value of support networks:

“I was one person who could not come out, I was a hotelier and I found myself infected and when I came to WOFAK, the way I was welcomed and I was told look life goes on. I couldn’t believe, but with the information and the good therapy I started coming and changing my career to at least fit now my status. I can say that WOFAK has really helped a lot of us, me and many other fellow women who are out there in different fields. So again we become a bigger voice, you know we become visible, now at least we are noticeable. Then the other people look at our lives, at us sharing our own experiences; and they are able to come out ... Five, ten years back there was really no environment [for positive women], but now there is an environment. When women go to the antenatal care clinic, you find that a lot of things have changed. We find that the PMTCT plans has become effective because of women with HIV/AIDS they are advocating for such changes ... Sensitising women to actually realise this is what they are supposed to do ... When they come here for group therapies at WOFAK, they interact, we can laugh with the virus and cry with it. But back in the house, you go back to the cage, because they don’t know and you don’t want them to know because you are not ready. So we prepare them for all that”

Innovative approaches to providing social support networks have been important to success stories in HIV service provision. COCEPWA (Coping Centre for People Living with HIV/AIDS) in Botswana is an NGO set up by and run by and for people living with HIV/AIDS. Although ART is free, stigma, fear and poverty keep many positive women from seeking help. One of COCEPWA’s projects is its ‘buddy’ network, in which an HIV-positive woman volunteers to befriend other women who are newly diagnosed, acting as a sounding board for their questions and fears¹⁴⁹. These networks can be invaluable in providing support that many women would otherwise not receive and addressing the social barriers they face.

Such networks should be well integrated into the community, for example work with community leaders, to facilitate the spread of de-stigmatisation. A study analysing the gender dimension of scaling up VCT services in Kenya found that a lack of endorsement by community leaders can prevent women from accessing services. Qualitative research indicated that it was considered important for community leaders to endorse HIV services in order to encourage others to attend¹⁵⁰.

Informal support networks include the support received from family and friends. Such personal support can greatly encourage women to utilise ART and other HIV services, whilst lack of support prevent them from doing so, as discussed above (Section 2.3). Involving a woman's family in her HIV treatment and care programme can provide her with much needed support in accessing and adhering to treatment. It is crucial that once enrolled in an ART programme, patients take the drugs consistently or risk becoming fatally ill. An informal support network can support, encourage and assist a women in adhering to her treatment regime – for example providing childcare while the woman attends clinic.

HIV services providers have identified the effectiveness of working with men in their programmes. An antenatal clinic in Pune, India, described how working with a woman's husband greatly helps retention and adherence in a context where there is a social norm of women's obedience within the family¹⁵¹. However, it should be noted that respect for a patient's privacy is first and foremost and involvement of family members should not go ahead without her informed consent.

On the other hand if women face resistance to their treatment programmes from family members, a formal support network can provide information, encouragement and determination needed to face and overcome this opposition.

In addition to local networks, women also benefit from the support of wider, **regional, national or international networks** of women living with HIV/AIDS. Such organisations are often established to develop solidarity between women living with HIV/AIDS, educate them about their rights, enabling them to create a unified voice and a forum through which to share experiences and develop action plans, and an advocacy platform from which to communicate issues of concern to policy makers.

A programme co-ordinator working for WOFAK in Kenya describes the value of WOFAK as a national network in influencing policy:

“When we sit at committees at the national level or district level, whichever level, we ensure that we are visible ... our voices are being heard and that has really created an impact, so that it's not just people living with HIV/AIDS but they are looking at it at different angle now. The policy makers are looking at it.”

These networks and committees can also provide valuable support to positive women in influencing government policy to promote a culture of openness on HIV/AIDS. HIV success stories in resource poor settings (for example Brazil, Uganda and Thailand) have been based on open debates of sexual behaviour¹⁵² and influential HIV/AIDS networks can play a role in reducing the stigma of HIV at the wider level.

There are numerous examples of women's self help support groups and networks which have been set up by positive women at local, national and international levels. However there are much fewer examples of such networks run for or by men. This places a greater burden of care onto women, both within the family and within society. Men should be encouraged to find support from such groups so that they have a source of support and do not wholly depend upon

women to care for them. This will release some of the burden of care from women at the family level and also within the wider community.

Recommendations:

- **Initiate or work with local self-help networks of women living with HIV/AIDS.**
- **Where appropriate consider involving family members in treatment schemes to support a woman's treatment (however, confidentiality is foremost).**
- **Link with regional, national and international networks to draw from their experience and connect to their wider influence.**

6.2.7. Strengthening the continuum of care

The continuum of HIV prevention and care refers to links between the different aspects of HIV/AIDS prevention, treatment and care – including education, testing, VCT and ART – which provide service users with information on other HIV services available and provide referral between services. Connecting HIV services in this way can provide patients with the information and referral required to access other services that they need and thus increase access.

Several HIV service providers and positive women amongst the key informants interviewed for this study identified the absence of these linkages as a key factor in low access to HIV services. In India and Kenya, it was noted that patients needed to proactively seek out different organisations for different aspects of care, including testing, care, treatment, PMTCT, information, social support, and economic support, which were often provided by different organisations. Thus links between these services would increase access to them^{153, 154, 155, 156}.

Similarly, the ability to access a number of services in one place at the same time can improve access for women requiring ART, in contrast to expecting them to visit different clinics at different times for their own needs and the needs of their children. Organisations that provide family care, not necessarily exclusively for women but which take account of their specific needs, can encourage women to access care for themselves as well as for their families^{157, 158}.

Many women find it easier to access **private providers** and services provided by **NGOs**, due to their greater geographical accessibility, flexible payment options, sympathetic staff attitudes and more informative approaches. This suggests that partnerships and better linkages between these providers and the public health system would improve women's access to the prevention to care continuum.

Supporting the service provided by the government health units is a strategy undertaken by many NGOs providing healthcare to the poor. Sangram in India identifies the utility of having one of their staff in public health centres, *“making public doctors treat people, cajoling them, forcing them, speaking sweetly, doing everything possible to just help people who need treatment”*¹⁵⁹. Supporting public services in this way can be a more efficient and effective use of NGO resources by avoiding duplication and strengthening the services that are already available.

There is also a strong need for **multisectoral approaches** in strengthening the continuum of HIV care. This involves working collaboratively across different government Ministries such as health, education, gender and community services. For example, Uganda has included mainstreaming HIV/AIDS prevention and control into different sectors, so that all segments of society have been given responsibility in taking a role¹⁶⁰.

Recommendations:

- **Develop a network HIV service providers, both clinical and non-clinical, to provide information for patients and referral and help the different services to understand the specific needs of different groups of women and assist them in providing gender equitable services.**

6.2.8. Reliable, long-term and regular supply of drugs for palliative care and opportunistic infections.

A reliable, long term and regular supply of drugs is fundamental if a course of treatment is to be effective and sustained. However, in many countries the number of people in need of ART greatly outstrips availability and access can be based on first come first served, which often favours male, educated, non-poor city dwellers¹⁶¹. The WHO identifies simplifying decision-making regarding who accesses ART as an important early step¹⁶². The development of such criteria requires a specific consideration of how this can improve equity, including gender equity. To assist improving gender equity in access, eligibility criteria should address existing disparities and ensure that different groups of women are afforded equal or proportionate representation among selected eligible participants¹⁶³. The WHO and UNAIDS recommend that eligibility criteria should ensure fair access to ART for vulnerable and disadvantaged groups, e.g. rural women, sex workers, widows and young women¹⁶⁴.

Explicit eligibility criteria made clear to staff and presented publicly is important to make ART access more transparent and accountable, rather than at healthcare workers' discretion¹⁶⁵. Transparent criteria could help prevent patients from being mistakenly charged for ART drugs, which they are in fact eligible to receive for free and discourage staff from charging fees fraudulently for clinic or personal income¹⁶⁶.

As well as supplying drugs for the long term, treatment programmes should also be designed to **assist women in adhering** to treatment so that their drugs are effective in the long term. Instead of refusing ART, where women are considered likely to default, programmes should assist in developing a patient's ability to adhere to treatment. This can include the provision of information about HIV and treatments, skills building, practical adherence tools and aids and counselling about attitudes and expectations¹⁶⁷.

Recommendations:

- **Develop, disseminate and follow eligibility criteria for access to ART**
- **Criteria should address disparities in access to services by different groups of women.**

In addition to these minimum requirements recommended by the WHO, our analysis of the factors influencing women's access to HIV services provides us with other essential considerations when developing a package of free ART.

6.3. Other complementary approaches needed

6.3.1. Food & nutrition

Lack of information about nutritional requirements to ensure the effectiveness of ART drugs or the costs to poor women of meeting these requirements can lead to serious side effects, presenting barriers to adherence and treatment continuation. Service providers and positive women's groups alike (eg Lynde Francis, the Centre, Harare) have identified the need for nutritional supplements, free food, or economic support to purchase the necessary food^{168, 169, 170}. However it must be considered that women's role as carers may mean that they will

sacrifice this food to give to their children or family so it is important to ensure such interventions benefit the women who are receiving ART.

Recommendations:

- **Provide nutritional supplements or appropriate economic support with ART**
- **Care should be taken to ensure that these do benefit women to which they are provided**

6.3.2. Improving women's status in society

Women's unequal access to ART and other HIV services is linked to broader empowerment and poverty issues. Supporting poverty reduction efforts will improve women's access to health services in the long term. The improvement of women's status can empower them to access information about healthcare, make independent decisions about their health and obtain the financial resources to afford treatment and associated costs. UNAIDS/UNFPA/UNIFEM¹⁷¹ identify the economic empowerment of women and girls as a key strategy in decreasing the HIV/AIDS burden on women, including increasing their access to care.

7. Conclusions

This paper has considered the evidence for the importance of free provision of ART to improve women's equitable access to HIV/AIDS treatment and care services, as well as the considerable challenges to ensuring such equitable access even in this event. Experiences to date of ART provision suggest that without explicit measures to improve gender equity, these services will be disproportionately accessed by middle-class men. Free ART provision is a key priority of women living with HIV/AIDS and would represent a necessary step for gender equitable access. However, free ART provision alone is unlikely to remove the many barriers to access by poor women, including: stigma, discrimination, blame and violence; poor quality public health services; gender norms and stereotypes in service provision; low access to information and low status and decision making power in the household and society.

The planned rapid expansion of ART on a global scale provides unique opportunities for 'getting it right' and learning lessons from previous scale-up programmes and services such as VCT. If these lessons are not learned it is unlikely that "free by 5" will make a difference for women living with HIV/AIDS. This paper has drawn on these lessons to develop a framework for ensuring that free drugs are provided in the context of approaches to enable gender equity in access service provision. The framework requires:

Priority setting by policy makers with the involvement of communities of women and men living with HIV at all levels of decision making and from the outset. This should include:

- An engendered monitoring and evaluation tool that is rolled out nationally
- A commitment to reduce geographical barriers and the costs of testing and other support services
- A health promotion and behaviour change strategy that explicitly considers and addresses the priorities and needs of different groups of women.
- Positive work place policies supporting existing HIV positive staff

Engendering the WHO minimum requirements for ART provision, including quality assured counselling, testing and clinical services. This should include:

- Taking measures to reduce stigma in the provision of all services
- Training for staff to raise awareness of gender issues and the effects of discriminatory and unethical practices, and disciplinary measures to prevent these practices
- Training for staff to improve the quality of information given to clients, including messages to dispel common myths discouraging women from accessing treatment

- Integration of gender equity concerns into quality assurance cycles
- Initiating or working with formal and informal support and advocacy networks of women living with HIV/AIDS at local, regional, national and international levels
- Developing a formal network of HIV service providers, both clinical and non-clinical, to improve linkages between public, private and NGO providers, building on their strengths in meeting the needs of different groups of women.

The provision of other enablers including ensuring adequate nutrition, and improving women's status in society.

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