In this review, socio-structural factors were explored as well as benefiting public health. To understand and address key barriers to and facilitators of women's access to ART, this goal is happening in the context of a constrained Development Goal of ending AIDS by 2030. Pursuit of antiretroviral therapy (ART) for women living with HIV.

BACKGROUND

In late 2015, the World Health Organization updated its guidelines on ART for prevention and treatment, since the beginning of the HIV epidemic, this is the first ever peer-led global study of care and treatment access for women living with HIV. It is well overdue.

The global review comes at a critical juncture in the epidemic where there is an increased focus being placed on strategic investments in health guided by specific, national and regional epidemiological contexts. In late 2015, the World Health Organization updated its guidelines on ART for prevention and treatment, recommending immediate offer of ART to all people living with HIV, regardless of CD4 count or clinical stage. ART is positioned as central to the Sustainable Development Goal of ending AIDS by 2030. Pursuit of ART is a human rights-based context. A myriad of gender-related and structural barriers make accessing ART a concern. Since the beginning of the HIV epidemic, this is the first ever peer-led global study of care and treatment access for women living with HIV.

THE REVIEW

A UNIQUE METHODOLOGY: WOMEN LED AND GOVERNED

The global review took as its starting point the major gaps regarding information on women’s access to HC care and treatment across the lifecycle, and in particular for adolescent girls and women not currently pregnant. The three phases of the review included: 1) A literature review related to women’s access to treatment and an unprecedented analysis of all available sex-disaggregated data from PEPFAR (United States President’s Emergency Plan for AIDS Relief), Global Fund for AIDS, Tuberculosis and Malaria, UNAIDS and other sources; 2) Community dialogues via focus group discussions (FGDs) in Bolivia, Cameroon, Nepal and Tunisia of 315 women (175), consultations with 14 Global Reference Group (GRG) members (14); one-to-one interviews with 8 of them and 2 at Punta de Mita (9); and an online discussion group with GRG members and 7 extra women (7). Thus, a total of 317 individual women were consulted in this phase; 3) Country case studies undertaken in Kenya, Uganda and Zimbabwe with in-depth focus groups (10, 18, 14); one-to-one interviews (9, 7, 10) and country-level policy scans to provide a fuller picture of women’s access in specific contexts. Younger and older women were purposively sampled. Numbers of participants by country/brief living with HIV, men living with HIV: Kenya (84, 20), Uganda (80, 12), Zimbabwe (218, 6). The International Community of Women Living with HIV East Africa led the case study work in Kenya and Uganda. Pangaara Zimbabwe AIDS Trust worked with members of the GRG to conduct case study work in Zimbabwe.

Few examples exist of HIV treatment access analyses in which women with HIV are placed at the center of design and implementation. Women living with HIV led the design and implementation of the review as they are best positioned to frame and prioritize the issues and areas that should be interrogated as part of an effort to fill these gaps. A Global Reference Group (GRG) of women living with HIV was constituted to guide the project throughout all phases. The 14 GRG members represent 11 countries and a range of diverse identities and experiences. The GRG was included in the development and revision of parameters for the extensive literature review, framing of priority topics and questions for a discussion guide used for FGDs and one-to-one interviews led by GRG members and other women living with HIV. Some GRG members are also involved in the final phase of the project, in-depth country case studies that probe issues and concerns raised in the previous phases. This project is one of a limited set of investigations of women’s perspectives of why they choose to initiate and remain on or discontinue treatment. The project did not engage women who had never accessed ART, one of several areas for additional investigation.

RECOMMENDATIONS: A SIX POINT PLAN FOR ACTION

1. HUMAN-RIGHTS: Define, implement and evaluate access in a rights-based framework that encompasses availability, affordability, acceptability and quality of care, to address gender-related social and structural barriers. This must include rights-based, voluntary and informed choice, with real options for women, so they can decide if and when to start, and how long to stay on treatment.
2. GENDER: Engage in more analysis of treatment access barriers with gender at the center, recognizing the intersectionality with other structural factors.
3. DIVERSITY: Fill the data gaps that exist across the treatment cascade for women in all their diversities, investigate, innovate and implement the findings by research to fill the existing gaps related to barriers and facilitators of women’s access to ART, including.
4. MULTIPLE LEVELS: Ensure that care and treatment packages include basic needs and account for gender-specific barriers at individual, household and community levels.
5. GENDER-BASED COMMUNITY ENGAGEMENT: Incorporate a gender analysis into expansion of support for community-based service delivery—a core component of UNAIDS’ Fast Track goals.
6. PEER-LED INVOLVEMENT: Harness the power and leadership of peer-led and -governed analyses of treatment access as part of a participatory research, implementation and evaluation framework.

THE WAY FORWARD

It is our hope that this extensive review will catalyze change in all countries and regions at all levels in the rooms, clinics and communities where women and girls are being offered ART. Women’s voices are clear, consistent and urgent in their articulation of what must be done to create a woman-centered, rights-based approach to holistic health and wellbeing. It is also our hope that the methodology used to produce it will be adopted and expanded as a basis for continuing to monitor progress and map gaps in the global AIDS response.

The full report proposes new dimensions and measures of access for the purpose of policy analysis, and an unprecedented analysis of all available sex-disaggregated data. Improving definitions of barriers to access, particularly at household and community levels. The full report proposes new dimensions and measures of access for the purpose of policy analysis, and an unprecedented analysis of all available sex-disaggregated data. Improving definitions of barriers to access, particularly at household and community levels. The full report proposes new dimensions and measures of access for the purpose of policy analysis, and an unprecedented analysis of all available sex-disaggregated data. It is our hope that this extensive review will catalyze change in all countries and regions at all levels in the rooms, clinics and communities where women and girls are being offered ART. Women’s voices are clear, consistent and urgent in their articulation of what must be done to create a woman-centered, rights-based approach to holistic health and wellbeing. It is also our hope that the methodology used to produce it will be adopted and expanded as a basis for continuing to monitor progress and map gaps in the global AIDS response.