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Gender and Care: Access to HIV Testing, Care and Treatment

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Introduction

HIV/AIDS transmission in the Middle East and North Africa region (MENA) has been on the rise for the most of the last decade. By the end of 2007, there was an estimated 380,000 people living with HIV/AIDS in the region (WHO/UNAIDS/UNICEF, 2008). The expansion of HIV testing in recent years, albeit still to a limited extent, has contributed to the increasing number of reported HIV cases, although limited reliable data and weak surveillance systems in the region make it difficult to accurately estimate the number of cases of HIV/AIDS or to determine trends over time. The spread of HIV in the MENA region remains relatively small except in Sudan which has the highest prevalence in the region. Although in recent years there has been a global momentum to expand ART access in low to middle-income countries, the MENA region lags behind and has the lowest regional coverage. In 2007, only 7% (5–10%) of those in need actually received therapy (compared to 5% (4–8%) in 2006) (WHO/UNAIDS/UNICEF, 2008).

The reported risk factors present in most of the countries of the region include injecting drug use, commercial sex work, men who have sex with men, youth, conflict, refugees, labor migration, and gender inequality (Jenkins and Robalino 2003). In addition, the limited available data indicate a growing feminization of the HIV epidemic in the region (UNDP/HARPAS 2005/6). Women and girls now constitute almost half of all people living with HIV/AIDS in the region compared to 40% in 2001. Young women aged 15 to 24 years are more than twice as likely to be living with HIV/AIDS as young men in the region. Similar to the HIV/AIDS situation in other regions of the world, particularly in sub Saharan Africa, women in the MENA region are more vulnerable to HIV infection than men. This is due to many factors including lack of negotiating power in their relationships including marriage, limited access to education among women and girls, and relative lack of knowledge about HIV/AIDS (UNDP/HARPAS 2005/6).

This paper focuses on the important gender dimensions of access to HIV testing, care and treatment in the MENA region. In the context of the global HIV/AIDS epidemic, gender is an important underlying factor in HIV risk perception, risk of infection, access to HIV testing, care, and support, and the ability to cope when infected or affected by HIV. Although integrating gender issues into HIV/AIDS programs can be challenging, the effectiveness of such programs are greatly enhanced when gender specific needs of men and women are considered (Gijsbers van Wijk et al., 1996; Standing, 1997).

The Barrier of Stigma

In the traditional and religious environment in the MENA region, not unlike some other regions of the world, strong taboos with consequent stigma are associated with HIV/AIDS. HIV/AIDS is often associated with homosexuality, sex outside of marriage and drug use which are all considered sinful behaviors in the region. In a 2006 interview with Oussama Tawil, former UNAIDS director for the MENA region, he emphasized the impact of culture on stigma faced by people living with HIV and AIDS (PLWHA) in the MENA region. He stated, “One of the main issues with HIV/AIDS is its relationship with social and behavioral issues which are very sensitive, such as sexual behaviour and sexuality – very sensitive topics in all cultures, not least in Arab and Muslim cultures.” (IRIN 2006). Fear of casual contact with PLWHA is still prevalent, despite HIV awareness campaigns in the region. PLWHA are often rejected from everyday family life, community life and work space. He went on to say “what you have in the region now are isolated families, small communities, living with this condition. It’s not at a point that it’s so visible. But obviously there are individuals trying to deal with living with HIV/AIDS. Whether their families are aware or not, the reactions of the neighbors, the reactions of the community, the issue of marriage for these people are small tragedies taking place.”

Attitudes towards PLWHA in the MENA region are variable depending on the social and cultural background and also on the mode of acquisition of the infection. Most of the time rejection is related to the behavior leading to the state of vulnerability to HIV rather than HIV itself. HIV infection is viewed therefore as a punishment, a result of morally, socially, and religiously unacceptable behavior. For example, men who acquired HIV through sex with men (MSM) are often rejected by family members, particularly male family members, for engaging in homosexual activity (Abukhalil, 1997; Francesca, 2002). In general however, HIV-infected women in the region often face greater stigma than infected men (UNDP/HARPAS 2005/6). The Arab region has the second lowest Gender Empowerment Measurement (GEM) in the world, a key factor for the great vulnerability of women in terms of acquisition of HIV and to stigma associated with living with HIV/AIDS (UNDP/HARPAS 2005/6). Married women who acquire HIV from their husbands are often compelled to maintain the bonds of marriage for social and economic reasons. They also often bear the burden of shame for the couple. According to some reports, “even a married woman who has been infected by her husband will be accused by her in-laws...in such a male-dominated society no-one ever accepts that the man is actually the one who did something wrong” (IRIN 2005). Unmarried women who acquire HIV from a sexual partner are expected to feel guilt for their “sexual misbehavior.” Working women tend to not disclose their HIV status to the larger community for fear of losing their employment. They may also harbor guilt with resultant depression leading to a sense of powerlessness in defending their rights.

There is concern that stigma serves as a barrier for access to HIV prevention and care services for at-risk populations in the region. Although limited data are available on HIV care and treatment programs for at-risk populations, few programs have been developed which target vulnerable populations; and harm-reduction approaches are not embraced by most countries in the MENA region (Hasnain, 2005). However, a pilot study conducted in 2006 demonstrated that reaching at-risk population is possible with proper training, careful planning and

supervision. In that study, government collaboration with international agencies and local non-governmental organizations was critically important in encouraging at-risk populations to participate in the study leading to the collection of a wealth of information, previously unavailable, on HIV knowledge and behavior (Soliman, et al 2008).

Gender-related Barriers to Care

In the MENA region, there are significant obstacles to meeting women's health needs, in general, since many cultural and practical issues often make it difficult for women to access health care services (Doyal 1996; Gijsbers van Wijk et al., 1996; Standing, 1997). Impediments include women's responsibilities to take care of the home and children, and also, women often do not have adequate money and resources for transportation to and from healthcare facilities. In some circumstances, going to the clinic (reproductive health, maternal and child health, antenatal clinic) is the only moment a woman is entitled to go out alone and meet other women for socializing. Many women prefer to be assessed by female health care providers; however, in many parts of the region, there are limited numbers of female care providers. Moreover, women often need to obtain permission from a male, either husband or other family member, before they can go to the clinic. Most of the time rejection is related to the behavior leading to the state of vulnerability to HIV rather than HIV itself. Therefore, HIV infection is viewed therefore as a punishment, a result of morally, socially, and religiously unacceptable behavior (Amowitz, L.L. et al., 2004; Hasnain, 2005). These issues underscore the need for woman-friendly services and also the involvement of husbands and other family members in education and outreach efforts in promotion of women's health care needs.

The conservative social traditions in the region limit women from accessing reproductive health services. A pilot study in a rural Egyptian community revealed that women rarely, if ever, sought care for reproductive health issues. For example, approximately half of the women were diagnosed with female genital schistosomiasis after cervical biopsies; however, most of these women considered the symptoms "normal" and rarely informed their husbands or female relatives (Taalat 2001). Moreover, the study results suggested a general neglect of women's health, specifically reproductive health. Women were found to be unwilling to complain to their husbands if they are unwell, fearing that their husbands would subsequently divorce them and find another wife. Women, generally, did not discuss these kinds of problems with female friends and relatives, fearing that the information would reach others. The low socioeconomic status of women in the region makes it very difficult for women to recognize and address reproductive health issues.

Similarly, efforts to prevent HIV transmission from pregnant women to their infants in the MENA region are impaired by the relatively low rates of antenatal care in the region. Less than 70 percent of pregnant women have at least one antenatal checkup, putting the region behind East Asia (excluding China) and Latin America, in this regard. Women often cite difficulty in accessing health services as a major reason for not receiving antenatal care. In general, pregnant women in the region do not seek regular antenatal care, and often only seek medical advice when experiencing symptoms. In a study on mental health in Morocco, about half of the women who had not sought care during pregnancy reported that they did not seek care because they had no problems; another 22 percent reported that such services were not available to them; and 10 percent said the services were too costly (Roudi-Fahimi 2003). Since men are often the key decision makers regarding women's health care, there is a need for involvement of men in issues related to women's health including HIV/AIDS treatment and care.

In many regions, including the MENA region, there are also gender inequities in health care which have negative effects on men (Braitstein et al., 2008; Greig et al., 2000). Traditional masculine roles cast men as taking risks, being unconcerned about their health, and not needing

help or healthcare (Greig et al., 2000). These perceptions create barriers for men in accessing HIV prevention, testing, and treatment (Varga, 2001; Hawkes and Hart, 2000; Mane and Aggleton, 2001). This is particularly true for accessing prevention, testing and care for sexually transmitted infections. Women are more likely than men to attend health services because of the availability of women-targeted reproductive and child health clinics. Health services that address the needs of men, therefore, remain underdeveloped, and men are more likely to seek care through mechanisms outside the recommended clinical services, such as through pharmacies (Varga, 2001; Collumbien and Hawkes, 2000). Paradoxically, conventional views of gender inequality might have made it relatively easier for women than men in some settings to become engaged with HIV treatment services. In addition, the stigma associated with HIV infection, work or family responsibilities, homophobia, and masculine responses to health and disease may make it more difficult for men to accept an HIV diagnosis and to seek care and treatment (Mane and Aggleton, 2001).

In general, the barriers to health care services in terms of cost, location, distance to clinics, and scheduling often affect men and women differently. These gender-related barriers also likely affect the access of HIV prevention and treatment services. For example, men may be unable to take time from work to approach services for testing and follow up for care and treatment. Women may have restricted mobility, be unable to arrange childcare and often have fewer means to cover any direct or indirect costs (such as transportation), and in some circumstances, women in the region cannot leave home without being accompanied by a man of her household (Amowitz et al., 2004). The design and implementation of care and treatment programs must therefore address issues of transport, hours of operation and waiting time in clinics (WHO/UNAIDS 2004).

Labor Migration

In the global economy, international labor migration has become increasingly common (UNAIDS 2008). This is particularly true in many areas in the MENA region, where young males often seek employment opportunities in the Gulf States or West African countries. Migration for work is largely driven by poverty, high rates of unemployment, and the pursuit of better living standards.

In the MENA region, Egypt is the country with the largest number of out-migrant workers, with an estimated 3 million people, the majority of whom are men, working mostly in the Gulf countries (Jenkins and Robalino, 2003). Between 150,000 and 350,000 people in Egypt are screened for HIV yearly before they work abroad. Algeria, Iran, Jordan, Lebanon, Libya, Morocco, Syria, and Tunisia also report high levels of out-migration. For example, 25 percent of the Oman population consists of migrants from South and Southeast Asia, and Saudi Arabia hosts 850,000 Filipinos (Jenkins and Robalino, 2003). These migrant workers may be at increased risk for HIV due to separation from their spouses and exposure to multiple non-steady sex partners including commercial sex workers (IOM 2005). In addition, women are often at risk of HIV infection as the stay-at-home spouse of a migrant, mainly due to women's general inability to negotiate condom use with spouses when they return home. Also women left at home with limited resources to support families, often find themselves engaging in transactional sex to earn additional income further increasing their risk of HIV exposure (IOM 2005).

Migrant workers must receive HIV testing (as well as hepatitis B and C and syphilis testing) prior to obtaining a labor visa or a labor permit in most countries of the region. A positive test leads to denial of such visa and permit. Labor permits must be renewed at various intervals. International labor migrants who acquire HIV in transit or in destination countries, or who are already living with HIV, often cannot access HIV services. Migrant workers rarely have the

same entitlements as nationals to insurance which makes health care affordable, particularly if their immigration status is irregular. If the migrant worker acquires HIV while in the destination country, the worker is often immediately deported to his/her home country, frequently without undergoing any workup or treatment. Returning migrants have often been among the first men registered with HIV/AIDS in many countries and, after unknowingly transmitting HIV infection to their wives, consequently resulting in the first cases of pediatric HIV infection (Jenkins and Robalino, 2003; UNAIDS, 2008). This highlights the need for providing migrants with the health services they need ideally at their place of work as well as for their partners who remain in their country of origin.

In general, culturally and linguistically appropriate HIV programs are often scarce in host countries for migrant workers as these workers tend to live in geographically isolated areas, such as construction and mining sites, where there is little access to health services. In addition, migrant workers receiving antiretroviral treatment in the destination country may also have their treatment disrupted by deportation, if they are unable to access HIV services in the country to which they are returned (UNAIDS, 2008).

Refugees

Refugees are a particularly vulnerable group of migrants in the MENA region. The challenges of HIV prevention and care in conflict and post-conflict situations are increasingly being recognized (Hankins et al., 2002). Both male and female refugees are vulnerable to acquiring HIV/AIDS. According to UN reports, in the last decade there have been more than 70,000 refugees in the Republic of Yemen, mostly from Somalia and Ethiopia (United Nations, 2001). A recent assessment has shown that the Republic of Yemen has developed little capacity to manage HIV-infected individuals, whether they are Yemeni or foreign-born (Hankins et al., 2002, United Nations, 2001).

RECOMMENDATIONS

Multisectoral response and participation of PLWHA

Similar to other regions of the world there is an over-reliance on physicians in the response to HIV/AIDS in several MENA countries. However, there is a need for increased multi-sectoral links with the education system, community-based organizations and social movements that address the broad range of HIV/AIDS issues including stigma, and access to care (Jenkins and Robalino, 2003). The active participation of PLWA, including women and girls, is essential in designing effective strategies for prevention, care and treatment. In order to promote equitable access to these services, networks of women, especially of women living with HIV, need to be involved at all levels to adequately take into account their unique perspectives in planning, implementation, monitoring and review of these programs (WHO/UNAIDS 2004). There is however an encouraging landscape through the extensive development in most countries in the region of many civil society groups dealing with HIV prevention and care, psychosocial support and counseling. Many organizations of PLWHAs have developed in the region with active support from UN agencies, while in some countries, such organizations do not exist due to legal or structural barriers.

Capacity building of health care workers

Despite access to antiretroviral therapy in some countries in the region, the health sector in the MENA region has suffered from a general lack of sufficient skills in the management of HIV disease. Few physicians and other health workers have sufficient knowledge in the prevention and management of opportunistic infections or in the use of antiretroviral therapy. Capacity building and training incorporating gender sensitization is necessary in order to enhance knowledge, attitudes and skills of health workers in the frontline of these programs. Training

should address not only clinical issues, but also attitudes, biases and values of health care providers towards those affected by, and living with HIV/AIDS, since use of services and treatment adherence are generally influenced by patients' and communities' trust in those services and the staff.

Availability of antiretroviral treatment is likely to encourage more people, women and men, to seek HIV testing. However, concerns about stigma and violence (especially experienced by many women) may prevent them from seeking testing and counseling services. Similarly, in settings where clinical care to be provided to women requires their husband's consent, a potential for breach of confidentiality may result. There is a need for training of health care workers on issues related to stigma, confidentiality and to enhance their skills in supporting patient disclosure. This training should also include recognition of specific risks for women of HIV disclosure, such as partner violence, which may affect their ability to use HIV services and adhere to ART (WHO/UNAIDS 2004).

Integration of prevention and care services

There is a need for the integration of sexual health and family planning into HIV care. Because of the disproportionate impact of the HIV epidemic on women (in both social and biomedical terms), the separation of prevention and care/treatment services is likely to exacerbate the negative consequences of HIV disease for women. Specifically, the triad of HIV care/treatment, pMTCT, and reproductive health care, should be coordinated at the policy, planning and operational levels as a seamless continuum. Integrated services would provide opportunities to deliver interventions across the spectrum of needs of HIV-infected women, and men as well.

Ensuring availability of HIV Treatment

As in most of the world, women in the MENA region are chronically disadvantaged in their access to cash and productive resources. Insufficient funds or lack of control over household expenditures frequently prevent women from accessing ART. Free provision of HIV care, including antiretroviral drugs and supportive services, may result in increased enrolment and sustained adherence rates for women and young people in particular. In the MENA region, several countries provide antiretroviral drugs free of charge (Jenkins and Robalino, 2003). For example, in Algeria, the government has made these drugs available free of charge to eligible patients since 1998. Similarly, the Lebanese Ministry of Health has provided antiretroviral therapy free of charge to its citizens since 1998. In Morocco, the government has provided antiretroviral therapy to all eligible Moroccan citizens since 1999 and the Saudi Arabian Department of Health recently announced plans to build three AIDS-specific research and treatment facilities (Jenkins and Robalino, 2003). All countries in the MENA region follow these models and provide free and readily available access to antiretroviral therapy and related health and support services. Unfortunately, current services often suffer from frequent shortages of supplies, limitation in the classes of available drugs with no second line regimens, leading to interruptions of treatment and poor management of failures of first line protocols. Moreover, these services are available only to nationals while non-nationals have to either hide their positive status, seek treatment from outside sources (out-of-pocket or sent from their home country), or suffer the risk of deportation and loss of their work.

Attention to the needs of migrants and refugees

HIV/AIDS treatment and care among labor migrants and refugees must take into account several structural factors including poverty in the home country, inadequate health services and other support services, language difficulties, crowded or restrictive living conditions, and, with illegal migration, great reluctance to utilize any services at all. The most important priority for many migrant workers is saving money to send home to their families, resulting in

sacrificing even the simplest element of care. For long term and well-organized migrant labor, both sending and receiving countries should provide coordinated HIV/AIDS treatment services to ensure continuity of care (Jenkins and Robalino, 2003; IOM, 2005).

Pursuit of research to inform the response to HIV in the MENA Region

There remains a scarcity of data on the epidemiology of HIV and on impediments and facilitators for HIV prevention, care and treatment in the MENA region. Thus more research in these domains is needed, as well as research assessing knowledge and attitudes of healthcare providers and of the general population. Findings from such research can help inform future policy and practice recommendations and guide a comprehensive approach for addressing HIV in the region.

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