

# a long walk...

Challenges to women's access to HIV services in Asia

Participatory Action Research



Women's working group of APN+ [WAPN+]

InSide Front Cover

# A long walk

– Challenges to women's access to HIV  
services in Asia

Women working group of APN+

APN+  
2009



CONTENTS

1	Introduction	3
2	Recommendations	5
3	Study method	6
4	Study sample	6
5	Study findings	9
	5.1 HIV testing	9
	5.2 HIV information and counseling provided	10
	5.3 Quality of HIV Services	11
	5.4 Accessibility of ARVs	12
	5.5 Distance from services	14
	5.6 Income	14
	5.7 Migrants' access	17
	5.8 ARV adherence	17
	5.9 Treatment for opportunistic infections	19
	5.10 Reproductive health	19
	5.11 Other services	21
	5.12 Children's services	22
	5.13 Prevention of vertical transmission	23
	5.14 Discrimination within health care sector	24
	5.15 Discrimination in other sectors	25
6	Discussion	27
7	Further research	29
8	Acknowledgements	30
APPENDIX		

GLOSSARY OF TERMS

ARVs	antiretroviral medications
CD4 count	measure of immune system
FGDs	focus group discussions
HIV	human immuno-deficiency virus
OIs	opportunistic infections
pap smear	test to determine cervical dysplasia and pre-cancerous cells
STIs	sexually transmitted infections
Viral load	test to determine level of HIV activity in blood

1 Introduction

In Asia, HIV prevalence among women and girls is increasing; 40% of HIV-positive young people in south and south-east Asia are women and girls.<sup>1</sup> According to UNESCO, over one million youth between the ages of 15 to 24 in south Asia are infected with HIV, and more than half (62%) are young women.<sup>2</sup> In Cambodia, half of all new infections occur in married women and another one third occurs via vertical transmission from mother to child; since 2006 more women than men in Cambodia are reported to have AIDS.<sup>3</sup> Many women diagnosed as HIV-positive are mothers and it is important to keep them healthy in order to have optimal health and well being outcomes for themselves and their children.

This research study aims to examine the challenges that these increasing numbers of HIV-positive women and children face in getting access to antiretroviral drugs (ARVs) and HIV services in Asia. The study was designed and conducted by women living with HIV in six Asian countries. It was carried out throughout 2008, under the direction of the women's working group of the Asia Pacific Network of people living with HIV (APN+).

This study builds on previous research conducted by APN+ - the first documentation of HIV-related discrimination in four countries, which indicated that among people living with HIV, women experience significantly more discrimination than men do within the family and in communities. Because ARVs require a life-long commitment and because there is little documentation of people's ability to get access to HIV services including medication, APN+ felt that it was important and timely to examine the level of access to HIV services by various vulnerable populations; this report is one of three, the other two address issues faced by HIV-positive injecting drug users and HIV-positive men who have sex with men.

With the WHO "3 by 5" target, set in 2003<sup>4</sup>, access to HIV treatment increased globally, although by 2005, the target was short by 1.7 million people. According to the International Treatments Preparedness Coalition (ITPC), in India barely 10% of people with HIV were receiving ARVs<sup>5</sup> and action was needed to reach HIV-positive children. On 23 December 2005 the United Nations General Assembly adopted a resolution requesting UNAIDS and its co-sponsors to assist in "*facilitating... scaling up HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it.*" Throughout Asia the number of people on ARVs increased more than threefold since 2003, and reached an estimated 235,000 by June 2006.<sup>6</sup> This represents about 16% of the total number of people in need of ARVs in Asia. Only Thailand succeeded in providing treatment to at least 50% of people needing it.

<sup>1</sup> UNAIDS, UNFPA, UNIFEM. 2005. Women and HIV/AIDS. Confronting the crisis. <http://www.unfpa.org/hiv/women/report/index.htm>

<sup>2</sup> UNESCO. 2007. HIV/ AIDS and STIs. <http://www.unescobkk.org/education/hivaids/projects/adolescent-reproductive-sexual-health-arsh/information-resources-publications/hivaids-and-stds/>

<sup>3</sup> UNAIDS. December 2008. Epidemiological Fact Sheet on HIV and AIDS. Cambodia. [http://apps.who.int/globalatlas/pre-definedReports/EFS2008/full/EFS2008\\_KH.pdf](http://apps.who.int/globalatlas/pre-definedReports/EFS2008/full/EFS2008_KH.pdf)

<sup>4</sup> The World Health Organization set a target of three million people with HIV on ARVs by the end of 2005.

<sup>5</sup> ITPC. 2006. Missing the target. <http://www.aids-treatment-access.org/itpcupdatefinal.pdf>

<sup>6</sup> UNAIDS. December 2006. AIDS Epidemic Update. [http://www.unaids.org/en/HIV\\_data/epi2006/default.asp](http://www.unaids.org/en/HIV_data/epi2006/default.asp)

According to ITPC's most recent *Missing the Target* report<sup>7</sup> there is limited awareness of vertical transmission services for pregnant women even among health care workers and HIV-positive women are given wrong information on infant feeding. In Cambodia, ARV prophylaxis was not provided to mothers or infants in 88% of births involving an HIV-positive mother. Recommendations from this report include:

- Governments should increase access to the most effective triple-dose prophylaxis regimen.
- Governments should issue revised national infant feeding policies.
- UNAIDS, United Nations Population Fund (UNFPA), and UNICEF should provide technical support to governments to better integrate programs.
- Train health workers for sensitivity to human rights and gender-specific issues and compliance with principles of informed consent and confidentiality.
- Promote treatment literacy among women and children living with HIV.
- Improve financial support for HIV-positive women and encourage male partners of pregnant women to be tested for HIV.
- Initiate a wide-ranging campaign to raise the level of awareness about prevention of vertical transmission programs and services.
- Mobilise and encourage HIV-positive mothers to form or join psychosocial support groups that can also help them engage in income-generating activities.
- Ensure that all health care workers receive adequate training in breast-feeding management and counselling.

A country-by-country assessment of HIV and mobility in the Association of Southeast Asian Nations (ASEAN) countries revealed that migrants generally have little or no access to HIV information or services.<sup>8</sup> Most migrants are not covered by national AIDS programs - in Thailand, for example, registered migrants have access to health services with subsidized medical costs but ARVs are not included. In many countries migrants found to be HIV-positive through routine testing are sent home.

## 2 Recommendations

This study found that the major constraints on women's access to HIV services and treatments are: where women live, having sufficient income to sustain one's health and information available; the study also found that overall, older women had more unmet needs and greater levels of dissatisfaction with HIV services than younger women.

The findings of this study can be used to advocate for the following recommendations:

- Governments act responsibly to address discrimination and breaches of confidentiality within the public health system and engage women living with HIV to train health care workers on issues of HIV-related stigma.
- Governments and NGOs promote the concept that HIV is a chronic but treatable condition, and provide resources for increased treatment literacy and treatment adherence.
- Counseling services are expanded and women living with HIV are trained and employed as counselors within the public health system.
- Governments and NGOs support HIV-positive women's income generation, provide micro-credit schemes and assist women to build small businesses.
- HIV-friendly reproductive health services are integrated with HIV services to improve accessibility of services; accurate information about reproductive and sexual health is provided and regular cervical pap smears for HIV-positive women are promoted; no woman is coerced into sterilization.
- Women living with HIV are assisted to understand their rights and advocate for them.

<sup>7</sup> ITPC. 2009. *Missing the Target 7# Failing Women, Failing Children - HIV, Vertical Transmission and Women's Health*, <http://www.comminit.com/en/node/295133/347>

<sup>8</sup> UNDP. 2008. HIV/AIDS and mobility in South-East Asia. <http://www.undp.org/asia/asean-un-2008-report.pdf>



### 3 Study method

Two HIV-positive women leaders from each of six countries were trained in peer-based qualitative and quantitative research methods. A 57-item questionnaire was designed by all research trainees. In each country at least two women were responsible for data collection. The questionnaire was administered to a total of 1306 women living with HIV: Cambodia 268; China 334; India 236; Indonesia 180; Thailand 87; Vietnam 201. Study respondents were recruited via snowball sampling through support groups and health clinics. Questionnaires were analysed using standard statistical software<sup>9</sup>.

Thirty-eight focus group discussions (FGDs) were conducted with women living with HIV (Cambodia 4; China 2; India 12; Indonesia 8; Thailand 3; Vietnam 9). Each focus group included between six and twenty participants. Duration of focus groups ranged from 45 to 90 minutes. All study respondents were assured that the information collected for the study would be voluntary, anonymous and confidential.

### 4 Study sample

In all countries except China and Thailand, study respondents were drawn from both urban and rural areas, including:

**Cambodia:** Phnom Penh; Lvear Eam and Kein Svay Districts, Kandal Province; Srey Santhor and Orian Oueng Districts, Kompong Cham Province.

**China:** urban Beijing only (predominantly internal migrant workers).

**India:** Andhra Pradesh, Assam, Goa, Gujarat, Karnataka, Kerala, Maharashtra, Manipur, Nagaland, Orissa, Tamil Nadu, Uttar Pradesh, West Bengal.

**Indonesia:** West Java, including Bandung, Bekasi, Bogor, Cianjur, Cirebon, Jakarta, Sukabumi.

**Thailand:** Trad Province (bordering on Cambodia), Ranong Province (bordering on Myanmar), Payao Province (bordering on Laos and Myanmar); all rural areas and predominantly migrant workers and/or refugees.

**Vietnam:** Nine provinces including: Ho Chi Min City, Can Tho Province, Hanoi, Quang Ninh, Nam Dinh, Hai Duong, Bac Ninh, Ninh Binh.

Overall, 16.9% of respondents lived in the capital city, 26.1% lived in another city, 17.6% lived in a town and 39.4% lived in a village.

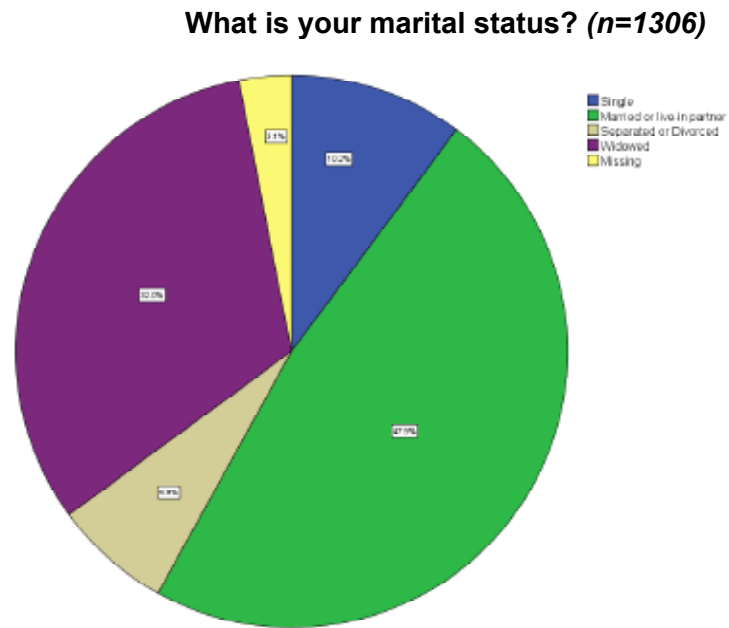


**Fig 1. Study Locations**  
From top left:  
**Cambodia, India, Indonesia, China, Thailand and Vietnam.**  
  
**\*Black & Red spots mark the study locations**



<sup>9</sup> Throughout the report, wherever significant relationships between variables are stated, these are based on Chi square tests executed via SPSS, where  $p \leq 0.01$ .

Mean age of respondents was 33.6 years (range: 10 to 68 years; standard deviation 8.1 years). One in two women (49.4%) was married and one in three (33.0%) widowed. Women over 30 years old were significantly less likely to be single than women under 30 years old, and women over 40 years old were significantly more likely than younger women to be widowed. Proportion of married respondents was highest in China (63.6%; see Appendix, Table 1). Although the high proportions of widows in India (48.3%) and Cambodia (46.2%) are similar, Indian women are far more likely than Cambodians to say they do not have a current partner (46.4% vs 9.1%).



Overall, one in five women (20.1%) said they do not have a current partner; one in two (49.3%) said they have a current partner who is HIV-positive, one in five (19.9%) said they have a current partner who is HIV-negative and one in ten (10.7%) said they have a current partner but did not know their status. Cambodian and Vietnamese respondents were most likely to have a partner who is HIV-positive (71.6% and 65.5% respectively) and Chinese respondents were most likely to be in a sero-discordant relationship (47.8%), Thai and Indonesian respondents were least likely to know the HIV status of their partner (31.8% and 28.1%) and Indian women were least likely to have a current partner (46.4%).

Overall, 7.7% of women said they identified as an injecting drug user and 10.9% as a sex worker; 16.9% of women said they identified as a migrant worker. In China these women were internal migrants who had come to Beijing seeking work; these respondents were asked if they had a legal right to access medical treatment when needed and 52.4% said they did not have that right. Migrants in Thailand were cross-border migrant workers or refugees from Myanmar, Laos or Cambodia, some of whom had fled from their own country and some of whom had chosen to come to Thailand seeking work. Some migrants had lived in Thailand for over twenty years. The Thai research team purposely targeted migrants for the study.

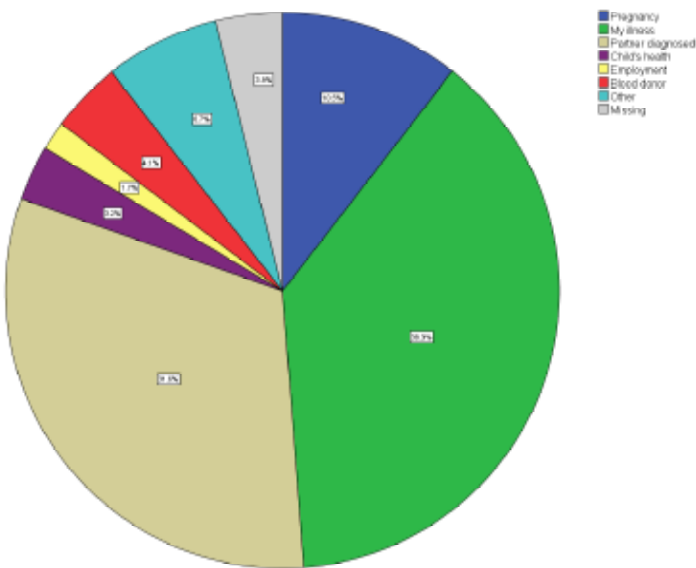
## 5 Study findings

### 5.1 HIV testing

On average women had known their HIV status for 4.6 years prior to the survey (range: a few months to 20 years). The majority of women (76.4%) were diagnosed between 2 and 10 years ago; women under 30 years had been diagnosed a mean of 3.7 years while women over 30 were diagnosed on average 5.1 years ago. Overall 82.5% of women said they were tested in a public facility or voluntary counseling and testing clinic, 5.9% at an antenatal clinic and 11.5% at a private facility.

The vast majority of women had an HIV test because of their own or their husband's illness (39.8% and 32.9% respectively); 10.9% because they were pregnant (35.6% in Thailand); 3.3% because of their child's poor health, 4.3% because they donated blood, 1.8% due to employment, and 6.9% for "other" reasons, including 62 women in China and Indonesia; most of whom identified as sex workers. The majority of women in India (56.6%) tested because their partner had been diagnosed as HIV-positive; in Cambodia and China the majority of women tested because of their own ill health (51.5%, 52.8%; see Appendix, Table 2).

**What was the main reason you had an HIV test? (n=1306)**



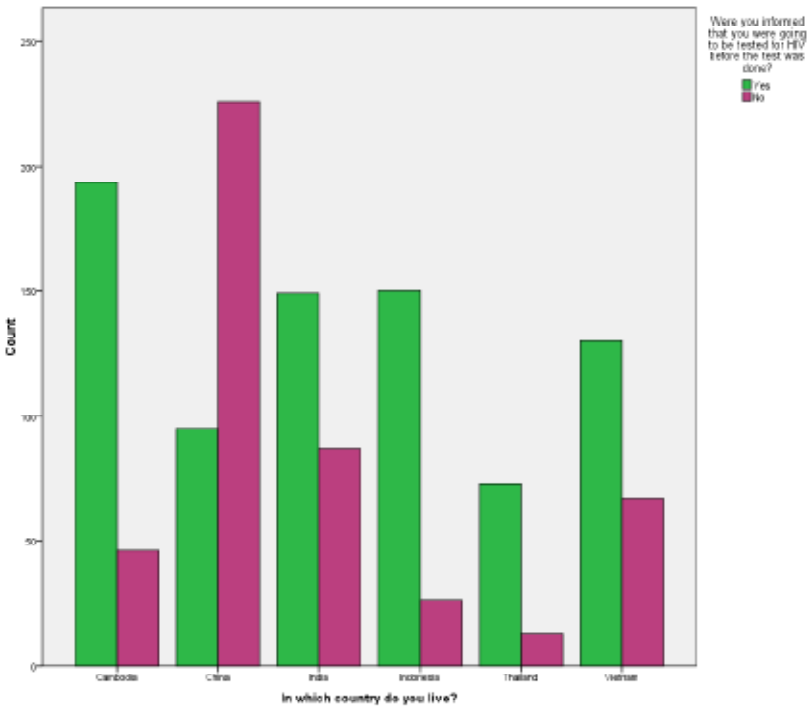
The proportion of women testing due to blood donation has decreased significantly over time: of women who were diagnosed over ten years ago, 23.5% were tested due to blood donation, compared to 4.7% of women diagnosed 5-10 years ago and 1.0% of women diagnosed in the past 5 years. The proportion of women who tested due to their partner's illness has increased significantly over time, from 21.6% ten years ago to 38.3% over the past two years. There is no significant change over time in relation to other reasons for testing. Highest rates of testing due to employment were seen in China (3.7%) and Indonesia (2.9%).

5.2 HIV information and counseling provided

The majority of women in all countries except China were informed they were going to be tested for HIV before the test (63.0%) and had post-test counseling (72.7%); women 40 years and older were significantly less likely than younger women to have received information before their HIV test (49.8% vs 66.8%) or counseling afterwards (60.3% vs 75.5%). Many FGD participants from different sites said they received counseling but the quality was poor.

*“[Doctors] are not enthusiastic and sometimes they said some heavy, bad words to patients. I want to be counseled by other people with HIV”.*  
(Vietnam)

In China 70.4% of respondents said they did not know they were being tested for HIV at the time and only 36.5% received counseling after their diagnosis. Women who identified as sex workers were more likely to know they were being tested compared to other women (73.5% vs 61.2%). Only 32.1% of blood donors and 45.0% of women who tested for employment were told they were being tested for HIV beforehand. Many migrant workers in FGDs said they had mandatory testing in the host country without counseling.



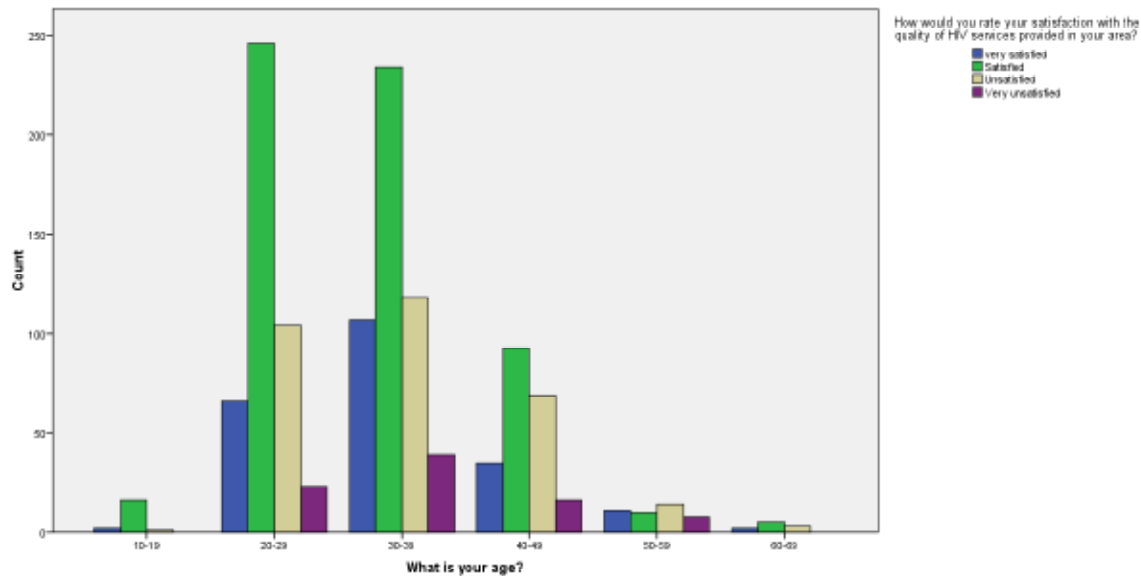
The majority of respondents in all countries except China received post-test counseling (see Appendix, Table 3). At the time they were tested for HIV, two in three women (65.8%) said their partner also tested, 16.2% said their partner was not tested (Cambodia 11.7% to Thailand 26.4%), 5.9% said they did not know if their partner tested and 12.1% said they did not have a partner at the time.

*“When I went for ante-natal care, the doctor told me I got HIV. I told him I knew all along but what can I do? My husband didn’t use a condom. The doctor told me to bring him in. I did but he didn’t come. Then I got an abortion when I was two-months pregnant. I had five abortions. When I got back home, I dragged him out of the house, not fearing people staring at us. He said he felt embarrassed, I said I don’t care. No condom, no sex. Here’s my last word.”*  
(Thailand)

5.3 Quality of HIV Services

Most women (63.3%) were satisfied with HIV services available in their area. Only in China was the majority of respondents (63.0%) dissatisfied with available services. Some Chinese women said there are restrictions on government reimbursements<sup>10</sup> of medicine costs available to low-income families and they were unable to benefit from the system; others said that it takes too long for reimbursements so many women have to borrow money in order to get access to health services.

There was a significant difference in satisfaction depending on where women lived: capital city 81.7% were satisfied, other city 66.6%, town 74.3%, village 58.3% (see Appendix, Table 4). There was also a difference in satisfaction depending on women’s age; allowing for the difference in location of residence, within rural villages, women over 40 years old were significantly less satisfied with available HIV services than were younger women (58.6% vs 67.9%).



Many women in FGDs spoke about the poor quality of some free government services. Women in several countries said that shortages of health workers means that people have

<sup>10</sup> Some provinces in China provide living allowances for low-income families affected HIV. This is usually a fixed amount and differs from province to province. To get this allowance, a doctor has to certify that the person is unable to work, and then s/he gets reimbursements from the local authorities; inevitably with either living allowances or reimbursement of medical costs, local authorities come to know the person’s HIV status and many people are afraid of breaches of confidentiality.



to wait for a long time before seeing a doctor and this discourages women from using services.

*“We have to wait in the emergency room and no one comes to check on us. When there is someone to check, it is not a proper check. I’ve had enough. I’d rather get a loan from someone [and pay for private services]. As well as that, we have to queue in a long line. We have to come very early in the morning when it’s still dark.”*  
(Indonesia)

Indian women said most doctors are unable to give quality personal time to women with HIV and the situation in some district hospitals is “deplorable” because many of the doctors are not trained or equipped to deal with HIV in general and women in particular. Other women spoke of breaches of confidentiality by health care providers which act to discourage access to treatment and care.

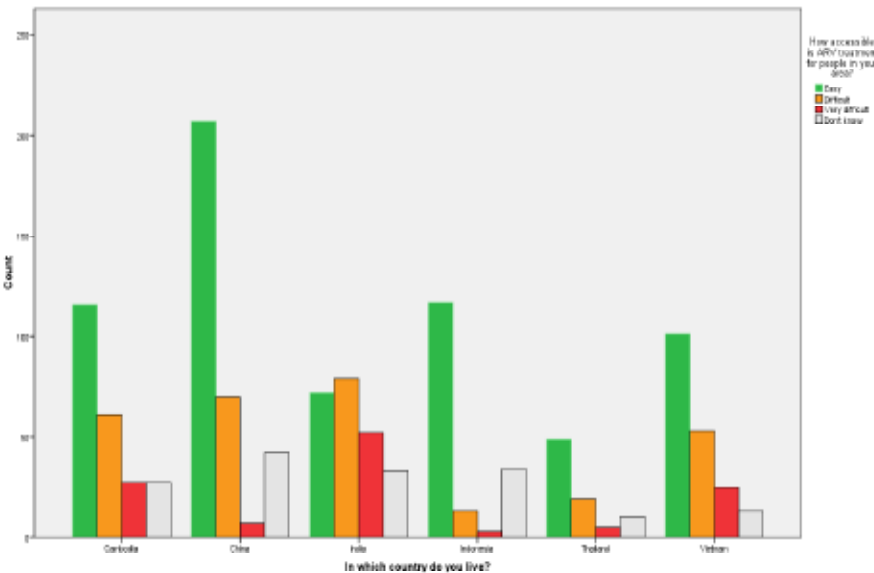
FGD participants in both Cambodia and China said services in hospitals are not integrated. This causes problems in terms of travel, time spent waiting for doctors, and discrimination from health care workers in services that are not used to and comfortable to treat people with HIV. Women who are HIV-positive and who also want reproductive health services or treatment for TB or Hepatitis must visit several different clinics or hospitals. One woman in China said she had to visit five hospitals to get all the services she needed.

Some Thai respondents said that attitudes of staff are very good and they are treated very well, however many female migrant workers were afraid to use services, or even take part in this study, for fear of being identified and returned home. NGOs that help migrants to access services are limited.

*“Even if I have money I won’t go to the hospital. They yell at me. Sometimes they are threatening, saying they will bring the cops to arrest us.”*  
(Thailand)

5.4 Accessibility of ARVs

The majority of women (65.1%) were currently taking ARVs (range: India 50.2% to Cambodia 86.1%); women 40 years and older were significantly more likely to be on ARVs than younger women (84.6% vs 59.0%). Most (85.9%) get them from a public health facility; 30.0% of women said they had not started ARVs. Just over half of the women (53.6%) said access to ARVs in their area is easy, 12.9% said they did not know, and **one in three women (33.5%) said access was difficult or very difficult**. Women who lived in the capital cities were significantly more likely to have easy access to ARVs than women in rural areas (61.5% vs 50.8%). Many HIV services for women and children living with HIV are available only in large urban centres. Respondents’ age had no relationship to their ability to access ARVs.



In the survey, one in three women on ARVs did not know what regime they were on - in Thailand over half of the sample did not know what ARV regime they were on. One in three women said they did not know if AIDS can be treated.

Many Indonesian women in the FGDs said that the government policy to provide free ARVs to people with CD4 counts below 200 is contra to WHO guidelines, which recommend ARVs if CD4 counts fall below 350. In Vietnam free ARVs and treatments for opportunistic infections (OIs) are available in some hospitals or clinics, but these are usually in large urban centres or in provinces that have PEPFAR<sup>11</sup> funding, so the number of people able to receive ARV treatment is restricted and the number of people needing ARVs and treatment for opportunistic infections (OIs) is much higher than the resources available. Some Vietnamese respondents said that some health care workers assume that it is a waste of money buying drugs for people whom they see as having no hope of surviving.

*“My CD4 count was only one and I had oral candida when I came to see my doctor. He said to my family members sooner or later I would die so it’s better to take me home.”*  
(Vietnam)

Some women complained that the drug supply system does not function adequately to ensure the availability of all needed drugs so stocks of drugs running out are common.

ARVs are free in many government facilities but some health care providers are unethical because they request money from them. In Thailand women said they get free ARVs and CD4 tests as well as TB tests and pap smears. These are available at particular hospitals, but if you do not live close by, travel expenses can be high.

*“I was very sick and I had to stay at home. My kid asked me why I didn’t go to the hospital. I said I can’t go because I don’t have the money. (Crying) We are also*

<sup>11</sup> President’s Emergency Plan for AIDS Relief



*human, why can't we go to the hospital? No money. No food. My husband sent me 3000 baht and it is not enough. I have to pay for the rent, the interest from a loan shark and for the electricity supply... [I owe] 7000 baht also plus 1000 baht interest per month [I borrowed the money] to apply for a health certificate for me and my friend."*  
(Thailand)

## 5.5 Distance from services

On average, the time it takes for women to travel to their nearest HIV service provider was 1.5 hours (range 0 to 30 hours). Twenty women in the survey said they regularly travel vast distances (100-280 kilometres) resulting in high transportation cost. In most countries, ARVs are provided only on a monthly basis, which means a journey to the clinic at least once per month if not more (mean 1.2 times per month); sometimes when there have been drug stock-outs, clients have had to return to the clinic every few days for their next supplies of ARVs.. Women rarely receive support for transport costs. Some FGD participants said they had stopped taking ARVs at times because they just cannot afford to get to the hospital.

*"Sometimes I have to visit the hospital more than once just to get my medication or to see my doctor."*  
(China)

Some Cambodian women said they had resorted to selling property to pay for travel costs to get to health services. Several women from different countries said they frequently borrow money in order to get to the hospital.

*"I borrow money from my relative to travel to the hospital to get ARVs and sometimes an NGO supports my transportation cost to go to the hospital. If I couldn't borrow money from my relative and I got no support from the NGO, I couldn't go to see the doctor to get ARVs because I work harvesting the grass in the fields and some days I can earn money for my labor when they need me but some days I can't earn money".*  
(Cambodia)

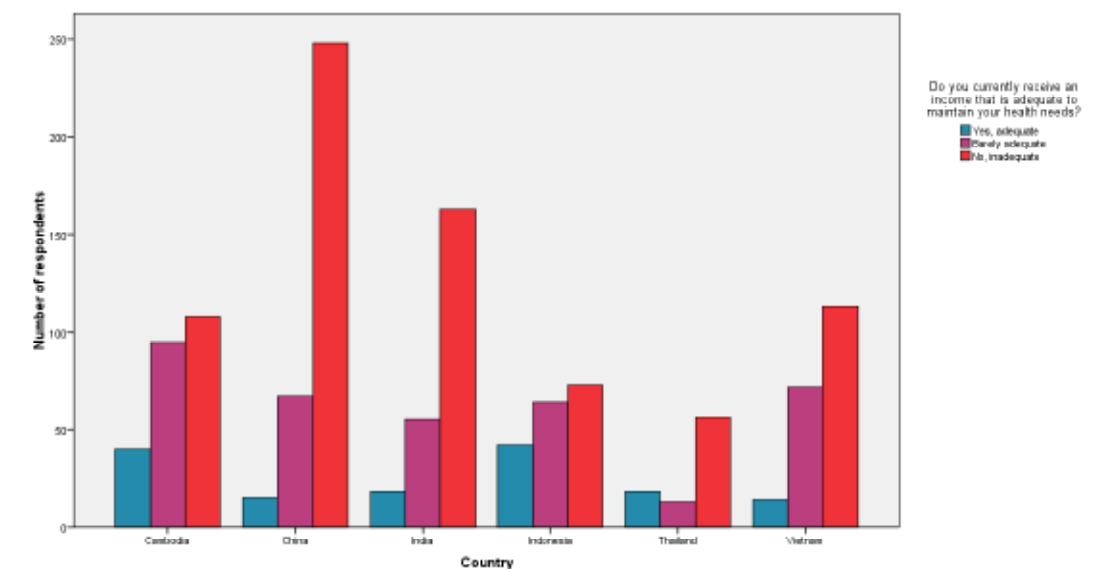
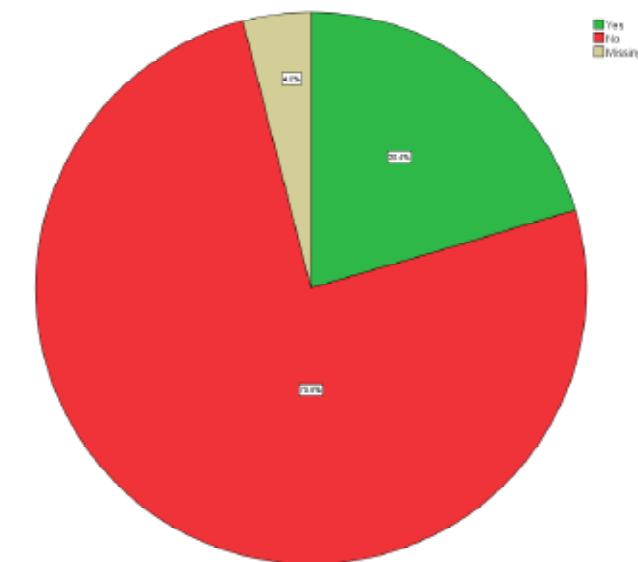
Some women choose to travel to large urban centres to get services because they are afraid of a breach of confidentiality if they use services close to home.

*"I didn't register for HIV treatment in my province, because I am afraid that people here will know that I am HIV-positive and I don't trust the quality of treatment here. At the moment, even though I am not on ARV treatment yet but I come to Ho Chi Minh City for health check monthly and each time I came there, it takes me two days and I get so tired of traveling but I feel more secure here."*  
(Vietnam)

## 5.6 Income

**Most women (78.7%) said they do not have adequate financial resources to access HIV services, including transport** and most women (59.7%) said they do not have sufficient income to maintain their health needs (range: 40.8% in Indonesia to 75.2% in China); 28.7% said their income was barely adequate; only 11.5% of women said they had sufficient income to maintain their health (4.5% in China to 23.5% in Indonesia).

**Do you have adequate financial resources to access HIV services including costs of travel? (n=1306)**

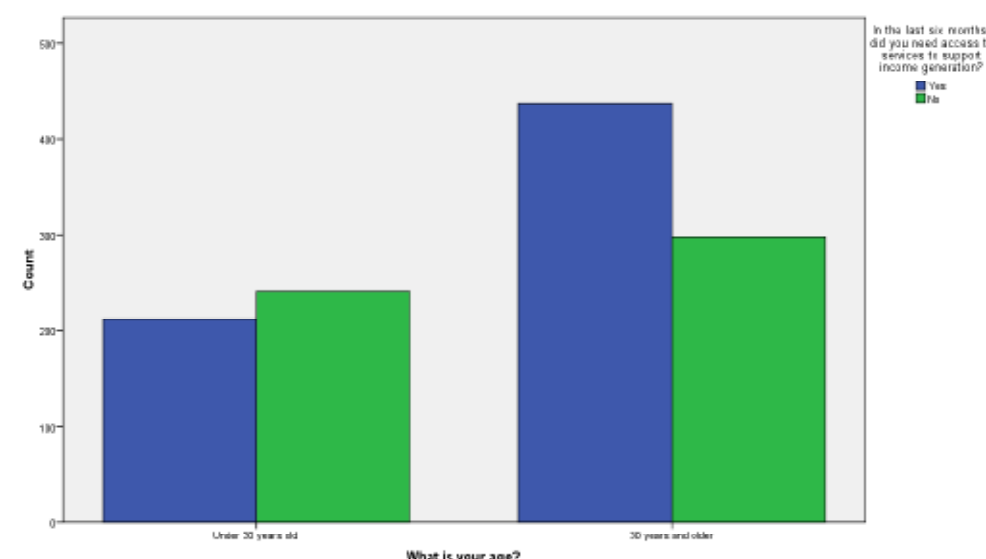


Income levels were unrelated to marital status but were related to location of residence. Women who lived in villages were significantly more likely than women in capital cities to say that their income was inadequate to maintain their health needs (69.1% vs 43.8%); and significantly less likely to say their income was adequate (6.6% vs 20.4%).

**Table A: Income versus location of residence**

	Has income adequate to maintain health needs?			Total
	Yes, adequate	Barely adequate	No, inadequate	
Village	6.6% (n=31)	24.3% (n=114)	69.1% (n=324)	100.0% (n=469)
Town	13.7% (n=29)	28.9% (n=61)	57.3% (n=121)	100.0% (n=211)
City (not capital)	12.4% (n=39)	28.0% (n=88)	59.6% (n=187)	100.0% (n=314)
Capital City	20.4% (n=31)	35.8% (n=72)	43.8% (n=88)	100.0% (n=201)
<b>Total</b>	<b>11.7% (n=140)</b>	<b>28.0% (n=335)</b>	<b>60.3% (n=720)</b>	<b>100.0% (n=1195)</b>

Overall 54.5% of women said they needed income generation support and 46.9% said they needed nutritional support for their children in the past six months. There was a significant relationship between age and the need for income support and nutritional support for children; women 30 years and older had a significantly greater need for income generation support (59.5% vs 46.7%) and nutritional support for their children (51.8% vs 38.8%) than did women under 30 years over the past six months. Women 40 years and older were significantly more unlikely to say they had adequate financial resources to access HIV services including travel costs than women under 40 years (15.0% vs 23.2%,  $n=1221$ ).



Women in several countries said **finding money for the next meal is most women's top priority**. Women in Indonesia said **they often face a dilemma as to whether to spend their money for transport to get ARVs or to buy food**. Most women in India said they got no income support from anybody; many have faced rejection from home, the community and society.

*"Positive people can hardly get a job, especially those whose status has already been disclosed to the public."*  
(Indonesia)

Most women discussed their acute need of money and their inability to secure an income; when work was available often it was very poorly paid. Women in India said most of them are illiterate and can only do physical labour but such work is very difficult, particularly in the heat on an empty stomach.

Only 23.1% of women said they knew of any programs that provide financial support for women living with HIV. Women who lived in rural areas had significantly greater likelihood of inadequate financial resources to maintain their health and get access to HIV services.

Few peer support groups have income-generating activities. Some women complained that where such projects exist, they generate very little income and the cost of transportation to the project can be more than the amount the woman earns in a day.

## 5.7 Migrants' access

In the FGDs some migrants said they had work permits or migrant identity cards, which enabled them to get free HIV services, others did not. Some women got ARVs free but had to pay for other medicines. In Thailand migrant workers who do not have a labor certificate are unable to get free ARVs or other services. Migrants are supposed to register with the head of the village to apply for the certificate but many are reluctant to do so. According to some women in the FGDs, they are afraid of "the eyes of Thai authorities who suspect them of illegally entering the area".

Although most migrants in Thailand say it is difficult for them to access the service, once they are included in the program, they are closely followed-up for continuity of care and treatment. One woman said that when she was pregnant and in jail the hospital sent the medicine to her.

In China many internal migrant workers cannot get access to services if they are not registered in the place where they work. Some said there has been a great improvement in the provision of services and treatment, and it is increasingly possible to get access to ARVs wherever they are, but other respondents said they were unsure how to get access to services. Some said that policies are not "harmonized" between different provinces; in some parts of China migrant workers only get free treatment if they travel back to their home, which can be difficult. Most migrants without identity cards pay for ARVs as well as treatment for OIs. One woman said staff at the hospital in her village asked her to go elsewhere for treatment. Another said in Beijing she cannot get reimbursed for treatment and if she goes back home, she is seen as someone who is abusing the system. Medical records are not centralised, so when doctors back home want to treat women they have to repeat HIV tests, which costs money. Some illegal migrant workers are afraid of being arrested so they limit their use of public healthcare services.

## 5.8 ARV adherence

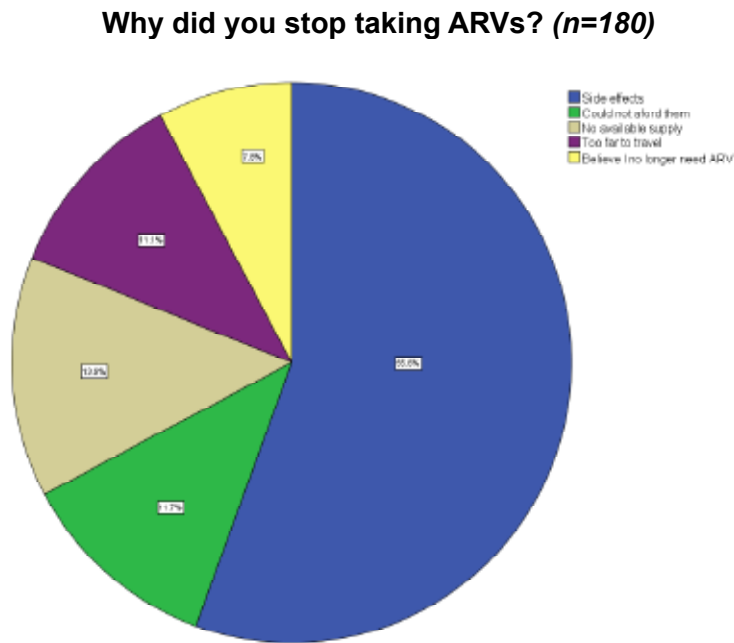
The majority of women had received counseling or training on how to take ARVs (71.0%) but **17.8% of 1222 respondents said they did not know why they had to take ARVs every day and at regular intervals** (6.0% in Cambodia to 31.9% in China).

Of 865 women who had started ARVs, 39.7% said they had, at some time, changed their regime and 17.8% said they had stopped their medication. Side effects were the major reasons for changing ARVs (80.0%) or stopping ARVs (66.6%). Other reasons for changing

regimes include drug stock outs (8.0%) and drug resistance (12.0%). Other reasons for stopping ARVs cited by at least twenty women included not being able to afford the medication and/or travel distance. In Vietnam, 12 of the 32 women who changed their regime had done so because their **drugs were no longer available**.

Fourteen women in the survey said they had **stopped taking their ARVs because they believed they no longer needed them**. Women lack proper information from their health care provider about adherence, including explanations about what to expect of ARVs in terms of side effects.

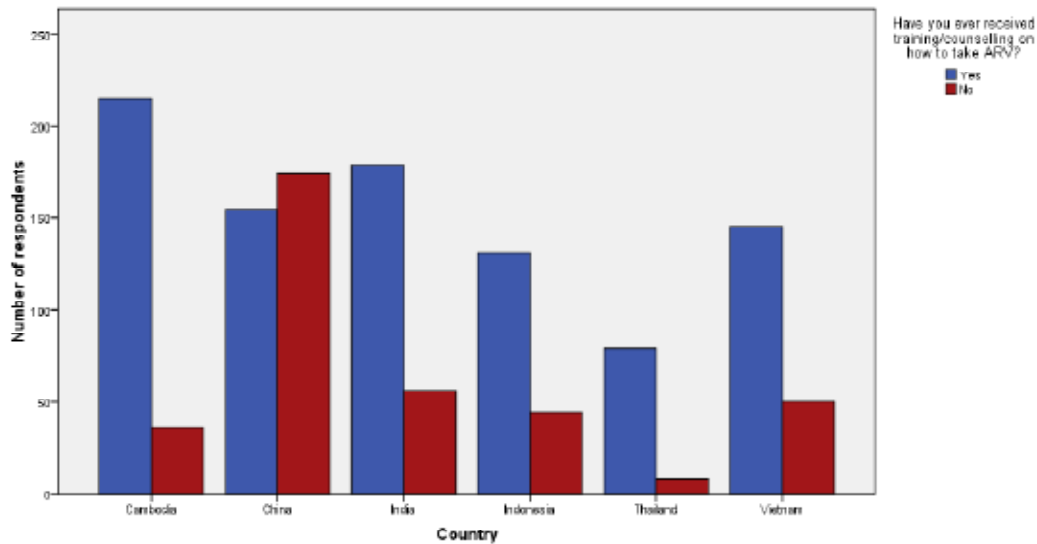
*“Some people living with HIV misunderstand. When they received and took ARVs for two or three months they feel better and healthy. They thought they have no HIV so they stopped treatment until they died.”*  
(Cambodia)



Many FGD participants did not know the difference between HIV and AIDS and many are unable to distinguish between ARV and OI drugs. A migrant worker in Thailand said she was taking two pills while the doctor prescribed only one but because most information is in Thai she was unable to understand the directions.

Several women said that the greatest obstacle to ARV adherence is limited counseling. All Indonesian FGD participants who are on ARV said they received only one session on adherence counseling, which is inadequate to prepare them for a lifetime of ARV therapy. Some said they started ARVs under pressure from their doctors, who are concerned only from a medical perspective and do not consider the patient’s mental preparedness. One woman said the doctor implied that she was irresponsible when she was not responding well to her ARV regime.

*“One doctor when I went for a checkup, commented that my CD4 and viral load levels didn’t change with ARVs, and he said that it wasn’t any use taking ARVs”*  
(China)



Vietnamese respondents said that doctors rarely give advice and sometimes they do not examine their patients but just write out a prescription and tell people that they have to take ARVs in the morning and in the evening.

5.9 Treatment for opportunistic infections

Over half of respondents said they were able to access free treatment for opportunistic infections (range: 44.4% of Chinese respondents to 66.8% of Vietnamese respondents); 35.9% of all respondents said they could not get free treatment for opportunistic infections, and 10.9% said they did not know if they could (Vietnam 3.5%, Indonesia 19.7%).

Cambodian women expressed concern over the shortage of drugs to treat opportunistic infections. Frequent drug stock outs means that they have to purchase the drugs from private pharmacists. Some Indian respondents said that only one or two types of drugs to treat opportunistic infections are available from their HIV service centre and they only provide medicines for three days so the client has to travel back and forth to get the medicine, adding to their expenses. In Indonesia, treatment for opportunistic infections is available in government hospitals and in some public health care services; some treatments are free and some are available at low prices.

5.10 Reproductive health

Overall 41.3% of respondents said pap smears were not available and 35.4% said they did not know if they were available and only 23.3% of women said that they knew that cervical pap smears were available to HIV-positive women in their area; the proportion of women who said pap smears were available varied greatly between countries (3.9% China to 83.7% of Thai women, see Appendix, Table 5). There was no relationship between knowledge of cervical pap smears and age of respondents.

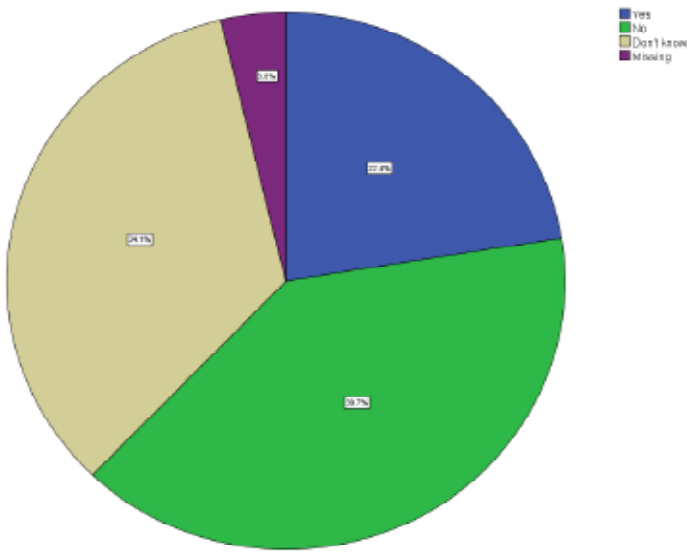
In the FGDs, **most women were unaware of what pap smears are**, where to get one or why it is important for women with HIV to have them regularly. Some respondents said they thought pap smears are only for women suspected of having cervical cancer; very few



women are aware of the increased risk of cervical cancer among women with HIV and the need for extra vigilance. Most participants said they have never had a pap smear.

*“What is cervical pap smear test?”*  
(India)

**Are cervical pap smears available to HIV-positive women in your area? (n=1306)**



One Chinese woman said she heard that free pap smears were available, but no one she knew had used the service. Another said that staff members at one hospital had intended to charge her ten times more than the usual cost for a pap smear once they found out her HIV status, so she did not have one. Another said that **staff working in gynaecology services will not treat women if they are known to be HIV-positive**. Some pregnant HIV-positive women who visit government clinics outside the area they are registered in say they have been told by health care workers that they will inform their local clinic (and thus breach their confidentiality) if the women return to their home town.

Many of the women in the FGDs in Cambodia spoke about the fact that they have reproductive health problems but they do not receive attention because HIV services only deal with HIV and there is rarely any referral to reproductive health services by doctors working in the HIV sector.

**Most FGD participants in Thailand said they have been coerced into being sterilised.** Women say that more often than not, the decision about whether to get sterilized is made by the husband and doctor, and the wife is not involved in the decision-making.

*“My husband asked me to be sterilised because my womb is not so good but he didn’t tell me I have HIV. And the doctor told me not to breastfeed my baby... My husband is Thai and he never slept with me ever since my baby was born, which means 13-14 years now. He’s a real player.”*  
(Thailand)

**5.11 Other services**

Most women (69.3%) said they needed access to counseling in the past six months; **significantly more women who are on ARVs needed counseling than women who were not on ARVs** - 71.1% vs 64.6%; women over 40 years old had a significantly higher need for counseling than younger women (84.0% vs 64.9%). Overall, 37.8% of women said they needed legal services; a majority of women over 40 years old said they needed legal services, significantly more than women under 40 (53.7% vs 32.7%); women who needed legal services were most likely to say they did not get access to the services they needed in the past six months – 22.1% of women who needed legal help were unable to get access to any legal services.

One in three women (33.9%) said they needed treatment for sexually transmitted infections in the previous six months; there was no relationship between need for STI services and respondents’ age.

Most women (86.7%) said they needed CD-4 testing and 47.1% said they needed viral load testing; the majority of women over 40 said they needed access to viral load testing, a significantly higher proportion than women under 40 (71.7% vs 40.0%), because older women are more likely to have been on ARVs longer.

Only 21.9% of women were able to get access to all the services they needed. Women got needed services from a government facility (43.1%), peer support group (34.9%), NGO (32.5%), or the private sector (5.2%); **15.2% were unable to access any of the services they needed**; place of residence was related to availability of services; only 6.8% of women living in the capital cities said they were unable to get access to any of the services they needed compared to 24.0% of women living in villages, women 40 years and older were significantly more likely to say they were unable to get access to any of the services they need in the past six months compared to younger women (23.5% vs 12.%).

In 50.1% of cases services were free; 46.3% of women said they had to pay for some or all of the services they received (in Thailand 83.9% of women said they paid for some or all of these services). Lack of money was the major reason respondents cited for not being able to get access to services they needed (28.6%); other reasons were fear of discrimination (15.6%), not knowing where to go (12.2%) and services not being available (10.2%).

The availability of CD4 counts varies greatly. In India it is free in government hospitals but at times staff members try to charge clients or ask them to go to private clinics (where the staff member has connections). Some women in Vietnam said they do not know their CD4 count and the only monitoring they have ever had is a blood test measuring their lymphocyte count, which is a less sophisticated measure of one’s immune system.

Most FGD participants said that if they need to change their ARV regime due to drug resistance, alternatives are often prohibitively expensive, Viral load testing is also usually unavailable or when it is available it is too expensive for most women; most women said they did not get viral load tests. Several participants said they would rather use their money for living expenses. Most women said they had never had viral load tests. No women said they had access to drug resistance testing.



There was confusion among many FGD participants about what services are available to them. For example, one woman in China said that Hepatitis B is treated for free but other participants said they had Hepatitis B and did not know that.

Indian women spoke about the high incidence of counterfeit medicine and bogus or quack doctors in the HIV field and the fact that women are often particularly vulnerable to them because of their lack of education. Over 70% of respondents in each country said that peer support was available in their area and the vast majority (75.8%) had received peer support services.

5.12 Children’s services

Of 1224 women, 84.6% said they had one or more children. On average, women had 1.5 children (range 0 to 9). Indonesian women had the least number of children (mean 1.0) and Cambodian women had the most children (mean 1.9).

Over 200 women (16.6%) said they had one or more HIV-positive children. Cambodian, Indian and Vietnamese women had the highest proportions of HIV-positive children (21.0%-23.0%), whilst Thai women had the smallest proportion (6.1%); 7.4% of women said they did not know their child’s HIV status (range: Vietnam 3.6% to Thailand 19.5%). Although women in Thailand and Indonesia were least likely to say they had an HIV-positive child, they were also most likely to say they did not know the HIV status of their child (22.7% and 18.1% respectively of the women who had children).

Table B: Children with HIV

	Mean number of children	Has HIV-positive child(ren))
Cambodia	1.9 (n=235)	22.0% (n=51)
China	1.5 (n=322)	9.4% (n=29)
India	1.7 (n=235)	23.0% (n=54)
Indonesia	1.0 (n=169)	13.5% (n=23)
Thailand	1.6 (n=85)	6.1% (n=5)
Vietnam	1.2 (n=191)	21.0% (n=41)
Overall	1.5 (n=1237)	16.6% (n=1224)

Women were asked if there is a paediatric doctor who can manage HIV cases in children in their area - 28.7% said there was (range: China 5.5% to Cambodia 47.1%); 39.5% said there was not (Indonesia 20.3%, China 57.4%); and 31.8% did not know (Vietnam 22.2% to Thailand 52.9%).

Overall, 36.2% of respondents said that paediatric ARV formula is available in their area (China 17.8%, Thailand 55.3%); 32.0% of respondents said it was not available (Thailand 1.2%, Vietnam 40.7%); 31.8% did not know if paediatric formula was available.

“I also heard [about ARVs for children] but the quantity is still very limited. We have to register first, then we can’t change from the regular ARV to solution right away.

The bureaucracy is too complicated. Maybe because the item is still rare, so it’s a bit complicated. So [my son] still uses the powder form. It’s okay; he’s already used to it anyway.”  
(Indonesia)

In most countries, children’s services are limited to large urban centres, requiring mothers to travel with their child(ren) every month to receive their ARVs. In Vietnam, for example, most HIV-positive children in the north need to register in Hanoi to get free OIs and ARV treatment, and it takes a full day to complete a medical check. The distance from a woman’s home town can be up to 250 km, which means an overnight stay. Likewise in the south, women from the provinces bring their children to Ho Chi Minh City for treatment and care. Women said that the services are very good there, but traveling so far can affect the health of the child, and if the child suddenly becomes ill, family members cannot take them to the registered hospital on time.

Treatment adherence for HIV-positive children is difficult due to limited knowledge and understanding about the importance of treatment adherence. Women said they receive little support to help them in taking care of their children.

Many Indian respondents said they feel anxious if they have to answer their children’s questions about their status. Many HIV-positive women in Thailand do not know their children’s HIV status. Several said doctors told them they would not test their child before they are seven or eight years old unless the child was sick.

“I took my kid to the doctor. He was three then. The doctor won’t allow any test. He said if the kid’s sick he’ll check it. When the kid reaches seven or eight and if he’s been ill, bring him in for a check-up. Now my kid’s eight and he’s well so I won’t take him in.”  
(Thailand)

5.13 Prevention of vertical transmission

One in ten women (10.5%) said no ARV regimes are available to prevent vertical HIV transmission among pregnant women (Thailand 0% to Vietnam 17.3%), 34.7% said they know that preventive ARV regimes were available and 54.8% of women did not know (Vietnam 44.5% to Indonesia 68.8%); Indian women were most likely to say that one-off dose Nevirapine is still used (41.5%), while Cambodian respondents were more likely to have access to more complex WHO-recommended ARV regimes (34.9%).

Many Chinese FGD participants said there is no referral system in Beijing, so HIV-positive women do not know where they can go to deliver their baby. In Thailand women said there is an “ever-changing policy” on migrant workers so migrant women who are pregnant are not certain how they will be treated by Thai authorities; therefore **a considerable number of migrant women do not attend the antenatal clinic because they are afraid they will be sent back to their homeland.**

With regard to information about breastfeeding, 45.7% of respondents said that such information is available (China 18.1% to Thailand 77.9%, see Appendix, Table 6), 22.9% said it was not (Thailand 2.3% to China 43.1%), and 31.4% said they did not know (Thailand 19.8% to Indonesia 54.1%).

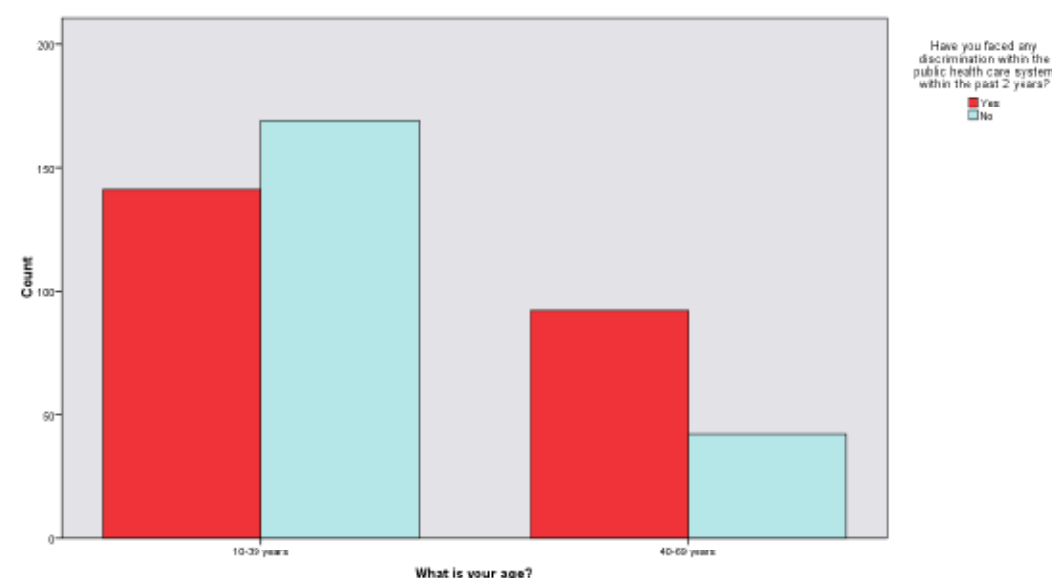
## 5.14 Discrimination within health care sector

About **one in two women (47.0%)** said they had faced discrimination within the public health system in the previous two years (Indonesia 29.2%; Thailand 29.9%; India 31.4%; Vietnam 44.4%; Cambodia 47.4%; China 73.4%).

**Women who lived in rural villages experienced significantly more discrimination than women in urban areas** (52.7% vs 43.3%). Of the 53 women who said they had been tested as a result of donating blood, 43 said they had experienced discrimination in the health sector in the past two years.

**Women who were not informed they were going to be tested for HIV subsequently experienced significantly more discrimination** than women who knew they were being tested for HIV (58.9% vs 39.4%).

A significantly higher proportion of women who identified as **migrants and/or refugees** said they faced discrimination compared to other women (62.0% vs 42.2%); among 444 women who lived in rural villages, **a significantly higher proportion of over 40 year-olds said they faced discrimination in the health sector within the past two years** than did younger women (68.7% vs 45.5%).



Women who identified as sex workers did not face more discrimination within the health system than other women. A higher proportion of women who identified as injecting drug users said they experienced discrimination in the health system compared to other women but the difference was not significant (52.7% vs 46.1%). Marital status had no correlation with levels of discrimination.

Stigma and discrimination happens in most hospitals at different levels, often in subtle ways. In some facilities doctors are reluctant to treat people with HIV. Women in FGDs in Vietnam said that some doctors postpone health checks or delay treatment; some said they have to wait a long time before receiving attention, and sometimes women are referred to other hospitals.

*"I went to a local health station for an STI check. Some nurses here said that 'You are AIDS people, you should not have come here, go home'."*  
(Vietnam)

One woman said that when she went for a check-up, the nurses started to whisper to one another about her HIV status so she left without seeing anybody. Some doctors refuse to perform operations on people if they know their HIV-positive status. In Beijing, women said it is very difficult to get access to surgery in hospitals, unless you know somebody in the hospital who can help. Some women said that their children with HIV also face discrimination. Some Indian women said they often feel that people blame them for "inflicting pain on the child"

*"My child had loose motions while attending the outpatient department. I asked for a pot of water from the ward attendants. There was no help coming so I looked around and found a dirty bucket. I fetched water in the bucket to clean my child. Immediately after, one of the hospital nurses came around and told me to wash the bucket clean and put it back in its place. I refused to listen to her which led to an altercation."*  
(India)

An FGD participant from China said that two years previously she had been hospitalised and was not told that she was to be tested for HIV. Over the following week, all patients were moved out of the ward she was in, and a week later she was told she was HIV-positive and asked to move to another hospital.

Some Indian women who work as peer counselors said they have faced discrimination from the nurses at the HIV service delivery centres.

## 5.15 Discrimination in other sectors

The vast majority of women (82.0%) said their family knows about their status (Indonesia 62.1% to Cambodia 91.3%). In 14.3% of cases, the woman's partner or a family member stopped her from getting access to HIV services (Indonesia 7.7% to China 20.1%).

Although the survey asked no questions about discrimination outside the health sector, within the FGDs many women raised concerns about stigma and discrimination in the community and the family. Women in several countries said they experience more stigma and discrimination than men do. In China and Vietnam respondents said that **women are judged as contracting HIV as a consequence of bad behavior but men are far less likely to face the same condemnation**. Some women said that most people regard women as the ones who "spread the virus", especially if they want to have a new partner.

Some women are isolated from family members or evicted from their home; some family members make them keep their soap, tooth brush, comb, etc separate from others; some are unable to participate in family gatherings; some husbands have left women and their whereabouts is unknown; some women said family members assume they are going to die so they do not get any property; some women are blamed for their husband's death or accused of killing their husband by black magic. Some Indonesian women said family members stopped them having a relationship with men, getting married and/or having children. Some Indian women said that the right to be treated with dignity and respect is

a challenge. Cambodian FGD respondents said stigma continues to be a huge barrier to women getting access to treatment and services. Some **women are reluctant to seek out health services because of fear of discrimination from their communities.**

Several women spoke of breaches of confidentiality by hospital staff which led to workplace discrimination such as dismissal, forced resignation and deportation. Women in Hai Duong province, Vietnam said people with HIV are not accepted as workers in the industrial zone or in some companies and factories.

*“The hospital administration put my husband’s type of sickness [HIV-positive] and then there was also a CD4 test and it was written on the bill that the test is special for people like us. So, now my husband is forced to resign from his workplace. They considered it as early pension. The pension money is very low; in fact, he’s been working in that company for 17 years.”*  
(Indonesia)

Some women are unable to operate their small food businesses because people in the community know their status and therefore will not buy food from them. In some cases women’s businesses have collapsed after their husband died because of assumptions that she must also be HIV-positive.

One woman in China said she was expelled from school after they learned about her status. Women in Vietnam said that many schools will not allow children with HIV to attend because of pressure from other parents. In Hanoi, two children whose parents died of AIDS had to study in a separate classroom to other students.

*“The teacher forced my child to have an HIV test when he was in grade three. When the result was negative, they didn’t believe and asked us to do another test.”*  
(Vietnam)

## 6 Discussion

Because it is not possible to select a random sample of women living with HIV, respondents were drawn from service delivery centres (clinics, out-patient departments, peer support groups) so the study is most likely to capture the views of women who are relatively well-informed of services available and are able to get access to them. It can be assumed, therefore, that women living further away from service delivery centres may have much greater difficulties in gaining access to the services they need. The respondents in the sample in China, for example, were drawn only from Beijing, where one might expect optimal service access; in fact it is worrisome that many Chinese respondents reported poorest access to counseling and adequate income to support their health needs.

Having a reliable income is critical to being able to access quality health care and ARVs for the rest of one’s life. Study findings indicate that the majority of women do not have an adequate income to support their health care needs, particularly with travel each month to service delivery centres and the costs of medications and monitoring tests. Women constitute 70% of the world’s poor, and HIV leads to greater impoverishment because of health care costs and sometimes inability to earn money, so women living with HIV face more financial constraints in getting access to health services than men with HIV face. Among a study of private sector patients in India, cost of medication was the major reason for treatment failure with clients spending over 60% of their income on ARVs.<sup>12</sup>

There is an urgent need to tackle income-generation issues for women living with HIV and provide job opportunities within the health sector; projects to increase women’s income generation opportunities, such as UNDP’s Women and Wealth Project,<sup>13</sup> are rare. Government and NGOs need to increase social support such as income generation projects, micro credit schemes and small grants so that women can benefit from expanded HIV treatment and services. The need for women-centred HIV impact mitigation programs, including income-generation projects for HIV-positive women, is one of the key recommendations of the Commission on AIDS in Asia.

Governments need to promote the benefits and availability of treatment for people living with HIV. Awareness of available HIV services is a critical issue. Respondents in several countries, including China and India said they do not know where to go to get various services. Women also need information about the risks of people who offer “magic cures”.

It is appalling that women diagnosed with HIV continue to be routinely coerced into sterilization in some countries. Information about women’s reproductive and sexual health was particularly poor. Women need appropriate, accessible information including the need for regular pap smears. These need to be provided free for women and widely promoted by government. Health services for women living with HIV should be integrated to enable women to get access to services such as STI checks, and treatment for OIs as well as other infections such as Hepatitis B and C.

<sup>12</sup> Shah B et al. 2007. Adherence to antiretroviral therapy and virologic suppression among HIV-infected persons receiving care in private clinics in Mumbai, India. *Clin Inf Dis* 44: 1235-1244.

<sup>13</sup> UNDP. The Women and Wealth Project. <http://www.wwp-we.org>



One in three women in the study was dissatisfied with the quality of HIV services in their area and one in three had difficulty getting access to services; if one considers that this study captured women who were connected to support groups or outpatient clinics, the level of satisfaction and access to services of HIV-positive women in the general community is most likely much lower than women captured in this study. Chinese respondents appear to have least access to information and counseling and are the least satisfied with the quality of services provided, even though all respondents were from the capital city. One data collector commented that women were reluctant to complain about services because they regard their health care workers “as their God or superior”.

One in two women said they had experienced HIV-related discrimination within the public health system within the past two years. Presumably some of this, but not all, was from health care workers who did not usually work in the HIV sector. This level of HIV-related discrimination is consistent with findings from other APN+ studies;<sup>14</sup> also consistent is women’s perception that they face more HIV-related discrimination than men. According to ITPC,<sup>15</sup> in Cambodia, major deterrents to women seeking treatment for HIV are fear of violence or ostracism as well as moralistic, negative and judgmental attitudes of health care providers. Women need information about their rights.

The quality and amount of counseling available to women is limited by relatively small numbers of counselors who have heavy workloads. Consequently, most women are poorly informed about HIV treatments and a considerable number (17.8%) said they do not know why it is important to take ARVs daily and at regular times; the vast majority of people who stopped taking ARVs said they had received information or counseling about ARVs but the counseling provided to these women was obviously inadequate to enable them to adhere to their ARV regime. Adequate and appropriate adherence counseling is vital in all locations to prepare people for life-long ARV therapy. There is a need to recruit more counselors, particularly HIV-positive female counselors, within public health systems. The needs of older women living in rural areas may easily be ignored but are more likely to need these services and the population of women living with HIV is aging. This is a pressing need in particular for more counsellors and legal advisors.

Breaches of confidentiality and HIV-related discrimination by health care providers reduce access to care and treatment. Practical, updated training, which includes meeting people living with HIV, is needed for all health care staff, especially in government hospitals. Codes of ethics and professional conduct in health care provision should be implemented and monitored, with appropriate forms of redress in cases of professional violations.

Long distances to HIV services create enormous challenges to getting access to ARV services, particularly for children with HIV. More treatment facilities are needed at local hospitals, and governments and NGOs must consider transport subsidies for impoverished women who live far from services. When women have proven to be drug adherent, doctors should consider prescribing longer periods of medication (for example, two or three months at a time, as is the norm in the west) so as to reduce travel costs; HIV-positive people’s organisations can lobby for such policy changes.

The availability of CD-4 testing varies greatly across the region and within some countries. More research is needed into the availability of CD-4 testing. Access to laboratory testing to monitor health status is essential in order to optimize the use of ARVs.

Of concern is the relatively high proportion of women in Thailand and Indonesia who do not know their child’s HIV status, particularly in light of the fact that HIV-positive children who get access to ARVs early are have a better prognosis.

Policies towards migrants with HIV are inconsistent across the region. Many migrants experience great levels of discrimination and have poor access to services, particularly if they live in rural areas. In countries where there are high numbers of migrants, information must be available in the languages of the migrants.

## 7 Further research

Several countries provide HIV services to women on low incomes but whether these meet women’s needs requires further research. No information is known about the costs of women’s transport when they get access to regular HIV services.

It is impossible to accurately assess the impact of distance to women’s ability to access services because the women captured in this study had access to services and/or support groups. It would be helpful to determine which services women are needing but not getting.

## 8 Acknowledgements

Data collectors: Pheng Pharoazin and Pen Moni (Cambodia); Rachel Ong and Xiao Li (China); Daxa Patel, Shabana Patel and Asha Ramaiya (India); Suksma Ratri and Santi Sardi (Indonesia); Areerak Aumin, Marisa Nedjaiboon, Nipakorn Nanta, Apichai Maiakree (Thailand); Huynh Nhu Thanh Huyen and Nguyen Thi Tuyet Lan (Vietnam).

Data input and analysis: Hongxia Zhang, APN+ consultant; Mujeeb Ur Rahman (India); Supicha Bantip (Thailand), Skand Amatya (Thailand), Cathy Kolokitas (APN+)

Research training, data analysis and report writing: Susan Paxton (APN+)

Project coordination: Frika Chia Iskandar (APN+)

<sup>14</sup> APN+. 2004. AIDS discrimination in Asia. <http://www.apnplus.org/Publications.asp>

<sup>15</sup> ITPC. 2009. *Missing the Target 7: Country reports: Cambodia* <http://www.aids-treatment-access.org>



# APPENDIX

**Table 1: Marital status**

	Cambodia (n=251)	China (n=326)	India (n=236)	Indonesia (n=178)	Thailand (n=87)	Vietnam (n=194)	Total (n=1272)
Single	4.4% (n=11)	16.6% (n=54)	3.4% (n=8)	15.7% (n=28)	0%	17.0% (n=33)	10.5% (n=134)
Married / de facto	45.0% (n=113)	63.5% (n=207)	41.9% (n=99)	41.6% (n=74)	58.6% (n=51)	43.8% (n=85)	49.4% (n=629)
Separated /divorced	4.8% (n=12)	7.4% (n=24)	6.4% (n=15)	12.9% (n=23)	5.7% (n=5)	5.7% (n=11)	7.1% (n=90)
Widowed	45.8% (n=115)	12.6% (n=41)	48.3% (n=114)	29.8% (n=53)	35.6% (n=31)	33.5% (n=65)	32.9% (n=419)
Total	100%	100%	100%	100%	100%	100%	100%

**Table 2: Reasons for HIV testing**

	Cambodia (n=241)	China (n=325)	India (n=235)	Indonesia (n=170)	Thailand (n=87)	Vietnam (n=196)	Total (n=1255)
My illness	51.5% (n=124)	52.8% (n=172)	23.8% (n=56)	30.6% (n=52)	36.8% (n=32)	32.7% (n=64)	39.8% (n=500)
Partner diagnosed	36.9% (n=89)	14.7% (n=48)	56.6% (n=133)	38.2% (n=65)	19.5% (n=17)	31.1% (n=61)	32.9% (n=413)
Pregnancy	7.9% (n=19)	4.3% (n=14)	13.2% (n=21)	2.9% (n=5)	35.6% (n=31)	18.9% (n=37)	10.9% (n=137)
Child's illness	1.7% (n=4)	1.2% (n=4)	3.4% (n=8)	5.3% (n=0)	0%	8.7% (n=17)	3.3% (n=42)
Blood donor	0.4% (n=1)	14.4% (n=46)	0.9% (n=2)	1.2% (n=2)	0%	1.5% (n=3)	4.3% (n=54)
Employment	0.4% (n=1)	3.7% (n=12)	0.4% (n=1)	2.9% (n=5)	0%	1.5% (n=3)	1.8% (n=22)
Other	1.2% (n=3)	9.2% (n=30)	1.7% (n=4)	18.8% (n=32)	8.0% (n=7)	5.6% (n=11)	6.9% (n=87)
Total	100%	100%	100%	100%	100%	100%	100%

**Table 3: Information received before and after test**

	Informed about HIV test beforehand	Received counseling after test	Partner tested around same time
Cambodia	80.8% (n=194)	93.4% (n=213)	71.2% (n=158)
China	29.6% (n=95)	36.5% (n=111)	71.7% (n=223)
India	63.1% (n=149)	71.6% (n=169)	69.1% (n=163)
Indonesia	85.2% (n=150)	89.2% (n=149)	54.3% (n=95)
Thailand	84.9% (n=73)	98.8% (n=85)	54.0% (n=47)
Vietnam	66.0% (n=130)	80.6% (n=158)	62.1% (n=121)
Overall	63.0% (n=791)	72.7% (n=885)	65.8% (n=807)

**Table 4: Satisfaction with HIV services**

	Village (n=458)	Town (n=210)	City (not capital) (n=312)	Capital City (n=209)	Overall (n=1177)
Very satisfied	14.4% (n=66)	23.3% (n=49)	16.3% (n=51)	21.8% (n=43)	18.2% (n=209)
Satisfied	43.9% (n=201)	51.0% (n=107)	50.3% (n=157)	59.9% (n=118)	49.9% (n=583)
Dissatisfied	30.4% (n=139)	19.0% (n=40)	27.9% (n=87)	16.8% (n=33)	25.0% (n=299)
Very dissatisfied	11.3% (n=52)	6.7% (n=14)	5.4% (n=17)	1.5% (n=3)	6.9% (n=86)
Total	100.0%	100.0%	100.0%	100.0%	100.0%

**Table 5: Availability of pap smears**

	Are cervical pap smears available to HIV-positive women in your area?			Total (n=1257)
	Yes (n=293)	No (n=519)	Don't know (n=445)	
Cambodia	19.1% (n=45)	51.5% (n=121)	29.4% (n=69)	100.0% (n=235)
China	3.9% (n=13)	45.5% (n=151)	50.6% (n=168)	100.0% (n=332)
India	19.6% (n=46)	37.4% (n=88)	43.0% (n=101)	100.0% (n=235)
Indonesia	32.4% (n=56)	31.8% (n=55)	35.8% (n=62)	100.0% (n=173)
Thailand	83.7% (n=72)	2.3% (n=2)	14.0% (n=12)	100.0% (n=86)
Vietnam	31.1% (n=61)	52.0% (n=102)	16.8% (n=33)	100.0% (n=196)
Overall	23.3%	41.3%	35.4%	100.0%

**Table 6: Information on breastfeeding available**

	Counselling and information about breastfeeding is available to pregnant HIV-positive women			
	Yes (n=562)	No (n=281)	Don't know (n=386)	Total (n=1229)
Cambodia	63.3% (n=140)	12.2% (n=27)	24.4% (n=54)	100.0% (n=221)
China	18.1% (n=58)	43.1% (n=138)	38.8% (n=124)	100.0% (n=320)
India	65.8% (n=154)	11.1% (n=26)	23.1% (n=54)	100.0% (n=234)
Indonesia	24.7% (n=42)	21.2% (n=36)	54.1% (n=92)	100.0% (n=170)
Thailand	77.9% (n=67)	2.3% (n=2)	19.8% (n=17)	100.0% (n=86)
Vietnam	51.0% (n=101)	26.3% (n=52)	22.7% (n=45)	100.0% (n=198)
Overall	45.7%	22.9%	31.4%	100.0%

InSide Back Cover



Asia Pacific Network of People Living with HIV/AIDS  
51/2 Soi Ruam Rudee, Ploenchit Rd.  
3rd floor, Ruam Rudee Building III  
Bangkok 10330 THAILAND  
T : +66 2 2557477-78  
F : +66 2 2667479

[www.apnplus.org](http://www.apnplus.org)

The funding for this research was kindly provided by UNAIDS, UNDP and Ford Foundation