

HIV FUTURES 8

Women Living with HIV in Australia

Australian Research Centre in Sex, Health and Society

2017

INTRODUCTION

HIV Futures 8 is a survey about the health and wellbeing of people living with HIV (PLHIV) in Australia. The study forms part of a series of cross-sectional surveys that have been run every two to three years since 1997. Funded by the Australian Government Department of Health, the aims of the study are to provide information about factors that support physical and emotional wellbeing among PLHIV. The study is designed to inform the Australian National HIV Strategy and guide community and clinical service provision for PLHIV.

In order to explore the complexity of factors that support health and wellbeing among PLHIV, HIV Futures 8 is a broad survey covering issues such as financial security, housing status, anti-retroviral treatment use, general health issues, stigma and discrimination, clinical and support service use, aging, drug and alcohol use, sexual health, relationships, and social connectedness.

HIV Futures is run by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University. Findings from HIV Futures 8 are presented as a series of short reports. These, along with more information about the study and copies of reports from previous HIV Futures surveys, can be found on the ARCSHS website: latrobe.edu.au/arcshs

METHODS

HIV Futures 8 is a cross-sectional survey of PLHIV. The survey was open to people aged 18 years or older who were currently living in Australia. Data were collected using a self-complete survey that could be filled in online or using a booklet that was supplied to prospective participants with a reply-paid envelope. Participants were recruited through electronic advertising in a range of forums including: advertisements sent through the email lists of HIV community organisations; advertising on relevant websites; social media advertising, particularly Facebook including targeted posts to Facebook groups for PLHIV; advertisements on 'dating apps' used by gay men and other men who have sex with men and; flyers and posters displayed in HIV clinics. Hard copies of the survey were distributed through the mailing lists of HIV community organisations and made available in the waiting rooms of HIV clinics and community services. Data were collected between July 2015 and June 2016.

Full details of the study protocol and method have been published elsewhere and are available on the ARCSHS website: latrobe.edu.au/arcshs/projects/hiv-futures

SAMPLE

HIV Futures 8 was completed by 895 people living with HIV in Australia. Of these, 90.5% (n=804) were men and 8.3% (n=74) were women while four people described their gender in other terms. There were six people who identified as transgender.

The majority of the sample were men who identified as gay (78.7%, n=697), 5.6% (n=50) identified as bisexual and 4.3% (n=38) as heterosexual.

There were 21 participants (2.3%) who identified as Aboriginal or Torres Strait Islander.

The age of participants ranged from 19 to 86 years. The average age was 51 years. Over half (56.3%, n=485) were aged 50 years or older.

The majority of participants were born in Australia (74.7%, n=649) and spoke English as their first language (91.2%, n=792).

Participants came from all states and territories in Australia as detailed in Table i.

The majority of participants were working (53.8%, n=474) either full-time (38.6%, n=341) or part-time (15.2%, n=134). There were 18.1% (n=160) who were retired/no longer working.

There were 234 (26.7%) participants who had tested positive to HIV within the five years prior to the survey (from 2010 onward). Of these, the majority (77.0%) were under 50 years of age. However, there were 51 participants (23.0%) aged 50 or older who had been diagnosed in 2010 or more recently.

There were 844 participants (96.6%) currently using antiretroviral therapy. Of these, 756 (91.0%) reported they had an undetectable viral load as of their most recent test. (Note, these figures exclude missing data).

Full details of the study sample are available on the ARCSHS website latrobe.edu.au/arcshs

Table i. States and territories in which participants currently live

	n	%
ACT	20	2.3
NSW	306	34.5
NT	6	0.7
QLD	136	15.3
SA	65	7.3
TAS	10	1.1
VIC	265	29.9
WA	78	8.8

*Nine participants did not identify their state/territory

BACKGROUND

In 2015, there were just under 3,000 women living with (diagnosed) HIV in Australia, representing around 10% of the overall number of Australians currently living with HIV (The Kirby Institute, 2016). The experience of living with HIV can be very different for women than it is for men. In Australia, the majority of people living with HIV are gay or bisexual men. While support services and networks often have programs for women, the Australian HIV sector is, by necessity, focused on where the majority of the epidemic sits, which is communities of gay men. Women living with HIV may be more isolated from services or other people living with HIV as a result. While this is not necessarily the case for all women, it may mean women navigate their HIV treatment and care (and their everyday lives) differently from gay men – including their use of services, the clinicians they consult, the relationships they form and their feelings about HIV disclosure and stigma.

Women living with HIV are a diverse group. Many were born outside of Australia, most commonly in countries where the HIV prevalence is high, including regions in Africa and South East Asia. Women living with HIV are also diverse with respect to their ages, the length of time they have been living with HIV and the places where they live. So, it is difficult to collect data that represent the needs and experiences of all women, particularly given this is a relatively small group of women who may find it difficult to engage in research due to issues such as language barriers, fear of HIV disclosure, or disconnection from HIV networks and services.

We have been following the experiences of women living with HIV through the HIV Futures surveys since 1997. With each survey, women have represented between six and ten percent of respondents – around 70 to 80 women. While this number is small, it is enough to reveal important information about the lives of Australian women living with HIV. In this report, we present findings from HIV Futures 8 related to women living with HIV.

DEMOGRAPHIC CHARACTERISTICS OF WOMEN

The 74 women who completed the survey were aged between 19 and 80 years, with a median of 49 years. The majority of women were heterosexual (90.4%), while four women identified as bisexual and two as lesbian.

The majority of women were born in Australia (68.5%, n=50), spoke English as their first language (87.3%, n=62) and were Australian citizens (64.8%, n=46) or permanent resident (28.2%, n=20). There were five women (7.0%) who were not permanent residents or citizens. One woman was on a temporary working visa, two were New Zealand citizens and two were on bridging visas. Of the women not born in Australia, 10 were born in Europe or the United Kingdom, six were born in African countries (Kenya, South Africa, Zambia or Zimbabwe), three in South Asian countries (China or Thailand), three in New Zealand and one in the United States.

Two women were of Aboriginal or Torres Strait islander origin.

Respondents came from all states and territories, and most commonly lived in a capital city or inner suburb (42.5%, n=31), regional centre (23.3%, n=17) or outer suburb (20.5%, n=15). A smaller number of women lived in rural areas (13.7%, n=10).

EMPLOYMENT AND HOUSING

Over half of the women were currently working, with 38.9% (n=28) in full-time employment and 16.7% (n=12) in part-time employment. The remaining women were either unemployed (13.9%, n=10), not working or retired (9.7%, n=7), receiving the disability support pension (5.6%, n=5), studying (5.6%, n=4), or they nominated one of the 'other' categories.

When asked whom they were currently living with, the most common response was pets (41.5%, n=31), followed by a partner or spouse (36.5%, n=27). Around one-quarter of the women lived alone (27%, n=20), a similar number with dependent children (25.7%, n=19) and 14.9% (n=11) with other family members. Three women (4.1%) lived with friends or flatmates and three (4.1%) selected another response.

Most women lived in housing that they either owned or were purchasing (39.2%, n=29) or were renting privately (36.5%, n=27), while 14.9% (n=11) lived in public housing. The remainder lived rent free, in community housing or selected 'other' type of housing (9.5%, n=7).

INCOME AND FINANCIAL SECURITY

Respondents were asked to nominate their main sources of income, with more than one response possible. Just over half of the women nominated a government benefit as a main source (51.4%, n=38), while just under half (48.6%, n=36) nominated a salary or wages. Seven of these women selected salary and a government benefit. Other sources of income were partner support (12.2%, n=9) and savings or superannuation (10.8%, n=8). Two women indicated 'other' categories.

Respondents were asked to estimate their current yearly pre-tax household income. As shown in Table 1, just over one-third of women lived in households in which the yearly income was up to \$29,999, while 15.1% lived in households earning between \$30,000 and \$49,999. In total, just 15% of women lived in households in which yearly earnings totalled \$80,000 or more. In comparison, the 2015/16 national average full-time income was approximately \$80,000 per year and the average income for all workers (full-time or part-time) was approximately \$60,320 per year (ABS, 2016).

Table 1. Annual household income (before tax)

Yearly income	% (n)
Negative or zero income	2.7 (2)
\$1-\$29,999	34.2 (25)
\$30,000-49,999	15.1 (11)
\$50,000-79,999	16.4 (12)
\$80,000-99,999	4.1 (3)
\$100,000-\$124,999	4.1 (3)
\$125,000-149,999	2.7 (2)
\$150,000-199,999	4.1 (3)
Don't know	2.7 (2)
Prefer not to answer	13.7 (10)

The HIV Futures 8 survey included questions about respondents' experience of money difficulties in the past 12 months, such as not being able to pay bills, needing to ask friends or family for money and so forth. These questions are used as indicators of financial stress. If none or one of these events occurred this is classified as *little or no financial distress* and if two or more occurred this is classified as *significant financial distress* (Wilkins, 2016). The Household, Income and Labour Dynamics in Australia (HILDA) survey found that indicators of financial stress are linked to deprivation, i.e. not being able to afford items that are considered essential (Wilkins, 2016).

Of the 74 women, 32 (43%) did not select any of these responses, which may indicate that they had not experienced any financial stress, that none of these specific circumstances applied to them, or that they simply chose not to answer the questions.

Of the 32 women who responded to at least one item, the most common was asking for financial help from friends or family (47.6%, n=20), followed by not being able to pay their electricity, gas or telephone bills on time (38.1%, n= 16), asking for help from welfare or community organisations (28.6%, n=12), pawning/selling something (23.8%, n=10) or going without meals (21.4%, n=9).

Of the 74 women respondents, 29.7% (n=22) were categorised as having *little or no financial stress*, while 27.0% (n=20) were classified as *having significant financial stress* (see Table 2).

Table 2. Percentage of women (n) with financial stress

Little or no financial stress	29.7 (22)
Significant financial stress	27.0 (20)
Did not answer/Not applicable	43.2 (32)

The HIV Futures 8 survey also included a measure of credit constraints, that is, the ability of a person to be able to borrow money (Wilkins, 2016). Respondents were asked if they would be able to raise \$3,000 in one week in the event of an emergency. Those who indicated *I would have to do something drastic to raise the money* or *I don't think I could raise the money* are defined as 'credit constrained', while those who indicated *I could easily raise the money* or *I could raise the money but it would involve some sacrifices* are defined as 'not credit constrained' (Wilkins, 2016).

According to this measure, 56.1% (n=41) of the women were credit constrained. The most common response to these items was: *I don't think I could raise the money* (39.7%, n=29). Of those who said they could raise the money, one-quarter said *I could easily raise the money* (24.7%, n=18), while 19.2% (n=14) said *I could raise the money but it would involve some sacrifices* and 16.4% (n=12) said *I would have to do something drastic to raise the money*.

HIV TESTING AND DIAGNOSIS

The average number of years women in this study had been living with HIV was 15.5. Some had been living with HIV for less than 12 months, while the longest time living with HIV was 32 years. There were 15 women (20.3%) who had been diagnosed with HIV in the past five years (since 2009).

The majority of women indicated that they contracted HIV through sex with a man (85.1%, n=63). Four contracted HIV through injecting drug use.

Sixteen women (21.6%) indicated they were travelling interstate (n=5) or overseas (n=11) at the time they contracted HIV.

We asked respondents to tell us the main reason they took a HIV test at the time they were diagnosed. The most common reasons were that their partner had tested positive (27%, n=20) or that they became ill (27%, n=20). Four women were tested as part of a visa requirement, four after a particular risk episode and three were tested during pregnancy.

We asked respondents the type of clinic at which they had been tested when they received their HIV diagnosis. The most common testing locations were their regular doctor (27%, n=20) or the first available doctor (21.6%, n=20), while 18.9% (n=14) had tested at a hospital and 12.2% (n=9) at a sexual health clinic. Four women indicated that they had used rapid testing clinics.

Around half of the women (53.7%, n=36) had never taken a HIV test prior to receiving their diagnosis, and 80.5% (n=29) of these cited that the reason they had not tested previously was that they did not think they were at risk. The remainder (n=5) selected 'other' in response to this question.

TREATMENT

The majority of women (94.4%, n=68) were currently using antiretroviral treatment (ART) (see Figure 1) and, of these, 86.7% (n=59) indicated they had an undetectable viral load (HIV viral suppression) as of their most recent test (see Figure 1).

Of the women who were currently taking ART, 42.6% (n=29) indicated that they commenced ART more than two years after diagnosis, while 29.4% commenced ART within three months of diagnosis. There were eight women (11.8%) who indicated that they commenced ART when highly active anti-retroviral treatment first became available (around 1996).

Reflecting current treatment guidelines that recommend initiating ART for all HIV-infected individuals regardless of CD4 count (ASHM, 2015), 76.9% (n=10) of women diagnosed in 2010 or later had started taking ART within three months of diagnosis, compared with 15.1% (n=8) of those diagnosed prior to 2010.

Figure 1: Current use and non-use of ART

Full sample (N=74)		
Using ART*	Not using ART*	
94.4% n=68	5.6% n=4	
Viral suppression*	Never used	Have used before but not currently
86.1% n=62	n=2	n=2

*figures exclude missing data

HEALTH AND WELLBEING

Participants were asked to rate their current state of physical health using a five-point scale (poor to excellent). The majority of women (62.2%, n=46) rated their health as very good or excellent.

We also asked participants to assess their overall sense of wellbeing (incorporating physical, mental and emotional wellbeing). The majority of women (65.8%, n=48) reported their wellbeing to be good or excellent.

The rate of diagnosis of *mental health conditions* is high among people living with HIV. This was evident in this sample of women with 41.7% (n=30) indicating they had been diagnosed with a mental health condition within their lifetime and 33.8% (n=24) having received medical treatment for a mental health condition in the past six-months. Anxiety and depression were the most common conditions with which women had been diagnosed. As a point of comparison, in the 2014-15 Australian National Health survey, 19.2% of Australian women reported having a mental or behavioural condition (ABS 2016a).

Women cited a range of other health conditions with which they had been diagnosed during their life time including: asthma (n=11), arthritis (n=9), osteoporosis (n=8), hypertension (n=6), diabetes (n=5) or cancers (n=5).

There were four women who had been diagnosed with hepatitis B and 12 who had been diagnosed with hepatitis C.

We asked participants about recent sexual health screening. Just under half the women (46.5%, n=33) had been screened for sexually transmissible infections in the past 12 months, while 27.8% (n=20) were screened for syphilis alongside their most recent HIV viral load test. There were four women who had been diagnosed with a sexually transmissible infection in the past 12-months.

There were 21 women (28.4%) who indicated they currently smoke tobacco (or use tobacco products) on a daily basis, while five (6.8%) smoked tobacco less than daily. By comparison, the 2014-15 National Health Survey indicated 12.1% of Australian women smoked tobacco daily (ABS 2016a).

There were 18 women (40% of the 45 women who responded to this question) who indicated their typical daily alcohol consumption was three or more standard drinks, while 13 women (20%) indicated that, at least monthly, they consumed six or more drinks on any one occasion.

We asked women about their *non-medical* use of a range of drugs. The drugs most commonly used by women *occasionally* or *regularly* were: pain killers or analgesics (29.4%, n=20), marijuana (21.2%, n=14) and tranquilisers or sleeping pills (14.7%, n=10).

PREGNANCY AND CHILDREN

The majority of women (64.9%, n=48) had children, while 19 currently lived with dependent children.

There were 29 women who indicated they had been pregnant while living with HIV. Fourteen women indicated they had, at some point in their life, terminated a pregnancy due to their HIV status.

There were 21 women who had given birth to a baby while they were HIV positive. We asked these women to tell us more about their experience of their most recent pregnancy. One woman did not respond, so there were 20 women who answered these questions. All of these women were living in Australia when they became pregnant and gave birth in Australia. For 10 women (50%) this was an unplanned pregnancy, for 10 (50%) it was planned. The majority of women (90%, n=18) were aware of their HIV status when they conceived the baby and 95% conceived via sexual intercourse (one used home-based artificial insemination).

There were four women (20%) who gave birth vaginally, while 16 (80%) had a caesarean delivery, of which 10 indicated this was an elective caesarean to reduce the risk of mother-to-child HIV transmission.

ART was available to 95% (n=19) of the women during their pregnancy and 12 women (60%) indicated they used ART during their entire pregnancy. One woman suspended ART for the first trimester while others indicated they used ART in other ways but did not elaborate.

Sixteen women (20%) reported their baby was HIV negative when they were born. One woman reported her baby was born with HIV while others were unsure or did not respond.

Four women (20%) breastfed their baby.

RELATIONSHIPS AND SEX

Approximately half (47.9%, n=34) the women described their relationship status as single. The same number (47.9%, n=34) were in a regular relationship. One of these women indicated she was in a regular relationship with more than one partner (polyamorous). (Six women did not respond to this question or described their relationship status in 'other' terms).

Of those women in a regular relationship, 91.7% (n=33) were in a relationship with a man, one was in a relationship with a woman and one responded 'other' to this question.

Of those in a regular relationship, 72.7% (n=24) were with a HIV negative partner, while 23.5% (n=8) were with a HIV positive partner. One woman did not know her partner's status, while one did not respond to this question. None of the women indicated their current partner was using pre-exposure prophylaxis (PrEP), but four women reported their partner had used post-exposure prophylaxis (PEP) at least one time.

When asked about sexual relationships, 54.8% (n=40) indicated they had *no sex* at present, 35.6% (n=26) had a *regular sexual relationship* with one person, while 6.8% (n=5) had *casual sex* only. Two women had sex with a regular partner as well as other sexual or romantic partners.

We asked a series of questions about the impact of living with HIV on women's sexual lives:

- 51.4% (n=36) indicated their HIV status negatively affected their sexual pleasure
- 43.4% (n=30) reported they had stopped having sex due to their HIV status
- 66.6% (n=46) agreed or strongly agreed with the statement *I am afraid of telling potential partners of my HIV status in case they reject me*
- 65.2% (n=45) of women agreed or strongly agreed with the statement *Few people would want a relationship with someone who has HIV.*
- 55.1% (n=38) disagreed or strongly disagreed with the statement, *Being HIV positive has helped me form more satisfying relationships*, although 31.9% (n=22) agreed/strongly agreed with this statement.

Despite many women reporting that HIV had negatively affected their sexual and intimate relationships, there were some signs that the effectiveness of ART was changing this, with 66.6% (n=46) agreeing/strongly agreeing with the statement *I feel more confident having sex when my viral load is undetectable.*

When asked about experiences of violence, 42.6% (n=29) reported they had experienced being *pushed, grabbed, shoved, kicked or hit*, five of these within the previous 12 months. There were 21 women (31.4%) who reported being forced to take part in unwanted sexual activity (one of these within the past 12 months), while 32.4% (n=22) reported that they had been in a violent relationship with a partner or spouse at some point in their life.

USE OF HIV SERVICES AND NETWORKS

Most women (84.5%, n=60) had regular or occasional contact with at least one HIV organisation. There were five women who had no contact and six who had previous, but not current, contact.

There were 20 women who indicated they regularly or occasionally use online social networking to connect with other people living with HIV. In particular, 14 women were part of The Institute of Many (TIM) Facebook group and 18 women were part of a private online group for HIV positive people.

We asked women to describe, in their own words, what HIV services they found most useful. The most common responses were counselling and peer support services, along with social programs and events, including retreats for HIV positive women and other informal social events. A number of women also mentioned practical services including legal help, financial support and the provision of free grocery items. Information and new knowledge about HIV was also highly valued. Several women noted they appreciated publications produced by HIV organisations as well as websites and discussion groups.

COMMENTARY

By Jane Costello, President of Positive Life NSW and a member of Femfatales, the NAPWA National Network of Women Living with HIV.

The following is an edited version of an address delivered by Jane Costello at the launch of HIV Futures 8 at the Australasian HIV & AIDS Conference in Adelaide, November 2016.

I have been asked to provide a woman's perspective on Futures 8, and while I acknowledge that Futures 8 is about the lived experience of all people living with HIV, I would like to focus specifically on women living with HIV – a marginalised population that I believe is missing from much of our national discourse and dialogue around HIV, which has major implications for public health policy and service delivery in Australia. Women continue to be largely invisible in our HIV response, and women with HIV are a minority who live with inequality, in silence and secrecy. That inequality, silence and secrecy feeds a climate of stigma and discrimination, as well as an assumption that HIV is simply not an issue for women.

Around 10% of the population of people living with HIV in Australia are women, and Futures 8 does provide a representative sample of women's voices. Of the total number of people who completed the survey (895), just under 10% of these were women. Futures 8 therefore, is a critical piece of research on the health and wellbeing of our community, and gives us evidence and data. This evidence is around testing and treatment, and women's lives more generally.

Additionally, it provides us with a snapshot of the differences within the increasingly diverse community of people living with HIV in Australia. If we don't understand these differences and apply them selectively to the areas of health policy, programs, service delivery and research, we are not going to understand or be able to address the very particular issues and unmet needs that affect that women face in their everyday lives.

I have said it before: there are gender differences in HIV in Australia. We are doing better in terms of research data on HIV aggregated by gender to enable us to better understand gender difference, but there is more that could be done, particularly on treatment initiation, engagement and retention in care. I will touch briefly on testing and treatment. Respondents were asked to state the main reason they took an HIV test the time they were diagnosed with HIV. The most common reasons that women gave for taking a test was that their partner tested positive or they became ill. Most women living with HIV in Australia have been infected as a result of heterosexual sex, and in the 2016 Kirby Institute Annual Surveillance Report 20% of new diagnoses of HIV in Australia were attributed to heterosexual sex. HIV doesn't discriminate.

Arguably, everyone is at risk, and as a heterosexual woman living with HIV for the past 22 years, it frustrates me that heterosexuals are still not named as a priority population in the Australian National HIV Strategy. Unsurprisingly, only 2.7% of women completing the Futures 8 survey indicated that it was because they were a member of a risk group, clearly not seeing themselves as part of any of the priority populations.

Around half of the women had never taken an HIV test prior to receiving their HIV diagnosis, and 80.5% of these gave the reason that they did not think they were at risk. As a result, very few women in Australia are diagnosed with newly acquired HIV. Women are often late presenters with advanced HIV, which has already significantly damaged their immune system, and many newly diagnosed women present with an AIDS defining illness.

While there is a relatively well-established culture of HIV testing within the gay community, this is not the case in the wider community where HIV is still most commonly perceived as a gay male disease. I truly believe that we should be setting a better standard for women's health in this country whereby an HIV test is routinely offered as part of a sexual health check across the board. I would go further to say that for all sexually active women a sexual health check should be a part of a comprehensive health check, and we need to empower women to view this as a way of taking control of their own health and wellbeing.

What continues to be shocking in a developed country such as Australia is the substantially disproportionate rate of HIV diagnosis amongst Aboriginal and Torres Strait Islander women compared with non-Indigenous women, and the high rates of diagnosis among women from a CALD background. While Australia has long been recognised for its response to HIV, particularly among gay men and other men who have sex with men, sex workers and people who inject drugs (who are considered the priority populations), we have dropped the ball with our First Nation women and migrant populations.

Futures 8 gives us a clear snapshot of the number of women on treatment and with an undetectable viral load at 94.4% and 86.1% respectively, which is fantastic news, but there are still gaps in research into the efficacy of anti-retroviral treatments and side-effects that are specific to the female body, as well as a lack of research into hormonal differences between men and women and the impact these have on women with HIV and treatments. Additionally, there is a paucity of research on the reproductive health of women living with HIV, as well as the psychological issues for women with HIV in relation to reproduction and family.

There are particular issues for women living with HIV in relation to: disclosure and the negotiation of sexual relationships; reproductive health, as I have already mentioned, including pregnancy, childbirth, breastfeeding and family life; career paths; and coping mechanisms. There is a greater likelihood that women with HIV will live in outer suburban or regional locations and this has an impact on women's access to treatment and care. By comparison with gay men, there is a lack of support networks, both formal and informal for women.

Futures 8 highlights the alarming numbers of women with HIV living in poverty with over one third of women living in households in which the yearly income was less than \$29,999. In total, only 15% of the women surveyed lived in households in which yearly earnings totalled \$80,000 or more. According to measures defined in Futures 8, 56.1% of women were credit constrained. Women living with HIV are disproportionately affected by family violence, and cultural factors are a further multiplier of women's risk of family violence. Approximately 40% of women in Futures 8 also indicated they had a medium-to-high risk of alcohol-related harm, and there are high rates of women with HIV diagnosed with mental health conditions.

Futures 8, therefore, continues to be an important and increasingly valuable piece of research, providing a critical snapshot of the lives of people living with HIV in Australia. The question is, as researchers, clinicians and community, how do we use its findings and leverage these to prioritise women's health, and to progress items of work that ensure that the needs of a marginalised group of people living with HIV are met? We need to start advocating for women in a way that is thoughtful and responsive to their specific needs if Australia is serious about health equity and improving the health outcomes for women living with HIV.

SUGGESTED CITATION

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