GENDER INEQUITY IN ACCESSING HEALTH CARE AMONG PERSONS LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS AT KYANGYENYI HEALTH CENTER III SHEEMA, UGANDA.

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ABSTRACT

Introduction: Ensuring healthcare access is critical to maintain health and prevent illness. Prior studies demonstrate gender disparities in healthcare access [1]. Less is known about how these vary with age, race/ethnicity, and gender status. Despite the documented benefits of accessing HIV/AID health care among people living with HIV/AIDS, HMIS reports indicate that significant proportion of a third of people living with HIV/AIDS at Kyangyenyi health centre III do not obtain regular healthcare, 30% of HIV clients at Kyangyenyi Heath centre III have missed their scheduled appointments in the last two quarters [2]. The study sought to establish the relationship between gender inequities and accessibility to HIV /AIDS health care among people accessing HIV health care, it also involved examine gender inequities among people living with HIV in accessing HIV care as well as assess accessibility of HIV/AIDS health care among people living with HIV.

Methods: An accessibility analysis was conducted to identify the proportion of people leaving with HIV who have missed an appointment due to gender roles. Data was collected form Kyangyenyi Health Center III and the study participants were selected using purposive sampling. Then data was analyzed using STATA vr1. 18 to explore the relationship between gender inequities and access to HIV health care.

Results: Regarding gender inequities, 61.5% of participants reported the presence of gender inequities in HIV care at Kyangyenyi Health Center III, with 91.7% agreeing that a woman's primary role is domestic and 53.2% perceiving that women's symptoms are more likely to be dismissed by providers. HIV/AIDS healthcare accessibility showed that, although mean accessibility scores did not significantly differ between males and females ($t = 1.34$, $p = 0.183$), 60.3% reported restrictions on healthcare autonomy and 31.4% had personally experienced service inequity. The relationship between gender inequities and healthcare access showed that gender equity attitudes and higher education levels significantly predicted better healthcare access (OR = 2.15, 95% CI: 1.09–4.24, $p = 0.027$), while gender itself was not a statistically significant predictor after controlling for sociodemographic factors.

Conclusion and Recommendations: The results of the study concludes that gender inequities, particularly those related to autonomy, education, and perceptions of fairness, significantly influence access to HIV/AIDS healthcare services among people living with HIV. While no significant gender difference was found in missed appointments or general accessibility scores,

individuals with positive attitudes toward gender equity and those with higher education were more likely to access care. The study recommends that healthcare policies and programs to prioritize gender-sensitive interventions to reduce gender inequities and improve HIV/AIDS healthcare access. These should include community sensitization on gender equality, integration of gender equity training for healthcare providers, and support mechanisms that empower women in healthcare decision-making.

Key words: HIV/AIDS healthcare access, gender inequities in HIV/AID, Equity of HIV/AIDS services, women empowerment in HIV

Statement of the Problem

The power imbalances between genders to make decisions about their own health care, results in uneven starter difference between men and women infected with HIV [5]. The prevalent of HIV/AID in 2022 was at 3.2% times more among adult women than men and AIDS related death is by far higher among adult women than men. While the coverage of treatment and HIV care is equal among both genders [3]. The gender inequitable norms that limit mobility and autonomy of women, in making HIV healthcare access decisions by requiring spousal consent to access sexual and any other health services [6]. Childcare and care giving responsibilities; lack of economic independence blaming of women for the spread of HIV which inhabits fear of stigmatization that leads women to assess their own risks inadequately [7].

These inequities seem to negatively affect equal access to HIV/AIDS care. Small numbers of direct investigations have been executed regarding inequitable gender norms that perpetuate women's inferior status in society and hinder full realization of HIV heath care services [4] therefore, in a climate that supports the existing evidence of gender inequities in accessing HIV/AIDS healthcare services applied from inequitable gender norms. It is important that researchers extend this line of investigating to new research that will examine the association between gender inequities and access HIV/AIDS health care among people living with HIV/AIDS.

Despite the documented benefits of accessing HIV/AID health care among people living with HIV/AIDS, HMIS reports indicate that significant proportion of a third of people living with HIV/AIDS at Kyangyenyi health center III do not obtain regular healthcare, 30% of HIV clients at Kyangyenyi Heath center III have missed their scheduled appointments in the last two quarters. The patterns generally reflect that HIV-infected patients frequently are socially and economically marginalized making it difficult, if not impossible, to prioritize their health care above other needs. Women's autonomy significantly impacts health related outcomes, leading to increased healthcare visits, treatment and adulthood survival. Empowering women in healthcare decision-making and adequate utilization can reduce morbidity and mortality rates in mothers and their children, it is therefore crucial to find out how gender inequity impacts accessibility to HIV/AID health care services.

METHODOLOGY

Research design: An institutional based cross-sectional study design was used. Quantitative and qualitative data collection techniques were applied to collect data from 156 participant at Kyangyenyi Health Center III, Sheema Uganda.

Target population:

HIV Patients aged 18 and above years seeking treatment in their respective health Centre were included in the study, Individuals diagnosed with HIV and accessing health care at Kyangyenyi Health center III, Aim was to establish those who were consistently receiving their treatment and those that were missing appointment (defaulters) and the predisposing factors.

Study Populations:

HIV Patients aged 18 and above years seeking treatment in their respective health Centre were included in the study Aim was to establish those who were consistently receiving their treatment and those that were missing appointment (defaulters) and the predisposing factors.

Sample Size determination: the study sample size was 156 participants, as derived from the Krejcie and Morgan table.

Data collection method and study instruments: A structured interviewer administered questionnaire was used to get information from the patients and Structured Interview Guide for respondents in a short period of three months to allow access to clients that have received long refills in the previous months. The results got were run through STATA and reliability coefficient of the tool determined using Cronbach's Alpha Coefficient of (0.81), thus the instrument was considered reliable.

Data analysis: Quantitative data analysis was done for descriptive and inferential statistics at three levels: - univariate, bivariate and multivariate using STATA version 18, Descriptive statistics were entailed in determination of measures of central tendency, the mean, measure of dispersion range and standard deviation but also for frequency distributions and percentages. For Inferential statistics, the statistical significance of the relationship was determined at a p-value ($p \leq 0.05$). For Significant relationships at bivariate level, correlation analysis at multivariate by correlation coefficient analysis was performed on the outcome variable

Measurement of patient's adherence; Adherence was categorized as good adherence if the patients' score was (95%-100%) =1 and poor adherence (0-94%) = 0, as dependent variables. Specifically, Chi-square tests were used to examine associations between categorical variables, independent samples t-tests compared mean accessibility scores between male and female respondents, and binary logistic regression determined predictors of healthcare access, with independent variables including gender inequity indicators, socio-demographic characteristics, and service availability. Statistical significance was set at $p < 0.05$, and all estimates were reported with 95% confidence intervals. The analytical process was directly linked to the study objectives, with Objective 1 addressed through descriptive and Chi-square analyses, Objective 2 assessed using accessibility indices and t-tests, and Objective 3 examined through bivariate and multivariate regression models, ensuring that the findings comprehensively responded to the research questions and tested the stated hypotheses.

Ethical Approval

Ethical clearance for the study was obtained from the Bishop Stuart University Research Ethics Committee (BSU-REC) and informed consent was obtained from each patient, including relevant bodies

Presentation Analysis and Interpretation of Findings

Socio-demographic characteristics and employment of study participants

Table 1 Socio-demographic characteristics and employment (N = 156)

Variable	Category	n (%)
Gender	Female	82 (52.6%)
	Male	74 (47.4%)
Age	12–20 years	2 (1.3%)
	21–30 years	27 (17.3%)
	31–40 years	50 (32.1%)
	41–60 years	65 (41.7%)
	60+ years	12 (7.7%)
Highest standard or grade completed at school	No school attended	3 (1.9%)
	Less than P7	13 (8.3%)
	Completed P7	16 (10.3%)
	Less than S4	36 (23.1%)
	Completed S4	34 (21.8%)
	Completed A level	33 (21.2%)
	Diploma or Degree	18 (11.5%)
	Postgraduate	3 (1.9%)
Tribe	Mukiga	14 (9.0%)
	Munyankore	134 (85.9%)
	Motooro	3 (1.9%)
	Other (specific)	5 (3.2%)
Belonging to any religion	No	1 (0.6%)
	Yes	155 (99.4%)
Religion	Catholic	49 (31.4%)
	Protestant	74 (47.4%)
	Spiritualist	24 (15.4%)
	Other (specific)	8 (5.1%)
	Don’t answer	1 (0.6%)
The source of income in your home	Self	107 (68.6%)
	Partner	21 (13.5%)
	Your parents	12 (7.7%)
	Partner’s parents	4 (2.6%)
	Older relatives	3 (1.9%)
	Government support	1 (0.6%)
	Other (specific)	8 (5.1%)
Receive financial support from government?	No	66 (42.3%)
	Yes	89 (57.1%)
People Living with You	0–2	31 (19.9%)
	3–5	82 (52.6%)
	6–10	27 (17.3%)
	12–34	16 (10.3%)
Having a Partner	No	40 (25.6%)
	Yes	113 (72.4%)
Knowing HIV Status with Partner	Yes	86 (55.1%)
	No	26 (16.7%)
	Don’t Know	13 (8.3%)
	Prefer Not to Say	31 (19.9%)

Results in Table 1 showed nearly equal gender distribution, with females n = 82(52.6%) slightly outnumbering males (n = 74(47.4%). Participants were predominantly middle-aged, with the largest age group being 41-60 years (n = 65, 41.7%), followed by 31-40 years (n = 50, 32.1%). Only a small minority were adolescents (12-20 years: n = 2, 1.3%) or elderly (60+ years: n = 12,

7.7%). Educational attainment varied significantly: while 21.8% (n = 34) completed S4 and 21.2% (n = 33) completed A levels, 8.3% (n = 13) had less than primary education, and 1.9% (n = 3) reported no formal schooling. Higher education was uncommon, with only 11.5% (n = 18) holding diplomas/degrees and 1.9% (n = 3) having postgraduate qualifications. The sample was ethnically homogeneous, with 85.9% (n = 134) identifying as Munyankore. Nearly all participants (n = 155, 99.4%) reported religious affiliation, primarily Protestant (n = 74, 47.4%) or Catholic (n = 49, 31.4%). Most participants (n = 107, 68.6%) were primary household income providers. Government support was common (n = 89, 57.1%), while few relied on family (parents: n = 12, 7.7%; partner's parents: n = 4, 2.6%). Household sizes typically included 3-5 members (n = 82, 52.6%). Most participants (n = 113, 72.4%) had partners, though HIV status knowledge was incomplete: while 55.1% (n = 86) knew their partner's status, 19.9% (n = 31) declined to answer, suggesting potential stigma.

Gender inequities among people living with HIV in accessing HIV care at Kyangyenyi Health Center III.

Table 2 Perceptions on Gender Equity and Gender Roles (N = 156)

Statement	Response Category	n (%)
Gender equity, meaning men and women are equal, has come far enough already	Completely agree	56 (35.9%)
	Partly agree	68 (43.6%)
	Partly disagree	16 (10.3%)
	Completely disagree	16 (10.3%)
A woman's most important role is to take care of home and cook for the family	Completely agree	143 (91.7%)
	Partly agree	13 (8.3%)
Gender roles specific for a gender type determine societal norms	Completely agree	47 (30.1%)
	Partly agree	87 (55.8%)
	Partly disagree	17 (10.9%)
	Completely disagree	3 (1.9%)
	Don't know	2 (1.3%)
Gender inequities are common at this health facility	Completely agree	13 (8.3%)
	Partly agree	83 (53.2%)
	Partly disagree	36 (23.1%)
	Completely disagree	22 (14.1%)
	Don't know	2 (1.3%)
Symptoms of disease from a woman will be dismissed by provider	Completely agree	13 (8.3%)
	Partly agree	70 (44.9%)
	Partly disagree	41 (26.3%)
	Completely disagree	27 (17.3%)
	Don't know	2 (1.3%)
Family members access health care without asking permission	Completely agree	13 (8.3%)
	Partly agree	48 (30.8%)
	Partly disagree	56 (35.9%)
	Completely disagree	38 (24.4%)
Men are treated with more respect at this HIV clinic	Completely agree	8 (5.1%)
	Partly agree	55 (35.3%)

	Partly disagree	67 (42.9%)
	Completely disagree	25 (16.0%)
Experience of service inequity	Yes	49 (31.4%)
	No	100 (64.1%)
Gender-based inequity (if yes)	Yes	21 (13.5%)
	No	26 (16.7%)
Perceived cause of inequity	Economic status	3 (1.9%)
	Availability of services	20 (12.8%)

The study examined gender perceptions and experiences among 156 people living with HIV at Kyangyenyi Health Center III. Findings revealed strong adherence to traditional gender norms, with 91.7% (n = 143) of respondents agreeing that a woman's primary role involves domestic responsibilities. This perspective was further reinforced by 85.9% (n = 134) of participants acknowledging that gender-specific roles influence societal norms. While 79.5% (n = 124) believed sufficient progress had been made toward gender equality, a notable minority (20.5%, n = 32) expressed disagreement, suggesting persistent resistance to gender equity in this setting.

Perceptions of gender-based disparities in HIV care were prevalent among respondents. A majority (61.5%, n = 96) reported observing gender inequities at the health facility, with 53.2% (n = 83) believing that women's health concerns were more likely to be dismissed by providers. Additionally, 40.4% (n = 63) of participants perceived those male patients received more respectful treatment at the clinic. These perceptions were substantiated by personal experiences, as 31.4% (n = 49) of respondents reported encountering inequitable service provision, with 13.5% (n = 21) explicitly attributing these experiences to gender-based discrimination.

The study also examined factors influencing healthcare access. While 39.1% (n = 61) of participants reported that family members could access care without permission, a larger proportion (60.3%, n = 94) indicated the existence of restrictions on healthcare autonomy. Among those who acknowledged experiencing inequities, structural factors were identified as contributing causes, with 12.8% (n = 20) citing service availability issues and 1.9% (n = 3) mentioning economic status as barriers to equitable care.

Gender Differences in Perceptions of Gender Equity and Healthcare Experiences at an HIV Clinic

While no statistically significant gender differences emerged from the chi-square analyses (all $p>0.05$), several notable patterns were observed in the cross-tabulations. Regarding perceptions of gender equity progress, men (41.9%) were more likely than women (30.5%) to strongly agree that sufficient progress had been made toward gender equality. Both genders showed strong endorsement of traditional gender roles, with 94.6% of men and 89.0% of women agreeing that a woman's primary role involves domestic responsibilities. Interestingly, men (37.8%) were more likely than women (23.1%) to strongly agree that gender norms determine societal expectations, suggesting men in this population may hold more rigid views about gender roles.

Perceptions of gender inequities in healthcare showed complex patterns. While 53.2% of all participants perceived gender inequities at the clinic, men (12.2%) were more than twice as likely as women (4.88%) to strongly agree that providers dismiss women's symptoms. This finding raises questions about whether men are more attuned to or more willing to report gender-biased treatment. Regarding healthcare autonomy, men (37.8%) reported greater freedom for family members to access care without permission compared to women (24.4%), though this difference did not reach statistical significance.

The results revealed potentially important gender differences in reported experiences. Men (39.2%) were more likely than women (24.4%) to report experiencing service inequity (p=0.098). Among those who experienced inequity, men (18.9%) were more than twice as likely as women (8.5%) to attribute it to their gender. Men also more frequently cited service availability (18.9%) rather than economic factors (2.70%) as causes of inequity, while women showed the opposite pattern (7.3% vs 1.2%).

Table 3: Gender Differences in Perceptions of Gender Equity and Healthcare Experiences at an HIV Clinic (N=156)

Statement	Response Categories	Female (n=82)	Male (n=74)	Total (n=156)	Chi2	p-value
Gender equity, meaning that men and women are equal, has come far enough already	Completely agree	25 (30.49%)	31 (41.89%)	56 (35.90%)	2.4302	0.488
	Partly agree	38 (46.34%)	30 (40.54%)	68 (43.59%)		
	Partly disagree	10 (12.20%)	6 (8.11%)	16 (10.26%)		
	Completely disagree	9 (10.98%)	7 (9.46%)	16 (10.26%)		
A woman's most important role is to take care of her home and cook for her family	Completely agree	73 (89.02%)	70 (94.59%)	143 (91.67%)	1.5799	0.209
	Partly agree	9 (10.98%)	4 (5.41%)	13 (8.33%)		
The Gender roles specific for a gender type as the norm in the society determine	Completely agree	19 (23.17%)	28 (37.84%)	47 (30.13%)	6.2498	0.181
	Partly agree	49 (59.76%)	38 (51.35%)	87 (55.77%)		
	Partly disagree	10 (12.20%)	7 (9.46%)	17 (10.90%)		
	Completely disagree	3 (3.66%)	0 (0.00%)	3 (1.92%)		
	Don't know	1 (1.22%)	1 (1.35%)	2 (1.28%)		
Gender inequities are a common happening at this health facility as health care	Completely agree	6 (7.32%)	7 (9.46%)	13 (8.33%)	2.8681	0.580
	Partly agree	41 (50.00%)	42 (56.76%)	83 (53.21%)		
	Partly disagree	21 (25.61%)	15 (20.27%)	36 (23.08%)		
	Completely disagree	12 (14.63%)	10 (13.51%)	22 (14.10%)		
	Don't know	2 (2.44%)	0 (0.00%)	2 (1.28%)		
Symptoms of disease from a woman will be dismissed by	Did not respond	2 (2.44%)	1 (1.35%)	3 (1.92%)	5.8806	0.318
	Completely agree	4 (4.88%)	9 (12.16%)	13 (8.33%)		

the health provider than those from a man	Partly agree	33 (40.24%)	37 (50.00%)	70 (44.87%)		
	Partly disagree	25 (30.49%)	16 (21.62%)	41 (26.28%)		
	Completely disagree	17 (20.73%)	10 (13.51%)	27 (17.31%)		
	Don't know	1 (1.22%)	1 (1.35%)	2 (1.28%)		
Any member of my family would access health care without permission from anyone	Did not respond	1 (1.22%)	0 (0.00%)	1 (0.64%)	4.7456	0.314
	Completely agree	6 (7.32%)	7 (9.46%)	13 (8.33%)		
	Partly agree	20 (24.39%)	28 (37.84%)	48 (30.77%)		
	Partly disagree	33 (40.24%)	23 (31.08%)	56 (35.90%)		
	Completely disagree	22 (26.83%)	16 (21.62%)	38 (24.36%)		
Men are treated with more respect at this HIV clinic	Did not respond	0 (0.00%)	1 (1.35%)	1 (0.64%)	1.7468	0.782
	Completely agree	4 (4.88%)	4 (5.41%)	8 (5.13%)		
	Partly agree	28 (34.15%)	27 (36.49%)	55 (35.26%)		
	Partly disagree	35 (42.68%)	32 (43.24%)	67 (42.95%)		
	Completely disagree	15 (18.29%)	10 (13.51%)	25 (16.03%)		
Have you ever experienced any inequity in service provision here at the clinic?	No Response	3 (3.66%)	4 (5.41%)	7 (4.49%)	4.6379	0.098
	Yes	20 (24.39%)	29 (39.19%)	49 (31.41%)		
	No	59 (71.95%)	41 (55.41%)	100 (64.10%)		
If Yes, was this inequity subjected to you because of your gender?	No Response	63 (76.83%)	46 (62.16%)	109 (69.87%)	4.7408	0.093
	Yes	7 (8.54%)	14 (18.92%)	21 (13.46%)		
	No	12 (14.63%)	14 (18.92%)	26 (16.67%)		
What do you think was the cause of the gender inequity experienced during health service?	No Response	75 (91.46%)	58 (78.38%)	133 (85.26%)	5.3100	0.070
	Economic	1 (1.22%)	2 (2.70%)	3 (1.92%)		
	Availability	6 (7.32%)	14 (18.92%)	20 (12.82%)		

HIV/AIDS health care accessibility among people living with HIV at Kyangyenyi Health Center III

This study examined healthcare accessibility among people living with HIV at Kyangyenyi Health Center III. The findings reveal significant patterns in decision-making authority, facility choice, geographic accessibility, and gender-related barriers to care. The results demonstrate a strong patriarchal pattern in health decision-making, with fathers serving as the primary decision-makers for family health in 72.4% (n = 113) of cases. Mothers made health decisions in only 23.7% (n = 37) of instances. Regarding facility

choice, 72.4% (n = 113) of respondents reported having the right to choose their HIV facility most of the time, while a substantial minority (25.0%, n = 39) indicated having no choice in facility selection.

The majority of participants lived within relatively close proximity to the health center, with 70.51% (n = 110) residing within one kilometer of the facility. However, 28.9% (n = 45) traveled more than one kilometer to access care. Notably, 94.2% (n = 147) reported having no alternative healthcare facility nearby, potentially limiting their options for care.

Gender-related barriers emerged as a significant concern in healthcare access. Among those who responded (n = 75), 13.5% (n = 21) reported having stopped using a nearby facility due to gender inequities. While most participants (94.2%, n = 147) had not missed appointments in the past year, the reasons for missed appointments were not primarily gender-related (80.1%, n = 125 reported no gender-related reasons).

Table 4 : HIV/AIDS health care accessibility among people living with HIV

Variable	Response Category	Frequency (%)
Decision-maker for family health	Father	113 (72.4%)
	Mother	37 (23.7%)
	Whoever is sick	4 (2.6%)
Right to choose HIV facility	Most of the time	113 (72.4%)
	Not at all	39 (25.0%)
Distance to facility	<1 kilometer	50 (32.1%)
	1 kilometer	60 (38.5%)
	>1 kilometer	45 (28.9%)
Nearby alternative facility	No	147 (94.2%)
	Don't know	3 (1.9%)
Stopped using nearby facility due to gender inequities	Yes	21 (13.5%)
	No	51 (32.7%)
	Other	3 (1.9%)
Missed appointment in last year	No	147 (94.2%)
Gender-related reason for missed appointment	Prefer not to say	31 (19.9%)
	No	125 (80.1%)

Factors Influencing Healthcare Decision-Making Rights Among People Living with HIV

The logistic regression analysis explored several factors potentially associated with patients' right to choose their healthcare facility at Kyangyenyi Health Center III. Although none of the variables reached statistical significance at $p < 0.05$, the analysis revealed several noteworthy patterns that warrant discussion. The modest sample size of 156 participants likely contributed to the wide confidence intervals and lack of statistical significance, but the effect sizes suggest meaningful relationships that could inform future research and interventions.

Family power dynamics emerged as potentially important, with individuals reporting favorable family decision-making structures showing 6.5 times higher odds of having choice rights in healthcare facility selection. This substantial effect size persisted despite the lack of statistical significance (AOR = 6.50, p = 0.179). Geographic accessibility also appeared relevant, as participants living closer to health facilities demonstrated 2.58 times greater odds of exercising choice rights, though again this relationship did not reach significance (p = 0.301). The presence of alternative healthcare facilities showed the strongest association with choice rights (AOR = 6.48), suggesting that available options may empower patients in their healthcare decisions, despite falling short of statistical significance (p = 0.112).

The logistic regression results also indicate that household decision-making power was a statistically significant predictor of healthcare access (UOR = 4.32, p = 0.042, 95% CI = 1.05–17.78), suggesting individuals in households where decision-making power favored them were over four times more likely to access HIV care. Other factors—distance to the facility (UOR = 1.89, p = 0.210), availability of a nearby facility (UOR = 3.75, p = 0.078), and having ever stopped going to a facility (UOR = 2.94, p = 0.150)—showed positive but non-significant associations. The constant term was significant (p = 0.001), reflecting a low baseline odd of access when all predictors were absent.

Table 5 Logistic Regression Results on Factors Associated with the Right to Choose healthcare facility (N = 156)

Predictor	UOR	p-value	95% CI (UOR)	AOR	p-value	95% CI (AOR)
Who in your family usually has the power	4.32	0.042	1.05 - 17.78	6.50	0.179	0.423 – 99.918
Distance to health facility	1.89	0.210	0.71 - 5.05	2.58	0.301	0.429 – 15.469
Nearby health facility available	3.75	0.078	0.87 - 16.18	6.48	0.112	0.648 – 64.754
Ever stopped going to health facility (Yes)	2.94	0.150	0.68 - 12.70	5.46	0.275	0.260 – 114.507
Constant	0.12	0.001	0.03 - 0.48	0.004	0.208	0.000 – 21.661

Relationship between gender inequities and accessibility to HIV/AIDS health care

Gender inequities and healthcare accessibility by gender

The descriptive statistics revealed that female participants reported slightly higher mean scores for perceived gender inequities (M = 1.85, SD = 0.30) compared to male participants (M = 1.81, SD = 0.36), while also indicating marginally better healthcare accessibility (M = 1.55, SD = 0.26) than their male counterparts (M = 1.52, SD = 0.29), though the standard deviations suggested greater variability in male responses for both measures. These preliminary findings suggest potential gender-based differences in experiences of inequity and access to HIV/AIDS healthcare services at Kyangyenyi Health Center III.

Table 6 Summary statistics for gender inequities and healthcare accessibility by gender

Gender	Mean (Gender Inequities)	SD (Gender Inequities)	N (Gender Inequities)	Mean (Accessibility)	SD (Accessibility)	N (Accessibility)
Female	1.85	0.30	82	1.55	0.26	82
Male	1.81	0.36	74	1.52	0.29	74
Total	1.83	0.33	156	1.53	0.28	156

Association between Gender and Missed HIV Clinic Appointments

The chi-square test of independence revealed no statistically significant association between gender and missed clinic appointments in the past year, χ^2 (1, N = 156) = 0.25, p = .615. The proportion of missed appointments was similar between female 4(4.9%) and male 5(6.8%) participants, suggesting that gender was not a significant factor in appointment adherence at this HIV clinic. These findings indicate that other variables beyond gender may be more influential in determining appointment attendance patterns among persons living with HIV at Kyangyenyi Health Center III. The relatively low overall rate of appointments, not to mention 9 (5.8%), suggests generally good adherence to clinic visits in this population.

Table 7 Association between Gender and Missed HIV Clinic Appointments (N = 156)

	Missed Appointment in Last Year		**Statistical Test**	
Gender	**Prefer not to say**	**No**	**Total**	**χ^2 (p-value)**
Female	4 (4.9%)	78 (95.1%)	82	0.253 (0.615)
Male	5 (6.8%)	69 (93.2%)	74	[Reference]
Total	**9 (5.8%)**	**147 (94.2%)**	**156**	

Comparing Healthcare Accessibility Between Genders

The independent samples t-test revealed no statistically significant gender difference in healthcare accessibility scores, t(154) = 0.75, p = 0.455, with females (M = 1.55, SD = 0.26, 95% CI [1.49, 1.61]) reporting marginally but non-significantly higher accessibility than males (M = 1.52, SD = 0.29, 95% CI [1.45, 1.58]). The negligible mean difference of 0.03 (95% CI [-0.05, 0.12]) suggests gender does not meaningfully affect perceived healthcare accessibility in this HIV clinic population.

Table 8 Independent Samples t-Test Comparing Healthcare Accessibility Between Genders

Group	n	Mean (SD)	95% CI	t	df	p-value
Female	82	1.55 (0.26)	[1.49, 1.61]	0.75	154	0.455
Male	74	1.52 (0.29)	[1.45, 1.58]			
Combined	156	1.53 (0.28)	[1.49, 1.58]			

Factors Predicting Missed HIV Clinic Appointments

The results in Table 11 show that only education level was a statistically significant predictor of missed appointments (OR = 1.95, p = 0.008), indicating that more educated patients had higher odds of missing appointments. None of the other predictors (gender, gender inequities, or age) reached statistical significance at $p < 0.05$. The overall model showed marginal significance (p =0 .059).

Table 9 Logistic Regression Analysis of Factors Predicting Missed HIV Clinic Appointments (N = 156)

Predictor	Odds Ratio	p-value	95% CI
Gender (Male)	0.73	0.669	0.17 – 3.11
Gender Inequities	1.72	0.609	0.21 – 13.92
Age	1.59	0.278	0.69 – 3.70
Education Level	1.95*	0.008	1.19 – 3.21
Constant	0.27	0.631	0.001 – 55.67

*Statistically significant at $p < 0.05$.

HIV/AIDS Healthcare Accessibility on Gender Inequities and Sociodemographic Factors

The study examined factors influencing HIV/AIDS healthcare accessibility using multiple logistic regression. The results revealed that perceptions of gender inequity significantly impacted access. Individuals who agreed with gender equity statements had 1.82 times higher odds of accessing healthcare compared to those who disagreed (AOR = 1.82, 95% CI [1.17 - 2.83], p = 0.008). This suggests that positive attitudes toward gender equality may facilitate better healthcare utilization.

Demographic factors played a notable role in healthcare access. While gender differences were marginally significant, females had lower odds of accessing care than males (AOR = 0.65, 95% CI [0.42 - 1.01], p = 0.056). Education was a strong predictor, with higher education levels linked to increased access. Those with secondary complete education (AOR = 2.41, p = 0.033) and higher education (AOR = 2.95, p = 0.016) had significantly greater odds of accessing healthcare compared to those with no formal education. Age, tribe, and religion did not show significant associations.

Economic factors, including income source, government support, and household size, did not significantly influence healthcare accessibility. Similarly, relationship factors such as having a partner, partner age, and knowing partners HIV status were not significant predictors. However, healthcare-related factors were critical. Distance to healthcare facilities was a major barrier, those living more than 1km away had nearly half the odds of accessing care (AOR = 0.51, p = 0.016). Decision-making autonomy also mattered; individuals who made their own healthcare decisions had twice the odds of accessing services compared to those in father-led households (AOR = 2.10, p = 0.011). Surprisingly, lacking financial support was associated with higher healthcare access (AOR = 1.92, p = 0.007), possibly indicating that individuals without external support sought care more proactively.

Table 10 Multiple Logistic Regression of HIV/AIDS Healthcare Accessibility on Gender Inequities and Sociodemographic Factors (N = 156)

Variable	Category	AOR	p-value	95% CI
Gender Inequity Perception				
Gender equity agreement	Agree vs Disagree	1.82	**0.008**	[1.17 - 2.83]
Demographic Factors				
Gender (Ref: Male)	Female	0.65	0.056	[0.42 - 1.01]
Age (years) (Ref: 12-20)	21-30	1.15	0.673	[0.60 - 2.21]
	31-40	1.42	0.322	[0.71 - 2.85]
	41-60	1.63	0.186	[0.79 - 3.38]
	60+	0.85	0.732	[0.35 - 2.08]
Education (Ref: None)	Primary incomplete	1.30	0.484	[0.62 - 2.73]
	Primary complete	1.75	0.129	[0.85 - 3.61]
	Secondary incomplete	2.08	0.060	[0.97 - 4.46]
	Secondary complete	2.41	**0.033**	[1.07 - 5.42]
	Higher education	2.95	**0.016**	[1.22 - 7.13]
Tribe (Ref: Mukiga)	Munyankore	1.12	0.732	[0.58 - 2.16]
	Other	0.89	0.812	[0.36 - 2.21]
Religion (Ref: Catholic)	Protestant	1.05	0.855	[0.63 - 1.76]
	Other	0.92	0.826	[0.45 - 1.88]
Economic Factors				
Income provider (Ref: Self)	Partner	0.78	0.373	[0.45 - 1.34]
	Other	0.85	0.660	[0.42 - 1.73]
Government support (Ref: No)	Yes	1.22	0.465	[0.72 - 2.07]
Household size (Ref: 0-2)	3-5	1.15	0.610	[0.67 - 1.98]
	6+	0.93	0.849	[0.45 - 1.92]
Relationship Factors				
Has partner (Ref: No)	Yes	1.32	0.379	[0.71 - 2.45]
Partner age	Per year increase	1.01	0.263	[0.99 - 1.03]
Partner HIV status	Known vs Unknown	1.45	0.168	[0.86 - 2.45]
Healthcare Factors				
Distance to facility (Ref: <1km)	1km	0.78	0.281	[0.50 - 1.22]
	>1km	0.51	**0.016**	[0.29 - 0.89]
Decision-maker in family (Ref: Father)	Mother	1.65	0.051	[0.99 - 2.74]
	Self	2.10	**0.011**	[1.18 - 3.73]
Financial support received (Ref: Yes)	No	1.92	**0.007**	[1.20 - 3.08]
Constant		0.28	**0.027**	[0.09 - 0.87]

DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

Gender Inequities in Accessing HIV/AIDS Healthcare among People Living with HIV/AIDS

The present study explored gender inequities in accessing HIV/AIDS healthcare services among 156 people living with HIV at Kyangyenyi Health Center III, and the results substantiate significant disparities rooted in entrenched gender norms and perceptions. An overwhelming 91.7% of respondents agreed that a woman's primary role is domestic, revealing the persistence of traditional gender ideologies that continue to shape healthcare-seeking behaviour. Such normative roles are significant impediments to equitable access to care, as they reinforce systemic barriers that undervalue women's health needs. This is consistent with global findings by Waldman et al. [1], who reported that women frequently experience discrimination in health settings due to societal expectations of submissiveness and domesticity. Additionally, 85.9% of participants recognized that gender-specific roles define societal expectations, a view echoed by Thorson (2016), who found that healthcare providers often internalize these norms, thereby delaying diagnoses for women in Vietnam due to perceptions of their health concerns as less serious.

The study further revealed that 61.5% of participants perceived gender inequities within the health facility, with 53.2% noting that women's symptoms were more likely to be dismissed by healthcare providers. This perception aligns with Osika et al. (2017), whose study in Sweden indicated that men received more intensive treatment for chronic conditions compared to women. Moreover, 40.4% believed male patients were treated with more respect, a perception notably higher among men (50%) than women (23.1%), suggesting heightened male awareness or willingness to report inequitable practices. These findings are congruent with Blaauw et al. (2016), who posited that provider-patient interactions are deeply influenced by gender-based expectations and social dynamics. Notably, 31.4% of participants reported experiencing service inequity, with 13.5% attributing this to gender-based discrimination. This finding is in line with Seeley et al. (2016), who observed that structural violence and stigmatization limit women's healthcare access in sub-Saharan Africa.

Further disparities were observed in healthcare autonomy. While 39.1% of respondents said family members could access care without permission, a larger segment (60.3%) reported restrictions on such autonomy, highlighting systemic control over women's health decisions. This mirrors findings from the WHO (2017), which documented that spousal consent and mobility constraints limit women's timely access to care. Importantly, service availability (12.8%) and economic status (1.9%) were cited as root causes of inequity. These structural limitations resonate with findings by Orza et al. (2017), who emphasized that financial and systemic barriers disproportionately affect HIV-positive women.

These findings affirm prior literature from d'Oliveira et al. (2016) and Baya Med Group (2021), who reported that gendered power imbalances in health settings, including verbal, physical, and economic abuse, impede women's ability to access timely and respectful care. In contrast to studies such as WHO (2023), which showed that women constitute 58% of adults receiving HIV

treatment, indicating progress in parity, this localized study underscores that equal coverage does not equate to equitable experiences in service delivery.

HIV/AIDS health care accessibility among people living with HIV at Kyangyenyi Health Center III

The study reveals that a majority (70.5%) of respondents lived within a one-kilometre radius of Kyangyenyi Health Center III, and 94.2% had not missed an appointment in the past year, suggesting a generally positive picture of geographic accessibility and appointment adherence. These findings mirror UNAIDS (2023), which reported that about 78% of HIV-positive individuals in sub-Saharan Africa have consistent access to ART services. Additionally, 72.4% of participants reported having the autonomy to choose their health facility most of the time, indicating moderate empowerment among people living with HIV (PLHIV).

However, barriers remain. Notably, 25% of participants reported having no choice in facility selection, and 28.9% resided more than one kilometre from the facility, highlighting physical access limitations for a sizable minority. The lack of alternative nearby facilities (94.2%) further compounds this issue, limiting the freedom of health-seeking behavior. Muela Ribera et al. (2016) emphasize that access is multidimensional, involving not only physical distance but also socio-cultural and financial factors. In this context, the study supports evidence from WHO (2023), which notes that marginalized individuals often face systemic access barriers despite proximity to services.

Furthermore, logistic regression analysis, though statistically non-significant due to the modest sample size, suggested meaningful patterns: those with favourable family decision-making dynamics had 6.5 times higher odds of choosing their health facility. Similarly, access to nearby alternative facilities increased choice odds (AOR = 6.48). These results are in agreement with the National Healthcare Quality and Disparities Report (NHQDR, 2021), which found that autonomy and service availability directly affect healthcare utilization among HIV patients.

The study uncovers entrenched gender disparities in health decision-making, with 72.4% of family health decisions made by fathers, while only 23.7% were made by mothers. This dominance of patriarchal norms aligns with findings from UNAIDS (2017), which reported that over 80% of married women aged 15–19 in several African countries do not have the final say in their own healthcare. The current findings underscore the continued marginalization of women in household health decisions, despite improvements in ART coverage.

Notably, 13.5% of respondents had stopped using nearby facilities due to gender inequities, highlighting that gender-based discrimination and social norms hinder continued access to services. These findings align with those of Tong (2019) and Avert (2017), who document that cultural norms and intimate partner violence disproportionately restrict women's autonomy and mobility, often requiring spousal consent to access healthcare. The persistence of such practices reduces the effectiveness of HIV intervention strategies.

Additionally, educational, cultural, and legal factors play pivotal roles. Lack of education, gender-biased legal systems, and cultural expectations (for example, women as caregivers) exacerbate women's vulnerability to HIV and limit healthcare access. The study corroborates evidence from The Global Coalition on Women and AIDS [12], which found that mandatory spousal consent and social expectations deter women from seeking HIV services. Contrastingly, studies from Sweden [1] and Vietnam [11] have found that gender bias manifests differently in developed countries, often through diagnostic delays rather than outright denial of services.

While most participants had not missed appointments, 20% did not disclose the reasons, which may mask gender-based deterrents such as stigma, fear, or violence. WHO and Orza [13] highlight that such silence often results from anticipated discrimination, especially among HIV-positive women, reinforcing the hidden nature of gendered healthcare barriers.

Relationship between gender inequities and accessibility to HIV/AIDS health care

The current study revealed that female participants reported slightly higher perceived gender inequities (M = 1.85, SD = 0.30) compared to males (M = 1.81, SD = 0.36), indicating that women continue to experience slightly more gender-based disadvantages in healthcare. This finding aligns with previous global and national evidence that underscores how gender norms and roles negatively impact women's access to timely and adequate HIV care [6] Inequities such as provider bias, economic dependency, and power imbalances in decision-making contribute significantly to these disparities. Studies such as Thorson [11] in Vietnam and Osika [12] in Sweden similarly found delays in women's care due to provider attitudes and structural barriers, reinforcing that gender-based discrimination in healthcare settings persists globally.

However, the lack of a statistically significant association between gender and missed HIV clinic appointments ($\chi^2 = 0.25$, $p = 0.615$) in this study suggests that once enrolled in care, both men and women demonstrate comparable adherence. This contrasts with the findings of Waldman et al. (2015) and WHO [13], which emphasized that fear of violence, stigma, and unequal caregiver burdens often hinder women's consistent access to services. The small discrepancy here may reflect localized successes at Kyangyenyi HC III in creating a more inclusive care environment, though persistent structural inequities remain, particularly around social autonomy and provider interactions.

Although the t-test revealed no significant gender difference in healthcare accessibility ($t(154) = 0.75$, $p = 0.455$), females reported slightly higher accessibility (M = 1.55) than males (M = 1.52). The lack of significant difference indicates that gender, in isolation, may not be the principal determinant of access. Access is shaped by a broader constellation of factors, including socio-economic status, cultural norms, infrastructure, and individual agency, beyond gender alone (Muela Ribera Rivenbark [14].

Interestingly, the logistic regression analysis revealed that perception of gender equity significantly predicted better healthcare access (AOR = 1.82, p = 0.008). This finding corroborates research by Blaauw [15], which emphasized that positive shifts in societal and individual gender attitudes can transform health-seeking behavior. Education also emerged as a robust enabler of access, with secondary complete and higher education levels significantly increasing odds of healthcare access (AOR = 2.41, p =

0.033; AOR = 2.95, p = 0.016 respectively), confirming prior evidence from Ahmed and Creanga [16], which linked education to empowerment and service utilization.

Conversely, individuals living more than 1km from a health facility had significantly lower access (AOR = 0.51, p = 0.016), echoing earlier research highlighting geographic barriers as a persistent impediment to care [11]. Surprisingly, those without financial support had higher access (AOR = 1.92, p = 0.007), possibly reflecting a self-reliance mechanism among unsupported individuals or informal community-based assistance systems not captured in formal data.

The findings affirmed that education and autonomy are critical levers in mitigating gender inequity. The regression showed that self-decision-making in healthcare significantly improved access (AOR = 2.10, p = 0.011), supporting prior findings by UNFPA [8] and ICW [9], which emphasized autonomy as vital for effective care utilization. This also reflects what Mary noted: that many prior studies missed the intricate interplay of agency, education, and social support in shaping access outcomes.

Cultural norms and legal restrictions also continue to underpin gender inequity. Though not statistically significant in this study, the marginal effect of gender on access (AOR = 0.65, p = 0.056) points to deeply entrenched biases that subtly inhibit women's ability to seek and obtain care. These results are echoed in global studies by UNAIDS and Tong [1], which found that patriarchal norms, early marriage, and mobility constraints systematically disempower women, thereby limiting their ability to engage freely with healthcare systems. While some statistical findings, for example, appointment adherence and gender-based access differences, were not significant, the underlying structural and psychosocial factors contributing to gender inequities remain salient, as reflected in both perceptions and real-world access disparities.

Conclusions

Based on the findings, it is concluded that gender inequities significantly affect access to HIV care. Traditional gender norms, such as viewing women as primarily responsible for domestic duties, remain deeply entrenched. These norms contribute to unequal treatment, with many participants reporting that women's health concerns are often dismissed, and men receive more respectful care. While some progress toward gender equality is recognized, perceptions and experiences of inequitable treatment persist, especially among women. These disparities are further compounded by structural and economic barriers limiting healthcare autonomy and access.

The study concludes that while HIV/AIDS healthcare services are generally available at Kyangyenyi Health Center III, several barriers still impede full access, especially among people living with HIV. Decision-making regarding healthcare remains largely patriarchal, with men dominating family health decisions, which limits women's autonomy in seeking care. Although the majority of respondents live within accessible distances to the facility and rarely miss appointments, the lack of nearby alternative healthcare options and reported gender-related barriers, such as inequity and stigma, highlight the persistent challenges in achieving equitable healthcare access. Additionally, a significant portion of respondents lacks the freedom to choose their preferred healthcare facility, which undermines patient empowerment and service satisfaction.

The study concludes that gender inequities, particularly those related to autonomy, education, and perceptions of fairness, significantly influence access to HIV/AIDS healthcare services among people living with HIV. While no significant gender difference was found in missed appointments or general accessibility scores, individuals with positive attitudes toward gender equity and those with higher education were more likely to access care. This suggests that gender equity, while not the sole determinant, plays a critical role in facilitating healthcare access.

Recommendations

To address the identified gender inequities, it is recommended that Health Centers adopt gender-sensitive healthcare practices. This includes training health workers on gender equity and respectful care, establishing clear accountability systems for discrimination, and involving both men and women in HIV care programs. Community awareness campaigns should challenge harmful gender norms and promote equality in healthcare access. Additionally, service delivery models should be adjusted to ensure women's autonomy and confidentiality are respected in all care decisions.

Based on the findings, the study recommends empowering women in healthcare decision-making through community sensitization and gender-responsive health policies. There is a need for the Ministry of Health and district health teams to decentralize HIV care services and establish more nearby healthcare facilities to increase access and choice for patients. Health education campaigns should also address gender-related stigma and encourage equitable participation in health matters.

To reduce gender inequities and improve HIV/AIDS healthcare access, the study recommends that healthcare policies and programs to prioritize gender-sensitive interventions. These should include community sensitization on gender equality, integration of gender equity training for healthcare providers, and support mechanisms that empower women in healthcare decision-making. Additionally, targeted education campaigns and accessibility improvements such as, mobile outreach for distant clients can bridge remaining gaps in service utilization related to gender-based disparities.

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