

Gender and HIV/AIDS: Understanding and Addressing Stigma and Discrimination Among Women and Girls

Barbara Clow and Linda Snyder

In my view, ...the most vexing and intolerable dimension of the pandemic is what is happening to women. ...Gender inequality is driving the pandemic, and we will never subdue the gruesome force of AIDS until the rights of women become paramount in the struggle. ... I challenge you, [therefore] to enter the fray against gender inequality. There is no more honourable and productive calling. There is nothing of greater import in this world. All roads lead from women to social change, and that includes subduing the pandemic.

Stephen Lewis, *United Nations Special Envoy for HIV/AIDS in Africa*¹

Introduction

Stephen Lewis has been among the most prominent and impassioned personalities in the campaign to raise awareness about the role of gender in the HIV/AIDS pandemic, particularly in the latter half of his tenure as UN Special Envoy for HIV/AIDS in Africa. His efforts complement the work of researchers, decision makers, advocates, and service providers from around the world who have laboured for more than a decade to explicate the ways in which women and girls are differentially infected and affected by HIV and AIDS-related illnesses. His words, therefore, provide an appropriate and powerful point of departure for this discussion of gender, HIV/AIDS and discrimination.

The paper begins with an overview of the ways in which sex and gender work together to put women and girls at risk of HIV infection. While both men and women are contracting HIV and dying of AIDS-related illnesses, gender inequity throughout the

¹ Stephen Lewis. (2006). *Keynote address* at the closing session of the XVI International AIDS Conference. Toronto, Canada. Retrieved from Stephen Lewis Foundation Website, 31 March 2008. http://www.stephenlewisfoundation.org/news_speech_item.cfm?news=1382&year=2006.

world is deepening the suffering of women and girls as well as contributing to the spread of HIV. Moreover, gender roles and expectations contribute to stigmatization of women and girls, particularly those from marginalized populations.

The second part of the discussion provides a gender-based analysis of the HIV/AIDS epidemic in Canada, followed by a brief comparison with South Africa's experience with HIV. Although the two countries are vastly different – in terms of infrastructure, culture, history and the scope and impact of HIV – nonetheless, the trajectory of the pandemic is disturbingly similar, at least with respect to the vulnerability of women and girls.

Disadvantaged groups of women and girls in both Canada and South Africa have been hardest hit by HIV and AIDS-related illnesses.

The last section of the paper addresses international recommendations for responding to the HIV pandemic, specifically the implications of United Nations (UN) and World Health Organization (WHO) guidelines for countries with a low incidence of HIV infection. By comparing the management of HIV in South Africa and Canada, the argument will be made that international guidelines, by ignoring gender and the plight of women and girls, contribute to the spread of HIV. Moreover, because the guidelines recommend focusing on those at highest risk of HIV infection, they may serve to deepen the stigma associated with positive sero-status and encourage discrimination and marginalization of women and girls infected and affected by HIV/AIDS. Low incidence countries, including Canada and China, may be in a position to learn from this analysis and to fashion more effective responses to the pandemic.

Sex, Gender and HIV

Since the end of the Second World War, there has been an increasing tendency in Western societies to distinguish between the words “sex” and “gender”. Although these terms share common linguistic and historical roots, feminist researchers, activists and social commentators have sought to associate the word “sex” with biological structures and physiological processes that differentiate the male from the female body while defining “gender” as the array of roles, relationships, personality traits, attitudes,

behaviours, values and relative power that society ascribes to females and males on a differential basis.² “Sex” is, therefore, innate to the physical body, while “gender” is a product of socially constructed norms and expectations. For example, babies are usually born with external genitalia that identify them as male or female, but girls and boys acquire beliefs and behaviours, such as how to dress or express emotion, that are defined socially as either feminine or masculine.

Feminists and other social activists adopted the strategy of distinguishing between sex and gender in order to expose and challenge stereotypes that were being used to deny women access to labour markets, educational and political institutions, and the full range of political, economic and social benefits enjoyed by men in their communities. For example, stereotypes that characterized women as more emotional and less logical in their thinking than men were used to exclude women from high-paying and prestigious jobs in the natural and applied sciences. While much progress has been made in breaking down barriers to women’s rights and well-being, at least in some parts of the world, the HIV/AIDS pandemic has demonstrated how much more needs to be done – and urgently – in the area of gender equity.

Women and girls are almost always at greater risk than men and boys of exposure to and infection by HIV. Physiological factors, or *sex differences*, are partly responsible for increased vulnerability among women. Delicate tissues in the female reproductive tract are more receptive to viral transmission, especially if these tissues sustain injury or are immature, as among younger women.³ Moreover, the larger area of the female reproductive tract creates increased opportunities for transmission of the virus, particular in comparison with the single point of entry in the penis⁴. In addition, women and girls are exposed to greater concentrations of HIV during heterosexual intercourse than are

² Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health. (2002). *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach*. London, UK: Commonwealth Secretariat; Health Canada. (2003). *Exploring Concepts of Gender and Health*. Ottawa: Minister of Health.

³ Interagency Coalition on AIDS and Development. (2002). *HIV/AIDS and Prevention Options for Women*. Ottawa: ICAD; Nikki Kumar, June Larkin and Claudia Mitchell. (2001). “Gender, Youth and HIV Risk.” *Canadian Women’s Studies*. Vol 21. Summer/Fall.

⁴ Nikki Kumar, June Larkin and Claudia Mitchell. (2001). “Gender, Youth and HIV Risk.” *Canadian Women’s Studies*. Vol 21. Summer/Fall.

their male partners because semen tends to carry a higher viral load than vaginal secretions. As a result, women and girls are far more likely to be infected by HIV-positive male partners than they are to pass on the virus to their male partners. According to one report, teenaged girls in sub-Saharan Africa were infected at rates five to six times greater than teenaged boys.⁵

Gender differences, especially those that contribute to social, political, and economic inequity, are also responsible for the heightened vulnerability of women and girls. In many parts of the world, women and girls have less power and fewer resources than men and boys. Economic dependency as well as violence and coercion make it difficult for women to negotiate safe sex practices, such as condom use, to refuse sex or to leave a relationship that puts them at risk. Gendered customs and social values also contribute both to the spread of HIV and greater vulnerability among women and girls. For example, ubiquitous social norms that encourage multiple sexual partners for men but frown on this practice among women, not only increase the likelihood of women being exposed to HIV, but also contribute to stigmatization and marginalization of women who contract the disease, regardless of whether they have had one or many sexual partners. Similarly, in some cultures women who are widowed not only lose their rights to family property and land, but they themselves may be “inherited” by a male relative. These types of customs leave women economically dependent and, when the husband had died of AIDS, they contribute directly to the spread of HIV.⁶

Stigma, discrimination and marginalization of all kinds – as well as the threat of HIV/AIDS – follow women and girls. When women and girls test positive for HIV, they may be ostracized, abandoned, abused, or even killed. While any woman or girl diagnosed with HIV is liable to face discrimination, the situation of women and girls who are already marginalized or are living with the burden of intersecting inequities is more dire still. Tolson and Kellington, for example, noted that “it is the people who are the

⁵ Commission on the Status of Women. (2001). “Agreed conclusions on women, the girls child and HIV/AIDS.” 45th Session of the UN Commission on the Status of Women. New York: United Nations.

⁶ Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health. (2001) *Gender Mainstreaming in HIV/AIDS*.

bottom of the social and political hierarchy in their society, whose risk for HIV/AIDS is greatest. For a woman in Vancouver, living on welfare in a dangerous area, using valium or heroin or alcohol to cope, her risks are determined not by the right personal selection of a healthy option, but instead by a socially-determined lack of options.”⁷ In Canada, women who engage in commercial sex work, use injecting drugs or come from racialized populations are among those at greatest risk of stigma and discrimination, particularly when a diagnosis of HIV is added to their burdens.⁸ In a study of Aboriginal women in Canada, for example, Ship and Norton observed that “many HIV-positive First Nations women live in secrecy because of the multiple forms of stigma associated with the disease, including being branded ‘promiscuous’, ‘a bad mother’, and ‘deserving of HIV/AIDS.’”⁹ Jackson likewise notes that female sex trade workers, rather than their male clients, have been blamed for the spread of HIV, thereby deepening the stigma and discrimination they experience.¹⁰ In such situations, women and girls fall deeper into poverty, social isolation and various forms of dependency. They may enter into sex trade work or selling blood simply to support themselves and their children, they may begin to utilize substances of various kinds to escape the realities of their lives, but these activities all increase their risks of exposure as well as the spread of HIV¹¹.

All of this is not to suggest that sex and gender do not contribute to HIV vulnerability among men. While women and girls are generally more at risk physiologically, the

⁷ Margreth Tolson and Stephanie Kellington, “Changing the Balance of Power: The Listen Up! Project and Participatory Research with Marginalized Communities,” in Carol Amaratunga and Jacqueline Gahagan., eds. (2002). *Striking to the Heart of the Matter: Selected Readings on Gender and HIV*. Halifax: Atlantic Centre of Excellence for Women’s Health.

⁸ Peggy Millson, Alexandra Moses, Naushaba Degani, Chere Chapman, Carol Majro and Evelyn Wallace, “Gender, Injection Drug Use and HIV Risk in Ontario, Canada,” and Lois Jackson, “HIV Prevention Programmes and Female Prostitutes: The Canadian Context,” in Carol Amaratunga and Jacqueline Gahagan., eds. (2002). *Striking to the Heart of the Matter: Selected Readings on Gender and HIV*. Halifax: Atlantic Centre of Excellence for Women’s Health.

⁹ Susan Judith Ship and Laura Norton., “HIV/AIDS and Aboriginal Women in Canada,” in Carol Amaratunga and Jacqueline Gahagan., eds. (2002). *Striking to the Heart of the Matter: Selected Readings on Gender and HIV*. Halifax: Atlantic Centre of Excellence for Women’s Health.

¹⁰ Lois Jackson, “HIV Prevention Programmes and Female Prostitutes: The Canadian Context,” in Carol Amaratunga and Jacqueline Gahagan., eds. (2002). *Striking to the Heart of the Matter: Selected Readings on Gender and HIV*. Halifax: Atlantic Centre of Excellence for Women’s Health.

¹¹ Claire Higgins-Dickson. (2006). “Discrimination and HIV in China.” International Conference on HIV and HBV Carriers. Beijing, China; Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health. (2001) *Gender Mainstreaming in HIV/AIDS*.

exception to this rule is men who have sex with men, specifically a man who is a “bottom” and assumes the receptive role in anal intercourse. Like vaginal and cervical tissue, the tissues of the intestinal tract are highly fragile and injury makes them more susceptible to HIV infection. And like the female reproductive tract, the intestinal tract offers a large expanse of tissue for infection to take hold.¹² Gender norms also create risks for men. The most obvious example is the tremendous stigma attached to homosexuality in many countries around the world. Men who have sex with men (MSM) may feel compelled to conceal their sexual preferences, thereby putting their partners – female and male – at increased risk of HIV infection.¹³ At the same time, gender stereotypes of masculinity affect both straight and gay men. Societal norms that assume males are knowledgeable about sex may leave everyone in the dark; men and boys feel unable to ask for information while women, girls and “bottoms” may assume that they don’t need to ask for information. Gender norms for men also encourage multiple sexual partners and, in some cases, sexual aggression, both of which contribute to the spread of HIV.¹⁴ Male sex trade workers seem to be equally vulnerable to violence, coercion and dependency as their female counterparts.

While both women and men are suffering the effects of the pandemic, it is also true that more women and girls are living with HIV and AIDS-related illnesses – more than men and boys and more than ever before. According to the latest statistical report released by UNAIDS, women accounted for half of the adult population living with HIV around the world, but in sub-Saharan Africa – the epicentre of the pandemic – women accounted for nearly 61 percent of adults living with HIV and the proportion of women affected in

¹² Nikki Kumar, June Larkin and Claudia Mitchell. (2001). “Gender, Youth and HIV Risk.” *Canadian Women’s Studies*. Vol 21. Summer/Fall.

¹³ Family Health International. (2001). “HIV Interventions with Men who have Sex with MEN.” State of the Art Briefs on HIV/AIDS, quoted in Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health, *Gender Mainstreaming in HIV/AIDS*; Interagency Coalition on AIDS and Development, (2004) “Fact Sheet: HIV/AIDS and Homophobia” and (2006) “Fact Sheet: HIV/AIDS and Gender Issues,” Retrieved 30 March 2008, http://www.icad-cisd.com/content/pub_details.cfm?id=194&CAT=9&lang=e.

¹⁴ Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health. (2001). *Gender Mainstreaming in HIV/AIDS*; Interagency Coalition on AIDS and Development, (2004) “Fact Sheet: HIV/AIDS and Homophobia” and (2006) “Fact Sheet: HIV/AIDS and Gender Issues,” Retrieved 30 March 2008, http://www.icad-cisd.com/content/pub_details.cfm?id=194&CAT=9&lang=e.

other parts of the world is continuing to climb steadily.¹⁵ It is also the case that gender norms and roles create an unequal balance of power between women and men, with women and girls having “fewer legal rights and less access to education, health services, training, income-generating activities and property.”¹⁶ And finally, women and girls are taking up the work of caring for those living and dying with HIV and AIDS-related illnesses: girls are kept home from school and social activities to provide care for their younger siblings or ill parents, grandmothers step in to provide care for millions of children orphaned by HIV/AIDS. In the process, their ability to protect and provide for themselves and their families is eroded. Foregrounding the role of gender in the pandemic is, therefore, critical. To paraphrase Stephen Lewis and many others, “the face of AIDS is the face of a woman.”¹⁷

Sex, Gender and HIV/AIDS in Canada

Canada has always been, and continues to be, defined as a country with a low incidence of HIV/AIDS. As compared with other nations around the world, only a tiny percentage of the Canadian population is infected or affected. According to current estimates from UNAIDS, approximately 60,000 Canadians, or 0.3 percent of the population, are living with HIV.¹⁸ China, with a much larger population, has many more people living with HIV, but the prevalence rate, at 0.1 percent, is even smaller than in Canada.¹⁹ It is also deemed a low-incidence country.

¹⁵ UNAIDS, (2007) *AIDS Epidemic Update*, Retrieved 30 March 2008, http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

¹⁶ Commonwealth Secretariat and Maritime Centre of Excellence for Women’s Health. (2001). *Gender Mainstreaming in HIV/AIDS*.

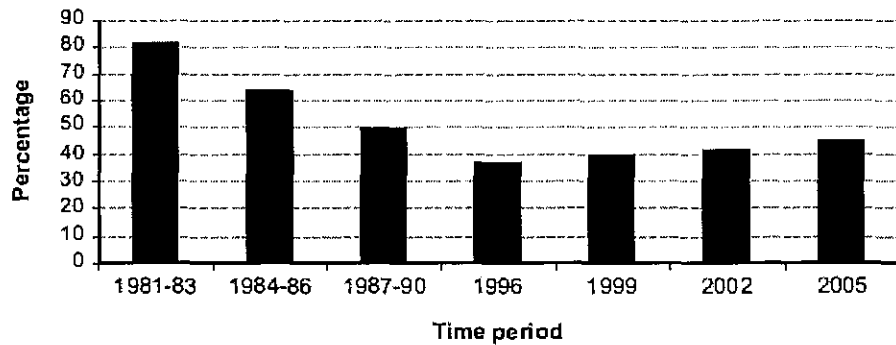
¹⁷ Stephen Lewis, quoted in “Globalization Failing Victims of Global HIV/AIDS Pandemic”, 27 June 2004, National Union of General and Public Employees, Retrieved 15 March 2008 from http://www.nupge.ca/news_2004/n27jn04a.htm.

¹⁸ UNAIDS. (2007). *Country Responses: Canada*. Retrieved 30 March 2008 from [www.unaids.org/en/Country Responses/Countries/canada.asp](http://www.unaids.org/en/Country%20Responses/Countries/canada.asp).

¹⁹ UNAIDS. (2007). *Country Responses: China*. Retrieved 30 March 2008 from [www.unaids.org/en/Country Responses/Countries/china.asp](http://www.unaids.org/en/Country%20Responses/Countries/china.asp)

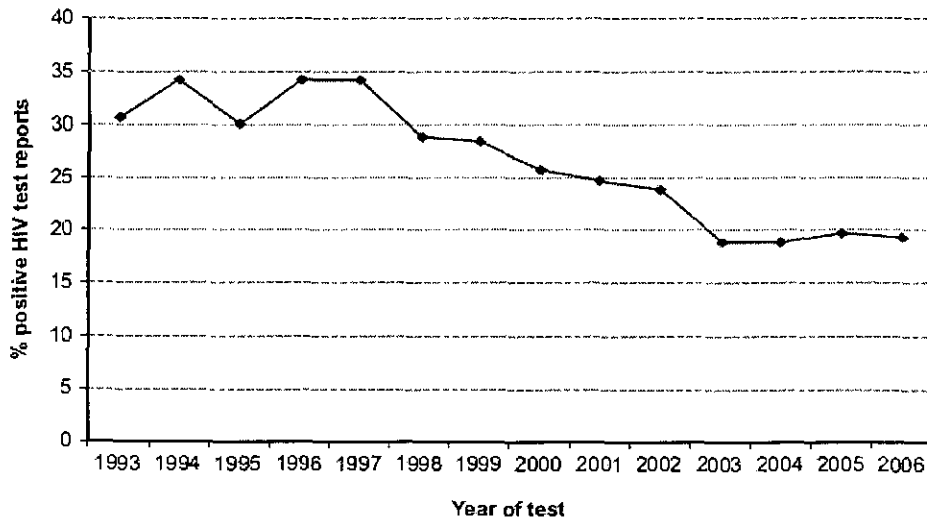
At the same time, the epidemic in Canada seems to be “confined” to specific populations. Men who have sex with men (MSM) and injecting drug users (IDU) accounted for close to 70 percent of those living with HIV at the end of 2005.²⁰

Figure 1. Distribution (%) of estimated new HIV infections among MSM, by time period



Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

Figure 2. Proportion of adult positive HIV reports attributed to IDU, by year of test 1993-2006



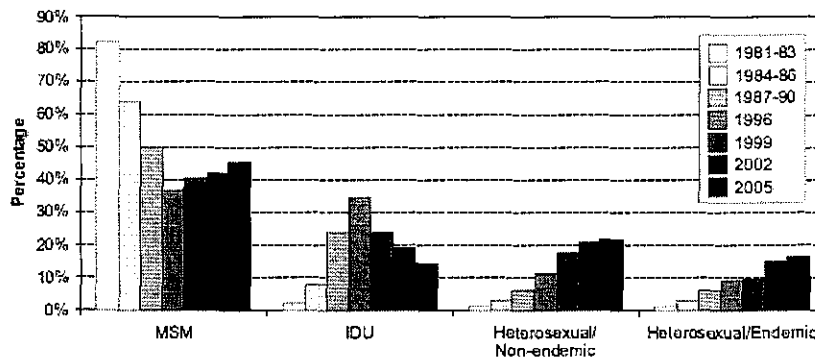
Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

²⁰ Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

The fact that rates of new infections among MSM and IDUs have dropped dramatically, particularly from the early days of the epidemic, is routinely cited as a good news story, a sign of the successful management of HIV in Canada.

But there are other significant changes in patterns of HIV infection that demand our attention. Between 1995 and 2006, HIV infections attributable to heterosexual contact – alone or in combination with other factors – have increased alarmingly, from 7.5 percent to 37 percent.²¹ Similarly, AIDS diagnoses attributable to heterosexual contact in the same period have risen from 7 percent to approximately 26 percent.²²

Figure 2. Estimated exposure category distributions (%) of new HIV infections in Canada, by time period



Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

While these trends in transmission of HIV affect both men and women in every age category, they have profound implications for women. In 2000, approximately half of women diagnosed with HIV had contracted the virus through heterosexual contact. In 2006, this proportion had reached 76 percent. Thus, while people living with HIV and

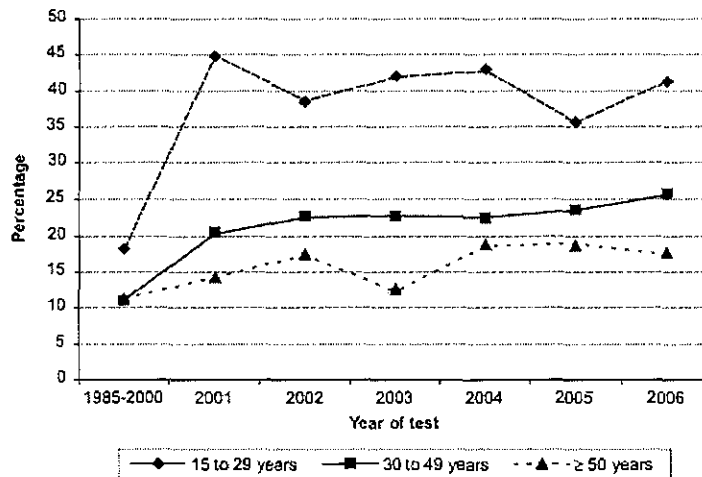
²¹ Public Health Agency of Canada. (2004). *HIV and AIDS in Canada, Surveillance Report to June 30, 2004*. Ottawa: Public Health Agency of Canada; Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

²² Public Health Agency of Canada. (2004). *HIV and AIDS in Canada, Surveillance Report to June 30, 2004*. Ottawa: Public Health Agency of Canada; Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada; *Canada Statistics Summary*. (2007). Retrieved 30 March 2008, www.avert.org/canstatg.htm.

AIDS in Canada are still most likely to be men who have sex with men and/or injecting drug users, those newly infected with HIV are increasingly likely to be heterosexual women.

Infection rates among women of all ages in Canada are increasing. Between 1997 and 2006, the proportion of adult females diagnosed with HIV has risen from 12 percent to nearly 28 percent. Moreover, the proportion of adult women living with diagnosed AIDS has increased from 6.1 percent in 1994 to 24.2 percent in 2006.²³ But the biggest change has been for young women, between the ages of 15 and 29 years. Females accounted for 12 percent of all new infections in this age group in the early 1990s, but the proportion has increased almost four fold by 2006.²⁴

Figure 1. Percent of all positive HIV test reports accounted for by women by age group and year of test, 1985-2006



Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

²³ Public Health Agency of Canada. (2004). *HIV and AIDS in Canada, Surveillance Report to June 30, 2004*. Ottawa: Public Health Agency of Canada; Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada; *Canada Statistics Summary*. (2007). Retrieved 30 March 2008, www.avert.org/canstatg.htm.

²⁴ Public Health Agency of Canada. (2004). *HIV and AIDS in Canada, Surveillance Report to June 30, 2004*. Ottawa: Public Health Agency of Canada; Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada; *Canada Statistics Summary*. (2007). Retrieved 30 March 2008, www.avert.org/canstatg.htm.

Not only are women and girls in Canada experiencing heightened risks of HIV infection, particularly through heterosexual contact, but also when they are infected with HIV, they are more likely to have poorer health outcomes than men and boys. According to Health Canada, women tend to “... have a lower survival rate than men... [as a result of] late diagnosis and delay of treatment because of misdiagnosis of early symptoms; exclusion from drug trials and lack of access to antiviral treatment; lack of research into the natural history of HIV in women; higher rates of poverty among women and lack of access to adequate health care; and the tendency of many women to make self-care a lower priority than the care of children and family”.²⁵ In a study of AIDS-related deaths in Vancouver between 1995 and 2001, women were found disproportionately to have died without having received any treatment.²⁶ The stigma associated with a diagnosis of HIV makes it challenging for women to seek and get the care they need. One woman, after learning that she was HIV-positive, learned that her doctor “didn’t want me in his office. He said I would infect his staff.”²⁷

HIV poses a growing threat for all women and girls in Canada, but some populations are much more vulnerable to infection than others. While the rates of infection among white Canadians have been dropping steadily in recent years, black Canadians and Aboriginal peoples have experienced disproportionate increases. Aboriginal persons, for example, represent approximately 3 percent of the total population of Canada, but in 2006, 23 percent of all new HIV infections were found among Aboriginal people.²⁸

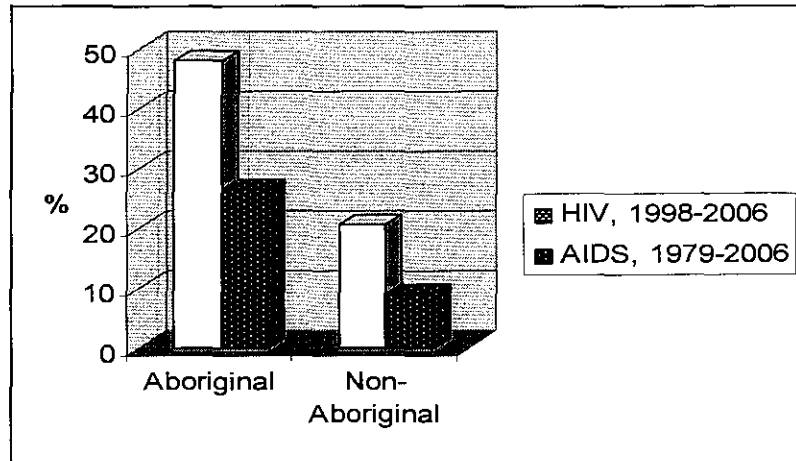
²⁵ Women’s Health Bureau. (1999) Women and HIV/AIDS Factsheet. Ottawa: Health Canada.

²⁶ Joanne Csete. (2005). *Vectors and Vessels: HIV/AIDS and Women’s Rights in Canada*. Toronto: Canadian HIV/AIDS Legal Network.

²⁷ Study participant, quoted in Margreth Tolson and Stephanie Kellington, “Changing the Balance of Power: The Listen Up! Project and Participatory Research with Marginalized Communities,” in Carol Amaratunga and Jacqueline Gahagan, eds. (2002). *Striking to the Heart of the Matter: Selected Readings on Gender and HIV*. Halifax: Atlantic Centre of Excellence for Women’s Health.

²⁸ Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada

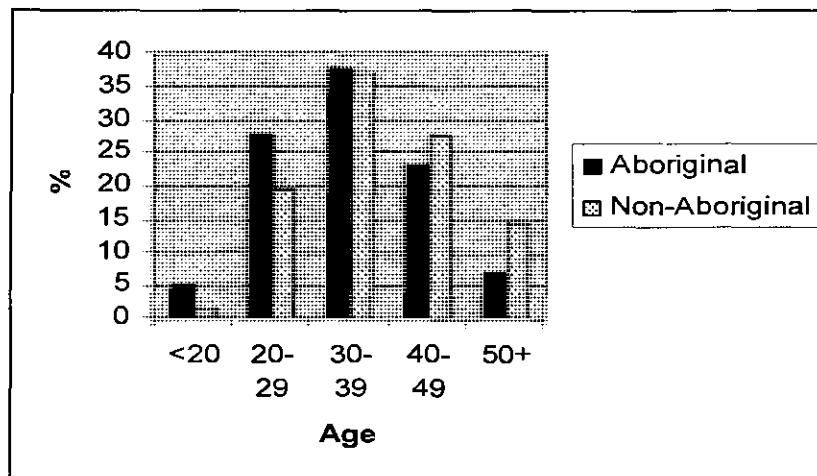
Comparison of reported AIDS cases and positive HIV reports among Aboriginal and non-Aboriginal Females



Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

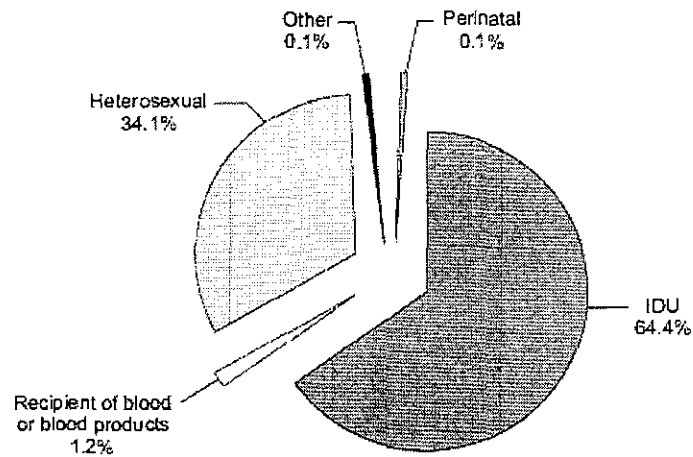
There are also stark differences between Aboriginal and non-Aboriginal women and girls when it comes to age at diagnosis and modes of transmission: Aboriginal females are generally diagnosed at a much younger age than non-Aboriginal females and are more likely to be infected through injecting drug use rather than heterosexual contact.

Comparison of age at time of diagnosis for reported AIDS cases and positive HIV tests among Aboriginal and non-Aboriginal women and girls



Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

Figure 3d. Distribution of exposure categories among positive HIV test reports of Aboriginal females (n = 672), January 1998-December 31, 2006

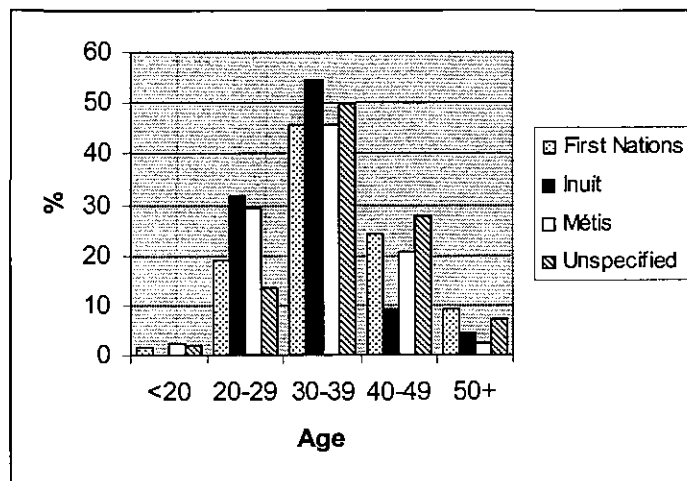


Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

It is also important to bear in mind that the “Aboriginal” category, like the “non-Aboriginal” category, includes many different populations and communities, each with its own culture, history, legal status, geographic location, etc. The latest Canadian report on HIV/AIDS reveals significant variation among Aboriginal women and girls in Canada, particularly with respect to age of diagnosis and method of exposure. First Nations and Inuit women, for instance, are much more likely to be diagnosed with AIDS in their twenties and thirties, as compared with Métis women and women of unspecified Aboriginal descent, who are diagnosed later, in their thirties and forties. Injecting drug use is the most common method of exposure for First Nations peoples while heterosexual transmission accounts for the largest proportion of HIV infections among Inuit peoples.²⁹

²⁹ Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

Reported AIDS cases among women of First Nations, Inuit, Metis and unspecified Aboriginal descent in Canada, 1979-2006



Source: Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

While it is clear that women and girls of Aboriginal descent are much more vulnerable to HIV infection, the statistics themselves do not explain why. In part, the differences can be attributed to the fact that Aboriginal people are over-represented in high risk groups, such as injecting drug users, sex trade workers, and prison inmates. For example, a First Nations male is 24 times more likely to be incarcerated in a provincial jail than a non-Native male and a First Nations female is 131 times more likely to be incarcerated than a non-Native woman. Similarly, in some cities, up to 75 percent of those using needle exchanges are Aboriginal and a large proportion of those engaged in commercial sex work.³⁰ But Aboriginal people *are* over-represented in high-risk groups because of their histories as well as the social, political and economic realities of their lives.

Aboriginal people in Canada have suffered from the ongoing effects of cultural denigration, racism and colonialism. The legacy of this experience is apparent: on average, Aboriginal people have higher rates of incarceration, higher rates of suicide, drug and alcohol use, more poverty, and poorer health than the non-Aboriginal population of Canada. These are risk factors for HIV.³¹

³⁰ Canadian HIV/AIDS Legal Network, *Aboriginal Prisoners and HIV/AIDS: Legal Issues*, 2004-2005.

³¹ Canadian HIV/AIDS Legal Network, *Aboriginal Prisoners and HIV/AIDS: Legal Issues*, 2004-2005.

Aboriginal women and girls often face even greater challenges than either Aboriginal men or non-Aboriginal women and men. For example, 48 percent of Inuit females do not complete high school, as compared with 47 percent of Inuit males, 22 percent of Canadian females and 23 percent of Canadian males. Similarly, Métis people earn about \$7,500 less per year on average than non-Aboriginal Canadians, but Métis women earn \$11,000 less per year than Métis men.³² According to the Canadian Aboriginal AIDS Network, Aboriginal women are more than twice as likely to be living in poverty as their non-Aboriginal counterparts and they are more likely to be exposed to substance use and domestic violence on a daily basis. Ship and Norton likewise report that many of the Inuit women they interviewed had experienced abuse as children and then again later in life at the hands of men. Several of these women recognized that they used drugs and alcohol as a mechanism to cope with the abuse.³³ Aboriginal women also experience discrimination, both within their own communities and in dealing with non-Aboriginal health services. Because they fear being judged or spurned, because they fear having their children taken away from them, Aboriginal women are less likely to reveal their HIV status or to access services before it is too late.

In many ways, the experiences of women and girls in Canada, particularly those from marginalized populations, mirror those of women and girls around the world, in developing and developed countries. Women and girls in Canada typically face greater risks of exposure to HIV than do men and boys, both because of physiological differences between the sexes and as a result of gender inequity. Vulnerability and risk increase further for women and girls from marginalized populations. As researcher Joanne Csete concludes:

... while women in Canada may not suffer the extremes of subordination faced by many of their counterparts in other parts of the world, inequality and violations of women's human rights still contribute to their vulnerability and to the challenges they face in seeking treatment for HIV/AIDS. As in other parts of world, women living in poverty, women who inject drugs, Aboriginal women, women in the sex trade, and many

³² National Aboriginal Health Organization, "Presentation: Broader Determinants of Health in Aboriginal Context", Retrieved 30 March 2008 from http://www.naho.ca/english/pub_determinants.php.

³³ Canadian Aboriginal AIDS Network, and Ship and Norton, cited in Joanne Csete. (2005). *Vectors and Vessels: HIV/AIDS and Women's Rights in Canada*. Toronto: Canadian HIV/AIDS Legal Network.

women who come from countries where HIV is endemic are particularly vulnerable to HIV/AIDS, ...³⁴

Stigma and discrimination can affect anyone and everyone diagnosed with HIV in Canada, but the experiences of women and girls are generally worse. For example, both women and men who are HIV positive have been charged with aggravated assault for failing to disclose their HIV status to a sexual partner. But a woman charged in 2005 was “portrayed in the press as a sexual predator and wantonly promiscuous.” Moreover, as the charges involved a member of the Canadian Armed Forces, officials in the military chose to disclose the woman’s identity and HIV status across Canada and to the world, “though it is unclear that they did anything to emphasize to soldiers their own responsibility for safer sex.”³⁵ Similarly, pregnant women who test positive for HIV are regularly condemned for exposing an unborn child to the risk of infection and a woman who breastfeeds an infant in Canada could face prosecution. As with risk of exposure, women and girls from marginalized populations are more likely to suffer negative or more deeply negative consequences as a result of HIV. For example, women injecting drug users may be reluctant to seek medical help because they routinely experience discriminatory exclusion from health and social services, including women’s shelters and emergency services.³⁶ Similarly, African Canadian women living in Toronto discuss the discrimination that surfaces within their cultural communities and in the dominant culture. As one woman concluded, “We live with it every day. It’s not just HIV ... I’m Black ... I’m a woman ... I was a single mom ... on social assistance. Right there I cover all the grounds for you.”³⁷ Thus, while a recent survey suggests that Canadians are increasingly accepting of people living with HIV, stigma and discrimination continue to mark and mar the experiences of women and girls who test positive for HIV.³⁸

³⁴ Joanne Csete. (2005). *Vectors and Vessels: HIV/AIDS and Women's Rights in Canada*. Toronto: Canadian HIV/AIDS Legal Network.

³⁵ Joanne Csete. (2005). *Vectors and Vessels: HIV/AIDS and Women's Rights in Canada*. Toronto: Canadian HIV/AIDS Legal Network.

³⁶ S. Boyd and K Faith. (1999). “Women, illegal drugs and prison: views from Canada.” *International Journal of Drug Policy* Vol 10.

³⁷ E. Lawson, F. Gardezi, L. Clzavara, W. Husbands, T. Myers, W. Tharao and the Stigma Study Team. “How African and Caribbean people in Toronto experience and respond to HIV stigma, denial, fear and discrimination,” Retrieved 6 April 2008, www.accho.ca/pdf/Stigma%20Fact%20Sheet%20ENGLISH.pdf

³⁸ Public Health Agency of Canada. (2006) *HIV/AIDS Attitudinal Tracking Survey Final Report*. Retrieved 8 April 2008 from www.phac-aspc.gc.ca/aids-sida/publication/por/2006/exsum_e.html

Engendering the Response to HIV/AIDS

Given the challenges that women and girls face in protecting themselves against HIV exposure and infection, it might seem reasonable to expect that national governments and international agencies would already have devised gender-appropriate strategies and interventions for prevention, care, treatment and support. Many efforts have been and are being made to develop prevention methods for women and girls, including the female condom and microbicides. Educational and informational programs for women and men, girls and boys are also common in many countries around the world, including Canada and China. Increasingly, there is high-level acknowledgement of the role of sex and gender in the pandemic. Notwithstanding the efforts being made to control and eradicate HIV, the numbers of people – the numbers of women and girls – who are living with and dying from HIV continue to rise. Perhaps the time has come to revisit and re-evaluate national policies and international guidelines using a gender lens.

The United Nations and the World Health Organization have been in the vanguard of international responses to the HIV pandemic and the guidelines for dealing with HIV established by these organizations have been highly influential with national governments around the world, including the Canadian government. In recent years, both UNAIDS and WHO have developed greater awareness of the role of gender in the pandemic as well as the plight of women and girls infected and affected by HIV. Increasingly, their publications and recommendations include attention to gender as well as to women and girls. A significant exception, at least in our opinion, is the advice for effective HIV prevention in low incidence countries. UNAIDS and WHO differentiate between the responses needed in low-incidence countries, also labelled “low-level epidemic states”, and those needed in high-incidence countries or “generalized epidemic states.”

According to a recent UNAIDS report on HIV prevention,

An understanding of the nature, dynamics and characteristics of local epidemics is needed to ensure that HIV prevention strategies can be reviewed and adapted to fit local conditions. In low and concentrated HIV prevalence settings where the epidemic is nascent, attention needs to be given to prioritising HIV prevention among those at highest risk, identified after epidemiological and social mapping. In generalized HIV epidemics,

strategies for such populations combined with broader strategies to reach all segments of society at sufficient scale.³⁹

On the surface, this seems like a reasonable approach, based on the assumption that intensive intervention with those most likely to contract HIV will serve to contain the epidemic. It also seems like an eminently realistic approach to HIV, ensuring that amounts of money will be used to greatest effect. While targetted responses are excellent in theory, the history of HIV suggests that focused efforts have not only failed to stem the tide of the pandemic, but have also contributed to the spread of HIV among those already at greatest risk – women and girls. A comparison of the history of the epidemic in Canada and South Africa underscores the hazards of adopting a targetted approach to HIV/AIDS.

In many respects, Canada's experience with HIV has been dramatically different than that of South Africa. Canada, with an HIV prevalence rate below one percent of the population, has always been defined as a low incidence country while South Africa, with a prevalence rate of 20 percent or more, has long been among the countries with the highest incidence rate in the world. Yet what is often missed in analysis of the pandemic – and in international guidelines for prevention – is an appreciation that the early trajectory in many high incidence countries is identical to that of the trajectory in low-incidence countries. In South Africa, for example, the first case of HIV was diagnosed in 1982 – the same year as in Canada. And for the first years of the epidemic in South Africa, HIV was found predominantly in gay white men – the same as in Canada. Even as late as 1990, the incidence of HIV among women in South Africa was relatively low – 0.8 percent of pregnant women tested through antenatal clinics. The incidence of HIV among pregnant women in Canada in 2000 included an estimate of 0.3 percent among Aboriginal women in British Columbia.

Through the 1990s in South Africa, the prevalence of HIV increased steadily, from 1.4 percent of the adult population in 1992 to 24.5 percent in 2000. But equally significant was the shift in modes of transmission: by 1991 in South Africa the number of HIV

³⁹ UNAIDS. (2005). *Intensifying HIV prevention: UNAIDS policy position paper*. Geneva: UNAIDS.

infections attributable to heterosexual contact was on par with the number attributable to men having sex with men. Canada's prevalence rate also rose through the 1990s, though not as much or as quickly as in South Africa. At the same time, Canada began to experience a shift in exposure categories similar to that of South Africa. Between 1995 and 2006, HIV infections attributable to heterosexual contact – alone or in combination with other factors – increased in Canada, from 7.5 percent to 37 percent.⁴⁰ Infections among women and girls are overwhelmingly the result of heterosexual contact, at a rate of 76 percent.⁴¹ Moreover, by 2004, the Canadian government noted significant increases in HIV infection, particularly within specific populations: “Every day, approximately 11 Canadians become infected with HIV. There have been disturbing increases among those who are often socially and economically vulnerable. Injections drug users, women living in poverty, Aboriginal peoples, young gay men and prison inmates are increasingly threatened by the disease.”⁴²

The HIV epidemic raged in South Africa during the 1990s, in part because of political and social upheaval associated with the end of apartheid. While the country focused on eliminating racially-based oppression and establishing democracy, “the spread of the virus was not given the attention it deserved, and the impact of the epidemic was not acknowledged.”⁴³ At the same time, the challenges of fighting HIV in a resource-limited setting contributed to the escalation of the pandemic in South Africa. Canada, by comparison, has enjoyed both wealth and freedom from major social and political change in the last two decades, with the result that the epidemic has developed much more slowly here.

Nonetheless, the national response to HIV/AIDS in Canada and South Africa – particularly in the early years of the epidemic – also have some striking similarities. Both

⁴⁰ Public Health Agency of Canada. (2004). *HIV and AIDS in Canada, Surveillance Report to June 30, 2004*. Ottawa: Public Health Agency of Canada; Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

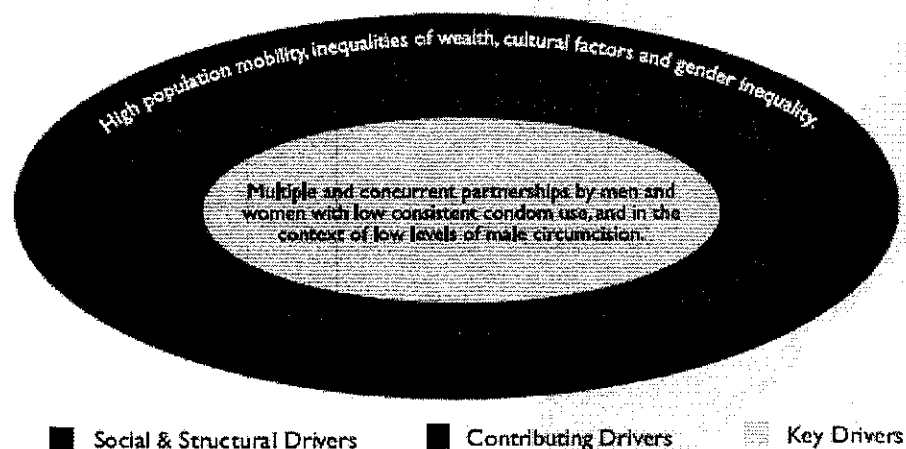
⁴¹ Public Health Agency of Canada. (2007) *HIV/AIDS Epi Updates*. Ottawa: Public Health Agency of Canada.

⁴² Public Health Agency of Canada. (2004). *Moving Forward Together*. Ottawa: Public Health Agency of Canada.

⁴³ HIV/AIDS in South Africa, Retrieved 20 March 2008 from www.avert.org/aidssouthafrica.htm.

countries followed the guidelines established by UNAIDS and WHO, targeting specific “high-risk” groups. According to Olive Shisana, Chief Executive Officer of the Human Sciences Research Council of South Africa, it was the wrong strategy.⁴⁴ By focussing on the risks facing specific groups within the population, rather than alerting everyone to the threat of HIV/AIDS, the government and civil society gave the epidemic time to become firmly established in a group that no one thought was especially vulnerable – women and girls. By 1993, it was clear that HIV in South Africa had been transformed from a low level to a generalized epidemic, as evidenced by a prevalence rate of more than one percent in pregnant women. In the post-apartheid era, the South African government has developed and adopted intervention strategies that address the impact of HIV/AIDS on all of society, including women and girls. At a recent meeting of the Southern African Development Community in 2006, which includes South Africa, the evolution and innovation in thinking about the role of gender in the HIV pandemic was apparent.

Figure 1: Drivers of the HIV Epidemic in SADC



Source: Expert Think Tank Meeting on HIV Prevention in High Incidence Countries in Southern Africa: Report, Maseru, Lesotho, 10-12 May 2006

Recommendations from the Think Tank also focused on the continuing need to address gender inequity across the spectrum of social, political and economic factors driving the epidemic.

⁴⁴ Olive Shisana, CEO, Human Sciences Research Council, to Barbara Clow, Executive Director, Atlantic Centre of Excellence for Women’s Health. (2004). Personal Communication.

Meanwhile, Canada has continued to pursue a targeted approach to HIV/AIDS. The *Federal Initiative to Address HIV* identifies eight populations requiring discrete and intensive intervention: people living with HIV/AIDS, gay men, injecting drug users, Aboriginal peoples, prison inmates, youth at risk, women at risk and people from countries where HIV is endemic. According to the Canadian government, a “populations-specific approach results in evidence-based, culturally appropriate responses that are better able to address the realities that contribute to infection and poor health outcomes for the target groups.”⁴⁵ While it is undoubtedly important to invest in helping those at greatest risk and in greatest need as a result of HIV, it is an approach that has failed to halt the pandemic because it ignores the role of gender. Women and girls do not comprise a sub-population of Canadian society; at 51 percent they are the majority of people living in Canada. Furthermore, women and girls are found in six of the seven other priority populations – among people living with HIV, people from HIV endemic countries, youth, injecting drug users, Aboriginal peoples, and prison inmates. The seventh population, gay men obviously does not include females, but not all men who have sex with men identify themselves as gay or confine their sexual activity to male partners, with the result that women and girls are also associated with this “target group.” Despite the fact that women and girls appear in or connected to every priority population, “the range of government-supported programs meant to address HIV prevention among women in Canada appears not to be the result of a coherent national strategy for addressing HIV/AIDS among women.”⁴⁶

At the same time, though the *Federal Initiative to Address HIV* is ostensibly “grounded in the concepts of social justice and the determinants of health,” there is no mention of gender or gender-based analysis.⁴⁷ Yet just as women and girls are represented in every priority population, so too is gender a cross-cutting theme – in society as well as in the HIV pandemic. Gender norms or stereotypes contribute to the attitudes and behaviours

⁴⁵ Public Health Agency of Canada. “Populations at risk,” Retrieved 8 April 2008 from www.phac-aspc.gc.ca/aids-sida/populations_e.html

⁴⁶ Joanne Csete. (2005). *Vectors and Vessels: HIV/AIDS and Women's Rights in Canada*. Toronto: Canadian HIV/AIDS Legal Network

⁴⁷ Public Health Agency of Canada. “Populations at risk,” Retrieved 8 April 2008 from www.phac-aspc.gc.ca/aids-sida/populations_e.html

of males and females in every society: they also put both males and females at risk of exposure to HIV. But because gender roles and expectations are differential and relational, they increase the vulnerability of women and girls to a greater degree. As a result, programs that help women prisoners to avoid contracting HIV are incomplete if they focus only on the period of incarceration because women's vulnerability does not stop at the prison gates. Similarly, policies to address the alarming increase of HIV among young people in Canada have to move beyond encouraging safe sex practices to deal with the social, economic and political disadvantages facing women and girls. Focusing on target populations encourages neglect of broader social forces driving the epidemic, including gender. As Csete observes, "HIV/AIDS programs that explicitly address the subordination that puts all women at risk of HIV appear to be rare in Canada."⁴⁸

Targetted responses to the pandemic also contribute to stigma and discrimination because they single out certain groups for intervention thereby fuelling fear and/or censure of everyone associated with these groups. The Canadian HIV/AIDS Legal network made the point that,

In spite of all that is known about the science of HIV/AIDS and about combating the epidemic, people living with HIV/AIDS still face stigmatization and discrimination every day. ... [And] People living with HIV/AIDS are not the only ones who suffer from stigma and discrimination. Groups of people linked with HIV/AIDS in the public mind – like intravenous drug users, gay men, sex workers, and people who come from countries where HIV/AIDS is widespread – also face stigma and discrimination.⁴⁹

Although attitudes towards people living with HIV/AIDS have been improving in Canada, a great deal of stigma and discrimination still exists. As recently as 2006, close to 30 percent of Canadians said they would not be comfortable working in an office with someone with HIV and 43 percent of parents reported that they would not be comfortable having their child attend school with an HIV positive student. One in ten Canadians

⁴⁸ Joanne Csete. (2005). *Vectors and Vessels: HIV/AIDS and Women's Rights in Canada*. Toronto: Canadian HIV/AIDS Legal Network

⁴⁹ Canadian HIV/AIDS Legal Network. (2005). Press Release: Stigma And Discrimination Are Fuelling The HIV/AIDS Epidemic In Canada, Retrieved 1 April 2008 from www.aidslaw.ca/publications/interfaces/downloadDocumentFile.php?ref=497

surveyed felt that those who contracted HIV got what they deserved.⁵⁰ In other words, targetted approaches to HIV prevention allow those in mainstream society to distance themselves from “others” in high risk groups, to believe that bad behaviour rather than systemic factors are responsible for the spread of HIV. The discrimination associated with this distancing creates barriers to testing and treatment and deepens the suffering of people living with HIV or assumed to be at risk of exposure, including women and girls. Interestingly, the HIV/AIDS Attitudinal Tracking Survey, a component of the Canadian *Federal Initiative to Address HIV/AIDS*, identified the sex of participants but did not investigate participant’s attitudes towards HIV positive women versus HIV positive men. As a result, no data on gender-based attitudes to HIV is available from this survey. But other research underscores the vulnerability of women and girls to negative interpretations, particularly if they belong to targetted groups such as commercial sex workers and women coming from HIV-endemic countries.

Conclusion

An analysis of the HIV/AIDS in Canada, including a comparison with the epidemic in South Africa, leads to three main conclusions. First, one of the principal drivers of the epidemic, in Canada and around the world, is gender. Women and girls are rendered vulnerable to infection as a result of widespread and diverse forms of gender inequity. Second, high-incidence countries have become sensitive to the role of gender in the pandemic, but in low-incidence countries such as Canada and China, policies and programs often remain gender-blind.⁵¹ Third, HIV/AIDS strategies should be generalized rather than targetted – because the epidemic is everyone’s problem and because gender affects everyone.

⁵⁰ “The Current State of the Epidemic: Why We Need to Step Up Our Efforts,” *Leading Together: Canada Takes Action on HIV/AIDS*, Retrieved 7 April 2008 from www.leadingtogether.ca/304_cur.html; ⁵⁰ Public Health Agency of Canada. (2006) *HIV/AIDS Attitudinal Tracking Survey Final Report*. Retrieved 8 April 2008 from www.phac-aspc.gc.ca/aids-sida/publication/por/2006/exsum_e.html

⁵¹ UNAIDS. (2007). *Country Responses: Canada*. Retrieved 30 March 2008 from [www.unaids.org/en/Country Responses/Countries/china.asp](http://www.unaids.org/en/Country%20Responses/Countries/china.asp); Sunyou Wu, Seena G. Sullivan, Yu Wang, Mary Jane Rotheram-Borus, Roger Detels, “Evolution of China’s response to HIV/AIDS,” *The Lancet*, Vol 369, 24 February 2007-2March 2007.