Engendering HIV/AIDS Policy

by Barbara Clow

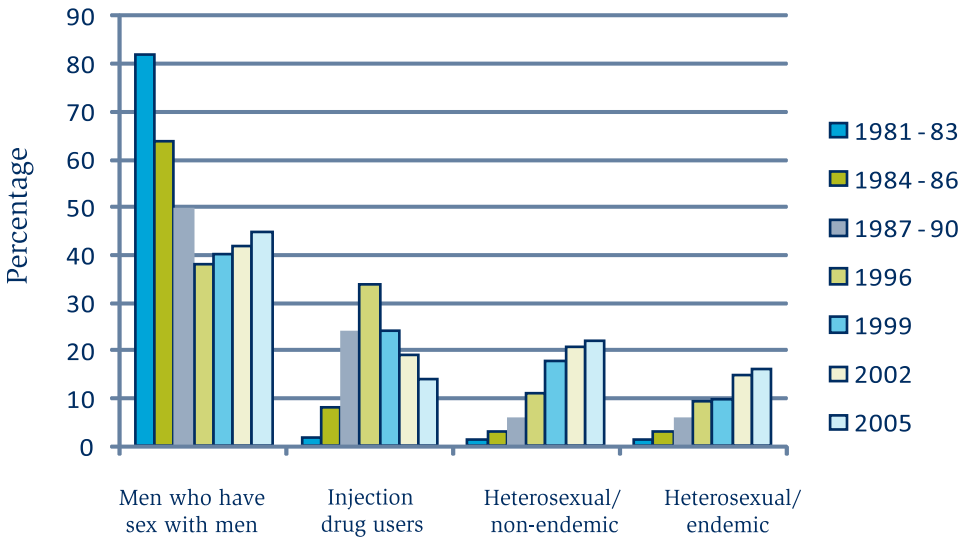
Introduction

Although the first case of HIV/AIDS in Canada was identified in 1982, a national strategic response did not emerge for nearly a decade. Through the 1990s, investments in HIV prevention, care, treatment and support remained fairly modest and were focused mainly on gay men and those infected through contaminated blood products. By 1998, there was a growing realization that while rates of infection had dropped for some people in Canada, the risks of infection and exposure were increasing for young people and many vulnerable groups, such as Aboriginal people, prisoners and women living in poverty.[1] The Canadian Strategy on HIV/AIDS consequently increased its investment and gradually began to adopt a "targeted" approach to the pandemic. By 2005, with the launch of the new Federal Initiative on HIV/AIDS, the government declared its intention to concentrate efforts on the needs of eight populations deemed at high risk: people living with HIV/AIDS, gay men, people who inject drugs, Aboriginal people, prisoners, vulnerable youth, women and people from HIV-endemic countries. While this approach may seem appropriate, in that it focuses limited resources on those most in need, it misses the mark by ignoring the gendered realities of those infected and affected by HIV and AIDS. Women's needs, for instance, cannot be addressed as if they constitute a specific sub-population, because they represent more than half of the population and are found in all but one of the other target groups. At the same time, a targeted response to the pandemic has, in other countries, contributed to the spread of HIV. It is, therefore, the purpose of this case study to consider Canada's current policy response for HIV/AIDS using a sex- and gender-based analysis.

Sex, Gender and HIV/AIDS in Canada

Canada has been, and continues to be, defined as a country with a low incidence of HIV/AIDS, with only a small percentage of the Canadian population infected or affected: approximately 60,000 Canadians, or 0.3 percent of the population, are living with HIV.[2] Moreover, the epidemic in Canada seems to be "confined" to specific populations. Men who have sex with men (MSM) – previously referred to as "gay men" – and people who are injection drug users (IDU) accounted for close to 70 percent of those living with HIV at the end of 2005.[3] Dramatic drops in rates of new infections among MSM and IDUs, particularly from the early days of the epidemic, are routinely cited as good news, a sign of the successful management of HIV in Canada (see Figure 1).

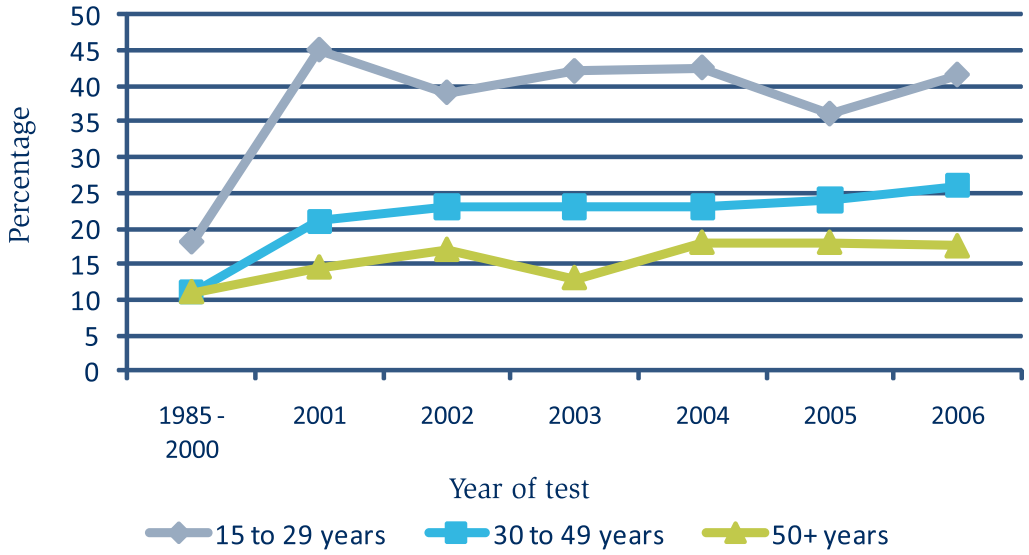
Figure 1. Estimate Exposure Category Distributions (%) of New HIV Infections in Canada, by Time Period.



Source: Public Health Agency of Canada. HIV/AIDS Epi Updates. Ottawa: Public Health Agency of Canada; 2007.

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.[3,4] AIDS diagnoses attributable to heterosexual contact in the same period have also risen from 7 percent to approximately 26 percent.[3-5] This means that while people living with HIV and AIDS in Canada are still most likely to be MSM and/or IDU, those newly infected with HIV are increasingly likely to be heterosexual women. The biggest change has been for young women, between the ages of 15 and 29 years, who accounted for 12 percent of all new infections in the early 1990s, but the proportion increased in this age group almost fourfold by 2006 (see Figure 2).[3-5]

Figure 2. Percent of All Positive HIV Test Reports Accounted for by Women, by Age Group and Year of Test, 1985-2006.



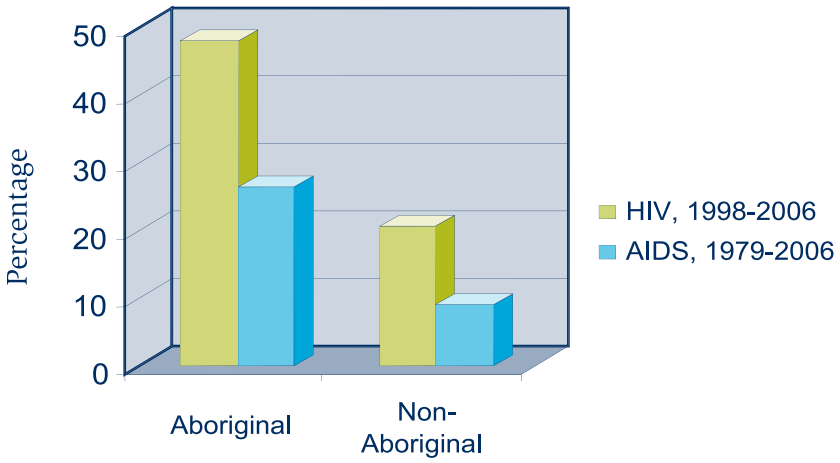
Source: Public Health Agency of Canada. HIV/AIDS Epi Updates. Ottawa: Public Health Agency of Canada; 2007.

Not only are women and girls in Canada experiencing greater risk of HIV infection, but when they are infected with HIV they are more likely to have poorer health outcomes than men and boys. Women tend to have a lower survival rate than men diagnosed with AIDS, because of late diagnosis and delay of treatment due to misdiagnosis of early symptoms; exclusion from drug trials and lack of access to antiretroviral treatment; lack of research into the natural history of HIV in women; higher rates of poverty among women; 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.[6]

Some groups of women and girls are much more vulnerable to infection than others. Black Canadians and Aboriginal peoples have had disproportionate increases while the rates of infection among white Canadians have been dropping steadily in recent years. 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 (see Figure 3).[3] Aboriginal females are generally diagnosed at a much younger age than non-Aboriginal females and are more likely to be infected through IDU rather than through heterosexual contact (see Figure 4). There is also significant variation in age of diagnosis and exposure among Aboriginal women and girls in Canada. First Nations and Inuit women 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

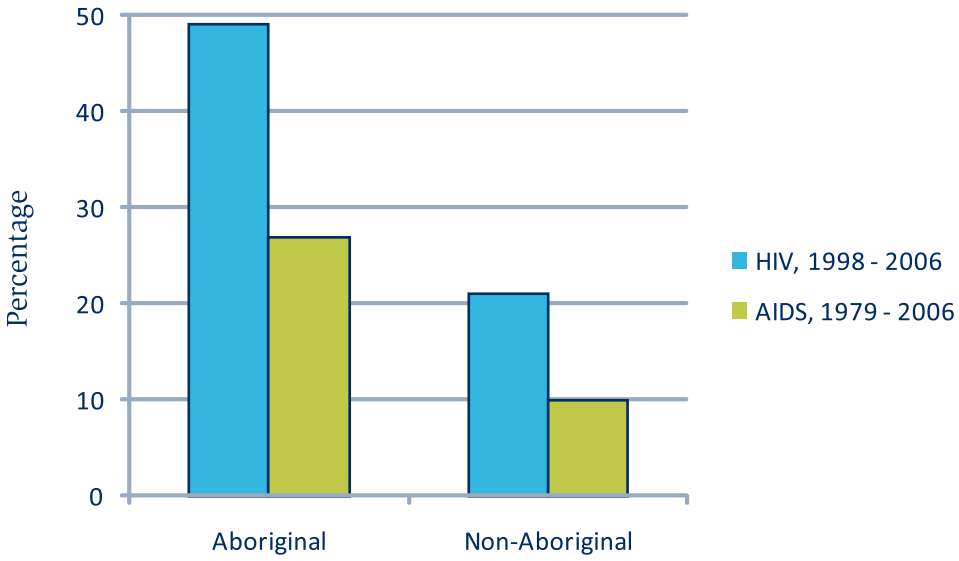
use is the most common method of exposure for First Nations peoples, while heterosexual transmission accounts for the largest proportion of HIV infections among Inuit peoples.[3]

Figure 3. Comparison of Reported AIDS Cases and Positive HIV Reports among Aboriginal and Non-Aboriginal Females.



Source: Public Health Agency of Canada. HIV/AIDS Epi Updates. Ottawa: Public Health Agency of Canada; 2007.

Figure 4. Distribution of Exposure Categories among Positive HIV Test Reports of Aboriginal Females, January 1998-December 2006.



Source: Public Health Agency of Canada. HIV/AIDS Epi Updates. Ottawa: Public Health Agency of Canada; 2007.

Something to Think About

Stigma and discrimination can affect anyone 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."[8,p23] 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."[8,p23] Similarly, pregnant women who test positive for HIV are regularly condemned for exposing an unborn child to the risk of infection and an HIV-positive woman who breastfeeds an infant in Canada could face prosecution.

COMMENTARY

Gender, Place and Mental Health

by Margaret Haworth-Brockman and Jayne Melville Whyte

In 2006, the Standing Senate Committee on Social Affairs, Science and Technology, – led by Senators Michael Kirby and Joseph Keon – issued a report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*,[1] which extensively documented the imperative and potential directions for meaningful change in Canada's mental health services. While the report is undoubtedly important for focusing attention on mental health, there has been criticism of its lack of attention to gender.[a] For example, while the report contains stories by women and some discussion of specific issues, such as criminalized women[b] and Fetal Alcohol Syndrome/Effect, there is no systematic analysis of the different needs and experiences of women and men with regard to mental health issues.

On behalf of Prairie Women's Health Centre of Excellence, Jayne Melville Whyte, with assistance from Joanne Havelock, reviewed the Senate Report.[c] Their analysis from the perspective of rural Saskatchewan demonstrates how gender and place – the location of residence – are crucial components of understanding and responding to the mental health issues of women.

Distance and transportation difficulties in accessing mental health services can prevent rural women from receiving the care they seek. Melville Whyte agrees with the Senate Report recommendations for an increased number of integrated community-based services and she points out the importance of ensuring that services are provided locally in rural areas. Yet, she notes that the limited privacy in small communities may prevent women and men from using local support services. The Senate report does recognize the need to eliminate the stigma associated with mental illness. Melville Whyte recommends that tele-health and phone support lines can be an effective complement to local services. She notes that more attention should have been paid in the Senate Report to the role of

a See Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions. Women, mental health, mental illness and addiction in Canada: an overview [Internet]. 2006 [cited 2009 Jan 14]. Available from www.cwhn.ca/PDF/womenMentalHealth.pdf

b The term "criminalized women" is now used by many feminists to "emphasize the social, economic, political, 'psy-entific,' and cultural processes which underpin the labelling of women as 'offenders'." See Maidment MR. "We're not all that criminal:" getting beyond the pathologizing and individualizing of women's crime. Women Ther. 2006; 29(3/4)z; 35-56, p. 40.

c This discussion is summarized from Melville Whyte J, Havelock J. Rural and remote women and the Kirby-Keon report on mental health: a preliminary gender-place analysis. Winnipeg: Prairie Women's Health Centre of Excellence; 2007.

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 prisoners. 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 frequent domestic violence. Aboriginal women also experience discrimination, both within their own communities and in dealing with non-Aboriginal health services.[7]

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:

> … 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 women who come from countries where HIV is endemic are particularly vulnerable to HIV/AIDS…[8,pi]

Engendering the Response to HIV/AIDS

Given all these facts, it might seem reasonable to expect that the Canadian government and international agencies would already have devised gender-appropriate strategies and interventions for prevention, care, treatment and support. Indeed, there is increasing high-level acknowledgement of the role of sex and gender in the pandemic. 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. Nevertheless, the numbers of people

– especially women and girls – living with and dying from HIV continue to rise. The time has come to revisit and re-evaluate national policies and international guidelines using a gender lens.

In recent years, both UNAIDS and World Health Organization, seen as leaders on HIV/AIDS, have developed publications and recommendations that now include attention to gender as well as to women and girls. A significant exception, 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 and those needed in high-incidence countries (referred to as "generalized epidemic states"). A recent UNAIDS report on HIV prevention reads that:

> 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 prioritizing 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.[9,p19] [emphasis added]

While targeted 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 actually 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 targeted approach to HIV/AIDS.

family violence as well as sexual and other abuse, as a cause of mental health issues for girls and women. Better training for rural police forces in understanding and handling mental health crises would also be beneficial. Overall, Melville Whyte emphasizes that we must address the underlying causes of stress and poor health for rural and remote women: the farm economy, poverty, Aboriginal issues, family violence, balancing work-family-community responsibilities and the need for inter-generational connections and cross-cultural understanding. She also highlights the value of involving rural and remote women in planning processes.

In the final analysis, place and gender play critical roles in mental health. Our response to the mental health needs of women and men living in Canada must include these factors if we hope to create effective and appropriate policies and programs.

References

1. Kirby M, Keon W. Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada [final report]. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology; 2006.

Canada and South Africa: The Importance of Gender

In many respects, Canada's experience with HIV has been dramatically different than that of South Africa. Canada, with an HIV prevalence rate below 1 percent, 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 analyses of the pandemic – and in international guidelines for prevention – is an appreciation that the early trajectory in South Africa is very similar to that of the trajectory in Canada. The first case of HIV in South Africa 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.

Through the 1990s in South Africa, the prevalence of HIV rose 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 infections attributable to heterosexual contact was on par with the number attributable to MSM. Canada's prevalence rate also rose through the 1990s, though not as much or as quickly as in South Africa, and at the same time, HIV infections attributable to heterosexual contact – alone or in combination with other factors – increased in Canada, from 7.5 percent to 37 percent.[3,4] By 2004, the Canadian government did note significant increases in HIV infection, in specific populations, including individuals who are often socially and economically vulnerable. For example, injections drug users, women living in poverty, Aboriginal peoples, young gay men and prisoners are increasingly threatened by the disease.[1]

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."[10, no page] 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 little major social and political change in the last two decades, resulting in the epidemic developing much more slowly here.

Nonetheless, the national responses to HIV/AIDS in Canada and South Africa, particularly in the early years of the epidemic, were similar. Both countries followed the guidelines established by UNAIDS and WHO, targeting specific "high-risk" groups – and this was the wrong strategy (Shisana O 2004, personal communication, Sept 17). Focusing on the high-risk groups, rather than alerting everyone to the threat of HIV/AIDS, led to the epidemic becoming 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 seen in a prevalence rate of more than 1 percent in pregnant women. In the post-apartheid era, the South African government developed and adopted intervention strategies on HIV/AIDS in all

of society, including women and girls. New recommendations focused on the need to address gender inequity across the social, political and economic factors driving the epidemic

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."[11] However, this well-meant approach has failed to halt the pandemic because it ignores the role of gender. Women and girls are not merely 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 7 of the 8 other priority populations: among people living with HIV, people from HIV endemic countries, youth, injecting drug users, Aboriginal peoples and prisoners. The seventh population, men who have sex with men, may not 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."[8,p.19]

Canada's *Federal Initiative to Address HIV/AIDS*[a] is ostensibly "grounded in" the concepts of social justice and the determinants of health, but there is no mention of gender or sex- and gender-based analysis.[11] For example, 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 must move beyond encouraging safe sex practices to deal with the social, economic and political disadvantages that women and girls face. Focusing on target populations encourages neglect of broader social forces driving the epidemic, including gender. "HIV/AIDS programs that explicitly address the subordination that puts all women at risk of HIV appear to be rare in Canada."[8,p.19]

Although attitudes towards people living with HIV/AIDS have been improving in Canada, there is still considerable stigma and discrimination. 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.[12] Approximately one in 10 Canadians surveyed felt that those who contracted HIV got what they deserved.[12,13] In other words, targeted approaches to HIV prevention allows many people 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. This discrimination creates barriers to testing and treatment and deepens the suffering of people living with HIV or assumed to be at risk of exposure.

a See Public Health Agency of Canada. Federal initiative to address HIV/AIDS in Canada. [Internet]. c2007 [cited 2009 Sep 18]. Available from www.phac-aspc.gc.ca/aids-sida/fi-if/index-eng.php

Conclusion

An analysis of 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, policies and programs often remain gender-blind.[2,14] Third, HIV/AIDS strategies should be generalized rather than targeted – because the epidemic is everyone's problem and because gender affects everyone.

References

1. Public Health Agency of Canada. Canadian strategy on HIV/AIDS: moving forward together [Internet]. c2006 [updated 2006 Sept 19; cited 2008 Dec 5]. Available from www.phac-aspc.gc.ca/aids-sida/fi-if/monitoring/can_strat-eng.php

2. Government of Canada. UNGASS country progress report: Canada. [Internet]. c2006 [cited 2008 March 30]. Available from http://data.unaids.org/pub/Report/2008/canada_2008_country_progress_report_en.pdf

3. Public Health Agency of Canada. HIV/AIDS epi updates. Ottawa: Public Health Agency of Canada; 2007.

4. Public Health Agency of Canada. HIV and AIDS in Canada: surveillance report to June 30, 2004. Ottawa: Public Health Agency of Canada; 2004.

5. Avert. Canada statistics summary: HIV statistics [Internet]. c2007 [updated 2009 Sept 4; cited 2009 Oct 21]. Available from: www.avert.org/canstatg.htm

6. Women's Health Bureau. Women and HIV/AIDS in Canada. Ottawa: Health Canada; 2004 [Internet]. c2004 [updated 2006 Mar 28; cited 2009 June 24]. Available from www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/hivaids-vihsida-eng.php

7. Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network. Aboriginal people and HIV/AIDS: legal issues [Internet]. c1999 [cited 2008 March 30]. Available from www.aidslaw.ca/publications/interfaces/downloadFile.php?ref = 1

8. Csete J. Vectors, vessels and victims: HIV/AIDS and women's human rights in Canada. Toronto: Canadian HIV/AIDS Legal Network; 2005.

9. UNAIDS. Intensifying HIV prevention: UNAIDS policy position paper. Geneva: UNAIDS; 2005.

10. Avert. HIV/AIDS in South Africa [Internet]. c2009 [updated 2009 Oct 12; cited 2009 Oct 21]. Available from www.avert.org/aidssouthafrica.htm

11. Public Health Agency of Canada. Populations at risk: why focus on key populations? [Internet]. c2007 [updated 2007 Sept 25; cited 2008 Apr 8]. Available from www.phac-aspc.gc.ca/aids-sida/populations_e.html

12. EKOS Research Associates Inc. HIV/AIDS – an attitudinal survey: final report [Internet]. c2003 [cited 2009 Oct 21]. Available from www.phac-aspc.gc.ca/aids-sida/publication/attitud/pdf/attitudsur062003_e.pdf

13. Public Health Agency of Canada. HIV/AIDS attitudinal tracking survey 2006: final report [Internet]. c2006 [updated 2006 Oct 27; cited 2008 Apr 8]. Available from www.phac-aspc.gc.ca/aids-sida/publication/por/2006/tab1-eng.php

14. Wu S, Sullivan SG, Wang Y, Rotheram-Borus M, Detels R. Evolution of China's response to HIV/AIDS. Lancet. 2007;369(9562):679-90.