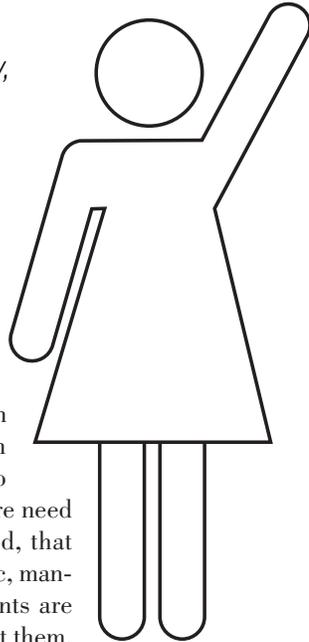


Bearing the brunt

An abridged version
of a speech on
International Women's Day,
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by Louise Binder



There is a common belief today we have the HIV epidemic under control in Canada. People think that infection rates are down, that HIV is no longer a killer, that people therefore need not worry about becoming infected, that treatments have made this a chronic, manageable disease, and that treatments are available to all Canadians who want them.

These beliefs are simply not true, and I would argue that women dispel these mistaken beliefs most starkly. In 2002, women accounted for nearly one-third of the new infections in Canada. Even more startling, in the 15 to 29 age group, they made up nearly one-half of all new infections.

What a devastating situation for these young women whose lives have barely begun. I remember too well the feeling of complete shock and total hopelessness I felt when I was given my diagnosis over the phone by my family doctor.

Is this tragedy an inevitable result of the perceived invincibility of youth or have we as a society failed these young women? I would argue that we must bear a portion of the blame for these infections. We know that women are biologically, economically, socially, and culturally more vulnerable to HIV infection than men. In a practical context, it means that women in violent relationships or who fear violence cannot negotiate safer sex practices. It means that women who are raped are more likely to be infected due to physical trauma that opens wounds for HIV to enter. It means that women who are dependent on their sexual partners for food and shelter for themselves and their children cannot demand condom use.

We have failed as a society to provide women with sufficient resources to leave unsafe relationships or with the tools to protect themselves. We need education and awareness programs targeted to women and their partners, more shelters for women to

escape the nightmare of violent relationships, adequate social assistance programs to give them independence, and more drug rehabilitation programs to ensure they can participate fully in supporting themselves and their families. We also need more money for research for microbicides, a user-controlled form of HIV protection. And we desperately need to tackle the stigma and discrimination that has made so many of us ashamed to declare our medical status publicly.

One of the most heartbreaking moments I can remember is a phone call informing me that my wonderful, bright, funny girlfriend Candace had jumped to her death from the fifteenth floor of her apartment building as her care worker made her bed in the other room. Her body had not yet succumbed to this disease, but the depression, fear, and shame she felt about her HIV status drove her to end her life.

There is clearly much work to be done to recognize the vulnerability of women to HIV. It is also clear that some groups of Canadian women, such as aboriginal women, have additional risk factors that increase their vulnerability to HIV. Research and common sense tell us that social factors, including racism and sexism piled on top of stigma, discrimination, and poverty, have more to do with vulnerability to HIV than does individual behaviour. Shockingly, aboriginal women make up one-half of all new infections among aboriginal people. Nearly one-half of these women are between the ages of 15 and 29. Aboriginal women are twice as likely to be infected by injection drug use than by sexual contact.

We need new and dedicated resources to reach these women and their partners. We need better harm reduction strategies, more affordable housing, more resources for women to leave violent relationships, and more childcare for single mothers.

Our society must create the necessary social environment to support self-determination. Otherwise, we will merely perpetuate the terrible situation in which this generation of women finds itself.

Imagine the layers and layers of discrimination a woman feels

because of her gender, because she is aboriginal, because she is an injection drug user, and because she is poor, unemployed, and probably homeless or underhoused. Nowhere is this social recipe for HIV more apparent than in Vancouver's Downtown Eastside.

Studies in Vancouver show that the incidence of HIV among female drug users is 40 percent higher than among male drug users. These women are more likely to be aboriginal, to be young, to have had non-consensual sex, to have an intravenous drug-using male partner, to inject heroin and cocaine, to smoke crack, and to need assistance with injecting.

I have watched, first hand, the impact of drug addiction and HIV on women. Last year, a dear, HIV-positive friend and colleague at Voices of Positive Women died. She was also an injection drug user,

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on and off, for many years. When she wasn't using, she was one of the most reliable and hard-working people I knew. She had a dignity I truly admired, and she never appeared to feel sorry for herself. She just couldn't beat her addictions. Finally, her liver failed due to a combination of disease and drug toxicities. Once again, the inescapable and only logical conclusion is that we urgently need resources for gender and population-specific programs, such as needle exchanges, safe injection sites, and street nurses.

Women from HIV-endemic countries in Africa and the Caribbean are another group who have been sadly overlooked and underestimated regarding their risk for HIV infection. When a report from the Toronto Hospital for Sick Children found that 70 percent of the maternal-infant transmissions of HIV at that hospital in 1996 had occurred among people from HIV-endemic countries, the magnitude of the problem could no longer be ignored. In-depth research showed that HIV-positive women from endemic countries represented a startling one-third of AIDS-related deaths in 1996 in Ontario. An estimated 30 to 40 percent of those infections occurred after the establishment of residence in Canada, contrary to the popular belief that these immigrants brought the virus to Canada.

For these women, deeply rooted socio-cultural and structural factors intersect with gender, race, class, political, and economic conditions. In these societies, where the well-being of the family and the community supersedes the well-being of the individual, strategies must target whole communities in order to modify cultural values, beliefs, norms, and practices that increase the risk of HIV infection.

Women in prisons also face high infection rates for HIV as well as for hepatitis C. Some enter prison with HIV, but many are

infected in prison due to injection drug use and tattooing. These infections are easily prevented by implementing policies that ensure access to clean needles and safe injection practices.

Clearly, we are dealing with an epidemic among women that is fuelled by complex social, economic, cultural, and racial factors. Discreet strategies are required to reach these groups of women effectively and to reduce their risk for HIV. This will require new resources and strategies developed by the communities themselves.

Not only is there much to be done for each group on the prevention front, but Canada also has much to do to ensure that treatments are reaching all of these populations. Treatment and prevention are inextricably linked. For those of us who have been able to obtain treatments, they have been nothing short of life saving. There is a widely held belief that everyone in Canada who needs treatment can access it. This is simply not true. Most provinces have a program to provide some medications to people, but these plans are not universal, comprehensive, or easily accessible.

Studies have shown that many women do not access medications. One Vancouver study showed that a shocking one-third of people who died from AIDS between 1995 and 2001 had not been taking antiretroviral treatment—in a province where medication is free. Those worst off were aboriginals, women, and the poor. Inability to access and navigate the system due to money, culture, language, and power barriers impedes access to medications.

In some cases, the system is simply too costly, with unaffordable co-payments or deductibles. Or it requires an ability to understand bureaucratic forms and procedures that are too complex for most people, or a level of tenacity that a marginalized person may well not have.

Canada made a wonderful start to turning this situation around when it introduced the Canadian Strategy on HIV/AIDS in the early 1990s. Sadly, this strategy is now woefully underfunded to meet the particular challenges faced by women, among others. More funding is also required by provincial governments.

Canada wisely endorsed the United Nations Declaration of Commitment on HIV/AIDS in June 2001. Full implementation of the priorities set out in this Declaration will go a long way to combat HIV in Canada.

I believe that HIV is much more than a virus. It has socio-economic, political, and ethical dimensions, the likes of which humanity has never before encountered. It has brought out the worst in some of us. But I believe that it has also brought out the best and will continue to do so. ⊕



Louise Binder is the chair of the Canadian Treatment Action Council.