WOMEN'S ISSUES: UPDATE

Addressing the gender inequalities that drive the HIV/AIDS epidemic among women and girls in Canada

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The face of HIV/AIDS has changed. In most parts of the world, the time is long past that HIV/AIDS can be regarded as affecting primarily gay men. Since the beginning of the epidemic, women and girls have accounted for a steadily larger proportion of new HIV infections in Canada, primarily as a result of sex with an HIV infected male partner. Part of women's vulnerability to HIV/AIDS is physiological. However, in Canada as in the rest of the world, the impact of the disease among women and girls cannot be understood without reference to their marginalization, subordination, and exposure to poverty and physical and sexual violence. Canada is beginning to recognize the need to address women's subordination in response to the epidemic. More action is needed.

An overwhelming number of women and girls in Canada are exposed to violence and abuse. Women in Canada are more likely than men to live in poverty and to be economically dependent on others. Women suffer sex-related stigma and discrimination at home, at work, on the streets. They tend to bear disproportionately the burden of caring for children and other family members. Many of these inequities themselves amount to human rights tragedies. They also lie at the root of women's vulnerability to HIV/AIDS. Patterns of HIV prevalence, as well as AIDS-related health outcomes, closely track poverty and social marginalization among women in Canada.

Virtually all women have to deal with social and economic subordination in some aspects of their lives, but some women in Canada face additional challenges that augment their HIV risk. HIV prevalence is higher among Aboriginal women who, due to historical and continuing marginalization of their communities, face heightened poverty, violence and exclusion. Some women in the sex trade may also face risks of violence and coercion, which is compounded by the criminal prohibitions related to prostitution that drive sex work underground into less safe venues. Women in prison in Canada often have poor access to prevention, treatment and care information and services. Women from HIV endemic countries may face racism and xenophobia, compounded by harmful traditional practices like female genital mutilation, and may fear deportation or lack information on their immigration status. These factors may prevent them from seeking HIV/AIDS services, including testing. HIV/AIDS-related stigma from their own communities may create additional barriers.

Prevention strategies in Canada risk being ineffective where they fail to take women's second-class status into account. Programs in Canada often focus on curbing particular behaviours like sex with multiple partners and condom use. But poverty, threat of violence, and economic dependence means that women often cannot choose when, with whom, and on what terms they have sex. Does it make sense to spend money urging women to use condoms when they may face violence, abuse, or economic abandonment for raising the issue with their partners? A broader approach

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is needed—one that focuses on getting women out of situations that put them at risk.

Current prevention strategies can contribute to women's subordination. In many provinces, pregnant women are tested for HIV routinely unless they take the initiative to decline testing. There is some evidence that women do not receive the information and counselling that are supposed to accompany HIV testing. They may not feel empowered to refuse testing, or they may not have a good understanding of the consequences of testing positive. Pre- and post-test counselling is especially important for women, who may face more stigmatization upon diagnosis than men. They may be accused of promiscuity or other bad behaviour. Women who risk violence, abuse or abandonment by partners on whom they are economically dependent will have especially difficult choices to make if they test positive. All women should be encouraged to take HIV tests, but the right of all women, including pregnant women, to informed consent should not be sacrificed.

Women may find it more difficult to start and maintain HIV treatment. Research shows that women tend to be diagnosed with HIV later in the course of the disease than men, which compromises the chances for successful treatment. This may be because women are not as readily referred for testing as men due to lingering misconceptions that they are not at risk. Upon diagnosis, women may have a hard time balancing their own need for treatment with the burden of caring for children, family members and partners.

Treatment programs are not sufficiently tailored to meet women's needs. Part of the problem is that the research has not focussed on women's treatment needs. Antiretroviral therapy is effective for both women and men, but it affects women slightly differently. For example, women may experience different changes in body fat distribution associated with antiretroviral therapy, of which the psychological impact specific to women is little understood. There is a shortage of scientific studies on sex differences in response to antiretrovirals, partly because women have been so underrepresented in large sample studies. Women have turned to informal networks and sharing of personal anecdotes to make up for the lack of research-based clinical information and advice on treatment that is tailored to women.

Governments in Canada have recognized some of these problems, but greater recognition and action are needed. Programs that address poverty among women and violence against women and girls should be expanded and linked to HIV/AIDS efforts. Research must be conducted on how prevention and treatment programs affect women compared to men. Prevention and treatment programs should be tailored to women's realities, including creating and expanding peer-driven programs that speak credibly to them. Treatment programs should take into account the constraints that women face in child care, transportation and other practical demands, as well as fear and stigma that they live with. Finally, human rights institutions need to be made more accessible and effective so that women can call on legal protection against discrimination.

These steps will not eliminate the gender inequalities that drive the epidemic among women in Canada. But they are steps in the direction of a more coherent, effective, rights-respecting response to HIV/AIDS among women and girls. ■