UNDERSTANDING THE EPIDEMIC

An Invisible Epidemic: The Implications of Gender Neutrality for Managing HIV/AIDS in Low-incidence Countries

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As the HIV/AIDS epidemic has grown and changed in the past fifteen years, the international community has focused increasingly on regions hardest hit by the pandemic—sub-Saharan Africa in particular. International agencies, funders and researchers, corporations, national and local governments, and civil society are under pressure to devise responses to and solutions for the devastation wrought by HIV/AIDS. However, limited attention has been paid to the role of gender in the epidemic or the heightened vulnerability and suffering experienced by women and girls. While gender blindness is beginning to recede with respect to high-incidence regions, for many low-incidence countries—including Canada—it continues to confound the management of HIV/AIDS. Unless we recognize gender as a crucial factor in the spread of HIV, low-incidence countries may soon be transformed into high-incidence countries.

There are many reasons why HIV/AIDS remains invisible in low-incidence countries such as Canada. First, we tend to ignore HIV precisely because the incidence is low; only a tiny proportion of our population—less than 0.3 percent—is living with HIV. Second, HIV/AIDS rates pale in comparison with many other chronic diseases. Because Canadians are more likely to live with and die from conditions other than HIV, policies and programs tend to focus on diseases such as cancer, cardiovascular disease, and diabetes. Third, we may ignore the epidemic because it seems to be confined to specific groups within our society—men who have sex with men (MSM) and injection drug users (IDUs) accounted for 70 percent of reported AIDS cases in Canada between 1999 and 2003. Canadians may assume that HIV/AIDS is a threat only to a small proportion of the population who engage in "risky behaviours" or, alternatively, they believe we have the means at hand to deal with the epidemic. As a result, we assume that HIV/AIDS will never pose the same challenges for us that it has for high-incidence countries. But changing patterns of HIV infection should sound an alarm for Canadians.

Between 1995 and 2001, transmission through heterosexual contact has risen alarmingly, from 7.5 percent to 30 percent. Similarly, AIDS diagnoses attributed to heterosexual contact in the same period have increased from 10.6 percent to 44.7 percent.[1] While these trends affect both men and women, they have had a deeper impact upon women. In 1998, approximately one-third of women diagnosed with HIV had contracted the virus through heterosexual contact. Five years later, in 2003, this proportion had risen to 65 percent. Thus, while people living with HIV and AIDS in Canada are still most likely to be MSM and/or IDUs, those newly infected with HIV are increasingly likely to be heterosexual women.

At the same time, infection rates among women of all ages are increasing. Among adults diagnosed with HIV between 1997 and 2001, the proportion who are female rose from 12 percent to nearly 25 percent, while the proportion of adult women living with AIDS rose from 6.1 percent in 1994 to 16.5 percent in 2002.[1] The biggest change has been seen among 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 had risen to nearly 50 percent by 2004.

Not only are women experiencing greater vulnerability and new kinds of vulnerability to HIV, they also 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."[2]

Vulnerable Populations in Low-incidence Countries

Some Canadians are more vulnerable to HIV infection than others. Rates of infection among white Canadians have been

dropping steadily in recent years, but Black Canadians and Aboriginal peoples have experienced disproportionate increases. Aboriginal people, for example, represent approximately 5 percent of the total population of Canada, but in 2004, 16 percent of all new HIV infections were found among Aboriginal people. Aboriginal women are likewise disproportionately affected by HIV compared with non-Aboriginal women. They are more likely to be infected through intravenous drug use—though heterosexual contact runs a close second—and they tend to be infected at earlier ages than non-Aboriginal women in Canada.

In part, these trends can be attributed to the fact that Aboriginal people are over-represented in high-risk groups, such as IDUs, sex trade workers, and prison inmates. For example, a female treaty Indian is 131 times more likely to be incarcerated than a non-Native woman.[3] Similarly, in a study of IDUs in Regina in 2000, 90 percent self-identified as Aboriginal.[4] More importantly, Aboriginal people *are* over-represented in at-risk groups because of the social, economic, and cultural conditions of their lives. Aboriginal women, in particular, are more likely to have inadequate or unstable housing or to be homeless; they are more likely to be unemployed or underemployed and living in poverty; they are more likely to have experienced sexual or physical abuse before the age of 12 or to be experiencing domestic violence currently; they are more likely to be isolated in a multitude of ways. All of these factors increase privation, dependence, and the risk of exposure to HIV infection.

Research, Policy, and Practice on HIV/AIDS

Despite the implications of these patterns of HIV infection for women, Canada's research, policies, and programs remain largely "gender neutral." Issues affecting women and girls are under-represented in research. For example, an analysis of recent annual meetings of the Canadian Association on HIV/AIDS Research (CAHR) reveals that fewer than 10 percent of conference presentations dealt with women, girls, or gender.

In a country such as Canada, which enjoys publicly funded health care and a standard of living among the highest in the world, we seem to think that we have little to worry about when it comes to HIV/AIDS. We have active prevention and education campaigns and we can, in theory, offer care, treatment, and support to all those infected and affected by the pandemic. But we would do well to shed these assumptions and attend to the experiences of countries ravaged by HIV/AIDS, such as South Africa.

The first case of HIV in South Africa was diagnosed in 1982 and the disease was initially found mainly among men having sex with men. By the early 1990s, things began to change rapidly in South Africa: the number of infections attributed to heterosexual contact equalled those ascribed to homosexual contact, and the proportion of women infected with the virus began to soar. According to Dr. Olive Shisana, president of the Human Sciences Research Council in South Africa, the absence of gender mainstreaming in policies and programs has been responsible, in no small measure, for the plight of women and girls in sub-Saharan Africa.[5]

The history of the epidemic in Canada resembles that of South Africa. The first case of HIV was diagnosed in 1982 and for many years the disease was found mainly in men having sex with men. While the shift from homosexual to heterosexual exposure and mounting vulnerability for women and girls has been slower in Canada, the trends nonetheless mirror those of South Africa. It is time that we recognized the central role of gender in the HIV/AIDS pandemic and it is time to amend our responses to the needs and experiences of women and men, boys and girls.

NOTES

1. Public Health Agency of Canada. *HIV and AIDS in Canada*. Ottawa: Queen's Printer, 2004.
2. Women's Health Bureau, Health Canada. *Women and HIV/AIDS Factsheet*. Ottawa: Queen's Printer, 1999.
3. Canadian HIV/AIDS Legal Network. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Toronto: Aids Law, 2002. www.aidslaw.ca
4. Findlater R, Young E, Bangura H, Sidaway F, Hay K, Archibald C, Siushansian J, & Williamson N. *The Regina Seroprevalence study: A profile of injection drug use in a prairie city*. Unpublished report. 2000. In Public Health Agency of Canada, *HIV/AIDS Among Aboriginal Peoples in Canada: A Continuing Concern.* www.phac-aspc.gc.ca/publicat/epiu-aepi/epi_update_may_04/9_e.html
5. Shisana O. *Gender and HIV/AIDS: Focus on Southern Africa.* Keynote Address, Inaugural International Institute on Gender and HIV/AIDS, Southern Africa, 2004. www.hsrc.ac.za/research/programmes/SAHA/news/20040607Paper.pdf