Gender Considerations for HIV/AIDS Target Populations

Submitted to HIV/AIDS Coordination and Programs Division
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Target Population: Aboriginal People

Prevalence and Incidence in the Population, Trends and Gaps

The term 'Aboriginal' refers to First Nations, non-Status, Inuit and Métis peoples. It is important to note that different Aboriginal groups are afforded different legal status and entitlements to health services in Canada.

Aboriginal people are over-represented in the HIV/AIDS epidemic in Canada.
Between 1998 and 2004, 1,010 of the 4,475 people diagnosed with HIV for whom ethnicity was reported were Aboriginal. Of these 554 are males, 453 are females and 3 are transgendered persons. HIV infection rates are rising among Aboriginal peoples, particularly among women: females represent nearly half of all positive HIV test results among Aboriginal persons, whereas in non-Aboriginal populations women represent approximately 20% of the positive test results. Of the 17,060 cases of AIDS diagnosed between 1979 and 2004 with information on ethnicity, 532 were reported to be Aboriginal (3.1%, 398 males, 1 transgendered person and 133 females). In 2003, Aboriginal persons accounted for 14.4% of the total reported AIDS cases with known ethnicity, an increase from a percentage of 1.2% before 1993. Aboriginal persons are being infected with HIV at a younger age than non-Aboriginals: 28.7% of those infected are under the age of 30. Injection drug use (59.4%) and heterosexual exposure (29.8%) are the leading exposure categories among Aboriginal people in Canada.

Gender Specific Issues for Aboriginal People

Research continues to find disproportionately high levels of HIV incidence and prevalence among Aboriginal Canadians of both sexes, but most alarmingly among women.

Both female and male Aboriginal persons test HIV+ at younger ages than non-Aboriginal counterparts, suggesting the need for education and intervention materials geared and targeted for younger ages: girls and boys.

Aboriginal women are particular vulnerable to entering the sex trade and adopting coping behaviours that put them at risk for HIV/AIDS because of their experience of: extreme poverty, histories of violence and abuse and feelings of powerlessness in a home community and on city streets. In a Manitoba study Aboriginal women related their journeys, leaving abusive rural homes, migrating to cities, being introduced to street drugs, and entering the sex trade as self-identified risks for HIV/AIDS.

Leaving home at a very young age means that women and men will be missing basic education and employment skills, so programs need to include social supports beyond those directly related to HIV/AIDS. Education and prevention programs are needed for boys and girls, separately, in home communities, *before* people migrate to the cities.

Culturally appropriate community-based interventions need to be developed in consultation with Aboriginal women that include consideration of the position of Aboriginal women in their immediate community, power relationships and possible histories of discrimination, violence and abuse.

Gender Considerations for HIV/AIDS Prevention, Care, Treatment and Approaches for Aboriginal People:

While we don't have all of the answers relating to gender considerations for aboriginal people, there are some questions that you can ask yourself to guide your work:

- When you are gathering information about Aboriginal people and HIV/AIDS in Canada, have you looked for and found statistics and other kinds of data (including qualitative information) for both females and males?
- Have you looked for and been able to find up-to-date, relevant research on gender differences, social power differences, opportunities and barriers, racial discrimination and the history of colonization to inform your work?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need among female and male Aboriginal people?
- Have you consulted Aboriginal agencies and individuals in the design and/or implementation of your funding application, study, program or policy? Who are your Aboriginal partners?
- Have you considered the different health service entitlements of Inuit, Métis, First Nations and other Aboriginal women and men? What is the ancestry of the Aboriginal women and men you will work with? Who provides their health care (provincial or federal)? What happens if they move to another jurisdiction?
- Have you captured the voices and perspectives of both Aboriginal men and women in your funding application, study, program or policy, as appropriate?
- Have you thought about the pressures on and the needs of different groups of women and men:
  - urban or rural and migration trends?
  - inner city or suburban?
  - on-reserve or off-reserve?
  - youth versus older women and men?
  - culturally and racially diverse?
  - lesbian, gay, bisexual, two-spirit, trans-gendered, and/or heterosexual?
  - street-involved or homeless?
  - those engaged in sex trade or survival sex?
  - those in or in conflict with the justice system?
- Have you tailored your work to the specific group with whom you will be working, taking these factors into consideration?
- Have you considered the ways in which gender roles and expectations will make it easy or difficult for Aboriginal women and men to be involved in, access or use your study, program or policy?
- Does your study, program or policy support both Aboriginal women and men who are at risk, infected and affected by HIV/AIDS? If you are focusing on one sex or gender, can you articulate why?

From Local to Global Context

Aboriginal people are over-represented in high risk groups of IDUs, sex trade workers and prison inmates. Aboriginal women are particularly vulnerable to HIV infection and the data demonstrates the alarming rise in incidence. Poor housing and sanitation on Reserves, lack of appropriate public education and services, and limited economic opportunities are systemic problems which are

quickly compounding the HIV/AIDS rates among Aboriginal people, women in particular. History shows that in other parts of the world, inattention to the most marginalized, and gender neutrality, can transform the picture of HIV/AIDS in a very short time.

Target Population: People from Countries Where HIV/AIDS is Endemic

Prevalence and Incidence in the Population, Trends and Gaps

The World Health Organization and UNAIDS, like other surveillance agencies, defines an "HIV-endemic country" as one in which: more than 1% of the population is infected with HIV; 50% or more cases can be attributed to heterosexual contact; HIV prevalence among women receiving prenatal care is greater than or equal to 2%; and the male to female ratio of infections is 2:1 or less. To date, only two regions of the world, Sub-Saharan Africa (7.4%) and the Caribbean (2.3%) are considered HIV-endemic and infection rates within these regions vary widely from country to country. In the Caribbean, for example, Haiti has an estimated prevalence rate of 5.6% as compared with 1.2% in Jamaica (Canada's prevalence rate is 0.3%).

In 1998, the Public Health Agency of Canada (PHAC) adopted "HIV-endemic" as an independent exposure category; previously it had been combined with heterosexual contact. But tracking HIV-positive people from HIV-endemic countries continues to be uneven because this category captures only those infected through heterosexual contact and misses those infected through injection drug use, blood and blood products, and homosexual contact. Moreover, HIV reporting often lacks information about country of birth or ethnicity. In 2002, the Canadian government mandated HIV testing as part of the routine immigration medical assessment; from January 2002 to June 2004, 772 immigration applicants tested positive for HIV, accounting for 12% of the positive HIV test reports during this period. Although mandatory testing of this kind creates a clearer picture of the HIV status of newcomers, it does not deepen our knowledge about people from HIV-endemic countries who migrated to Canada prior to 2002 – the vast majority. For all these reasons, we must view statistics for this population with considerable caution.

Between 1985 and 2003, people from HIV-endemic countries accounted for an estimated 3.9% of positive HIV test reports among adults in Canada. Given that heterosexual contact is the dominant mode of HIV transmission in endemic countries, it is not surprising that immigrant women are disproportionately affected; in 2003, 22.2% of positive HIV tests for adult females were attributed to origin in an HIV-endemic country, as compared with 6.7% of adult males. Mother-to-child transmission (MTCT), in turn, is also higher among women from HIV-endemic regions; in one Ontario study, 70% of MTCT was among women from these regions of the world. People from HIV-endemic countries also tend to be diagnosed at a younger age than other people living with HIV/AIDS in Canada.

Gender Considerations for People from Countries where HIV/AIDS is Endemic

The communities of people from countries where HIV is endemic are diverse, reflecting variations in historical backgrounds, language, ethnicity, culture, governance, economies, etc. Many of these communities are seriously affected by social, economic and political factors that increase the risk of exposure to HIV and create barriers to prevention, diagnosis, treatment and support. Stigma, prejudice and discrimination – coming from within communities as well as from the dominant cultures in Canada – further disadvantage immigrants, including those from HIV-endemic countries.

Both males and females from HIV-endemic regions face many of the same challenges, such as poverty, homelessness, underemployment, racism and fear of deportation. A lack of training in culturally appropriate care among front-line health care workers can also make it difficult for immigrants to trust and get health care and social services. For instance, men may be reluctant to

undergo HIV testing because of negative attitudes towards homosexuality and bisexuality in their culture or in Canadian society. Women may likewise fear being labeled promiscuous or unfaithful and being shunned by family and community if diagnosed HIV positive. In many cultures, it would be highly inappropriate for a male physician to attend a woman or for a female physician to attend a man, making it difficult for people from HIV-endemic countries to get appropriate services in their new Canadian communities.

At the same time, women and men also face specific challenges. Female immigrants are more likely to remain in the home after settling in Canada, and thus their language skills and their ability to navigate the health care system and other social services remain limited. The economic dependence of women on men can also affect men and women differently. Men may be reluctant to be tested or to reveal their HIV status for fear of losing their jobs, which could affect their self-esteem as well as the welfare of their families. Women in such circumstances might find it difficult to refuse or negotiate safe sex.

The PHAC, like other organizations monitoring the HIV epidemic, has tended to focus attention and efforts on immigrants coming to Canada from HIV-endemic regions and countries, but many of the challenges faced by these newcomers are identical to those facing other immigrant groups. We must be mindful that HIV status – positive or negative – cannot be assumed based on someone's country of origin, their sex or their sexuality. Rather, understanding the role of the determinants of health – poverty, gender, ethnicity, violence, etc. – is critical to the development of culturally competent diagnosis, care, treatment and support for those infected or affected by the HIV/AIDS pandemic.

Gendering HIV/AIDS Prevention, Care, Treatment and Support Activities for People from Countries where HIV/AIDS is Endemic

From the foregoing discussion, it is clear that we cannot provide comprehensive gendered guidelines for every situation facing every person arriving in Canada from an HIV-endemic country. But there ***are*** questions you can ask that will help to raise awareness of gender issues for during the development of policies, programmes, services and activities aimed at these populations.

- Does the data collected distinguish between girls and boys, women and men from countries where HIV/AIDS is endemic? Are you able to find statistics and other kinds of data for both females and males from this group?
- Have you looked for and been able to find up-to-date, relevant research on gender roles specific to the particular country you are working on, in order to inform your work?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need amongst men and women from HIV-endemic countries? How do these factors differ depending on the country of origin?
- Have you thought about the pressures on and the needs of different groups of females and males from HIV-endemic countries?
- Are men, women, boys and girls considered separately in the funding application, study, workshop, service, program or policy which you are developing? If not, can you articulate why you are working with one sex or the other?
- Have you captured the voices and perspectives of both females and males from HIV-endemic countries in your funding application, study, workshop, service, program or policy?

- Are both women and men representatives from the community of those from HIV-endemic countries involved in decisions about your funding application, study, workshop, service, program or policy?
- Is your work presented with language and a format that is accessible to both local women and men for the population your work is targeting? Does it address differences in social and economic power between women and men from this community?
- Does your study, service, workshop, program or policy support both female and males from HIV-endemic countries who are at risk, infected or affected by HIV/AIDS?

From Local to Global Context

HIV-endemic regions comprise some of the poorest and least developed countries in the world. Poverty does not cause HIV/AIDS, any more than lack of education or racism does, but these determinants of health all put people at greater risk of exposure to the virus and make it much more difficult for HIV-positive individuals to find, get and benefit from services. Policies and programmes for people from HIV-endemic countries, as for other disadvantaged populations, need to address the role of gender in their countries of origin as well as in their new homes.

Although countries in Sub-Saharan Africa and the Caribbean are the most severely affected by the HIV/AIDS pandemic, other regions of the world, including Eastern Europe, Asia and North America, are edging closer to HIV-endemic status. We need to learn from people and countries that have long grappled with HIV/AIDS; their knowledge, experience and voices can add to our understanding of the global challenge presented by HIV/AIDS and help chart the direction for altering its course here in Canada and around the world.

Target Population: Injection Drug Users

Prevalence and Incidence in the Population, Trends and Gaps

Of 28,020 HIV+ cases reported since 1985 when exposure category reporting began, 16.7% were attributable to injection drug use (IDU). Of this percentage, 68.8% were among males; an additional 2.4% were attributed to IDU men who have sex with men (MSM/IDU). However, the proportion of HIV positive tests attributed to IDUs has decreased gradually from 1999 (28.3%) to 2003 (18.4%). The proportion of HIV positive tests among adult females attributed to IDU peaked at 47.5% in 1999 and declined to 27.0% in 2003. Since 1996, approximately $^1/_3$ to ½ of new HIV+ results among women are attributed to IDU. The co-occurrence of Hepatitis C with HIV is high in IDU populations, averaging a rate of 19.6% across study participants from several provinces.

Of 18, 463 cumulative adult AIDS cases with known exposure category (to June 2004), 7.4% (1,366) were attributed to IDU; of these 73.3% were males, 4.3% (794) were attributed to MSM/IDU. Women represent 26.5% of the total cumulative adult AIDS cases attributed to IDU. There has been a rise in the rate of IDU among reported adult AIDS cases from 6.1% in 1993 to a peak of 21.4% in 1998 with rates between 15% and 21.1% since 1998. Female AIDS cases attributed to IDU increased steadily from 18.0% in 1992 to a peak in 1998 at 46.2%, dropping to 39.6% in 2000.

Age and ancestry are both factors to consider. The age group with the highest incidence of HIV attributable to IDU is 30-39 (43.8%) followed by people aged 40-49 (31.3%); however injection drug use can start by age 16, increasing the risk for youth. Aboriginal women and men are over-represented in IDU populations: a 2002 found 63% of all new HIV infections among Aboriginal persons were attributed to IDU.

Gender Considerations for Injection Drug Users

Many IDUs are involved in the sex trade or engage in survival sex. Up to 14% of male IDUs reported having had sex with another man in the last 6 months, which in instances where the sex was without condoms, would further increase risk for HIV infection.

Condom use is inconsistent for females and for males. For women, they report using condoms most of the time during penetrative sex with male partners, but less so during oral sex. In a Canadian study, HIV positive women report they can insist that paying clients use condoms, but in fact clients frequently do not, a discrepancy between perceived and actual ability to negotiate condom use.

Women with past and current experience of poverty, violence and abuse, racial discrimination, limited education, and other barriers to employment may enter the sex trade. Substance abuse and IDU are behaviours adopted to cope with the stress and insecurity of street life, and are often normalized behaviours within this community. Women's initiation into drug and alcohol use is often directly associated with the presence of a substance-using male sexual partner.

Men and women engaged in the sex trade tend to also have more risky injection behaviours. Sharing needles is common among men and women, perhaps more common among women. In prisons, women inmates may be more likely to share needles with partners, compared to their male counterparts.

Gender Consideration for HIV/AIDS Prevention, Care, Treatment and Approaches for IDUs:

There is not yet a great deal of research about the particular circumstances that lead women and men to the intersecting risks of injection drug use, street living and sex trade work, though there is some strong early work. The fact that the risk factors do overlap in some cases, and are compounded by gender roles and power imbalance needs to be addressed to prevent further HIV/AIDS transmission as well as treat those already infected. There are some questions which can help to ensure your work on IDUs and HIV/AIDS takes into account gender considerations:

- When you are gathering information about injection drug users in Canada, have you looked for and found statistics and other kinds of data (including qualitative information) for both females and males?
- Have you looked for and been able to find up-to-date, relevant research on gender differences that lead to IDU and high risk behaviours to inform your work?
- Have you considered the ways in which sexual biology and gender roles and expectations can create different types and degrees of risk or need among female and male IDUs?
- Have you consulted former and present male and female IDUs in the design and/or implementation of your funding application, study, program or policy?
- Have you captured the voices and perspectives of both female and male IDUs in your funding application, study, program or policy?
- Have you thought about the pressures on and the needs of different groups of female and male IDUs: urban or rural and migration trends; inner city or suburban; Aboriginal and non-Aboriginal; on-reserve or off-reserve; youth versus older users; culturally and racially diverse; lesbian, gay, bisexual, trans-gendered, and/or heterosexual; street-involved or homeless; those engaged in sex trade or survival sex; those in or in conflict with the justice system?
- Have you considered the ways in which gender roles and expectations will make it easy or difficult for male and female IDUs to be involved in, access or use your study, program or policy?
- Does your study, program or policy support both female and male IDUs who are at risk, infected and affected by HIV/AIDS?

From Local to Global Context

The Canadian HIV/AIDS Legal Network has highlighted the urgency of the situation of injection drug use and HIV/AIDS in the country as a "public health crisis", and that the spread of HIV among injection drug users in Canada merits serious and immediate action. With Canada's international reputation for respecting human rights law and harm reduction measures, it follows that Canada should lead in the international response to not only our own "public health crisis", but one which is reflected across borders and across continents. Injecting drug use is increasingly prevalent in the world, with recent estimates indicating that there are over 13 million people injecting drugs globally. The number of countries reporting HIV infection among IDUs has more than doubled in the last decade, from 52 in 1992 to 114 in 2003. Injecting drug use is now being attributed to over

10% of new HIV infections globally, but the numbers are significantly higher in particular regions such as Central and Eastern Europe, the former Soviet Union and Central Asia.

Given the situation at home and abroad, Canada has a key role to play in developing alternatives to the harsh policing practices of enforcing drug prohibition, which have been shown to lead to human rights abuses (including assault, torture and extra-judicial executions), to fuel vulnerability to risky injection practices and to limit drug users' access to prevention, care, treatment and support services. Some harm reduction strategies for HIV and IDUs include services such as needle exchange programs, methadone therapy, safer injection sites and peer-driven interventions.

Target Population: Men Who Have Sex with Men (MSM)

Prevalence and Incidence in the Population, Trends and Gaps

From the earliest days of the HIV pandemic, the largest proportion of those diagnosed with HIV and AIDS-related illnesses have been men who have sex with men (MSM). Before 1999, for example, close to 75% of positive HIV test results among male adults were attributed to men who had sex with men. Although this number decreased to around 50% by 2000, it has remained relatively constant since then, meaning that MSM still represent a major proportion of those infected and affected by HIV. Of the estimated 56,000 people in Canada living with HIV/AIDS at the end of 2002, 58% were MSM.

As with other populations in Canadian society, rates of HIV infection vary across the country for MSM. The highest rates of infection for MSM are found in Canada's largest urban centres, though recent studies suggest that the concentration of HIV and AIDS among MSM in these cities may be a result of larger communities of men who have sex with men, as well as better access to HIV testing, treatment, care and support.

Like others at risk of exposure to HIV, MSM are most likely to be infected through unprotected sexual activity – consensual or otherwise – and through the use of injection and other drugs. For instance, in one study of young gay and bisexual men in Vancouver and Montreal, 56% of HIV positive men and 40% of HIV negative men engaged in unprotected sex. The Ontario Men's Survey similarly found that 40% of participants reported having had unprotected sex with another man during the preceding year. According to the same study, men who exchanged sex for gifts or other kinds of benefits, rather than money, and those who used illicit drugs were more likely to test positive for HIV.

Gender Considerations for Men Who Have Sex with Men

Before launching into a discussion of gender considerations for MSM, we need to be clear about who falls into this category. The label MSM comprises not only men who identify themselves as gay or bisexual – whether openly or not – but also transgendered men and men who engage in sexual activity with other men while still regarding themselves as heterosexual. Because we have tended to think of gender in terms of females and males, we have almost no information on the gender identities, roles and behaviours of MSM. How, for example, does the gender identity of a gay man compare with that of transgendered man or a bisexual man? What other factors, such as economic status, educational status, age, health status or rural versus urban living interact with gender roles, and in what way? How are the roles and expectations different or similar in long-term and casual relationships for each of these groups of MSM? In other words, we need to develop a more complicated interpretation of gender and power that will allow us to better understand and respond to the gendered realities of the lives of men who have sex with men.

In the meantime, we need to appreciate that many of the risk factors for MSM are similar to those for other populations at increased risk of exposure to HIV. For instance, males engaged in same-sex trade work face challenges to negotiating safe sex, some of which would be similar to those faced by women involved in sex trade work. Males and females who are economically and socially dependent tend to encounter similar types and degrees of risk of HIV exposure. Men who are in long-term same-sex relationships are just as likely to experience fatigue with the limited safe sex practices currently available as are men and women involved in different-sex relationships, which

creates special challenges for sero-discordant couples of every sexual orientation. MSM may face greater challenges around negotiating caregiving, simply because women are often socialized to provide care for others while men may have to acquire the outlook and skills for caregiving. But whether a relationship is same-sex or different-sex, those involved must find ways to negotiate caregiving responsibilities for those infected and affected by HIV/AIDS.

Homophobia and stigma slow down the progress of necessary research, knowledge development and broader understanding of the gendered considerations for MSM. This double stigmatization has led to limited evidence-based findings which could help to improve prevention, treatment, care and support activities for this population.

Gendering HIV/AIDS Prevention, Care, Treatment and Support Activities for Men Who Have Sex with Men

Clearly, we have a long way to go in understanding gender considerations for MSM who are at risk of HIV and AIDS. We need more research and more dialogue if we hope to build effective and appropriate programs, services and policies. Although we don't have all the answers for MSM and gender considerations relating to HIV/AIDS, we do have questions that can help to guide our work.

- Does the data collected describe characteristics of the MSM? How can you find out more about the target population? What do you know of the age range, drug use, and income levels for instance? Are you able to find statistics and other kinds of data for this group?
- Have you looked for and been able to find up-to-date, relevant research on gender roles to inform your work?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need amongst MSM?
- Have you clarified the community of MSM with whom you will be working and have you been specific in the funding application, study, workshop, service, program or policy which you are developing?
- Have you reflected the experience and perspectives of MSM from a range of ages, ethnic backgrounds and socio-economic standing in your funding application, study, workshop, service, program or policy?
- Are there individual MSM from the community involved in decisions about your funding application, study, workshop, service, program or policy?
- Is your work presented with language and a format that is familiar to the MSM community your work is targeting? Does it address differences in social and economic power among men from this community?
- Have you thought about the pressures on and the needs of different groups of MSM, for instance those in the sex trade, IDU, trans-gendered and two-spirit? Have you considered the differences for those coming from and now living in rural and urban settings; inner city or suburban; with or without community supports or sponsors; levels of education? Have you considered the possibility of domestic violence, homelessness or poverty in the population?
- Does your work reflect an awareness of and sensitivity to what is already known about gender roles among MSM? Have you considered how these roles and expectations affect individuals' ability to access or use your work?
- Does your study, service, workshop, program or policy support MSM with different personal histories and circumstances who are at risk, infected or affected by HIV/AIDS?

From Local to Global Context

In the 1980s, throughout much of the world, HIV/AIDS emerged or was identified first among men who have sex with men. In many parts of the world today, MSM still constitute the groups most likely to be newly infected with HIV and MSM are among the people who have lived longest with AIDS – sometimes in excess of twenty years.

Despite these facts, we have been slow to recognize and respond to the needs of MSM. Just as women or Aboriginal people do not constitute a single group with a single set of risks or needs, so too MSM are diverse. The label MSM encompasses a wide array of the identities, behaviours, and roles as well differences in risk and need. Similarly, while we are gaining a better understanding of the role of gender in heterosexual populations at risk of exposure to HIV, we need to learn much more about the gender identities, roles and expectations among MSM and to tailor prevention, care, treatment and support for the gendered realities of their lives.

At the same time, we have frequently ignored the fact that MSM represent an invaluable resource for understanding the power of advocacy and collective action in the battle against HIV, and for gaining insight into the needs of people living with HIV/AIDS as a chronic illness. No other groups have more experience in these areas. Our efforts to support those infected and affected by HIV/AIDS and to stem the tide of the pandemic must take account of the varied challenges facing MSM and take advantage of opportunities to learn from and work with them.

Target Population: People Living with HIV/AIDS

Prevalence and Incidence in the Population: Trends and Gaps

According to the most recent estimates of HIV/AIDS prevalence, 56,000 people in Canada were living with HIV/AIDS (PHAs) at the end of 2002, a 12% increase from 1999. Of this number, approximately 48,300 (86%) are male and 7,700 (14%) are female. For women living with HIV/AIDS, this represents a 13% increase since 1999. Female PHAs are most often exposed to HIV through heterosexual contact and/or injection drug use (IDU), while male PHAs are most often exposed through a sexual relationship with another man (MSM) and/or IDU.

The vast majority (95%) of reported HIV and AIDS cases are located in the most densely populated provinces – British Columbia, Alberta, Ontario and Quebec. But AIDS is not evenly distributed within these regions. Aboriginal and Black Canadians are over-represented among reported AIDS cases in Canada, accounting for 14.4% and 20.7%, respectively, of cases with known ethnicity. Nearly half of all positive HIV test reports among Aboriginal and Black Canadians are for women, while only 16.7% of positive HIV test reports among White Canadians are for females.

Children and youth in Canada are also living with HIV/AIDS. As of 2004, there were 766 cases (1.4%) of HIV among youth aged 15-19 and 666 cases of AIDS (3.4%) among youth aged 10-24 years. For those under 19 years of age, blood and blood products represented the main avenue of infection (62%), followed by heterosexual contact (13%). Patterns of exposure for PHAs aged 20-24 were similar to those of the entire adult population.

From 1995 to 1997, HIV-related deaths dropped by 66% for males and 43% for females. New drugs, education, improved testing and surveillance have no doubt contributed to this decline, and have helped to transform HIV/AIDS in Canada from an acute to a chronic condition.

Gender Considerations for People Living with HIV/AIDS

The history of the HIV pandemic has helped to create gender and other social inequalities in diagnosis, treatment, care and support for people living with HIV/AIDS. Because AIDS was first identified in North America as an affliction of gay men and because the gay community was crucial to the development of both awareness and services, many programs and policies were created with limited attention to women's needs, the needs of MSM who do not identify themselves as bisexual or homosexual, and the needs of PHAs who are not white, middle-class, young, educated and urban. For example, the symptoms of HIV infection in women differ from those in men, with the result that women are frequently diagnosed late or misdiagnosed and often progress more swiftly than men to AIDS-related illnesses and death. Similarly, service providers cannot accurately assess the risks faced by all MSM simply by asking if the men are gay. And if HIV/AIDS is assumed to be a young person's disease – as it often is – services and policies may not be structured to meet the needs of HIV positive men and women over the age of 50, who have comprised approximately 10% of positive HIV test reports in Canada each year since the beginning of the epidemic.

Gender inequities deepen the disadvantages faced by some PHAs. Women typically have lower average incomes and lower status in Canadian society than do men, with the result that they are more vulnerable to poverty, violence and dependence – all of which make it harder to live with HIV/AIDS. For example, the British Columbia Positive Women Study found that women, particularly Aboriginal women, were significantly over-represented among PHAs dealing with food

insecurity issues. When asked about their experiences with care, treatment and support, most women reported that they had not received adequate pre- or post-test counseling, and 47% were not satisfied with their doctor's care.

Gender roles and expectations likewise affect the health and experiences of PHAs. Following diagnosis, for instance, men may be subject to homophobia regardless of their sexual orientation while women may be labeled as promiscuous or as prostitutes. Stigma and discrimination create barriers to diagnosis, treatment, care and support. Gendered assumptions about who gets HIV and why may also interfere with effective prevention and education programmes.

At the same time, women in our society are still identified, at least in part, as the carers. Nurturing children and caring for dependent adults are often regarded as "natural" activities for women. Indeed, the majority of both paid and unpaid caregivers in Canada are women. For PHAs, getting and giving care can prove deeply challenging. In the BC Study of Positive Women, for instance, more than half of participants were caring for children and 12% of these children were also HIV positive. Since women provide most of the care, who looks after the HIV positive women? Who looks after her children when the positive woman is unable to do so?

Gendering Prevention, Care, Treatment and Support Activities for People Living with HIV/AIDS

Although it is not possible to provide comprehensive gendered guidelines for every situation facing every PHA, there ***are*** questions you can ask that will help to raise awareness of gender issues during the development of policies, programmes, services and activities.

- Does the data collected about PHAs distinguish between girls and boys, men and women? What other data do you have about background, place of residence, income level, family responsibilities, age and access to treatment can you find for females and males?
- Have you looked for and been able to find up-to-date, relevant research on gender roles in order to inform your work? Does your work reflect an awareness of and sensitivity to what is already known about gender differences in this area? Have you considered the ways in which gender roles and expectations may affect how women and men feel about their ability to access or use your work?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need among females and males of all ages?
- Are men, women, boys and girls considered separately in the funding application, study, workshop, service, program or policy which you are developing? If not, can you articulate why you are focusing on one sex only?
- Have you captured the voices and perspectives of both females and males living with HIV/AIDS in your funding application, study, workshop, service, program or policy?
- Are both women and men involved in decisions about your funding application, study, workshop, service, program or policy?
- Is your work presented with language and a format that is accessible to local women and men for the population your work is targeting? Does it address differences in social and economic power between women and men from this community?
- Have you thought about the pressures on and the needs of different groups of women and men living with HIV/AIDS? Have you considered the specific needs of the lesbian, gay, bisexual,

transgender and heterosexual communities? Have you considered the impact of geography, poverty, culture and other determinants of health on male and female PHAs?

- How will your work support both females and males who are living with HIV/AIDS in Canada?

From Local to Global Context

In Canada today, the number of PHAs is small compared with many other countries – less than 0.3% of the population. But rates of new infections in Canada continue to climb and the introduction of more effective treatments suggests that the number of PHAs needing services and programmes will grow in the years ahead. Moreover, global trends in HIV infection demonstrate that women, especially marginalized women, are likely to represent a growing proportion of people living with HIV/AIDS. Policies, programmes, services and other activities must be geared to the gendered realities of all PHAs if we hope to provide adequate care, treatment and support to those in need.

Target Population: Prison Inmates

Prevalence and Incidence in the Population, Trends and Gaps

HIV prevalence in federal prisons increased by more than 35% between 1996 and 2000, and the numbers continue to grow. In 2000, 1.7% of the prison population was known to be HIV positive, with regional rates ranging from 0.75% in Ontario to 2.8% in Quebec. HIV is even more common among female inmates in federal prisons, 4.7% of whom were known to be HIV positive at the end of 2001. Moreover, the actual numbers of inmates infected with HIV may be much larger because many prisoners may not know or disclose their HIV status. Canadian Correctional Services (CCS) offers voluntary counseling and testing to all inmates, but it is voluntary and not all infected prisoners are diagnosed. (Inmates may refuse to be tested for complex reasons, including misconceptions about their level of risk, fear of the testing procedure, aversion to health care, anxiety of discovering their infection status and fear that other inmates will react negatively to someone who is HIV positive.) Even without tests on all prisoners, the rates of HIV are staggering – 6 to 70 times higher than in the general population.

A history of injection drug use (IDU), violence, men having sex with men, sex trade work, and social and economic exclusion are factors that contribute to the alarming rates of HIV infection among prisoners in Canada. A large proportion of prison inmates, 28-50%, have a history of injection drug use, and 65% of male IDUs in federal prisons reported injecting drugs during their incarceration. Among those who have injected while in prison, 50% to 75% reported having injected with a needle previously used by someone else. Inmates may already be infected before they enter the prison system, but injection drug use while incarcerated increases the risk of exposure. Aboriginal people are over-represented in the prison system: although they comprise less than 3% of Canada's population, they constitute up to 15% of inmates in provincial prisons and 17% in federal prisons. In Manitoba and Saskatchewan well over half the prison inmates are Aboriginal. The combination of HIV infection and incarceration is having a devastating effect on Aboriginal communities.

Much more research on the health status and health service needs of all inmates in Canada's prison systems is warranted. For instance, it is challenging to find reliable information about the differences between Aboriginal women and men in prisons, or of prisoners from other marginalized and vulnerable populations. We also need to know more about risk factors for inmates, including drug use and addiction, tattooing and piercing, and sexual behaviour, orientation and identity.

Gender Considerations for Inmates

Within the Canadian prison system, there is a clear need to invest in education – of staff and prisoners – as well as in clean needle exchange and distribution programs, voluntary counseling and testing, methadone maintenance programmes and access to condoms, dental dams and lubricants for safe sex. We also need to ensure that prisoners receive care, treatment and support comparable to what is available outside the prison system: nutritious food, health care services, anti-retroviral therapies and pain medications, etc. The introduction of non-invasive alternatives to blood testing, such as saliva and urine tests, might also increase willingness to test voluntarily.

Because women constitute a small proportion of the prison population, less than 10%, they are housed in a very small number of institutions. CCS has only five regional institutions for women across the country and women in provincial or territorial prisons are generally housed in separate

sections of men's prisons. As a result, they are more likely than male inmates to be separated from family and social supports, and resulting stress or depression can lead to increases in IDU and other behaviours that heighten the risk of exposure to HIV. Prison programmes and services, like the prisons themselves, were also designed to meet the needs of men. Women inmates need women-centred care and facilities, but these are lacking in many prisons. For example, female physicians are not consistently available for female prisoners, which can create serious barriers to diagnosis and care for women who are survivors of male physical and/or sexual violence. Moreover, prison doctors – like doctors in private practice – may not be familiar with the symptoms of HIV in women or the optimal use of HIV therapies for women. Women inmates also tend to have more health concerns than male prisoners; many have chronic conditions resulting from lives of poverty, violence, drug use, sexual assault, adolescent pregnancy and poor preventive health care. Female prisoners, like male inmates, need prevention, care, treatment and support programmes geared to their needs.

Gendering HIV/AIDS Prevention, Care, Treatment and Support Activities for Inmates

Meeting the needs of a diverse prison population in Canada presents many challenges, not least of which is widespread indifference to the health and well-being of those who are incarcerated. But there ***are*** questions you can ask that will help to raise awareness of gender issues during the development of policies, programmes, services and activities aimed at prison inmates.

- Does the data collected distinguish between male and female inmates? Are you able to find statistics and other kinds of data for both females and males in the prison system?
- Have you looked for and been able to find up-to-date, relevant research on gender roles specific to the population of the inmates with whom you are working?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need amongst men and women who are incarcerated? Have you considered the likelihood of homosexual, bisexual and heterosexual behaviour? Have you considered the specific needs of lesbian, gay, bisexual or transgendered prisoners?
- Are women and men, male and female youths considered separately in the funding application, study, workshop, service, program or policy which you are developing? Can you articulate why you are focusing on one sex and what gender considerations you will take into account?
- Have you considered how to record women's and men's experiences in your funding application, study, workshop, service, program or policy?
- Do both women and men have an opportunity to advise you in the development of your funding application, study, workshop, service, program or policy?
- Is your work presented in language and a format that is accessible to inmates, both women and men? Does it address differences in social and economic power within the prison community and outside prison?
- Have you considered the differences for those coming from and now living in rural and urban settings; inner city or suburban; Aboriginal or non-Aboriginal; with or without community supports or sponsors; levels of education, and the different ethnic and cultural backgrounds inmates have? Have you considered the possibility of domestic violence, homelessness or poverty amongst the population? How may these factors have a different effect on women or on men?
- Does your study, service, workshop, program or policy support both female and male inmates? If your focus is on one population, can you articulate which aspects may or may not be

equivalent for the other sex? How can you ensure that you are proceeding in a culturally appropriate and receptive manner?

- Have you considered the attitudes and expectations of the prison guards and officials? How will you take their roles, responsibilities and social expectations into account?

From Local to Global Context

Canada's prisons – like penal institutions around the world – are far from perfect, especially for those infected with HIV. Further study and more action are needed to improve the health and well-being of prisoners in Canada. As the Canadian HIV/AIDS Legal Network argues, we have a moral and a legal obligation to prevent the transmission of disease in prisons and to promote the health and well-being of inmates: "the state's duty with respect to health does not end at the gates of prisons." Investment in the health of prison inmates, female and male, is also an investment in the health of all Canadians. At some point, most prisoners return to their homes, families and communities and protecting inmates from disease will also protect those outside the prison system.

Around the world, limited attention is given to the plight of prisoners for a variety of reasons, including strained human and financial resources, and cultural taboos against men having sex with men or against injection drug use that make it difficult to speak about the transmission of HIV as well as prevention, care, treatment and support. Creating a humane, responsible system of corrections today may be more possible in places like Canada than in countries devastated by war, disease, political instability, or global economic policies. Let's not waste the opportunity to model excellence in the care of prisoners to the rest of the world.

Target Population: Women

Prevalence and Incidence in the Population, Trends and Gaps

Women represent a growing proportion of those with positive HIV test reports in Canada; rising from 11.9% in the early 1990s to more than 25% in 2003. 2004 data also show that women and girls constitute 23% of new infections, a figure that has doubled since the 1980s.

Not only are women in general at increased risk of HIV in Canada, but the highest rates of new infections in women are among young women, aged 15-29 years. In 2003, young women made up 42.5% of newly reported HIV cases as compared with 15% prior to 1998. Moreover, heterosexual contact is responsible for a growing proportion of infections among females, 64.8% in 2003 – up from 47% in the 1980s. Injection drug use (IDU) is the next major risk factor for women, accounting for 27% of new infections in 2003. But rates of infection from IDU have been dropping steadily since the early 1990s, as have the risks for women of contracting HIV via blood or blood products.

The numbers of Canadian women who are living with AIDS is increasing, both due to the increasing number of new infections in women and the fact that 96% of women living with HIV are now taking antiretroviral medications. Approximately 7,700 women – or 25% of all reported cases – were living with AIDS in 2003, a proportion that has risen from 6.4% in the period before 1995.

Gender Considerations for Women

While HIV/AIDS prevention, diagnosis, care, treatment and support options are increasingly available in Canada, they do not always meet the needs of women. Sex differences between women and men as well as gender roles, expectations, and inequalities in Canadian society place women at increasing risk of exposure to HIV infection.

Women and girls face unique risks of exposure to HIV due to the structure of their reproductive tracts. Because women have a large surface area and delicate tissues in the vagina and because the virus is more highly concentrated in seminal than in vaginal fluid, the risks of HIV transmission are greater for a woman than for a man having sex with an infected partner. As a result, women may become vulnerable to HIV through the risky behaviour of their male sexual partners, including unprotected sex with males or females and injection drug use. We need more information about the risk-taking profiles for HIV infection in heterosexual males as it may inform HIV prevention efforts for their female sexual partners.

In addition to biological vulnerability, women also face greater social and economic vulnerability to HIV infection. Power relations, which guide sexual negotiation and planning, often limit women's choices. Women who are economically or socially dependent on a sexual partner may not be able to refuse sex or to negotiate for condom use. Meanwhile female-controlled prevention methods, such as the female condom, might help women to protect themselves against exposure to HIV and other sexually transmitted infections, but these are not widely used, accepted or available in Canada.

Social expectations regarding female and male sexual behaviour also contribute to the gender differences in vulnerability. Because young men are expected or encouraged to be sexually adventurous, they may engage in risky sexual behaviour or become involved with multiple sexual partners. They not only put themselves at greater risk of contracting HIV, but also they increase the

risks for all of their sexual partners. Women and girls may defer or be expected to defer to their male sexual partners, who may not, in fact, have reliable information about sex or HIV/AIDS.

Forced or violent sex and survival sex are products of power and gender inequalities, but they also create heightened risk of HIV transmission because they result in trauma to the delicate tissues of the female reproductive tract. Among women in Canada marginalized women have the least amount of power and are consequently among the most vulnerable to forced or survival sex.

At the same time, there are significant differences in patterns of injection drug use among women and men, which we need to understand better if we hope to intervene effectively and appropriately. Findings from one study, for example, found that HIV incidence rates among female IDUs in Vancouver were about 40% higher than those of male IDUs. We need further investigation of the relationship among gender, IDU, poverty, homelessness, mental health, and sex work.

Living with HIV/AIDS can be very different for men and women. Because of their reproductive roles, women face issues associated with contraception, conception, pregnancy, birthing and mothering. Women's hormonal cycles affect how they react to drugs, which have – for the most part – been tested only on men. Pregnant and breastfeeding women need information, support and care to prevent transmission of the virus to their children. Finally, women are typically the primary caregivers within households and whether or not they are sick themselves, they are often responsible for the care of others.

HIV/AIDS Prevention, Care, Treatment and Support Activities for Women

Although it is not possible to comprehensive guidelines for every situation facing every woman there ***are*** questions you can ask when undertaking any activity that will help to raise awareness of and responsiveness to gender differences.

- Does the data collected distinguish between girls and boys, men and women? Are you able to find statistics and other kinds of data for girls and women?
- Have you looked for and been able to find up-to-date, relevant research on gender roles to inform your work?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need among women? Does your work reflect an awareness of and sensitivity to what is already known about gender differences in this area? Have you considered the ways in which gender roles and expectations may affect how women feel about their ability to access or use your work?
- Are women and girls considered separately in the funding application, study, workshop, service, programme or policy which you are developing?
- Have you captured the voices and perspectives of women in your funding application, study, workshop, service, programme or policy?
- Are women at the local level involved in decisions about your funding application, study, workshop, service, programme or policy?
- Is your work presented with language and a format that is accessible to local women? Does it address differences in social and economic power between women and men?
- How will you take into account differences among women: rural vs urban; Aboriginal and non-Aboriginal; new immigrants, women in poverty, street workers, mothers and caregivers, for instance?

From Local to Global Context

At the end of 2005, there were more than 40 million people around the globe living with HIV and AIDS. Close to half of those infected, 17.5 million, are women and the majority of new infections in people under 25 occur in females. Although the face of HIV/AIDS today is increasingly female, this was not always the case. In many parts of the world – such as South Africa – the HIV pandemic began among men who have sex with men and moved swiftly into the heterosexual population. Rising infection rates among women and girls in Canada, and the growing proportion of women and girls exposed through heterosexual contact suggest that we need to act now if we hope to prevent HIV from becoming more widespread. Programmes, policies, services and other activities need to be developed with an appreciation of the needs of women and girls, and the gendered realities of their lives.

Target Population: Youth

Prevalence and Incidence in the Population, Trends and Gaps

Youth represent a small proportion of people living with HIV/AIDS in Canada: 1.4% of those with a positive HIV test are between the ages of 15 and 19. Nonetheless, the number of new infections has been rising steadily. In 1999, 445 people between the ages of 15 and 29 tested positive for HIV, as compared with 511 in 2003. Similarly, in 1995, there were 567 reported cases of AIDS among 10 to 24 year olds in Canada, but by June 2004 that number had risen by more than 20%, to 687.

At the same time, the pattern of HIV infection has been changing for male and female youth. Between 1985 and 1998, females accounted for just 15% of positive HIV test reports among those aged 15 to 29 years. By 2004, 42.5% of HIV positive test reports for this age group were female.

Sources of infection among youth also vary by age and sex. In 2004, for instance, contaminated blood and blood products accounted for 62% of infections among 10 to 19 year-olds living with AIDS, followed at some distance (13%) by heterosexual contact. For "older" youth – those aged 20 to 24 – living with AIDS, 51% of infections were attributed to men having sex with men, followed by 21% who were exposed through heterosexual contact.

Many research studies suggest that female and male youth may be exposed to HIV in different ways. For example, the Vancouver Injection Drug User Study (VIDUS) demonstrated that for injection drug users under the age of 24, females were much more likely to be HIV positive than males. Current statistics on the sources of HIV infection for youth present challenges for understanding sex and gender differences. On the one hand, statistics for HIV positive youth under the age of 15 do not differentiate between males and females when reporting on exposure categories. On the other hand, statistics for adults do differentiate between females and males, but they report on all adults over the age of 15 years. Sources of infection for adults point to significant differences between females and males: more than half of women with HIV positive tests were infected through heterosexual contact and a further 38% were infected through injection drug use; by comparison 70% of men testing positive contracted HIV through sexual contact with another male and 13% were infected through injection drug use. Clearly, we need more information about the particular patterns of exposure and infection for females and males between the ages of 10 and 29.

Gender Considerations for Youth

Some aspects of youth outlook and experience that may increase the risk of HIV infection are common to females and males. Risky sexual behaviour, such as inconsistent condom use, was documented among 12 to 16 year olds of both sexes. Similarly, street-involvement, injection drug use, and sexual contact with a male who has sex with males increase the risks of exposure for both males and females. Lack of information or misinformation about HIV also places youth at risk; according to the 2002 Canadian Youth Sexual Health and HIV/AIDS Study, more than two thirds of grade nine students and just under half of grade eleven students believed there is a vaccine to prevent HIV/AIDS and that the HIV/AIDS can be cured if treated early enough. Indeed, students surveyed about HIV/AIDS in 1989 were more knowledgeable than those surveyed in 2002.

At the same time, there are important differences between female and male youth that create different types and degrees of vulnerability. While males and females are both engaging in

unprotected intercourse, young women are less likely than young men to use condoms – a trend that increases with age. But male youth are more likely than female youth to have multiple sexual partners, and to avoid seeking accurate information about sexual health. These types of differences in behaviour, knowledge, and attitude are often tied to gender roles and expectations. For example, females are more likely than males to be held responsible for contraception and unintended pregnancy, with the result that they may use contraceptive methods that are very reliable for preventing pregnancy, such as birth control pills, but that do not protect against HIV or other sexually transmitted infections. But females also have more opportunities than males to learn about HIV because they are more likely to talk openly about sex and to have regular contact with knowledgeable health care providers and educators. Males, by comparison, are expected to be knowledgeable about sex and may hesitate to ask questions for fear of feeling foolish, stupid or unmanly.

Gendering HIV/AIDS Prevention, Care, Treatment and Support Activities for Youth

Ask yourself these questions when undertaking any activity to help raise awareness of and responsiveness to gender differences among youth.

- When you are gathering information about youth in Canada, have you looked for and found statistics and other kinds of data for both females and males?
- Have you looked for and been able to find up-to-date, relevant research on gender roles to inform your work?
- Have you considered the ways in which gender roles and expectations can create different types and degrees of risk or need among female and male youth?
- Have you consulted male and female youth in the design and/or implementation of your funding application, study, program or policy?
- Have you captured the voices and perspectives of both female and male youth in your funding application, study, program or policy?
- Have you thought about the pressures on and the needs of different groups of female and male youth: urban or rural; inner city or suburban; on-Reserve or off-Reserve; culturally and racially diverse; lesbian, gay, bisexual, trans-gendered, and/or heterosexual; street-involved or homeless; those engaged in sex trade or survival sex; injection drug users; those in or in conflict with the justice system?
- Have you considered the ways in which gender roles and expectations will make it easy or difficult for male and female youth to be involved in, access or use your study, program or policy?
- Does your study, program or policy support both female and male youth who are at risk, infected and affected by HIV/AIDS?

From Local to Global Context

Although youth currently constitute a small proportion of reported HIV and AIDS cases in Canada, as a group they have been greatly affected by the HIV/AIDS epidemic at a global level. Female youth are among the hardest hit. In sub-Saharan Africa for example, 76% of young people aged 15-24 living with HIV/AIDS are female. If youth in Canada are to protect themselves against HIV, they need information and skills, policies and programs that are tailored to the gendered realities of their lives.