Draft for [illegible]

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SEXISM AND HIV/AIDS

The saying in the last five years has been that the face of AIDS is changing. While the statistics indicate that more and more women are testing positive, whether the face of AIDS is changing is questionable. Women have been infected and affected from the onset of this epidemic, however they have not been visible. Part of the reason for their invisibility is the sexism which women experience in today's world.

Sexism can simply be explained as the discrimination or prejudice against women based on their gender. To put sexism into the context of HIV/AIDS is to speak about the exclusion of women in this epidemic. Women are the fastest growing population of HIV infected persons and AIDS is one of the five leading causes of death to women between the ages of 15-44. In all reality, because of the exclusion of women, their place in our world, it is really impossible to determine how many women are actually infected with HIV. We can conclude however, that whether or not a group has access to resources, support and power determines to what degree they will fare with respect to health care. Women are not faring well with respect to HIV/AIDS.

From the beginning women have been excluded from the HIV/AIDS agenda. The invisibility or discrimination of women with respect to HIV/AIDS can be traced back to when HIV/AIDS was first portrayed. When AIDS first came into the picture in 1981, the primary image was the infected person was the image of a dying homosexual man. Later there became known a 4-H club which represented the targeted high risk groups - homosexuals, hemophiliacs, heroin addicts and hookers. Even with this expanded image HIV/AIDS was and continues to be thought of as a gay male disease, despite the fact infected males may have female partners, and that infected females may have same sex partners. Focusing on particular targeted groups has resulted in profound isolation for HIV positive women. As well, the educational initiatives and service provisions have been focused on high risk groups, rather than high risk behaviours or situations.

Well into the second decade of the AIDS epidemic, there continues to be denial that HIV/AIDS is revelant to and a reality in women's lives. As more attention is given to women, women are perceived as a target group. This serves to ignore the diversity among women, including ethnicity and class. Racism further compounds the lives of women. Women of colour do not have the same access to existing services and

resources due to the barriers caused by racism, thus experience more isolation and denial. Women cannot be viewed as one target group as they really only have gender in common. Race, culture, language barriers. poverty, violence, substance abuse and sexual orientation are among the many factors which need to be taken into consideration when addressing women and HIV/AIDS.

AIDS not unlike other health threats, tend to lean towards the path of disadvantaged groups.. Women make up the majority of these groups, with the number of women suffering from poverty, homelessness, violence, substance abuse and incarceration all on the rise. When women seek out information about HIV/AIDS, they are subjected to a community which is not tailored to women, do not have women's issues integrated into policy and procedures and are not able to meet the support and resource needs of HIV positive women. There are several places todays world that the exclusion of women or sexism can be easily seen, such as in the women's role as a caregiver, in treatment and research issues and in addressing women's sexuality.

WOMEN AS CAREGIVERS

Traditionally women have had the role and responsibility for household labour and child care. This role often includes her place in the bedroom, child care, shopping, cooking, cleaning, rearing her children and emotionally supporting her family, friends and community. This of course results in less time for herself. This labour is not considered paid labour, thus limits the women's access to pensions or supplementary health insurances. HIV infected women need rest, health care and self care which for most women is beyond reach because of their normal struggles in society. For HIV positive women this position can significantly reduce life expectancy. One may argue that these roles are changing, but in the lives of women this change is not happening fast enough. The factors of women's daily work have fundamental influence of their quality of care.

TREATMENT AND RESEARCH ISSUES

The HIV/AIDS epidemic has exposed serious faults and negligence on the part of the global health care systems in relation to women. Basic and applied research involving women in relation to HIV/AIDS is seriously lacking. Across the globe, survival times are shorter for

women than men, which means women are dying faster after receiving the AIDS diagnosis. Women are the most mis-diagnosed, under-diagnosed and under-served population in the context of HIV/AIDS. The human cost of this exclusion faces women today - tragically. As a result, diagnosis of HIV/AIDS comes too late in a women's illness or not until after her death, therefore the numbers of women dying of AIDS is grossly under-reported. The common reasons for this under-reporting are

a) Physicians and health care practitioners often don't relate women's medical symptoms to HIV.

b) Women are not encouraged to be tested.

c) Women, because of being socialized to be caregivers and nurturers are more likely to put their own health on the backburner. This is due to being generally in the position of caring for others before caring for ourselves.

d) The lack of access to support and resources which could play a meaningful role in womens lives.

Treatment and research structures are profit-driven communities. Thus, women are less likely to be an inviting population because of the poverty which women in general experience. What profits can be made if women are too poor to access the services. There is an urgency to address issues such as access to treatment and research, services and education which address women's needs. These are limited to women due to a global society which has not adequately addressed womens' needs or allowed them to become educated about themselves.

SEXUALITY

Through discrimination by gender, women's sexuality has been absent from the HIV/AIDS agenda. Hetrosexual transmission remains the principle mode of transmission of HIV for Canadian women. Education strategies have been developed around transmission, by promoting safer sex, but do not take into consideration women's reality. There needs to be a switch from safer sex education strategies which present high risk groups and behaviour to talking about high risk situations such as sexual assault, poverty and domestic violence. The notion of risk behaviour implies a sense of individual choice and power which many women do not have. There is an inherent power imbalance that exists between many men and women in sexual relations. The

educational aspect of safe sex ignores this power imbalance and does not address the dangers of negotiating safer sex practices, or recognize cultural and ethnic values. Every 17 minutes, in 1993, a sexual assault involving forced intercourse took place - the victims being 90 percent women. In our life time 1 out of every 4 women will be sexually assaulted, thus sexual relations in general are not safe for women.

Women's sexuality around HIV/AIDS is linked with their self esteem and sexual life style choices. The denial, lack of knowledge and discomfort women experience around their own sexuality continues to be detrimental to women accessing comprehensive support, education and /or health care. AIDS has forced society to talk about sex. Women very seldom have the opportunity to talk about their bodies, sexual relations and what gives them pleasure in an open, supportive and safe environment. There are few realistic portrayals of womens' positive sexual experiences. Women are stilled view as either the whore or virgin with no understanding of womens' sexuality. Women's sexual identities have not been integrated into the HIV/AIDS education or support work, whether women are hetrosexual, lesbian, bisexual or have chosen not to identify with a label. Positive sexuality has to be incorporated into our language about women, especially women who are HIV positive.