DISCOURSE OF EXCLUSION: AIDS EDUCATION FOR WOMEN IN METRO-VANCOUVER

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ABSTRACT

This thesis examines the evolution of HIV/AIDS education for women in metro-Vancouver. The research focuses on two questions, "What AIDS education programs for women currently exist in Vancouver?" and "How effective has AIDS prevention education for women been?" Since the reported incidence of HIV/AIDS continues to rise, the latter question leads to a further issue, "Why have some women been excluded from the HIV/AIDS discourse?"

I chose to investigate these issues from a socialist feminist perspective. This perspective, which focuses on women's position within the economy, society, and family, guided my analysis of information I gathered from a variety of sources. These included both primary and secondary sources, namely: brochures; magazines; newspapers; television reports; journals; books; presentations; and interviews.

The findings of the research reveal that, at the onset, preventative educational strategies did not exist for metro-Vancouver women because the gendering of the AIDS epidemic rendered women invisible. Since subsequent AIDS education focused on "risk groups" rather than risk behaviors, many women who do not belong to a "risk group" still believe that they are not at risk.

Consequently, gender appropriate strategies for AIDS prevention education need to be further developed. As well, these strategies are only one part of the solution. Belief systems, social scripting, and perceptions of one's self and others are the more challenging and difficult pieces to change, as are the underlying root causes of drug addiction and promiscuity.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vi</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>The Problem</td>
<td>1</td>
</tr>
<tr>
<td>AIDS - The Gay Disease?</td>
<td>3</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>5</td>
</tr>
<tr>
<td>My Connection to the Study</td>
<td>7</td>
</tr>
<tr>
<td>Methodological Basis of the Study</td>
<td>8</td>
</tr>
<tr>
<td>Significance and Justification of the Study</td>
<td>10</td>
</tr>
<tr>
<td>CHAPTER 2: CONTEXT</td>
<td>12</td>
</tr>
<tr>
<td>Literature Review</td>
<td>12</td>
</tr>
<tr>
<td>Feminist Theory</td>
<td>12</td>
</tr>
<tr>
<td>History of AIDS</td>
<td>16</td>
</tr>
<tr>
<td>Barriers to Effective Aids Prevention Education for Women</td>
<td>30</td>
</tr>
<tr>
<td>A Feminist Approach</td>
<td>32</td>
</tr>
<tr>
<td>CHAPTER 3: RESEARCH METHODS</td>
<td>35</td>
</tr>
<tr>
<td>Feminist Research</td>
<td>35</td>
</tr>
<tr>
<td>Research Site</td>
<td>38</td>
</tr>
<tr>
<td>Interview Data</td>
<td>39</td>
</tr>
<tr>
<td>Documentary Sources</td>
<td>44</td>
</tr>
<tr>
<td>CHAPTER 4: HIV/AIDS EDUCATION IN METRO VANCOUVER</td>
<td>47</td>
</tr>
<tr>
<td>Vancouver and the AIDS Discourse</td>
<td>47</td>
</tr>
<tr>
<td>The Positive Women’s Network (PWN)</td>
<td>49</td>
</tr>
<tr>
<td>Community Education Initiatives</td>
<td>52</td>
</tr>
<tr>
<td>The Physician’s Education Project</td>
<td>53</td>
</tr>
<tr>
<td>Women and AIDS Project</td>
<td>58</td>
</tr>
<tr>
<td>Condomania - The Vancouver Condom Awareness Campaign</td>
<td>60</td>
</tr>
<tr>
<td>Women's Outreach</td>
<td>62</td>
</tr>
<tr>
<td>Youth Community Outreach AIDS Society (YouthCO)</td>
<td>67</td>
</tr>
<tr>
<td>Asian Society for Intervention of AIDS (ASIA)</td>
<td>75</td>
</tr>
<tr>
<td>Intravenous Drug Use</td>
<td>80</td>
</tr>
<tr>
<td>Drug and Alcohol Meeting Support (for women) (DAMS)</td>
<td>82</td>
</tr>
<tr>
<td>Politics and British Columbia</td>
<td>86</td>
</tr>
<tr>
<td>Conclusion</td>
<td>88</td>
</tr>
<tr>
<td>CHAPTER 5: POWER, POLITICS, AND PREVENTION EDUCATION - A METRO VANCOUVER PERSPECTIVE</td>
<td>90</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Naming AIDS</td>
<td>94</td>
</tr>
<tr>
<td>The Construction of Sexuality</td>
<td>96</td>
</tr>
<tr>
<td>Sexuality</td>
<td>97</td>
</tr>
<tr>
<td>Socialist Feminist Theory and the Concept of Power</td>
<td>98</td>
</tr>
<tr>
<td>Power</td>
<td>99</td>
</tr>
<tr>
<td>Political and Social Issues</td>
<td>101</td>
</tr>
<tr>
<td>Education Issues</td>
<td>107</td>
</tr>
<tr>
<td>Adult Oriented Prevention Education Initiatives</td>
<td>114</td>
</tr>
<tr>
<td>The AIDS Discourse and &quot;Family Values&quot;</td>
<td>119</td>
</tr>
<tr>
<td>Conclusion</td>
<td>121</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 6: CONCLUSION</th>
<th>126</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Focus</td>
<td>126</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>130</td>
</tr>
<tr>
<td>Implications for Practice</td>
<td>133</td>
</tr>
<tr>
<td>Implications for Research</td>
<td>135</td>
</tr>
<tr>
<td>Conclusion</td>
<td>137</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPENDIX 1</th>
<th>139</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX 2</td>
<td>140</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>141</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1: PWN information pamphlets ................................................. 51
Figure 2: Women’s Outreach Pamphlet Series ....................................... 63
Figure 3: Excerpt from “Women Who Have Sex With Women” .............. 65
Figure 4: YouthCO pamphlet and in-house produced postcard ............... 69
Figure 5: YouthCO. “Spicy” ‘zine and article on health issues for HIV+ youth ................................................................. 71
Figure 6: “JIFFY POP” ‘zine and article .................................................. 72
Figure 7: Federal Government “Women and AIDS” pamphlet .................. 73
Figure 8: “Grrls on Grrls” pamphlet published by ACT ........................ 74
Figure 9: Excerpt from “Grrls on Grrls” ............................................... 74
LIST OF TABLES

Table 1: Women interviewed, dates, and organizations ...........................................39
Table 2: Table of Secondary Sources ..................................................................45
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CHAPTER 1:
INTRODUCTION

The Problem

Acquired Immuno-Deficiency Syndrome (AIDS) and Human Immuno-Deficiency Virus (HIV) have touched all sectors of the Canadian population. Research on early- and mid-1990's trends in AIDS and HIV has shown that AIDS and HIV cases among women are growing faster than in any other segment of the population (Ewing, 1993; Strathdee, Hogg, & Schechter, 1995). Women who engage in unprotected sexual intercourse or inject drugs are at a high risk of becoming infected with HIV. In fact, according to Pearl (1990) it "is what, in some cities, is most likely to kill them."

Ornstein (1989) in a study about knowledge, attitudes, and behaviours of Canadian adults found that 90% of respondents were able to provide a reasonably accurate account of how HIV is transmitted and fairly accurate description of the disease. With respect to prevention, the research also showed that 90% of adult respondents gave correct information about the effectiveness of various forms of birth control, abstinence, and monogamy in controlling the spread of HIV. The only public misconception identified appeared to be around the effectiveness of the diaphragm in the prevention and reduction of HIV transmission.

Even though AIDS is recognised as a critical health issue, and Canadian women are aware of how HIV is transmitted and of the increase in heterosexual
transmission, research indicates that many women at risk have not changed their 
behaviour (Ornstein, 1989). The question the research fails to answer is “why”? 
The thrust of my thesis is that the necessary inference from the research is 
that the approaches used in HIV/AIDS education for women are fundamentally 
flawed. Most health behaviour areas agree that knowledge of risk alone is 
insufficient to produce behaviour change for most people (Kelly & Murphy, 1991). It 
seems evident that messages contained in traditional AIDS education are no longer 
useful or sufficient and need to be reformulated to speak directly to the specific 
experiences of the target population – in this instance, women. Given the diversity 
of women’s experiences within our society, it is important that such programs not 
simply reflect mainstream women’s experiences. It is important to encompass a 
spectrum of experiences – such as those of lesbians, women of colour, teenage 
women, sex trade workers, and white middle class women.

Further, this thesis will be framed within a feminist discourse and will 
explore the evolution of AIDS education for women in metro-Vancouver. In as 
much as values and politics are inherent in any educational program and permeate 
the material, questions of content and pedagogy cannot be neatly separated. My 
research, therefore, will analyse and explore how well existing AIDS educational 
programs serve women, taking into consideration questions about what is taught 
and how.
AIDS – The Gay Disease?

The spread of Acquired Immuno-Deficiency Syndrome (AIDS) and Human Immuno deficiency Virus (HIV) in Canada has followed a pattern similar to that of the United States. AIDS and HIV remain predominantly an epidemic confined to gay and bisexual communities as well as the intravenous (IV) drug user population and other marginalized groups thereby perpetuating the illusion of the "otherness" of the disease by the general population. Because the epidemic has primarily been confined to these populations, denial and disassociation from the disease have lulled the general public, especially women, into a false sense of immunity. Hence, the spread of HIV and AIDS becomes as much a sociocultural phenomenon as it does a medical or biological issue (Fee, 1992; Marjoribanks, 1995; Sontag, 1988). The salient linkage with male homosexuality has left most women out of the AIDS equation.

This becomes quite apparent within the historical definition of AIDS itself. In 1982, the Centres for Disease Control (CDC) in Atlanta, Georgia, constructed a definition of AIDS by gathering together a list of life threatening disorders and infections which indicated severe immune deficiency from HIV disease. By 1992, the definition had been revised twice but still relied on 23 infections that appeared in gay men and still excluded many HIV related conditions common in women. It was not until 1993 that a broader definition of AIDS came into effect. The expanded definition now included invasive cancer of the cervix, pulmonary tuberculosis, and recurrent bacterial pneumonia frequently seen in women and IV drug users. Also incorporated into the classification of AIDS were people with HIV and a count of
200 or fewer CD4 cells per cubic millimetre of blood. According to the March 1993 issue of "New Woman" magazine, the effect of the new definition would be to double the number of reported cases of HIV in women in the United States in 1993 (Ewing, 1993).

A similar phenomenon occurred in British Columbia. The estimated number of HIV positive women was underrepresented. In British Columbia, using seroprevalence rates in 1989, 2.69 per 10,000 women were diagnosed as HIV positive but by 1992, this rate had increased to 4.95 per 10,000 women. In Vancouver, the rates were much higher revealing a ratio of 12.4 per 10,000 women in 1992. In 1993, 320 women tested HIV positive (Strathdee, Schechter, Hogg & O'Shaughnessy, 1994). By February 1996, out of the 8,999 reactive HIV tests, 902 women tested positive.

Thus the notion of AIDS as primarily a gay male disease is not substantiated in literature. In part, the under-representation of women in the AIDS epidemic arose as a result of misdiagnosis or, in some cases, no diagnosis. No less a factor is the failure of traditional AIDS education to educate women about the risks and realities of HIV/AIDS transmission. I intend to demonstrate how the transmission of HIV and AIDS is closely tied to women's status in society. Women's voices were excluded from the AIDS discourse because it was designed to target the gay, male population. Once again, women were examining their experiences through the experiences of men.
Socioculturally, the roles women have as mothers, partners, friends, sisters, and caregivers are different than those of men. This includes stresses unique to women including such things as pregnancy, separation from their children and accompanying guilt, violence in their relationships, and, more often than not, a culture of poverty. Any education program, which does not recognise these factors, will allow for the continuing social construction of the disease.

**Purpose of the Study**

The purpose of this research, ultimately, is to assist in decreasing the number of HIV/AIDS infected women in Vancouver. Identifying what does and what does not work will do this; thereby, providing a rationale for changing the way in which AIDS prevention education is undertaken, as well as suggesting recommendations that will make the content more situation specific and the delivery more comfortable for women.

My initial research question was “What AIDS education programs for women currently exist in Vancouver?” My research suggested that the answer to this was population specific. Programs exist that target sex trade workers and some immigrant women, for example, but no programs, other than the “canned” popular advertisements advocating condom use, exist for single, middle class working women age 35+. From this information flowed two questions: “How effective has the AIDS prevention education for women been in decreasing the incidents of HIV and AIDS amongst women?” and “Why have certain groups of women been excluded?”
In order to answer the first question, I needed to obtain statistical information on the reported incidents of HIV/AIDS in women in Vancouver. If statistically it could be demonstrated that the number of HIV infected women have decreased, then one possible conclusion drawn from that evidence is that the education programs have been successful. Unfortunately, however, such a simplistic perspective only provides a partial and incomplete analysis of the problem. For example, reported incidents of HIV/AIDS are predicated on the number of women being tested for HIV or whether the death certificate cites AIDS or the opportunistic infection/disease as the cause of death. Statistics alone are indigent indicators of the living reality of the HIV/AIDS epidemic.

In order to answer the second question, "Why have some women been excluded from the HIV/AIDS discourse?" I needed a context through which I could examine this issue. I became interested in women's choices, for example, choosing a life on the street, career choices, and the option of motherhood, to name a few. This led to the two following questions, "Of what significance is culture, gender, sexual identity, race, social values, and class on the formation of choice, or is choice a mythical construct?" and "Is HIV/AIDS socially constructed?" By "social construction" of the disease I mean that AIDS is not simply viewed as a disease with a clinical presentation the way that some cancers, for example, are. A diagnosis of AIDS is not objective and value-free but tied to the historical and social context from which it was born. The medical establishment and other "scientific" communities such as psychology and anthropology, along with the government and the media
have structured the disease in such a way that the focus was and continues to be tied
to membership in a specific group such as gays, sex trade workers, IV drug users,
and the black and Hispanic communities.

**My Connection to the Study**

This thesis is a result of an ongoing interest in women’s issues and, more
specifically, the women and AIDS issue, which I brought with me upon entering the
Adult Education Master’s degree program. This interest in women’s issues
developed from experiences as a white, middle class woman working within, from a
feminist perspective, a hierarchical, patriarchal, bureaucratic system. My interest in
women and HIV/AIDS resulted from my volunteer work with sexually abused pre-
teens, as a mother of a teenage adopted daughter, and as a single middle aged
woman. As I pursued my graduate studies, I began to realise that the voices of
women on the issues of sex and sexuality, as well as on HIV and AIDS, were just
starting to be heard. The healthcare and education systems, like all governmental
agencies and systems, have historically been a male domain. Men hold most
authority positions; hence, the perspective of healthcare and education initiatives,
which flows from these systems, is male oriented—patriarchal in origin.

Through my volunteer experiences, experiences as a mother, and as a woman
I have discovered that what I believed to be “common sense” was not seen as such
by others. I have observed decisions about sex education curriculum in schools, for
example, being made on the basis of a politician’s personal agenda without any
thought of his responsibility to others. Was withholding information about sexually
transmitted diseases and contraception an example of the exercise of power as a method of control? Reading the historical literature on the women and HIV/AIDS issue made me realise that women's health issues have been ignored and women elided from the AIDS debate on the basis of gender. This, in turn, led me to ask “Why?” I chose to examine these issues from a socialist feminist perspective as I felt Socialist Feminist Theory provided the most holistic approach to women's issues.

**Methodological Basis of the Study**

I investigated the research questions using background information from three venues: socialist feminist theory; women and AIDS literature and research; and interviews.

I chose to investigate the gender politics of the disease (social, economic, and political) and its impact on AIDS education for women in the metro-Vancouver area from a socialist feminist perspective. Feminist theory addresses the question of women's subordination to men—how it arose, how and why it is perpetuated, and how it can be changed (Acker, 1987). The socialist feminist perspective focuses on women's position within the economy, society, and the family. Socialist feminist theory asserts those bureaucratic systems, be they health care or education or organisations, must be changed to accommodate the needs of both men and women. This perspective also illuminates the gender politics of the disease.

The literature review on the issue of women and HIV/AIDS demonstrates that historically women were excluded from the diagnosis and treatment of HIV/AIDS on the basis of gender. Barriers to including women in the HIV/AIDS
discourse were systemic. Women were systematically disadvantaged from inclusion in drug trials by such discriminatory research practices as: the criteria for admission; lack of consideration for a woman's family responsibilities; and poverty. However, even if some of these barriers were eliminated, many feminist theorists would assert that the subordination of women is deeply rooted in the low status and function of women in a patriarchal capitalistic society. For the purpose of this research, I have used Hartmann's definition of patriarchy as found in Rosemarie Tong's *Feminist Thought: A Comprehensive Introduction*. Here, patriarchy is defined as "a set of social relations between men which have a material base, and which though hierarchical, establish or create interdependence and solidarity among men that enable them to dominate women" (Tong 1989, pg. 181).

I employed a number of research sources to acquire information about metro-Vancouver women and HIV/AIDS. These included personal interviews, a literature review of journal articles, newsletters, books, speeches, and proposals put to the government requesting funding.

This research has been valuable to me as I have learned much and now recognise the value and validity of doing research that is personally significant. How easily I could have been one of the women I read about. I have struggled with some of the issues these women have, and yet in other ways I know nothing about their struggles. The politics of the research, and my personal political agenda, namely to change how AIDS prevention education for some groups of women is
designed and delivered, is integral to this research. I also recognise, however, that I must be cognisant of my biases in order not to skew my findings.

Significance and Justification of the Study

The purpose of education must be to empower - to give people the ability to participate fully in struggles, large and small, to gain respect, dignity, and power. Some existing AIDS prevention education programs for women are biased both in what is included and omitted. At present, some programs also serve as an instrument of the dominant ideology, reproducing the existing social order and maintaining the political and cultural status quo.

Women's experiences are diverse depending on where they fit in the social milieu. In order to effect behaviour change, women must see that what is taught has relevance to their personal story - their life experience. AIDS prevention education programs, to be meaningful, need to capture these diverse experiences and not simply use language and concepts based in only one experience. Further, public health messages need to be realistic so women can identify with them (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1990). Many of the programs I reviewed incorporated the experiences and needs of the particular population targeted.

I hope this research will contribute to the body of knowledge about AIDS for women in metro-Vancouver. I further hope to make recommendations on how to improve HIV and AIDS education for women. To develop the argument for more broad based AIDS prevention education program based on women's values, voices, and experiences, I present the research findings through the next five chapters.
In Chapter 2, I discuss the relevant literature and, from that, develop the theoretical framework. In Chapter 3, I discuss the methodological perspectives and methods. In Chapters 4 and 5, I present and analyse the data. Chapter 4 examines both the evolution and the current state of AIDS prevention education for women in metro-Vancouver by looking at metro-Vancouver specific issues. Chapter 5 focuses on the economic, political, cultural, and social influences that indirectly influence the transmission of HIV and AIDS. Chapter 5 also focuses on concepts of power and deconstructs public "education" on AIDS prevention looking beyond the apparent or superficial at the conflicting messages that still exist for women about women within our culture. In Chapter 6, I conclude with the implications of the findings and recommendations for further research.
CHAPTER 2:

CONTEXT

This chapter provides the context for the study. This is accomplished through a review of relevant literature and by providing the theoretical framework necessary for data analysis. The language, conceptual structure, and critiques needed for analysis are framed by the literature review and divided into three parts: feminist theory; a history of the AIDS epidemic, 1981-1996, and concluding with barriers to effective AIDS prevention education for women.

LITERATURE REVIEW

Feminist Theory

Feminist theory has evolved into a complex theoretical framework through which social issues can be explored and examined, and research questions investigated. A fundamental component of feminist theory is self-critique and in keeping with this tenet, feminist theory remains dynamic continuing to re-define itself and adapt in the face of ongoing social change. Feminist theories act as a guide to understanding gender inequality and a signpost for action (Acker, 1987).

Feminist theory has been challenged on a number of fronts. Critics have pointed out that often differences between women have been ignored in favour of the monolithic category "women" thereby ignoring the issues specific to class and/or race (Jaggar & Rothenberg, 1993). As Jaggar et al. (1993) point out "...universal generalisations about women are almost certain to be false (pg. 113)." The authors go on to emphasise those different groups of women experience subordination in
very different ways, and "...that some may not even be conscious of or concerned
about subordination at all; that some women exercise power over others—as well
as over some men (pg.113)."

Social theories are issue driven. Social, political, and personal dynamics have
changed; hence, what once was viewed as the critical presenting issues of feminism
are now "...not only often viewed as irrelevant to contemporary social analysis but
sometimes even as illegitimate (Jaggar et al., pg. 113). Clearly, according to Jaggar et
al. (1993) "...what appears to be the most urgent issues facing feminism vary
according to social perspective and historical moment; and that there is no uniquely
privileged standpoint from which a final or authoritative feminist theory may be
constructed” (p. 113).

This is not to say that feminist theory should be abandoned but rather when
developing future theories "...we must be sensitive not only to difference but also to
dominance, self-reflective about the ways in which our perceptions are influenced
by our own situations and, above all, that each of us must listen respectfully to
women whose situations and perceptions are very different from our own" (Jaggar
et al., 1993, p.114).

Socialist feminists believe that the focus of the women's movement should be
on changing existing social structures and institutions, not on incorporating women
into the existing structure. Socialist feminists believe that institutions and structures
must be changed from within and without—valuing both men's and women's
experiences to create a balance.
To overcome what socialist feminists saw as limitations to traditional Marxist feminist theory, specifically, the gender blind character of Marxist thought (the theoretical primacy of worker's oppression over the oppression of women) socialist feminism hypothesised two different approaches, dual system theory and unified system theory. These provide a more comprehensive explanation of women's oppression.

Dual-system theorists maintain that patriarchy and capitalism are distinct forms of social relations and distinct sets of interest, which, when they intersect, oppress women in particularly egregious ways. For women's oppression to be fully understood, both patriarchy and capitalism must be analysed first as separate phenomena and then as phenomena that dialectically relate to each other. What makes dual systems theory exceptionally complex is that although all dual systems theorists describe capitalism as a material structure or historically rooted mode of production, only some describe patriarchy as a material structure or historically rooted mode of reproduction/sexuality. Others describe patriarchy as a nonmaterial structure—that is, a largely ideological and or psychoanalytic structure that transcends the contingencies of space and time (Tong, 1989, pg. 175).

Unified-systems theorists analyse capitalism and patriarchy together through the use of one concept. According to these theorists, capitalism is no more separate from patriarchy than the mind is from the body. This is an even more ambitious form of socialist feminism than is the dual-systems approach, for if there is one conceptual lens through which all of the dimensions of women's oppression can be
filtered, then it may be possible to unite all of the feminist perspectives (Tong, pg. 175).

Socialist feminists argue that women's subordination can only be adequately understood when viewed through the lenses of sex/gender, sexuality, and class (Jaggar et al., 1993). However, the race-blind properties of socialist feminist theory limit the usefulness of this frame of reference.

Political and economic structures have a direct affect on women. Women's subordination "...must by analysed in terms of four interlocking social structures: production, reproduction, sexuality, and childrearing" (Jaggar et al., 1993, pg. 122). Aptly put, Gaskell and McLaren (1987) advise that socialist feminists situate the cause of gender oppression in economic structures that benefit the few; for example, the way capitalism shapes gender relations in modern industrial societies.

Transformation of structures in their entirety is the only satisfactory method of change.

This discussion looks at the chronology and evolution of AIDS education in Vancouver from a socialist feminist perspective. Suggesting changes to the existing educational programs means making these programs more compatible to women's diverse needs but not to the exclusion of men. Socialist feminist theory would argue the importance of restructuring or changing the educational programs (in this case) to meet the needs of women rather than fitting women into existing educational program. The hierarchical system of imposing information and change from the top down does not serve either men or women well. Ideally, both men's
and women’s experiences should be valued and reflected in education in order to create a balanced program which is comfortable for both sexes.

History of AIDS

To frame my discussion of the chronology of AIDS education in Vancouver, I felt it was important to have a larger awareness of women’s place within the AIDS epidemic starting from the discovery of the virus in 1981 through to present. The chronology is compelling. As Rosser (1991) points out,

> scientific theories are not objective and value-free but are paradigms that reflect the historical and social context in which they are conceived. In our culture, the institutionalised power, authority and domination of men frequently result in acceptance of the male worldview or androcentrism as the norm. (p. 230)

As the story unfolds it becomes apparent that the medical establishment, media, and government created a gendered syndrome to the detriment of women. The message to the general public was clear: “ordinary” women who engaged in “ordinary” sex did not get HIV/AIDS. The only women at risk were those who did something excessive with their bodies (Holland et al., 1990). By equating HIV/AIDS with male homosexuality, researchers and scientists and medical practitioners were able to ignore and discount the growing body of clinical evidence that showed women were contracting HIV/AIDS that manifested itself differently in women. What occurred in Vancouver reflected the prevalent attitudes about HIV/AIDS held in North America.

Although the chronology of the AIDS epidemic in the United States and Canada has been recounted many times, for the purpose of this paper it is important
to review it from a woman-centred perspective. The gendering of the epidemic not only served to exclude women from the AIDS equation but impacted subsequent policy and planning around the epidemic.

During the early stages of the epidemic, most of the information about HIV/AIDS specific to North America came out of the United States. Not only did Canada rely on the medical expertise exported from the United States about the aetiology of the disease, but embraced attitudes, beliefs and prejudices that accompanied the clinical package. Such attitudes and beliefs fettered the efforts of concerned activists to have women included in AIDS education and research in a meaningful way. The efforts of activists met extraordinary resistance, the end result being that all early attempts to include women in the HIV/AIDS equation were thwarted.

Activists pointed out that although the North American epidemic may have been first identified in the gay population, medical data from Africa presented a different clinical picture and challenged the primacy of homosexual intercourse and needle sharing as routes of transmission (Patton, 1994).

Despite this information to the contrary, the medical establishment, politicians, and the media continued to perpetuate the myth of the "otherness" of the AIDS epidemic. The message that North Americans heard and embraced was that only valueless, invisible people—gays, African-American and Latino drug addicts, women of colour, sex trade workers—get AIDS. Most of the population,
and certainly mainstream women, were immune; hence, there was little incentive to fund research, find a cure, or provide education.

In 1982, the Centres for Disease Control (CDC) in Atlanta, Georgia issued their first surveillance definition. This would be revised many times in the following years. The CDC definition of AIDS was used as a barometer to measure the prevalence of the disease throughout the United States. AIDS is not one fixed disease but has a set of indicator diseases; specific conditions that individuals get depending on their age, sex, general health and endocrine differences (Rosser, 1991; Corea, 1992; Patton, 1994; Easton, 1994).

The initial definition put forth by the CDC included no gynaecological symptoms; rather, the definition was confined to what was observed in a small number of gay white males. As the understanding of the epidemic grew, although gynaecological symptoms specific to AIDS were found in women, these symptoms were excluded from the definition until 1993 (Corea, 1992; Patton, 1994). It is unclear why gynaecological symptoms were not included. Perhaps it was because men created the definition. Whatever the reason though, the impact of exclusion was to disqualify women from government assistance available to men, exclude them from scientific studies and inhibit access to treatment - all of which served to cause unnecessary hardship, suffering, and, ultimately, death. During the first decade of the disease, women were prohibited from accessing HIV testing! Given that the CDC definition did not include gynaecological indicators, there is no accurate account of how many women between 1981 and 1993 may have died from
AIDS. The death certificates would have listed the gynaecological condition not AIDS as the cause of death (Corea, 1992; Patton, 1994).

Because the CDC defined AIDS by risk groups instead of risk behaviours, it was argued that women were not at risk for contracting HIV/AIDS (Holland et al., 1992). Reputable medical journals were reporting that women were not at risk. Feminist women practitioners argued that only studying AIDS in gay men violated common sense. If the primary AIDS risk behaviour was anal sex, then even on a physiological level it made no sense to exclude women (Barnett, 1998; Corea, 1992; Patton, 1994). Did women never have anal sex with men? Or did bisexual men never sleep with women?

In 1984, a pilot study undertaken by Stein and Flam medically demonstrated that women sex trade workers were contracting, suffering and dying from AIDS. These preliminary findings were discounted and funding to further study HIV/AIDS in women was denied (Flam & Stein, 1986). Although there is no tangible evidence, it was speculated the reason further funding was denied was predicated on the population base used in the original study – sex trade workers – women who continue to be marginalized by society (Stein, 1990).

When the first case of a North American sex trade worker suspected of having AIDS was reported by the media, and a potential threat to the heterosexual community identified, news coverage regenerated a debate on whether people with AIDS should be quarantined. Rather than focusing on fixing the problem through prevention education, the media focused on possible methods of identifying and
isolating sex trade workers with AIDS which included repression and control. Automatic testing of prostitutes and women in prenatal clinics; tattooing of HIV positive people; installation of electronic devices on people suspected of having AIDS were discussed as methods of control (Corea, 1992). When quarantine had been brought up previously as a possible method of control within the gay community, it had been met with vehement protestation. Now that the target was a sex trade worker, objections were notably absent. The media first sensationalised the significance of women as subjects of the disease and then marginalized them by creating behavioural categories which served only to further obscure the real issue – HIV/AIDS was not a respecter of persons; everyone was at risk.

Women now having been identified as possible vectors of HIV/AIDS, were seen as threatening the stability of the heterosexual community or, alternatively, as bad mothers threatening to pass HIV/AIDS onto their fetuses.

It is ironic that when the medical establishment finally acknowledged women could contract HIV/AIDS, the potential hazard identified was that infected women could, theoretically, pass HIV onto their fetuses. Proposed resolutions, advocated by many public organisations, were punitive and emphasised the primacy of the fetus and lack of concern for the women. Solutions proposed by fetal centred policy members included: mandatory testing of pregnant women to prevent the transmission of HIV to the unborn; hostile post-test counselling; criminalization of childbirth; medical treatment directed at the fetus as opposed to the needs of the women; exclusion of pregnant women from clinical drug trials; pressuring HIV,
pregnant women into having abortions and sterilizations; and, conversely, the
denial of abortion services to HIV infected women (Corea, 1992; Patton, 1994).

Although the CDC refused to incorporate women’s health problems into the
standard definition of HIV/AIDS, by December 1985, it published guidelines to
assist in the prevention of HIV transmission to fetuses. They advocated that women
in high risk groups for AIDS take the newly developed HIV test and that women
who were infected delay pregnancy until further research on perinatal transmission
was undertaken (Corea, 1992). Negligible attention continued to be given to the
heterosexual spread of AIDS and impact of the disease on women (Corea, 1992;
Patton, 1994).

Women, especially sex trade workers, now surpassed the gay male as
“other.” The probability of HIV/AIDS transmission from man to woman was
statistically greater than from woman to man. Women have a ten times greater risk
of contracting AIDS from the man than a man does of being infected by a woman let
alone the physical risk involved in prostitution (Patton, 1994). Women, heretofore
invisible in the debate, were now visibly attacked.

By 1987, the CDC revised the surveillance definition used to track HIV/AIDS.
Now the CDC included conditions affecting HIV infected children. Women were
still excluded from the definition even though the proportion of women diagnosed
with AIDS increased 39% in 1987 (Patton, 1990). It has been estimated that the effect
of not including women’s clinical presentation of AIDS in the “official” CDC
definition served to make AIDS a manageable epidemic (Patton, 1994). If women’s
and the IV drug users clinical protocol were included in the CDC definition, North America suddenly had a pandemic as opposed to a manageable epidemic confined primarily to the gay population and other marginalized groups. In retrospect, it is believed that by the mid 1980's there were as many women infected with HIV/AIDS as there were men in the early stages of the epidemic when the original clinical protocols and research interests were defined (Patton, 1994).

In the US, federal money had been allocated for AIDS clinical trials. This referred to new AIDS drugs being tested for efficacy. More often than not women were excluded from participation in these trials because of certain requirements; for example, participants were required to have a personal physician follow them. Most women with HIV/AIDS were often poor and, therefore, used public health facilities as opposed to having one specific attending physician follow them. The Food and Drug Administration (FDA) and National Institute for Allergy and Infectious Diseases (NIAID) excluded women of childbearing age from the guidelines unless these women could provide proof of appropriate contraceptives, which for the most part included the Pill or IUD.

Federal planners ignored cities with high caseloads of HIV/AIDS infections in women and utilised trials in cities with significantly fewer HIV/AIDS infected women. Programs were set up giving no consideration to the childcare and/or transportation needs of women participants. Testing sometimes-required hospitalisation and no childcare was provided. It was also often set up with no
consideration for mealtime or school hours making it difficult for women to participate.

A further criterion for participation was the necessary level of liver functioning* a participant needed to be included. Most of the women who had HIV/AIDS contracted it through IV drug use, a practice which often impairs liver function, thereby excluding them from participation. Finally, women included in the trials were examined according to the male model. No pelvic examinations were performed and so medical issues such as whether pelvic infections were made worse or better by AZT were never investigated. Although there was a constant trickle of information that suggested women's clinical presentation and progress differed from men, concern about this was not consolidated into research enterprises until 1990 after considerable pressure was exerted on researchers from international health care workers (Patton, 1994). Canada spends the least amount of money on research of all industrialised nations (BCTV News Hour, 1998) hence, there would be even less incentive to research the affects of HIV/AIDS on Canadian women than there was in the United States.

By 1988, despite growing evidence to the contrary, women were still being assured that their risk of contacting HIV was minimal. The media, including popular magazines, newspapers, and television, as well as reputable medical journals continued to downplay the heterosexual spread of HIV/AIDS and the risk to women. Norwood (1990) in a review of printed media coverage about women

* AZT, like all medications, are metabolized by the liver. Researchers did not want to confound their research results by including people with impaired liver functioning.
and AIDS recounted a series of editorials commencing 1987, in which The New York Times repeatedly conveyed to the public that the fears that [AIDS] was spreading to the heterosexual population were just that – unsubstantiated fears. The Times obscured the risk hetero-sex presented to women by burying the statistics of women infected heterosexually in the category “other” amongst their charts and graphs. These articles downplayed women’s concerns and repositioned the risk of HIV/AIDS outside the mainstream (Norwood, 1990).

Even though there was a growing compendium of research evidence indicating that infection rates among white and middle class women were increasing, these findings were omitted from the media’s reporting and the focus of risk remained confined to the generic woman who usually turned out to be the poorer black and Hispanic women, sex trade workers or partners of IV drug users. Norwood’s inquiry confirmed women were dying from HIV/AIDS related respiratory and infectious diseases without having been given an appropriate diagnosis. If a significant segment of the population was not “at risk” and consequently not in the statistical equation of the impact of HIV/AIDS in the United States and Canada, then the numbers and significance of the disease as reported to the public were more than suspect – they were incorrect and therefore the conclusions drawn from that data simply wrong.

Conversely, although women were reassured that they were at minimal risk of contracting HIV/AIDS, there was an increasing emphasis on women’s responsibility in the prevention of the transmission and spread of HIV/AIDS. The
education initiatives had not yet addressed the need to change the behaviour of heterosexual men (Holland et al., 1990).

Condom promotion campaigns were directed at women, despite reports that requiring condom use increased battering by their partners (Rosser, 1991). Such campaigns clearly demonstrated a lack of awareness of anatomy, gender role and power differences between men and women (Holland, et. al., 1990; Kippax, 1990). Many women argued that condoms were unacceptable to their current partners or were generally rejected because men did not like the interruption during sex (Holland et al., 1990). The efficacy of condoms in the prevention of AIDS transmission is predicated on consistent use. Research has demonstrated that most couples use condoms inconsistently (McLintock, 1997).

HIV/AIDS educators also advocated that women interview their partner or potential partner about their sexual and drug taking history prior to having sex.

One of the images in the campaign is a close up of a man and a woman, both young and conventionally attractive, apparently at the height of sexual passion, with the tag line, ‘and she’s too embarrassed to ask him to use a condom’. The small print under the picture reads: ‘Not surprising. What a time to be discussing it. Wouldn’t it have been easier to talk about it earlier...The implication seems to be that ‘talking about it earlier’ would have been relatively straightforward. The text continues ’... So if you chose to have sex (and remember it’s your choice) make sure he uses a condom. Talk to him about it today. And never, ever feel embarrassed...’ (Holland et al., 1990, p. 347).

No forethought was given to the practicality of such advice. What if the partner lied about his history? Or failed to disclose certain aspects because of embarrassment or discomfort? For whatever reason, deception was not recognised as a contributing factor in the spread of HIV/AIDS.
Also not recognised was that AIDS prevention education spoke to behaviour change, which in effect was a shift in power relations between men and women. In order to accomplish a change in behaviour, the structural determinants of behaviour (poverty, poor housing, lack of education and access to adequate health care and resources, acculturation problems, to name a few) would need to be addressed.

Significantly contributing to the silencing of the AIDS epidemic was the positions taken by organised religion and politically conservative governments. The “moral majority,” a group of religious zealots, and ultra conservative governments prevalent both in Canada and the United States during the late eighties censored much of the practical education material on HIV/AIDS transmission and prevention. They asserted that the material was too explicit, promoting and encouraging pre-marital sex, homosexuality, and/or drug use. The materials presented for public viewing were diluted versions of the originals and judged to be racist, sexist, incompetent, low-budget, poor quality, and boring by feminist practitioners and activists across North America (Patton, 1994). The educational presentations sanctioned by governments and organised religions featured a white, male doctor who talked or lectured about viruses and asserted the virtues of celibacy and “family” values (Holland et al., 1990). No consideration was afforded the target audience and the efficacy of information presented in a clinical fashion.

Because of inadequate materials, a group of feminist activists decided that the AIDS prevention message had to be delivered in a non-traditional forum. In January 1988, a small group of feminist practitioners, researchers, and lay people
met at the U.S. National Institute on Drug Abuse. They decided that a concerted effort to reach out to women most at risk was needed. These women practitioners agreed that it was imperative that prevention education takes into consideration the scope of women's experiences, however divergent that may be. A more holistic approach needed to be adopted. This collaborative effort resulted in a video entitled *AIDS is About Secrets*, which was professionally scripted and produced. The video examined secrets - those that women kept from each other or denied within themselves and looked at the issue of how men treated women. When the video was released, the government agency, which funded the video, distanced itself from the contents and refused to distribute it to clinics across the U.S. nor would it recommend the film. The government disavowed association with the video as it was concerned about the language and propriety of the film (Corea, 1992).

In June 1989, the Fifth International AIDS Conference was held in Montreal. A number of feminist practitioners were concerned about the lack of gynaecological protocol available to treating physicians of women with AIDS. Doctors Carola Mart and Michelle Allen put together a standard procedure outlining protocol for treating HIV infected women and women with AIDS for the Conference. Their efforts went primarily unnoticed as the poster had been placed in an obscure area in the back of the room (Corea, 1990). No body of organised research on the effects of HIV/AIDS on a woman's body was available at the conference; for example: no studies had been done to look at the effects of HIV on oestrogen receptors or other endocrine functions (Patton, 1994).
The differences in survival rates of men and women who had AIDS seemed to indicate that women died quicker than men did. According to a study conducted by the University of Medicine and Dentistry in Newark, New Jersey, the average middle class white male with AIDS lived 39 months after diagnosis whereas the average woman lived only 27.4 weeks after diagnosis (Corea, 1992). The findings begged the question, “why the discrepancy”? Were these differences because women were diagnosed later than men were? Because the population of women primarily affected were IV drug users? Or were there real differences between how the disease affected men and women? These questions and others articulated by women at the various conferences were often ignored. Rather, the focus of the women and AIDS issue was that of women as vectors of the diseases – those who transmitted HIV to their fetuses and infected innocent men.

Lesbians were even more invisible in the AIDS discourse. Out of the 7,000 papers presented at the Montreal conference, only one concerned lesbians and AIDS. There was no research on the incidence of woman to woman HIV transmission. Further, there were no statistics on the total number of HIV infected lesbians or bisexual women as the CDC did not ask women for sexual identification or about cunnilingus as a sexual practice (Corea, 1992).

In 1991, at the international AIDS conference held in Florence, Italy, requests made by female practitioners for a plenary session on research on HIV infected women were denied by the doctors and researchers who organised the conference.
One consequence of the lack of HIV/AIDS medical protocol for women was that few to no formal networks of support for women diagnosed with HIV/AIDS existed. By support, I mean social, community and medical support networks where women could access counselling, medical information, and support groups. The lack of these services further contributed to the isolation, anxiety, and hopelessness of women suffering with HIV/AIDS.

When the AIDS epidemic had finally been recognised as spreading to the heterosexual community, the medical establishment and politicians finally began to take notice. It is important to note that this shift to include women within the AIDS epidemic only occurred when their role as vectors was seen as problematic to the heterosexual male community. As victims of HIV/AIDS women had no voice. It took the realisation of a threat to the heterosexual community before women's experiences in the HIV/AIDS epidemic became somewhat visible. Clearly this speaks to the profound sexism and heterosexism embedded in our society and within the medical establishment. Through sexism women are rendered either invisible or inferior; through heterosexism women only become visible when they are connected with men.

Risk had changed; the epidemic was now affecting male, white, middle class suburbia. But despite medical evidence that it was behaviours that placed people at risk not inclusion in a specific group, AIDS education programs continued to focus on categories of people as opposed to risk behaviours.
Barriers to Effective AIDS Prevention Education for Women

The dominant theoretical model used to develop AIDS prevention education programs for the general public came from health education practices. Broadly speaking, there are two main paradigms that dictate types of program curriculum. The program looks to decrease the risk of the health problem either by behaviour modification of an entire population (population-based) or by targeting only high-risk populations (risk-based). Which paradigm is selected depends on the epidemiological nature of a health problem, the perceived difficulty of the behaviour change, and finally, but most importantly, the prevalent attitude toward those most likely to be at risk.

Population based strategies assume that many people are at some risk. There is a continuum whereby some people are more at risk than others are. In order to get “the biggest bang for the buck,” programs are designed to decrease risk behaviour in the entire population hoping that those at high, moderate, and low risk will adopt the behaviour change equally. Risk focused programs target specific populations and are, therefore, exclusionary. Risk is viewed as absolute. Either someone is or is not at risk. Proposed behavioural changes are targeted at those people who are identified by the experts as being at risk.

In a society wrought with homophobia, misogyny, racism, and sexism it is not surprising that when HIV/AIDS was first detected in North America in the gay population, the first prevention education paradigm utilised was solely risk focused. Because of this gendering of the epidemic, the public worried that explicit AIDS
prevention education material promoted stigmatised sexual practices and drug use. There was an outcry against the use of public funds for the purchase of condoms for free distribution to sex trade workers, in medical clinics, and schools. Risk reduction education was viewed as suspect, obscene, and immoral. Besides, education for the general public was believed unnecessary. Activists vainly attempted to have the emphasis shifted to risk behaviours.

In the mid-1980's, population-based education was utilised when it became apparent that the public had significant misconceptions with respect to the transmission of HIV/AIDS. The population based approach to education was adopted to educate the general public about the impossibility of contracting HIV/AIDS through casual or social contact and to foster empathy for those people who were HIV positive or dying of AIDS. The concurrent messages presented to the public led to a great deal of confusion. On the one hand, the public was told that they, personally, were not at risk for HIV/AIDS through social or casual contact. On the other hand, there was a campaign advising the public that everyone was at risk. Slogans like, “Anyone can get AIDS” or “Change or else” were prolific. For emphasis, AIDS education campaigns used a combination of scare tactics and ambiguous messages. What, in fact, the campaigns served to do was advance existing social stereotypes about class, race, age, and sexuality of HIV positive people and persons with AIDS thereby furthering the “them” and “us” dichotomy - those who needed to protect themselves from HIV/AIDS and those who needed
protection. This poorly planned and executed educational effort may actually have reinforced the erroneous belief in lack of risk (Patton, 1994).

Although there are many sociocultural barriers to effective AIDS prevention education for women, the gendering of the epidemic from the onset was by far the greatest barrier women had to overcome because it transcended medical, educational, and personal boundaries.

Policymakers were more concerned that HIV/AIDS did not crossover to the male heterosexual population than they were in developing a comprehensive HIV/AIDS prevention education program for women in relation to a disease that had already crossed boundaries. Further, because women who were first identified as HIV positive or who had AIDS were viewed as sexually deviant, little effort was directed at understanding the clinical presentation of HIV/AIDS in women let alone funnelling funding into the development of resources and educational strategies which could adequately address women’s specific needs. There was a conspiracy of silence surrounding the uniqueness of women’s clinical and social experience in the HIV/AIDS epidemic – one that ultimately was fatal for thousands of women.

A Feminist Approach

From a socialist feminist perspective, the path to effective, behaviour changing education requires emphasis on the humanistic values of care, connection, and responsibility but must also take into account concepts of power and authority. In other words, effective education must fit those values to the message and maintain a balance with issues of power and authority in order to have permanent
effects. Safer sex education, for example, must include men. The education should aim not just to educate men about the construction of masculinity and encourage alternatives to stereotypical ideas of what is masculine and feminine but teach men about the sexual and social needs of women (Holland, Ramazonoglu, Scott, Sharpe & Thomson, 1992). Research data indicates that often what stands between a woman and safe sex is the partner she is with (Holland et al., 1990).

Education programs should address and challenge sexism, homophobia, and male sexual violence. Issues of gender and sexual orientation also need to be incorporated, as do emotional and moral aspects of sexuality. This would allow for a holistic, balanced perspective. For women, socialist feminist education would be empowering. It would nurture and develop self-esteem and self-worth allying this to a personal awareness of sexual needs and desires thereby increasing self-confidence and allowing women to lay claim to their personal and sexual power (Holland et al., 1990).

From a socialist feminist perspective, HIV/AIDS prevention education requires a progressive agenda that promotes the idea that human sexuality cannot and should not be defined exclusively in terms of male heterosexuality. A feminist approach to education celebrates diversity and differences within human sexuality and as a result challenges sexism, stereotyping, and male sexual violence (Lenskyj, 1991). Further, a socialist feminist perspective can focus attention on the sexism, racism, and heterosexism that exist in society, the medical system, and research
institutions. As a result, this perspective can suggest changes to practices and structures in these areas.

The concept of a woman-centred rather than a gender-neutral curriculum will be further explored in Chapter 5.
CHAPTER 3:

RESEARCH METHODS

This study is about how much and what kind of AIDS prevention education is available to and for women in metro-Vancouver, as well as how effective these programs are in preventing HIV/AIDS. The data sources used in doing this study include both primary and secondary sources. In this chapter, I explain the research methods in three parts: research, research site, and data collection and analysis.

Feminist Research

Harding (1987) identified three characteristics of feminist research. First, feminist research is about women and their daily experiences. Second, the research is designed for women. Finally, the researcher is positioned in the same critical plane as the subject matter. This research captures these three qualities.

First, this research is about metro-Vancouver women and the HIV/AIDS prevention education offered to them from 1981 to the present. Metro-Vancouver is a cultural cornucopia and the experiences of women are as diverse as their ethnic backgrounds, belief systems, education, and socio-economic status.

Second, this research is for women. Women’s experiences, values and ways of knowing for the most part remain invisible and undervalued - a reflection of our inferior status in society. This research attempts to make visible the experiences of metro-Vancouver women within the HIV/AIDS prevention education discourse.

Third, and finally, Harding (1987) maintains that a researcher should not be "detached" from the research, as in the objective stance of traditional scientific
methodology. Rather, the researcher should explore relevant issues with real people, not with people who are regarded as "subjects." Hence the researcher is not removed from the subjects and the subject matter, but is engaged in a personally meaningful experience with real people. The personal background information contained in Chapter 1, and the analysis below, indicate my willingness to actively participate in the research process, thereby making the process dynamic. Further, as a woman based within the popular culture of metro-Vancouver, I have shared some of the experiences that I have written about. This positions me within the same critical plane as the subject matter.

In North America, most of us are fairly comfortable with the concept of freedom as defined within a democratic society. We may not understand the intricacies of the laws the way constitutional lawyers or scholars do, but we understand the basic premise and hold the belief that freedom is our birthright. However, as members of society, we live within a culture that is also dominated and influenced by unseen powers. The opinions and facts we are "fed" are too often carefully filtered whether by politicians, the media or the medical establishment and then published where there is a "fit" with a pre-determined agenda. Since real controversy and debate is sometimes carefully avoided, the information we receive on that subject can be, in effect, censored. We are told that media statements, as well as the results of polls and studies, represent public opinions and values. But in reality, many of us fail to recognise ourselves or our experiences in their pages.
As a woman, I have often felt my perspectives and opinions are not reflected in "public" opinion. This research has allowed me the opportunity to speak out with that freedom denied elsewhere. Reactions to the information contained in this thesis may generate varied responses ranging from agreement to complaints, criticism, questioning, and even angry denunciation. These perspectives also need to be heard and respected, and even welcomed. This, of course, is easier to say than to do. The issue under discussion is highly sensitive and emotionally charged. It is difficult to be welcoming if one feels defensive or at risk. Notwithstanding having said that, the only danger I see is if the truth behind the reaction is really an effort to oppress, to take away the power of the speaker. When the debate is legitimate, then somewhere in this cacophony of opinion is an opportunity to work towards understanding.

This research is in many ways retrospective—historical—an attempt to map the territory of HIV/AIDS prevention education for women in metro- Vancouver. The research is also, however, intended to be a didactic and dynamic work, pointing the way toward future research and improving upon the education and services currently available. Interviewing women instrumental in the development and promotion of HIV/AIDS prevention education materials for women in Vancouver was an integral part of understanding and capturing both the historical and current status of HIV/AIDS education for women. Focusing on these sources made sense given the need for some kind of broad map of the territory and the resources available to the researcher, which were limited. The coterminous themes of power
and authority and their influence on AIDS prevention education for women in
metro-Vancouver emerged from the data gathered and connected to the research in
a complex way that unfolded as the work progressed.

Research Site

I limited the scope of this research to metro-Vancouver. When I initially
selected the site, I did so in part because Vancouver is the city in which I live and
also because the surrounding municipalities access services in Vancouver. I felt
metro-Vancouver provided a good example of paternalistic and patriarchal politics.
I did not include communities outside metro-Vancouver because of location specific
problems these communities face such as limited resources and funding, and
physical isolation. The greater share of resources and funding gets funnelled into
metro-Vancouver as this area does house in excess of 1.5 million people.

Vancouver is very fortunate in that there are many excellent AIDS resources
for both men and women. Services for HIV+ women include: the Oaktree Clinic, a
medical treatment centre for women and their families; Pacific AIDS Resource
Centre (PARC) Library which contains many books and videos on health, diet, and
living with HIV; Positive Women’s Network (PWN), an advocacy and emotional
support organisation for HIV+ women; AIDS Vancouver which provides welfare
advocacy, foodbank, financial aid, medical and treatment information; British
Columbia Persons With AIDS Society which provides peer counselling, free clothes
and other goods, financial aid for alternative medical treatment; St. Paul’s Centre for
Excellence has a library, resource people and provides treatment for people living with AIDS.

Interview Data

For the purpose of this research, I chose to speak with women who were directly involved in prevention education initiatives that targeted women in the metro-Vancouver area. I was not looking to exclude men or the initiatives and education available to men but, rather, wanted the primary focus of the education program/project to be women as this was women-centred research. It also served to limit the scope of the research.

I interviewed a total of nine women from seven different organisations.

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<tr>
<th>Name</th>
<th>Organisation</th>
<th>Date</th>
</tr>
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<tr>
<td>Barnett, Jacqueline</td>
<td>CDC – Education Coordinator</td>
<td>Sept. 9/98</td>
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<td>Bidd, Virginia</td>
<td>Rape Crisis Center – Peer Counselor, Administrator</td>
<td>June 16/99</td>
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<td>Dunnigan, Donna</td>
<td>DAMS- Community Outreach Worker</td>
<td>Nov. 05/99</td>
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<td>Asian Women’s Outreach – Educator</td>
<td>Oct. 25/99</td>
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<td>Sargeant, Sheena</td>
<td>YouthCO – Educational &amp; Training Coordinator</td>
<td>Aug. 31/99</td>
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<tr>
<td>Tolson, Margreth</td>
<td>Women’s Outreach – Coordinator</td>
<td>Sept. 7/99</td>
</tr>
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Table 1: Women interviewed, dates, and organisations.
The Positive Women's Network (PWN) has an educational services department, which focuses on community needs such as educating physicians. Expanded volunteer core and support staffs were brought on to support women with HIV and AIDS as well as meet the challenges of education. The women's support group explores how issues such as self-identity and other personal, psychological, and economic factors influence the unsafe or safer sexual practices of women in Vancouver. PWN is a non-profit organization founded in 1989 in Vancouver, British Columbia. PWN helps support women living with HIV/AIDS make their own choices by providing safe access to services and resources. I interviewed Marcie Summers, Executive Director, and Janet Madsen, Communication Co-ordinator, of PWN. To confirm the information about PWN contained in Chapter 4, on September 07, 1999 I once again met with Marcie Summers and had her review the information contained therein. Unfortunately, due to time constraints I was unable to do this with the other women interviewed.

The Women's Outreach Education Department is a part of AIDS Vancouver. Framed within a holistic and feminist perspective, Women's Outreach strives to raise awareness and understanding of HIV/AIDS in women's lives. The program incorporates analysis and confrontation of the personal, social, and political barriers to women's health and seeks to promote healthy safer living for all women.

This program targets women whose access to HIV prevention and support information is limited by poverty, alcohol and drug use, incarceration, abusive relationships, sex trade work, and literacy. Women's Outreach also designs and
produces educational pamphlets and materials that are used both nationally and internationally. I interviewed Margreth Tolson, Co-ordinator, Women’s Outreach.

The British Columbia Centre for Disease Control Society (BCCDCS) functions as the primary co-ordinating body for the province in the detection, management, control, and prevention of communicable diseases. STD/AIDS Control, a division within BCCDCS, co-ordinates province-wide efforts to reduce the spread of sexually transmitted diseases and to minimise their adverse effects in British Columbia. Staff from STD/AIDS Control also provides expert consultation to the Minister of Health, public health officials, medical personnel, private industry, and the general public regarding STD/HIV/AIDS policy and procedures.

A part of the BCCDCS’s mandate is the establishment of HIV standards and guidelines for clinical, educational and counselling practice. The training team at STD/AIDS Control designs and delivers tailored education/counselling recognising that STD/HIV/AIDS crosses all ethno-cultural-religious borders; therefore, cultural sensitivity is required in the development and delivery of each workshop. Much of the culturally sensitive education initiatives are done from a woman-centred perspective. At the BCCDC, I interviewed Jacqueline Barnett, Education Co-ordinator.

YouthCO, founded in April 1993, is the only AIDS service organisation in Canada dedicated exclusively to meet the needs of both HIV+ and HIV- youth. The service delivery model used by the organisation is a health promotion and harm reduction model. The agency is run by and for youth providing outreach,
preventative education, and support to youth infected or affected by HIV/AIDS. I interviewed Sheena Sargeant, Educational and Training Co-ordinator. I reviewed a number of the educational materials developed in house by YouthCO as well as the materials used from external sources.

Tomiye Ishida is the Asian Women’s Outreach Co-ordinator for the Asian Society for the Intervention of AIDS (ASIA). ASIA focuses on HIV/AIDS prevention education and outreach in the Asian community. The women’s program is a fairly new initiative and is only in the infant stage of development. The goals of the women’s outreach co-ordinator are to develop educational materials that are relevant to the needs and experiences of Asian women, and develop strategies to better access “mainstream” Asian women.

At the Drug and Alcohol Meeting Support (DAMS) centre for women, I interviewed two Community Outreach Workers, Donna Dunnigan and Leslie Remund. These women do street and hotel outreach focusing on the women of the downtown Vancouver Eastside. Many of the street women Donna and Leslie work with are First Nations Women. The outreach is less structured than found in organisations such as the CDC, PWN, or Women’s Outreach. No AIDS materials are handed out. Rather the AIDS prevention education is done one on one in informal settings such as providing education to women over coffee and a cigarette. The education is based on the needs of the woman at that specific time in her life.
I spoke briefly with Virginia Bidd, Peer counsellor/administrator from the Rape Crisis Centre. I obtained statistical information concerning the number of sexual assaults in Vancouver.

The interviews varied from one and one-half hours to two hours, during which I took detailed notes. All women interviewed enjoyed the opportunity to talk about the concepts and the challenges of AIDS prevention education. I used a combination of open and closed questions that elicited information in the following areas: AIDS prevention education initiatives directed at health care professionals; AIDS education for youth and street kids; AIDS prevention education for metro-Vancouver women including immigrant and refugee women; the ease with which women are able to access information and assistance; and perspectives on the barriers, strategies, and characteristics women bring to the AIDS discourse. The interviews were not limited to the structured questions but rather evolved in the interview process.

In closing, I feel it is important to acknowledge the work performed by the Oaktree Clinic in Vancouver. The Oaktree Clinic is located at Vancouver’s old Shaughnessy Hospital and offers specialised care for women and children infected with HIV. They offer “one stop shopping” for services provided by physicians, social workers, nurses, dieticians and pharmacists to help improve the quality of life for families. Because British Columbia has the highest cumulative incidence of AIDS in the country, the demand for the clinic’s services has far exceeded expectations (Kent, 1996).
The Oaktree Clinic was valuable in providing an understanding of the demographics of the distribution of HIV in metro-Vancouver. There was, however, reluctance on the part of the Oaktree Clinic to have me conduct interviews with the staff. In fact, I was unable to get beyond the woman who would return my phone messages. I was told that because of confidentiality and privacy issues, the Clinic preferred to not have people visit. I was referred back to the CDC and PWN for information. I believe that had I been able to meet with the team members at Oaktree Clinic I would yet have had another perspective which would have greatly enhanced my understanding of the problems facing metro-Vancouver women in the AIDS epidemic. It would also have provided me with the clinicians’ perspectives on possible solutions.

I used the resources at St. Paul’s Centre for Excellence but did not formally interview anyone. I chose to not conduct an interview at the Centre for Excellence because the Centre’s primary mandate is that of research and treatment of AIDS.

Documentary Sources

Most of my research data came from secondary sources gathered from the PARC library, various journals, books, newspaper articles and newspapers. The following table outlines the number and type of secondary sources used.
Table 2: Breakdown of Secondary Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Quantity</th>
</tr>
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<tbody>
<tr>
<td>Books</td>
<td>26</td>
</tr>
<tr>
<td>Brochures</td>
<td>32</td>
</tr>
<tr>
<td>Email Correspondence</td>
<td>01</td>
</tr>
<tr>
<td>Interviews</td>
<td>09</td>
</tr>
<tr>
<td>Journals</td>
<td>14</td>
</tr>
<tr>
<td>Magazines</td>
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<tr>
<td>Newspapers</td>
<td>21</td>
</tr>
<tr>
<td>Presentations</td>
<td>10</td>
</tr>
<tr>
<td>Reports</td>
<td>04</td>
</tr>
<tr>
<td>Television reports</td>
<td>03</td>
</tr>
<tr>
<td>Unpublished master's theses/papers</td>
<td>04</td>
</tr>
</tbody>
</table>

As part of my research, I also examined the Hansard, which is the official report of the debates of the British Columbia Legislative Assembly, with a view to determining what debates, if any, took place with respect to women and AIDS. I could find nothing in the Hansard that related specifically to the issue of women and HIV/AIDS but do note there were many lively debates over inconsistent government policy on the AIDS issue ranging from education and health care initiatives to funding of drug treatment. The lack of debate on women and AIDS issues in Victoria provides an interesting commentary on the status of women within the AIDS discourse. Clearly, our status in the AIDS discourse was so marginalized it did not even merit debate.

The data analysis of the interviews and the literature was done from a socialist feminist perspective as detailed in Chapter 2. Both deductive and inductive analysis techniques were used to analyse the data collected. I used informal conversations with health care professionals and colleagues where I work as a
method of focusing my analysis by communicating my thoughts and ideas and listening to their responses to these constructs.
CHAPTER 4:

HIV/AIDS EDUCATION IN METRO VANCOUVER

This chapter will examine HIV/AIDS issues specific to metro-Vancouver including prevention education available to women from 1989 to date. For the purposes of this thesis, the analysis will be limited to AIDS education for women age 15 years and older.

As outlined in Chapter 3, in more detail, materials used in the development of this chapter include Positive Women Network newsletters, minutes from meetings, research, personal interviews, journal articles, and newspaper articles. Chapter 5 will examine the political processes that direct and filter AIDS prevention educational programs for metro-Vancouver women.

Vancouver and the AIDS Discourse

In Vancouver, as in other North American communities, between 1983 and 1986, AIDS was treated as a new, potentially epidemic disease that affected only the gay community and a few other marginalized groups. Boshier (1992) observed that at this time the AIDS discourse was firmly entrenched in conservatism, homophobia, denial, and fear. Medically, little was known about the aetiology of the disease, and given the social stigmatisation associated with the gay lifestyle, minimal concern was afforded to research other routes of transmission, let alone find a cure. In fact, it was not until the Vancouver gay population mobilised around the issue of AIDS, putting pressure on politicians who controlled funding, that some action resulted. This, however, did not occur until the AIDS epidemic hit crisis
proportions provincially in 1987. It was only then the provincial and civic servants and politicians chose to intervene. Formal institutions were set up, formalised procedures adopted, and paid professionals replaced volunteers (Marjoribanks, 1995).

In 1983, the gay community established AIDS Vancouver as an AIDS education and awareness centre. A “hotline” was set up providing the only source of current information available about AIDS. Little epidemiological data was available including information about routes of transmission. This was in part because AIDS was a relatively new medical phenomenon characterised by a lengthy latency period between infection and onset of detectable symptom. As the gay community was the hardest hit by the virus and saw the most casualties, it was presumed the disease was isolated to the gay population and directly attributable to their sexual practices. Hence, AIDS became a disease of lifestyle and membership to a risk group.

In 1983, AIDS prevention education programs directed at gay Vancouver men were being developed. AIDS Vancouver took responsibility for developing education materials and outreach because the government was unwilling to do so (Marjoribanks, 1995). These programs were constructed, delivered and implemented by gay men for gay men. Both “straight” men and all women were excluded from the AIDS discourse. As Boshier (1992) points out “it is ironic that the preoccupation with one invisible group, homosexual men, has more or less been at the expense of another invisible group, women” (p. 127).
In 1985, the B.C. government offered AIDS testing free to the gay population in Vancouver. Women who wanted to be tested were discouraged from being tested or refused testing on the basis of gender and the misplaced belief that only "certain types" of women could get HIV. This served to perpetuate the myth that risk was associated with identity and not behaviour, which led to great confusion about prevention and contagion. Women continued to believe that they were not "the other" and, therefore, not at risk regardless of their sexual practices (Easton, 1994). Further, because women would not perceive themselves at risk, many would not have sought medical advice on HIV/AIDS even if they were symptomatic (Boshier, 1992).

In Vancouver between 1987-1992, gay men lobbied for a more succinct public policy around AIDS. Medically, researchers were beginning to see a scientific link between AIDS in the gay community and the spread of AIDS to the general population. There was some recognition of the need for action because of the shift in the discourse from a male-only, sexually transmitted and IV drug user disease, to a more heterosexual risk driven discourse.

The Positive Women's Network (PWN)

According to Summers (1984), prior to 1989 no formal support resource existed for positive women in metro-Vancouver. A few Vancouver women were meeting at a "grass roots" level. They called themselves the Vancouver Women and HIV/AIDS Support Network. They wanted to establish a service aimed at providing support, advocacy, and education for women living with HIV/AIDS. From their
work in the community and through discussions with other women activists in the province, this group realised that it was imperative that women be given meaningful status in the HIV/AIDS crisis. In an October 23, 1990 brief to the Government of British Columbia the committee writes:

HIV-infected women remain an invisible group: geographically dispersed, culturally diverse (range from street kids to college students to middle class housewives to successful professionals), afraid of revealing their status even to close friends and family. Their fear of stigma and discrimination and lack of a natural community makes it very difficult to reach them. Many of them are coping with other problems and crises, such as poverty, substance abuse, violence, and relationship problem (Vancouver Women & HIV/AIDS Support Network, 1990, p. 2)

At the time, parallel initiatives were in the making: Positive Women’s Network (PWN) and the Vancouver Women & HIV/AIDS Support Network later to become part of AIDS Vancouver (Women’s Outreach).

The mandate of the PWN would be support and advocacy for women living with HIV/AIDS. The Women’s Health Collective housed the staff, initially two full time employees between 1990 and 1992.

The materials developed by PWN are directed at HIV+ women. The materials cover various subject matters ranging from living with HIV/AIDS to activism. A quarterly magazine is published featuring articles on such topics as alternative therapies available for the treatment of HIV/AIDS, life stories about positive women, and HIV related menstrual abnormalities.

PWN offers a number of services and programs to assist positive women in the province in addressing the particular and complex issues of their lives. This includes but is not limited to: telephone counselling; one to one outreach/advocacy;
drop in centre; support for family and care providers; educational workshops; child
care and transportation subsidies; treatment information; physicians education;
information and referrals; home visits; weekend retreats; peer counselling;
information packets; public education and awareness.

When I spoke to Marcie Summers on September 07, 1999 she provided me
with a copy of a pamphlet designed by PWN about issues relevant to HIV+ women
and women living with AIDS.

Figure 1: PWN information pamphlets.

Summers states, "We kept hearing the same questions being asked by
positive women around the province. We saw a need to put out a basic set of
information pamphlets that would address the issues and provide women with
something they could reference in the future."
The series of pamphlets are packaged in a cardboard file cover and contain information on a range of topics including the use of IV drugs while pregnant to how to have safer sex. The pamphlets, written from a lay perspective, are easy to understand and limited to one topic per pamphlet.

**Community Education Initiatives**

By the summer of 1992, the PWN became a partner with AIDS Vancouver and the British Columbia Persons with AIDS Society in the Pacific AIDS Resource Centre. Also in 1992, Women’s Outreach was created as a department of AIDS Vancouver.

By 1994, PWN had become a credible national organisation receiving funding from both the provincial and federal governments. PWN had an active membership of over 100 positive women, a staff of four, a Board of Directors, and an extensive volunteer pool. The PWN formed a liaison with the British Columbia Centre for Excellence as well as with the STD/AIDS Resource Centre, Bellaclava House (for women in prison), and various transition houses and clinics such as Oaktree, in the lower mainland.

Summers states, “By 1995, PWN opened the women’s centre which provided hot lunches to HIV/AIDS positive women. It still is providing that same service today. The Centre also provided and continues to provide a safe place for HIV positive women to speak freely about issues that concern them. The women talk about abusive relationships, problems with children, difficulties at work, a new relationship – whatever is on their minds.”
In speaking and working with positive women, the staff of PWN began to recognise and comprehend the marginalization women living with HIV/AIDS faced every day.

"Most important" Summers declares, "it became evident to the staff of PWN that living with HIV/AIDS struck at the core of these women's identities: who they once were and who they are now."

PWN identified some of the fundamental needs of positive metro-Vancouver women to include the ability to access a sensitised, responsive health care system, treatment information and increased access to clinical drug trials. Research had demonstrated that women with serious HIV infection did not live as long as men (Canadian Press, 1995, pg. A11), possibly because of misdiagnosis, lack of early intervention, or an absence of treatment altogether. Prompt treatment of other sexually transmitted diseases (chlamydia, syphilis, and gonorrhoea), for example, reduced the incidence of HIV infection by 42 per cent. A three-year study confirmed experts' suspicions that STD lesions facilitated HIV transmission. Open sores gave the virus a better chance of getting into the body (Hooper, 1996, p. 62). The informal drop-in centre discussion groups highlighted deficiencies and inconsistencies in the awareness and knowledge about HIV amongst care providers.

The Physician's Education Project

The health care problems identified in metro-Vancouver were threefold. First, there was a lack of awareness and knowledge about HIV amongst health care providers. Women continued to go undiagnosed even when they had conditions
that were possible indicators of HIV such as cervical cancer or yeast infections (Canadian Press, 1995, p. A11).

Summers states, “Once a positive diagnosis was made, the doctor may refer the woman out of the practice because of feelings of ignorance about the disease or simply because of blatant discrimination.”

Second, women were reporting that their doctors often discouraged AIDS testing. A British Columbia study showed 17% of HIV-positive women had previously been denied an AIDS test according to Dr. Stephanee Strathdee from the British Columbia Centre of Excellence for HIV/AIDS (Canadian Press, 1995; Easton, 1994). Even when women complained of symptoms indicative of HIV/AIDS, testing was denied (Canadian Press, 1995, p. A11). Physicians were making their assessments based on the belief that only “certain types” of women could get HIV. This assignation of people to risk groups demonstrated a thinly veiled prejudice, which did not take long to turn into discrimination with serious consequences. Emphasis on risk groups rather than risk behaviours carried a danger of false complacency.

“If a woman did not identify herself with a risk group but engaged in risky behaviour [unprotected sex or needle sharing] then she may believe she is protected because of who she is rather than at risk because of the behaviour she engages in,” Summers said. “Third, despite women’s experiences and the reality of the risk of contracting HIV/AIDS, the dominant AIDS ideology was and continued to be male-centred.”
The diagnostic definition of the disease didn’t specify female diseases such as yeast infections, cervical cancer and pelvic inflammatory disease. The affected body had no cervix or uterus. As a result, medical treatment, preventative education strategies, media content and government policy all reflected male needs (Boshier, 1992; Easton, 1992). Health Canada, for example, had failed to acknowledge women might need a different dosage of the drug AZT because of limited understanding of how the virus affected women (Canadian Press, 1995, p. A11). Available treatment protocols and education initiatives were and continue to be filtered through the lens of a male oriented definition (Easton, 1992).

At a March 1993 Women’s Health Conference, Dr. Penny Ballem, Director of the Women’s Health Centre at University Hospital of British Columbia, stated that women needed to get into all levels of policy and decision making because the health-care system is patriarchal. Dr. Ballem further stated that women’s lives are different from the men who are the traditional decision-makers (Stainsby, 1993). The challenge for PWN was to rattle patriarchy through activism, advocacy, and education with a view to improving the quality of life for HIV positive women in metro-Vancouver and prevent women from contracting HIV.

Because a specific problem was identified amongst health care providers in the metro-Vancouver area, the Board of PWN established the Medical Education Committee. It consisted of local Board members, physicians, and positive women. The mandate was to examine health care issues experienced by HIV positive women and women with AIDS (PWN, 1996). The committee decided to conduct two
studies. The Positive Women’s Survey was designed and undertaken by Doctors Colleen Kirkham and Daphne Lobb. Dr. Janice Veenhuizen conducted the Physicians’ Survey.

The 1996 Lobb and Kirkham “Positive Women’s Survey” found that 11% of HIV positive women stated that they had become infected as a result of rape. Review of the questionnaire showed that there was no risk category called “non-consensual, forced, unprotected vaginal or anal intercourse” in the HIV/AIDS assessment tool. There was no acknowledgement of the HIV risk that sexual violence posed to women (PWN, 1996).

I contacted the Vancouver Rape Crisis Centre to inquire about statistical data. According to Virginia Bidd, Peer Counsellor/Administrator, the Vancouver Rape Crisis Centre estimates that two out of every three women in the metro-Vancouver area have been sexually assaulted. The degree of assault varies in severity from unwanted touching to rape. This statistic seemed high; however, when I looked at some information coming out of the United States the numbers estimated by the Rape Crisis Centre may not be out of line. In the United States statistics demonstrate that a woman is beaten every 15 seconds, and each day four women are killed by their batterers (Heise, 1993). Pharr (1993) states, “All in all, when the numbers of murders, rapes, and sexual assaults of girls are put together there emerges a grim picture of the brutal hate violence launched against women and girls” (p.61).

The Physicians’ Survey was developed to assess physicians’ needs regarding information about women with HIV (PWN, 1996). The two studies ran
concurrently. The results of both studies showed that general practitioners needed a broader understanding of the medical and psycho-social issues facing HIV positive women. Based on the research findings, the committee identified and outlined the core needs of women living with HIV and AIDS. These were the founding principles on which the Physicians' Education Project were designed (PWN, 1996).

This project was a valuable community initiative and most likely resulted in some positive changes in the way physicians interacted with HIV positive women patients. The project probably increased the physician's personal knowledge base of HIV and women. However, I could find no evidence of follow-up, either quantitative or qualitative, measuring the success of the project.

An incidental finding that flowed from the 1996 Survey conducted by Kirkham and Lobb concerned the difficulties HIV positive women experienced with home care providers. These HIV positive women, already vulnerable and weakened due to the illness, were often met with a lack of sensitivity, fear, and judgement by the home care provider. This increased the sense of isolation and lack of support HIV positive women experienced. In response, PWN organized discussion groups that taught HIV positive women how to more assertively address their needs with home care providers.

When I re-interviewed Summer on September 07, 1999 PWN was about to embark on a second joint initiative Physician’s Education Project province-wide. The goal was to educated physicians in the smaller communities on the effects of HIV/AIDS on women so to better meet the needs of HIV positive women and
women living with AIDS province wide.

**Women and AIDS Project**

"Historically, the Women and AIDS Project began," according to Summers, "in 1989 when a person from Health and Welfare Canada, with an interest in developing education for women who were HIV positive or who had AIDS, asked these women [Vancouver Women and HIV/AIDS Support Network] to put together a proposal for education funding."

The group caucused and in response wrote a proposal focusing on a preventative education mandate which took a health promotion approach. Prevention had been identified as a need given the incidence of HIV in women was increasing (Easton, 1994).

In 1990, the Vancouver Women and HIV/AIDS Support Network sought provincial government funding to meet the existing and future needs of HIV positive women in metro-Vancouver. Their goal was to provide a resource/referral centre on HIV/AIDS for women by building a network of community resources; to create a reputation of trust and confidentiality amongst HIV infected women; to help HIV infected women develop and enhance coping skills and to secure an ongoing funding source (Vancouver Women & HIV/AIDS Support Network, 1990, pg.1). Provincial funding was denied. At the time of the proposal there were 250 known HIV infected women in British Columbia and twenty known women with AIDS.
The Women and AIDS Project became the first federally funded project of its kind. The opening of the project coincided with the British Columbia government’s highly public pursuit of a young HIV positive prostitute. Victoria medical health officer, Dr. Shaun Peck, used the Communicable Disease Act to issue an order to confine the sex trade worker to the Royal Jubilee Hospital in Victoria. She was then placed in custody in Lethbridge, Alberta. This was the first time the “Quarantine” bill was used against an HIV carrier (Miller, 1990).

This woman was not seen as an individual suffering the physical ravages of HIV but as a vector threatening the well being of white male heterosexuality - that is the well being of her clients. Her identity, linked to the sexual practices of yet another marginalized group, sex trade workers, was situated outside the borders of the “general” population - someone from whom polite society needed to be protected. Her confinement, based on governmental policy, was justified in the name of the “greater good.” Having identified a sex trade worker in British Columbia as HIV positive also served to solidify conservative hegemonies reflecting the dominant social, ethical, moral and religious concerns.

By 1993, Epidemiologist Steffanie Strathdee from the British Columbia Centre for Excellence in HIV/AIDS estimated that about 500 British Columbia women were HIV positive but only 320 had tested positive. This figure was estimated by a complex statistical technique called back calculation (Wigod, 1993). It thus appeared that almost 50% of HIV infected women did not know they were infected (Strathdee et al., 1993; Wigod, 1993). This also meant that the number of HIV infected women
had close to tripled in the three years since the proposal had been put to the Social Credit government. With the limited funding provided by the federal government, one of the first tasks of the Women and AIDS Project was to inventory and assess the value of the educational materials on hand.

The Women and AIDS Project housed the largest collection of HIV/AIDS pamphlets from all over the United States and Canada. The staff reviewed the pamphlets and considered most of them "rubbish." The pamphlets either used fear or did not provide useful instruction. The Project decided to develop their own materials (Miller, 1990).

Condomania – The Vancouver Condom Awareness Campaign

In 1990, the Women and AIDS Project collaborated with the Vancouver Health Department on a community-based initiative to raise public awareness of the risk of HIV to women. The Vancouver Condom Awareness Campaign, "Condomania," was launched, based on social marketing principles successfully utilised in formulating and implementing broad-based behaviour change program. The campaign targeted women between the ages of 19 and 30. Statistically this age group was seeing a significant increase in the incidence of HIV. Public health officials recognised that effective prevention education for women had to go beyond platitudes which suggested women could "just say 'no' to unwanted sex" or "wear a condom." The goal of the campaign was to make condoms a more socially acceptable feature of everyday sexual activity (Wagman, 1993).
Most women were unaware of their personal risk of contracting HIV; therefore, informing women of their risk along with offering a prevention option had to be a salient feature of the campaign. Because the focus was condoms, and men ultimately control usage (whether the condoms are worn by the male or the female), it was important to acknowledge the role gendered power relations played in both the construction and practice of heterosexual sex (Holland et al., 1992). It was decided that men had to be included in the campaign.

The mandate of the campaign was then reformulated to integrate these changes and the target population became young adults between the ages of 19 and 30 with a special emphasis on women. The project was to span three years. The public promotion would consist of an advertising blitz each year of two one-month campaigns approximately six months apart. The community focused education ranged from visible advertising to soliciting the assistance of bars and nightclubs for a patron education campaign.

The third phase of the campaign, the follow-up and evaluation, never resulted. Although the project was an excellent initiative, the telephone survey and interviews were discontinued due to a lack of funds during the second campaign (Wagman, 1993). It is unfortunate that the project was unable to formally evaluate the campaign to determine if it was successful. As is often the case, funding is predicated on quick results that are not practically attainable in areas which target behavioural and attitudinal change. This, in concert with the Social Credit...
government’s emphasis on “family values” and conservative funding policies was the death of the project.

In an email communication with Lu Ripley, Co-ordinator of the school and community component of the current Condomania Campaign, Ripley states that this program trains youth, 18-24, to go into schools as older “peers” to talk about safer sex, relationships, and taking care of self. Ripley has been the Co-ordinator for the past three years. The Campaign targets grade 7-9 classes in Vancouver schools. Although the focus is on young men and women, the peer educators strive to encourage young men to take responsibility for safer sex.

Other components of the Campaign include:

- Volunteers who go to raves, sporting events, and concerts to staff information tables around issues of safer sex and condom use
- An interactive website aimed at young men (www.condomsite.com).

Women’s Outreach

On September 07, 1999 I spoke with Margreth Tolson, Coordinator, Women’s Outreach. In 1992, women’s HIV/AIDS education, Women’s Outreach, became a part of AIDS Vancouver. The mission statement of Women’s Outreach, Education Department sums up the philosophy of the program:

Using a holistic and feminist framework, Women’s Outreach works to raise awareness and understanding of HIV/AIDS in women’s lives. As HIV is one of many inter-related problems that affect women’s lives, this program incorporates analysis and confrontation of the personal, social, and political barriers to women’s health, and seeks to promote healthy, safer living for all women (1997/1998 Strategic Planning-Women’s Outreach, Education Department).

According to Margreth Tolson, “Women face serious obstacles to reducing
the risk of HIV/AIDS. Sex-trade workers, battered women, and incest victims lack control over their sexual activities and are unable to demand safe sexual practices from their partner(s) most often out of fear of violence.”

Tolson goes on to state, “With this in mind, the Women’s Outreach Program focuses its efforts on women whose access to HIV prevention and support information is limited by poverty, alcohol and drug use, incarceration, abusive relationships, sex trade work and literacy.”

The Outreach Program partner with several agencies in the downtown Eastside including: the Vancouver IV Drug Users Study project (VIDUS), Women’s Information and Safe House (WISH), Downtown Eastside Women’s Centre, and Powell Place. The program also provides support and education to women in drug and alcohol treatment centres, recovery houses, and in prison.

Women’s Outreach develops its educational materials in house. These materials are used both nationally and internationally. I reviewed many of the pamphlets.

Figure 2: Women’s Outreach Pamphlet Series

The pamphlets incorporate graphics with relevant information and include experiential quotes from women.
"Women & Abuse, and HIV" is one of the pamphlets in the series. The pamphlet begins by defining the issue—in this case emotional abuse is defined. To reinforce the meaning of the definition the pamphlet provides a quote from a woman who has experienced emotional abuse.

One woman said, "When you hear you're stupid, you're ugly, things like that often enough, you begin to believe it. Then you start to question everything you do. It's crazy making." (Women & Abuse, and HIV, 09/95)

The use of the quotes serves three functions: it adds a personal touch to the information provided; makes the reader aware that other women have had similar experiences, thereby making the reader's experience less isolating; and provides a concrete example of the definition.

"Women Who Have Sex with Women", another pamphlet in the series, discusses information relevant to lesbian sexual encounters. Women's Outreach made certain that the prevention education was not limited to the heterosexual sexual experience.

If you are having sex, you are at risk for getting HIV or other STD's. To protect yourself during sex:

A latex condom (male or female) is the best protection

- when you're using sex toys
- when you're having sex
  (penis/vagina, or penis/bum)

A dental dam, non-microwavable saran wrap, or a latex condom cut open is the best protection

- during oral sex with a woman
- rimming (licking bum)
Figure 3 show part of the contents of the “Women Who Have Sex with Women” pamphlet. The pamphlet deals with one specific subject and is not overwhelming. The language used is simple and the illustrations supplement the explanation.

Figure 3 : From “Women Who Have Sex With Women”.

“Women Who Have Sex With Men”, another pamphlet in this series, provides basic information on heterosexual routes of HIV/AIDS transmission. It candidly dispels the myth about the safety of having one sexual partner - pointing out that no one can be certain that his/her partner is being faithful. Unlike “Women and AIDS”, “Women Who Have Sex With Men” includes a discussion about alternative preventative measures should a woman’s partner refuse to use a condom during sex.

If your partner won’t use latex during sex, you can reduce your risks:

- 65 -
• Trying not to swallow your partner’s semen or vaginal fluid, or swallow as little as possible

• Use more lubricant to reduce rips and scratches in your vagina or anus (bum)

The pamphlet acknowledges that power plays an important role in negotiation and also acknowledges that sometimes a woman will be unable to negotiate safer sex with her partner.

Materials developed primarily target high-risk groups such as IV drug users, women in prison, street sex trade workers, and alternate schools. With regard to materials, programs and workshops, Tolson states, “The education must be credible, relevant and reflective of the living reality of women.”

Poverty affects many women who are at risk or infected with HIV. Women in poverty are less able to cope with this crisis in their lives. Poverty has a direct impact on women’s ability to provide adequate housing and care for themselves and their families.

Adequate shelter, adequate financial resources, assistance in dealing with various agencies, access to childcare, respite care and homemaker services, access to substance abuse treatment, nutritional and psychological counselling and support are all important aspects of helping women living with HIV/AIDS to maintain their health. (Vancouver Women & HIV/AIDS Support Network, 1990, p. 3)

The pamphlets are clearly written in simple but concise language, candid about risk and prevention. The pamphlets are written from a lay perspective and are, therefore, easy to read and comprehend. They discuss sex acts in an open, honest, and forthright manner using "household" words rather than clinical terminology. My only criticism is that the pamphlets are only published in English. When questioned about this, Margreth Tolson advised that, as mentioned
previously, the pamphlets are used internationally. Translation is at the discretion of the individual agencies. Translation is not simply changing the words from one language to another. Other factors come into play. Further, as with any project that is government funded, the pecuniary resources are limited.

Youth Community Outreach AIDS Society (YouthCO)

YouthCO is a non-profit AIDS service organisation dedicated to meeting the needs of both HIV positive and HIV negative youth. It is Canada’s only such organisation. YouthCO AIDS Society was founded in April 1993 when over 30 community organisations across British Columbia met to discuss the issues of Youth and AIDS. The outcome of the discussions suggested a need for youth-specific services. YouthCO employs three full-time and three part-time staff. An advisory board consisting of community professionals as well as over one hundred volunteers provides input and guidance (YouthCO AIDS Society Mini Biography).

Sheena Sargeant, Educational and Training Co-ordinator, in an August 31, 1999 interview, provided the organization’s mission statement: "Youth Community Outreach AIDS Society (YouthCO) is a peer-driven organisation. We strive to enable youth from all communities to address youth issues concerning HIV/AIDS, by acting as a resource and facilitator for educational initiatives and support services."

"Youth" is defined as young adults between the ages of 15 to 29. YouthCO provides outreach, preventative education and support to youth either infected and/or affected by HIV/AIDS.
Although the mandate suggests YouthCO is an AIDS awareness organisation for youth in general, upon review of the programs and materials their primary focus is gay and lesbian youth. "Straight" youth are not excluded from the education initiatives but the primary emphasis is on gay and lesbian youth.

"The education does promotes tolerance of sexual diversity and creates an awareness that homosexuality and lesbianism is not aberrant - just different," states Sargeant, "and different isn't necessarily bad."

YouthCO is involved in several community-based initiatives, which include:

- Speaker's Bureau
- Theatre Troupe
- Community Outreach
- Radio Committee
- Positive Youth Outreach (POP)

The Speaker's Bureau visits schools, youth organisations, correctional facilities, English as a Second Language classes, and service agencies, (healthcare professionals, youth workers, the Red Cross) providing information and education about HIV/AIDS and youth.

Sargeant advised, "These talks range between one and three hours. In a one hour presentation, only the "basics" are covered - routes of transmission, viruses, prevention. Longer presentations discuss social issues that are prohibitive to education and prevention such as racism, classism, heterosexism, and self-esteem."

At the end of the presentation pamphlets are made available on such topics as
safer sex tips and positive youth outreach program. Two "zines" (mini-magazines) are published in house, one by HIV+ youth in the POP program, the other by volunteers. The "zines" are also made available to the students. YouthCO obtains permission from the school board prior to conducting school visits.

The Theatre Troupe uses interactive, participatory techniques to demonstrate skills such as negotiation and assertiveness through role-play. They actively engage the audience thereby allowing the group to practice skills as well as start thinking and talking about issues specific to HIV/AIDS and youth.

Display tables are set up at local events such as the Vancouver Folk Festival, the Caribbean Festival, and Pride, for example, as part of the Community Outreach Program. Pamphlets, postcards, and stickers are handed out along with safe-sex resources such as condoms and gloves (See Figure 4). Demonstrations on how to make a dental dam from a condom, for example, are incorporated into the display.

A Radio Committee has been established but is not yet up and running. The Committee hopes to provide public service announcements on local radio stations. Studio Y (Youth Voices Radio Program) is an innovative, interactive way of getting
youth to think and talk about issues affecting them and HIV/AIDS.

The Positive-Youth Outreach Program (POP) and Project ‘SAFER’ was designed to allow HIV+ youth to identify their own support and advocacy needs and to develop a self-sustaining support model. The Programs are run by HIV+ youth for HIV+ youth and include social dinners, retreats, and confidential support groups (YouthCO AIDS Society Mini Biography).

Finally, YouthCO has a Materials Development Committee that creates its own materials including four youth oriented brochures. The Committee also designs tee-shirts, stickers, posters and rave cards that are “accessible, informative, and relevant” (Just What Do We Do?). The Committee also produces a monthly volunteer/community “zine” called “SPICEY”. “Jiffy Pop” is a “zine” produced less regularly. YouthCO also has a website: www.youthco.org.

The “zines”, Jiffy Pop and Spicey, are produced in-house. The March ’99 edition of Spicey #21 featured an article under the heading “International Perspectives” on being an HIV+ youth in the Netherlands. Michael Nieuwenhuizen reflected on how his HIV status affected his life, the educational resources available, as well as the Netherland’s attitude toward sexuality.

Information on upcoming local events is also highlighted. In that same edition of “Spicey”, for example, a full page was dedicated to a “women’s only” dance held at Club 23 and sponsored by the Asian Women’s Outreach Project. The event called “Random Acts of Sexuality” was designed to provide assistance to Asian women in making informed decisions about their sexual health. “Using
strategies taken from popular theatre, safer sex information will be provided in an entertaining and fun way throughout the evening. Examples include satirical skits where our skilled volunteers would act out scenarios and performers would roam around the club giving out informative packages (Spicey #21, March '99, pg.13).

“Spicey” also has articles on HIV/AIDS health issues for youth, an advice column, as well as poetry. The magazine is diverse in its content and written in the vernacular language of youth culture by youth (See Figure 5).

“Jiffy Pop”, like “Spicey”, is written by HIV+ youth but in a different format—cartoons, handwritten prose, poetry. The “zine” provides a forum through which thoughts, feelings, emotions, opinions and ideas can be expressed without fear of stigmatisation.
Not only is it a place for venting but provides insight into the frustrations, lack of sensitivity, and alienation HIV+ youth perceive, experience, and feel, often daily, in a society threatened by sexual diversity.

Sargeant of YouthCO provided me with three pamphlets on women specific issues, “Women and AIDS; Women who Have Sex With Men”, and “Grrls on Grrls...and HIV”.

“Women and AIDS” published in 1995 by the Canadian Public Health Association (See Figure 7) was the only pamphlet published in both French and English. The pamphlet was a total of eighteen pages, nine of which were in English. I found the pamphlet quite overwhelming. It was packed with A-Z information about HIV/AIDS. The print was small and information was crowded onto the pages. There was minimal use of graphics.

Reading this pamphlet, I felt there was implied culpability. There was a sense that women were seen as vectors of the disease: “About one baby in five born to HIV positive women in Canada is infected with the virus” (Women and AIDS, pg.4).
There was no evidence that power dynamics within relationships were considered. Statements such as, "You have the right to decide whether to have sex, what level of risk you take and what sexual activities are right for you" (Women and AIDS, pg.6) and "You can say no, and tell your partner you don’t want to have sex unless it is ‘safer sex’. You can 'play safe' by using condoms or by avoiding penetration" (Women and AIDS, pg. 6), predominated. Such iterations do not acknowledge, for example, that violence can result should a woman refuse to have sex with her partner.

The pamphlet also holds women responsible not only for practising safe sex but suggesting alternatives: "You can choose not to have any penetration at all and can find pleasure instead in massage, hugging, mutual masturbation and erotic fantasizing" (Women and AIDS, pg. 4). Overall, this pamphlet was very poorly crafted and not well thought out.

"Grrls on Grrls” published in June 1997 by ACT (AIDS Committee of
Toronto), on the other hand, is skilfully designed using a combination of graphics and information. The pamphlet is produced on glossy paper with bright, colourful pictures which catch the passer-by’s eye. The pamphlet is approachable. Written information is in plain language and interspersed with graphics, making the pamphlet less intimidating and highly readable.

By focusing on one issue, the risk of HIV to lesbians, the reader is not overwhelmed with too much information. The first page graphics show two women engaged in oral sex; the caption reads “Women do many different things in bed with each other. Oral sex is just one of them.” The pamphlet then discusses in explicit detail various sexual acts, including sadomasochism, the associated HIV/AIDS
risks, and preventative measures (See Figure 9). The pamphlet also addresses IV
drug use and the risk of contracting HIV and includes information on disinfecting
needles (See Figure 9).

YouthCO also uses some of the pamphlets developed by the AIDS Vancouver
Women’s Program. Those pamphlets have been the subject of an in-depth
discussion earlier in this chapter.

With the exception of the one pamphlet, all materials were in English only.
There appeared to be no information available for disabled youth or youth from
other cultures, although I was told that YouthCO does visit ESL classes. When
questioned, it appeared that some of these materials were used with the ESL classes.
How effective this material would be with different cultures is questionable.

When asked why YouthCO did not have programs/projects developed
specifically for young women, Sargeant told me that there has not been a demand
for that kind of resource. Those women who require or request women specific
support, advocacy or information are referred to P.W.N. YouthCO is doing valuable
work in the community providing a support resource as well as prevention
education for young adults.

Asian Society for the Intervention of AIDS (ASIA)

In a cultural cornucopia such as is found in Vancouver, providing effective
AIDS education becomes more complex because of multi-cultural factors. For the
purposes of this thesis, culture does not only refer to ethnicity, race, and colour but
rather includes a system of beliefs, institutions, and methods constructed by a
specific group to assist in the daily activities of problem solving, survival, and development. As mentioned previously, people of colour, and in particular women of colour, often receive inadequate medical treatment and late diagnosis. This can, in part, be linked to health and education systems that have not been responsive to cultural diversity in responding to the HIV/AIDS epidemic or the needs of women of colour in general.

In 1995, a group of gay Asian men approached AIDS Vancouver for funding of a gay Asian support group. These men felt that their needs were not being met with the information and education that was available through AIDS Vancouver. They felt that the cultural dimension/component was an important piece in understanding and in speaking to the needs of gay Asian men, and could only be fully understood by other gay Asian men. AIDS Vancouver agreed to the funding and the Asian Support AIDS Project (ASAP) was created. ASAP developed HIV education materials that were distributed to English as Second Language (ESL) classes as well as community centres. The project grew and diversified. Subsequently, ASAP became the Asian Society for the Intervention of AIDS (ASIA) an autonomous body separate from AIDS Vancouver.

ASIA now not only provided outreach to men who have sex with men (msm) but has expanded to include a women’s outreach as well as a Downtown Eastside “Reaching Out Project” whose focus is Chinese and Vietnamese IV drug users.

I spoke with Tomiye Ishida, Asian Women’s Outreach Educator on October 25, 1999.
Ishida states, “AIDS education and outreach for the Asian population is complex and must respond to cultural differences as well as confront the usual issues of sex, sexuality, death and homophobia.”

When asked what the greatest barrier to AIDS prevention education in the Asian community was, Ishida felt that language was the greatest barrier to AIDS outreach.

“From the perspective of most Caucasians, all Asians are the same. In reality, there is much diversity within the Asian community. Many different languages and dialects are spoken,” said Ishida, “further complicated in that the communities are culturally and ethnically diverse and include, Vietnamese, Chinese, Balinese, Latinos, and Japanese, to name a few.”

Reaching “mainstream” Asian women is particularly challenging because Asian women are confined to traditional roles and as a result often remain isolated in the home with their family.

“Asian women are confined to specific roles and do not have the freedom to go out and access and seek information on sex and sexuality. Add to this that most of these women are refugees and immigrants living in a foreign culture and you can appreciate the difficulty in accessing these women let alone doing AIDS prevention education and outreach,” states Ishida. “For women confined to the traditional roles of mother and wife even talking about sex, sexuality, and HIV is taboo. HIV/AIDS outreach, therefore, has to be subtly incorporated into other initiatives, for example, workshops on family health.”
By linking AIDS education to family health, Asian women are able to bring the information back into the family unit as it becomes relevant to the health and well being of their families. The primary connection to mainstream Asian women is through community centres and parenting groups.

The Asian community is often perceived as the “model minority”. This affects access to funding because government funding is predicated on need.

"IV drug use and prostitution, let alone HIV/AIDS, is not only not recognised as a problem by local and provincial governments it is also not acknowledged as a problem within the Asian community itself. Within certain Asian cultures, any illness or disability is something to hide,” says Ishida. “To acknowledge an infirmity is not only reflective of the individual but the whole family is shamed.”

In further conversation with Tomiye, I suggested that perhaps the community at large was also “shamed” putting even further pressure on the individual to maintain the shroud of secrecy. Tomiye reflected on this. She concurred stating that the Asian community was a visible minority and great pressure was put to bear on its people to assimilate even though, in reality, it is next to impossible to “blend in”. Another complicating factor in HIV/AID prevention is the Asian community belief that HIV/AIDS is a Caucasians problem brought on by our immoral lifestyle. Sound familiar?

Tomiye Ishida provided an example of how the IV drug problem remains invisible to the general population and within the Asian community itself. DEYS is
a needle exchange program on the Vancouver Eastside. It is well known that most IV drug using Asians stay out of public view and frequent shooting galleries. The group appoints one person to take in the needles for exchange so that it appears that the IV drug use problem is minimal. However, recently the frequency of Asians utilising the fix site has significantly increased.

According to Ishida, “Three years ago very few Asians were found in the IV drug using community, perhaps a total of 1% of the IV drug using population. Today it is over 2% and rising. In the Latino community the IV drug population has more than doubled.”

Part of Tomiye Ishida’s role as Asian Women’s Outreach Educator is to do referrals and outreach. Unfortunately, there are no resources available, not just for the Asian IV drug community, but for the IV drug using community, in general. With respect to resources that do exist, culture and ethnicity are not incorporated into the program

“The programs are designed from a white, male, Western, Protestant cultural perspective; hence, the programs are less meaningful and effective without any cultural adaptation,” states Ishida.

By way of example, Tomiye Ishida provides that when placed in a treatment facility the Asian IV drug user must first overcome the language barrier and the associated emotional trauma and frustration that occurs when trying to communicate. This person has no natural support group within the program adding to the isolation, vulnerability, and fear associated with being in a detox
program where nothing is familiar – not the language – not even the food. Then there are the physical aspects of drug addiction, the withdrawal, again with no indigenous support group. And, finally, there is the racism experienced, which further adds to isolation.

Not only are there a limited number of treatment facilities available but also there is a paucity of educational resources available.

“There is not a lot of HIV/AIDS information out there for the Asian community,” Ishida advises. “Translation is not simply a matter of language, translating English text into Vietnamese, Lao, Japanese or Korean. Translation must take into consideration differences among Asian cultures and consult with community groups in choosing content and illustrations in the materials produced. For example, consideration needs to be given to the views of the specific community on such issues as homosexuality, bisexuality, and sexuality in general. If this is not done, the materials will not be well received or utilised.”

In conclusion, Tomiye Ishida stated that there was not much in the way of specific outreach for women. Hers is a new portfolio that is still a work in progress. She would like to see more funding in order to develop education materials and treatment programs with an Asian cultural focus.

Intravenous Drug Use

As demonstrated in the previous discussions, Vancouver has a serious and significant intravenous (IV) drug use problem on the Eastside. The Vancouver Eastside community has the highest IV drug use in Canada and the highest transient
population. It is also one of the poorest neighbourhoods in all of Canada. It is here, on the streets of the Vancouver Eastside, that young sex trade workers walk the “kiddy stroll.”

Studies conducted by the British Columbia Centre for Excellence on the HIV/AIDS infection rate among injection drug users in Vancouver demonstrated that the infection rate was running at nearly 20% a year. Translated this means for every 1000 people who are negative at the beginning of the year, 200 will become infected by year-end. The epidemic skyrocketed in 1992 when Vancouver drug users altered their drug habits. Instead of injecting heroin two or three times per day, the drug users started injecting cocaine up to 20 times per day. Drug users started sharing and reusing needles with growing frequency despite the needle exchange program, thus creating a problem of epidemic proportions (Munro, 1997).

HIV and AIDS research has clinically demonstrated that newly infected people are much more infectious than those who have been harbouring the virus for a long time are. It is estimated that those newly infected are 100 times more infectious because the virus level in the blood spikes in the first few months of infection before settling down to a much lower level (Munro, 1997).

Feminists have long argued that drug addiction is a social problem. Reasons for drug addiction include unemployment, depression, poverty, low self-esteem, and for women, sexual abuse in childhood. If Millar’s calculations are correct, and one in four people “on the strip” are HIV infected, which he further estimates will be
at 50% within two years, this serious social and medical problem needs to be addressed on a priority basis. Clearly there are no easy solutions.

In Vancouver there is a flourishing market geared specifically to men who want to have sex with children. It is estimated that between 100 and 150 female sex trade workers between the ages of 12 and 18 work the “kiddy stroll” in Vancouver (Shortt, 1998). Consumerism drives that market. Many family men frequent the “kiddy stroll” on a regular basis. Somehow these men are not easily held accountable for their sexual behaviour. Instead, the “morally corrupt” and “sexually suspect” sex trade workers are held “responsible” for the spread of the disease to white heterosexual men, their wives, and their children.

The New Democratic government has allocated funding to the Vancouver Eastside. I spoke to two women involved in community outreach in this community.

**Drug and Alcohol Meeting Support (for women)(DAMS)**

On November 05, 1999 I met with Donna Dunnigan and Leslie Remund, two Community Outreach Workers working out of the Drug and Alcohol Meeting Support (DAMS) centre for women. DAMS employs a total of four (4) women, two outreach workers and two drug and alcohol counsellors. DAMS has been in existence for approximately seven years. Leslie Remund has been with the organisation for a total of four years. Donna Dunnigan has just recently been hired on as an Outreach Worker. The funding for Leslie Rumund’s position comes in part from the Oaktree Clinic as well as from DAMS. Leslie’s job is twofold: street and
hotel outreach and medical accompaniment.

DAMS base its programs on a “drug and alcohol harm reduction model”. Harm reduction is defined as incremental steps a woman makes toward being healthier.

Leslie Remund states, “Women are encouraged and supported in their attempts to minimize the negative consequences of drug and alcohol use. This does not necessarily mean sobriety. Even not using for a weekend allows a woman’s immune system to partly recover and is seen as a win.”

The drug and alcohol harm reduction program is not a “set” program but rather adapts its “curriculum” to the specific needs of the women in attendance. For example, there may be a need to focus on grief and loss or child apprehension issues.

Unlike the programs and outreach by organisations such as PWN or Women’s Outreach, DAMS outreach is more unstructured.

“Most times we fly by the seat of our pants,” laughs Leslie. “My goal is to access women not accessing other sources. Most of these women have grown up through systems. Systems are disempowering and don’t respect confidentiality. This group [the downtown Eastside] has been the subject of much research. It has been studied and studied again. These women don’t trust easily. They have been burned too many times.”

Donna Dunnigan adds, “Trust is a big issue for women on the street. It takes a lot to connect to people in general and when you’ve been on the street it’s really
tough. But when you have that moment [as an outreach worker], it is really powerful - meaningful.”

Remund believes the key to successful outreach in the downtown Eastside is threefold: maintaining a visibility in the community, being consistently out there, and understanding the culture. She has been in the community for four years, two of which have been doing outreach directly "on the street". She grew up on the streets, and is an example of a success story - she made it out. "Success" doesn't happen often enough.

Part of understanding the street culture is knowing how to get information across.

"You have to know when it is okay to talk - or not to. I use my instincts and the wisdom of my life experience," declares Leslie. "I watch body language, eye contact. I am aware of who is around - the woman’s social network, her pimp. I may have made a connection with someone in her social network and now is an opportunity for me to speak to her. I watch, I wait."

Leslie does not hand out any written materials on STD’s, HIV, or AIDS. She only gives out her DAMS business cards.

"Women don’t want to have that kind of information on them whether they are HIV+ or not. They don’t want their pimps to find it on them," states Remund.

According to Remund, “Most of the women we work with are native Indian. The native culture is a very oral culture. Information, tradition, history is passed down through story telling as well as through ceremony.”
Because many of the women are First Nations' Women, native customs are incorporated into the program. Every Thursday, for example, a Healing Circle is held. Although targeting First Nations' women, any woman is welcome.

In her second role, Remund does medical accompaniment. In this role, Leslie facilitates access to healthcare for women. She picks a woman up at her hotel and takes her to medical appointments. She acts as a liaison between the medical system and the woman. Leslie characterizes the medical system as a disempowering system run by power brokers that dictate and coerce women, and oftentimes punish women for being honest.

"If a woman seeks help for drug and alcohol addiction, the process of getting help puts her children at risk of being taken from her by the Ministry," declares Remund, "and HIV positive women, persecuted. I have worked with women who have finally come to a decision to go on anti-retroviral medications. I take her to a medical appointment only to find out she's been told by the doctor that she is not ready for the medications. It doesn't exactly inspire confidence in the [medical] system."

Much of Leslie Remund's time is spent manoeuvring systems and manoeuvring women through these systems.

"Often, the women I work with are involved in multiple systems: the legal system, the welfare system, the medical system, the child and family services system. It becomes quite overwhelming for these women, who aren't brave enough to stand up to the establishment and demand their rights. These women likely grew
up in a series of foster homes going from one abandonment to another abandonment
and in many cases abused by the system that was put in place to protect them.
Again, the trust issue comes up. They don’t trust the system.”

Continued funding is always a concern. As with any government funded
project ongoing funding is at the discretion of the government in power. The more
radical the program and the more conservative the government, the less likely it
becomes the project will survive. This, coupled with the marginalized standing of
sex trade workers and First Nations’ Women, doesn’t bode well for this program
should there be a change in government. The cost of funding such a program cannot
simply be looked at in terms of dollars and cents – but must be looked at in terms of
the human cost. The women that are served are mothers, sisters, daughters, and
friends and deserving of dignity, respect, support, and appropriate health care.

Politics and British Columbia

With a provincial election looming on the horizon, it is important, in my
opinion, to call attention to the bifurcated nature of British Columbia politics, which
has always caused huge shifts in public policy ranging from restrictive right wing
conservatism to a more socially responsible mandate. An intimate relationship
exists between the AIDS discourse and the political framework within which public
policy is set, priorities established and resources distributed (Boshier, 1992). Social
policy, be it education or health, is politically driven and predicated on the political
flavour of the day.
From mid-1980 to 1992, British Columbia was governed by the Social Credit, a conservative political party. Their policies and positions on issues can only be characterized as extreme right wing. In the mid-1980's, Mr. William (Bill) Bennett, son of W. A. C. Bennett founding "father" of the Social Credit party, was elected to the position of premier of the province. Mr. William (Bill) Bennett's financial policies were based on fiscal restraint and an across the province cut of 20% to the public sector resulted in a province wide mobilization of the labour movement called "Operation Solidarity."

In 1988, Mr. William Vander Zalm became Premier and party leader of the Social Credit party. In concert with the party's political positions were the leader's personal religious beliefs and family values platform. Vander Zalm, a Roman Catholic with ties to the fundamentalist movement, used his political position as a vehicle to advance his religious agenda. This included attempts to claw back gains women had made with regard to abortion rights and spilled over to the funding of public health education and medical research.

The Social Credit government was a government of minimal social conscience catering primarily to big business and corporate interests. The needs of minorities and the disadvantaged were secondary if not tertiary on the government's list of priorities.

In 1992, the political climate changed in British Columbia and the New Democratic Party (NDP) was elected to power. Characterized by a socialist-democrat party philosophy, the NDP have very definite views of social
responsibility. Unlike their predecessors, the NDP have stronger connections with labour and the working class. Although some might suggest that the NDP have become more corporate-friendly, the government still adheres to its socialist roots emphasizing the importance of education, social services, and health care over corporate interests. This has and continues to cause outrage in the corporate sector, which lobbies for fiscal restraint. As of the summer of 1999, the NDP are still in power; however, there is speculation that come next election, Mr. Gordon Campbell’s “Liberal” party with philosophies more akin to the ultra-conservative policies of Premier Mike Harris’ Conservative government in Ontario, will be elected. Should this happen, the province can expect to see cuts to social programs such as those just discussed with huge tax savings to corporations as the political pendulum in British Columbia swings to the far right.

Conclusion

In conclusion, despite the innovative initiatives of PWN, Women’s Outreach, DAMS, ASIA, and other community based resources, each day British Columbia sees an increase in the number of women diagnosed with HIV/AIDS (See Appendix 2). The women and AIDS issue is complex, tied to multiple psychosocial issues including poverty, sexuality, violence, ethnicity, and substance abuse (Easton, 1994). For some women none of the subject positions offered in the AIDS discourse fit their life experiences. If the woman is not an IV drug user or a sex trade worker, there is a great difficulty and confusion in assessing her risk. Within the AIDS discourse, the issues of aetiology, identity, and experience blur - our perceptions
coloured by our beliefs about who gets HIV/AIDS and why. In the end, AIDS
remains only a disease. It has no agenda but can be seen as a metaphor, ideology
and discourse that testifies to society's indifference to women's health.
CHAPTER 5:
POWER, POLITICS, AND PREVENTION EDUCATION
- A METRO VANCOUVER PERSPECTIVE

This chapter analyzes, from a socialist feminist perspective, the complex matrix of political, social, behavioural, and emotional factors that construct AIDS Prevention Education for metro-Vancouver women. This chapter also explores the issue of power and how it shapes choices and behaviour, and drives the AIDS discourse at several levels: political, medical, social, behavioural, intellectual, and emotional.

The social components of the AIDS discourse are not separate from strategies used in AIDS prevention programs in metro-Vancouver or from socialist feminist concepts of power. For example, this research has emphasized how the dominant discourse on AIDS structured the conceptualisation of its citizenship and political participation in a gender specific way. “Ordinary” women, because of their citizenship, continue to be elided from the AIDS discourse, as there is a perception of no “real risk” to heterosexuals.

Furthering the gap between the AIDS discourse and women is the belief by some women that the epidemic is being used as a vehicle to reinforce traditional, paternalistic and puritan values and the belief that patriarchy is using the epidemic to take back from women the little power they have gained over their sexuality (Holland, Ramazanoglu, Scott, Sharpe and Thomson, 1992). Such beliefs
demonstrate the scepticism and cynicism that is out there. Developing prevention
education for women who hold this belief will be difficult because it is their belief
system that must be challenged; yet those beliefs are based on the historical evidence
of repression found in women's history. For example, women's claims to personal
health choices, such as abortion, have most often been considered in relation to their
roles as reproductive units.

In British Columbia, former Premier Bill Vander Zalm appeared to view
women as reproductive incubators charged with the protection of men's offspring.
When the Supreme Court ruled he could not restrict access to abortions, he
threatened to stop paying for abortions. His position subordinated women's health
choices to that of "other" using women's reproductive capacities as a mechanism for
controlling women. In the name of "family values", Vander Zalm wanted to ban
abortion and restrict the distribution of contraception and sexual information. His
campaign to limit access to abortions appeared to be aimed at furthering his agenda
to restrict sexual encounters by raising the risks of such encounters for women
(Lapointe and Dickson, 1994).

On March 28, 1995, CBC's The National reported that an elected official within
Bill Vander Zalm's government proposed internment of gay men and others who
were HIV positive. This official suggested that these people be transported to an
uninhabited island off the coast of British Columbia. Given this hostile attitude it is
not surprising that the government, also anti-choice, would withhold funding for a
condom promotion initiative.
In Chapter 2, the status of North American women within the HIV/AIDS epidemic was examined. It became apparent that depictions of diseases such as HIV, AIDS or even anorexia, for example, are inextricably tied to and permeate politics, religion, medicine, and the media. Education is designed, delivered and received within a social context. Sometimes education reflects prevalent cultural values but at other times may conflict with social values, for example, the "ideal" woman’s body as depicted by the advertising industry contradicts the "educational" messages put out by government health organisations on appropriate body weight. Despite education, women continue to obsess about their weight, unable to "measure up" against the "ideal" body type depicted by unrealistic stereotypes seen in the form of anorexic models (Zimmerman & Dickerson, 1994). In fact, weight loss, a classic AIDS symptom, is often understood inappropriately as something favourable and, therefore, ignored by women.

Reviewing the number of contradictory messages that women receive about sex, sexuality, and body image, I found myself confronted by three separate but related matters concerning the politicisation of women and AIDS. First, the social and historical marginalization of women within our society, in concert with the political climate in British Columbia at the onset of the AIDS epidemic, directly influenced the education, information, and public health messages women in Vancouver received about HIV/AIDS.

Second, women trapped within specific constructs, in a male dominated society, were excluded from the AIDS discourse but when included were seen either
as vessels or vectors. Women became visible only in terms of the risk they posed to men such as when AIDS was initially studied in female sex trade workers. Rather than attempting to understand the manifestations and progression of the disease in women, the focus of these studies was epidemiological and the heterosexual transmission of AIDS to men (Rosser, 1991). As vessels or vectors, women were positioned as mediators between two interest groups (children and men), thereby making it difficult for them to assess their own risk, care for themselves, or see their experiences within the medical discourse. Further, because of the emphasis on the identification of risk groups instead of risk behaviour, many women were lulled into a false sense of immunity.

Third, some women are socialised into not questioning the validity of information received from a male dominated society. Hence, the HIV/AIDS and women discourse becomes intimately tied to the struggle women have had to free themselves from patriarchal social, sexual, political, and religious constructs.

The women’s movement has tried to re-define how women are viewed by society and how women view themselves. History consists of strong action and inevitable reaction. Women have become more outspoken against social constructs that stereotype and, therefore, restrict a woman’s ability to reshape her perception of herself; unfortunately in certain forums women have not made significant gains. For example, women continue to be excluded from research on drug efficacy or included in the medical model of how disease may effect women’s bodies differently. So, clearly, more work needs to be done to have women included with seriousness.
Close analysis of the history of AIDS prevention education for women in Vancouver, as well as the constructs which form the partial, incomplete and distorted perspective on HIV/AIDS and women, made me recognise that I wasn't just trying to recover a major (and neglected) female AIDS/HIV history. It also has served to remind me of just how much of women's history has been lost, misunderstood, and trivialised. The evidence demonstrates that our government has been remiss or even negligent, at times, in providing experience relevant AIDS prevention education programs to metro-Vancouver women.

I will continue my discussion with a review of the naming of AIDS. The naming of AIDS is significant in that there is power in the act of naming as it serves to both isolate for the dual purposes of inclusion and exclusion.

**Naming of AIDS**

Medical practitioners, including researchers and scientists, like to maintain an illusion of objectivity. They want to be perceived as viewing the AIDS epidemic from a "purely scientific base."

In scientific research, it is rarely admitted that data has been gathered and interpreted from a particular perspective. "Since scientific research centres on the physical and natural world, it is presumed "objective"; therefore, the term perspective does not apply to it. However, the decisions, either conscious or unconscious, regarding what questions are asked, who is allowed to do the asking, what information is collected, and who interprets that information create a particular vantage point from which knowledge or truth is perceived" (Rosser, 1991, p. 230).

The clinician strives to understand the aetiology of the disease, transmission routes, and chronicle the effects on the immune system. The media, religious and
governmental perspectives centre on the social, moral, political, and economic consequences of the epidemic. These converge and separate with ease depending on the agenda being advanced.

Although the naming of AIDS was not indigenous to Vancouver, British Columbia, its evolution is important as it demonstrates that bias and selectivity exist even within the scientific community not just the public at large. It also demonstrates feminist concerns about the power of naming. The way in which the disease was defined ultimately determines who lives and who dies.

When AIDS was first identified in the gay population, the first name identified the affected population, Gay Related Immune Deficiency (GRID). Subsequent labels suggested included Acquired Community Immune Deficiency Syndrome (ACRIDS); Community Acquired Immune Deficiency Syndrome (CAIDS), and finally Acquired Immune Deficiency Syndrome (AIDS) (Leap, 1990).

Although there is a descriptive element to the naming of the syndrome, closer scrutiny unmasks moral judgement in the name. The use of the term “acquired” implies intentionality; the person “acquired” the syndrome in much the same way as one would acquire a house or a car. They “went out and got it.” Because acquisition implies intention, having the syndrome becomes culpable, linked to the stigmatised sexual practices of the gay population, for example, or IV drug use. It became a disease of lifestyle and choice linked to membership within a group. AIDS became a crisis of identity. Fernando (1993) states the naming of the syndrome reflected “the social, ethical, moral and religious concerns of the naming
establishment” (p. 13). Even the “objective” lens of science was caught up in implied moral evaluation on aetiology. By linking the syndrome with categories of people and lifestyle, the general population was distanced from the effects and felt safe. AIDS was “acquired” by being a certain person not because of behaviours (Boshier, 1992). The naming of the syndrome served to galvanise that link between the disease and membership in a certain group that still exists today.

Tied to the naming of AIDS was the diagnostic definition. As mentioned previously, it was not until 1993, that the definition included female specific diseases such as yeast infections, pelvic inflammatory disease, and cervical cancer (Corea, 1992; Patton, 1994). To reiterate, women were dying from AIDS without ever having been diagnosed with the condition.

The Construction of Sexuality

It has been argued that sexuality is socially constructed. In other words, our sexual practices, beliefs, and attitudes are forged primarily from within a paradigm. In North America this frame of reference or paradigm is white, male, heterosexual and predominantly Christian. This lens not only defines sexual practice but encompasses what people know and believe about sex and sexuality and dictates what they believe is natural, proper, and desirable (Holland et al., 1990).

Gendered power relations play a role in the construction and practice of heterosexual sex and same sex relations. Power differences can result because of age, class and ethnicity. Of particular significance in the negotiation of safer sex in heterosexual encounters is the power which men can exercise over women (Holland
et al., 1990). Sex cannot simply be looked at within the isolated context of pleasurable physical activity. There is both symbolism and socio-cultural determinates attached to sexual behaviour including notions of romance, love, and caring. "Anxiety about HIV and AIDS is difficult to bring into the sphere of everyday life precisely because it calls trust and intimacy into question" (Holland et al., 1992, p. 277).

The unequal power balance within sexual relationships along with the social construction of sexuality poses a difficult challenge for educators. As demonstrated in Chapter 4, to be perceived as credible, education and outreach programs must reflect the diverse experiences of women and meet their needs. This is further complicated by the infusion of the psychosocial constructs of love and limerence that saturate pop culture. Hollywood depictions of romantic love have had a profound effect on attitudes, beliefs, and behaviour. Sex, we are told, should be spontaneous and natural. The woman relinquishes power to the man she loves. Here a woman's life work is, in the words of de Beauvoir, "to reflect men at twice their normal size" (Lenskyj, 1991, p. 285).

**Sexuality**

As mentioned above, within our culture, sexuality has been framed within the context of a heterosexual white male paradigm. The AIDS discourse pivots on the dual axes of homophobia and misogyny.

Homosexuality is a fundamental threat to white middle class male sexuality. Watney (1989) asserts that AIDS appears to threaten the fragile stability of the most
fundamental organising categories for both individual and collective identities, insofar as it raises the reality of sexual diversity.

When a core aspect of identity is threatened, it becomes easy for the majority – those who have more power – to confine and identify the difference, allowing for an intolerance rather than acceptance of that which is different. The power of labelling and blaming the victim gives “power over” the marginalized group. A “them” and “us” mentality develops that gives occasion to verbal and physical abuse, discrimination, homophobia, and ultimately hatred.

The AIDS epidemic, because of its potential affects on everyone, should have forced society to address prevention by dealing with issues such as sexual abuse and sexual diversity as well as poverty and violence. Because society does not celebrate diversity, and morality is based, in part, on puritan ideology, this is unlikely to happen. The dichotomy between “them” and “us” becomes more firmly entrenched. Misogyny becomes a by-product of this threat in the AIDS discourse because women are seen as potential vectors of the disease.

Socialist Feminist Theory and the Concept of Power

From a socialist feminist perspective, there is a direct relationship between power and the curriculum/education materials developed for AIDS prevention education for women in metro-Vancouver. The political arena is still predominantly male dominated. Political power determines funding for medical and educational needs, dictates what will be researched, and what curriculum and programs are developed.
An obvious result of androcentric bias is that women are ignored and become a disadvantaged group in terms of clinical research and health care. The focus on males leads to choices of research problems to examine disease, aetiology and treatment significant for men (Rosser, 1991).

Power

A woman’s definition of power and perception of her own and partner’s power directly influence the choices she makes and behaviours exhibited in the relationship. The concept of power is multifactorial and complex, making it difficult to define. Power is often seen as coterminous with authority. I will be limiting my discussion to “separate” and “connected” power within the AIDS discourse and prevention education for women in metro-Vancouver.

“Separate” power or “power over” is a distinctive type of social control or influence (Cockell, 1993; Jones, 1993). In many cases, the distinction between power and authority and force (concepts of authority and force are equated with power) becomes blurred; hence, the association between “power over” and physical and sexual abuse. In a relationship where one partner exerts “power over” the other person in the relationship, there is a surrender of private judgement. The person with less power in the relationship submits to the judgement of another without making the behaviour dependent on one’s own assessment of the merits of the command (Cockell, 1993; Jones, 1993). Separate power dominates in relationships where one person has or is perceived to have more authority than the other does.

“Connected” power is “power with” and is associated with influence and empowerment. With connected power, women participate equally with men in all
types of social interactions, including decision-making. As equals, women are then able to participate and negotiate, thereby influencing the final outcome. In gender neutral relationships, influence becomes disconnected from sexual politics. In this way, decision making is not compromised or predicated on membership in the privileged sex, race, class, or sexuality. Connected power adds meaning by coupling that action to a realm of value beyond the justification of efficiency or feasibility. Connected power is uncommon in many personal relationships between men and women (Cockell, 1993; Jones, 1993).

The concepts of “separate” and “connected” power apply to the dominant AIDS discourse, the development and delivery of prevention education programs for women in metro-Vancouver, and politics that control content and funding. The ability to make things happen, whether that be developing new education strategies, changing the focus of the AIDS discourse or practising safe sex, requires the use of both separate and connected power. In a hierarchical society a system can only be changed if a person in authority and position of power makes it happen. From a socialist feminist perspective, the system would be more effective if power was viewed as collaborative – team based – whether this be in interpersonal relationships or within a hierarchy. It also shapes the content and context of the information presented.
Political and Social Issues

The political and social issues that influence AIDS prevention education for women in metro-Vancouver will now be examined. The principles of separate and connected power will be used to interpret the evidence.

From mid-1980 to 1992, the Social Credit Party was in power in British Columbia. Known for their politically and philosophically conservative views, the government chose to distance itself from any initiatives that may have been deemed by the public as avant-guard; hence, there was no appetite or support for sex education in schools or for community health sex-education initiatives (Rayside & Linquist, 1992) let alone open dialogue around such politically sensitive topics as sexuality, HIV, and AIDS. Because the general public was not perceived to be “at risk,” the government remained resolute in their exceedingly right wing position supported (or tolerated) not only by the general public who provided their mandate by electing them, but also by the religious and medical establishments, and the media. The mantra resounding in communities throughout British Columbia was that AIDS only affected certain communities: IV drug users, gays, and other minorities – all of whom hold the place of scapegoat in society. This social comment about the value of people was both covert by what was left unsaid and overt through funding refusal and media commentary serving to entrench and insidiously encourage homophobia, stereotyping, and sexual alienation.

Boshier (1990) observed that prevention education must involve open discussion about sex and sexuality. Inconsistent messages and euphemisms about
exchanging body fluids are proven ineffective educational tools. Reluctance on the part of the government to enter into unedited dialogue about sex and sexuality shaped community health sex-education initiatives and impeded development of an effective sex education curriculum for young adults in the school system between 1980-1992. Public dialogue about sex and sexuality was significantly inhibited by government policy.

When the medical establishment finally came to recognise that more than gays and IV drug users were at risk of contracting HIV and developing AIDS, health officials encouraged the Vancouver School Board to develop an AIDS education program for Grade 12 students. The Vancouver School Board chose not to undertake any type of AIDS education program for the students (Marjoribanks, 1995). To be effective, prevention education must include accurate information about transmission, the use of prophylactics, and sexuality. The co-existent issues of sex and sexuality would need to be discussed in an open, honest, forthright manner as would the obvious and pivotal relationship between sex and life, sex and health, and the reality of sex and death (Easton, 1993). It was the fear of exploring alternative sexualities, in my opinion, that impeded the development of effective high school sex education curriculum.

The Vancouver School trustees ignored or diluted the recommendations of the medical establishment and chose to focus on anatomy and physiology. These "trustees" abdicated their responsibility and were thereby remiss in their duty as stewards of the public interest. Rather than take a leadership role, the government
chose to examine the HIV/AIDS issue through a narrow, restrictive fundamentalist lens, which viewed sex education and AIDS prevention education as promoting promiscuity, sexual experimentation, and alternative lifestyles. Boshier (1990) states:

In British Columbia, Canada, the number of HIV positive teenagers has recently doubled. In 1989 the conservative government commissioned an AIDS video intended for use in schools. When he saw it the Roman Catholic Premier felt it was an “advertisement for condoms,” would promote sex and promptly suppressed it. (p. 13)

Newspaper columnist Hume (1990) wrote:

There are 25 million people in Canada and every single one of us arrived on this planet the same way. Billions of people have sex every week. Some think we shouldn’t discuss this frankly. Our kids may watch a video in which women are gang-raped and cut up with chainsaws but they can’t watch one about plain old sex. These priorities reveal more than social neuroses; they are absolutely deranged. Political pharisees in Victoria and Ottawa still wrestle with the: morality” of attempting to address street kids and prostitutes in their own earthy language and imagery – a decision that gave Jesus Christ no second thoughts. ... Educational videos promote sex far less than the entire free enterprise system that Victoria and Ottawa trumpets so loudly ... Teenagers lose their virginity in high school not because our kids are corrupt, but because they are like us – with one difference: at 13 you can’t envisage your own mortality. The idea that one sweet moment tonight could lead to death six years later is impossible to imagine. And so our teen infection rate doubles in 12 months. ... The magnitude of what lies before us in terms of morality, ethics and material well being seems to elude most of our sleek, middle-class politicians. This wilful ignorance is the real sin, not whether a video urging sexually active teenagers to use condoms might somehow encourage the sexually inactive minority to experiment with sex. (Hume as cited in Boshier, 1990, p. 13)

Hume’s commentary is provocative. As a society, on a certain level, we accept violence against women. Little if any objection is raised about movies featuring the violent brutalization of women. Through many venues women are told that on a fundamental level we do not have much say on how our bodies will be used. Again
and again, women are not defined in terms of individuals but as an addendum - something created from and for man by a masculine God entity. Children are allowed to view these movies but, as Hume points out, educational videos about sex are censored and vetoed.

In 1992, the New Democratic Party was elected and remain in power today. This government inherited the AIDS crisis created by the politics, policies, and practices put in place by the previous government, one example of which was the growing drug problem and the parallel rise in HIV infections on the Vancouver eastside (Steffenhagen, 1997).

British Columbia is the only province that produces a comprehensive annual report on the health of its residents. Some startling statistics emerge from the information gathered. The poverty rate among British Columbia children remains high. The link between improper nutrition and poor health is well documented in research. One in four British Columbians smoke and one in seven drink heavily. First Nation’s people are the most disadvantaged of all residents and have the poorest health.

The downtown eastside of Vancouver is said to be one of Canada’s poorest neighbourhoods. Statistics revealed that in 1995, 236 people died from drug overdoses in Vancouver, most of them in the downtown eastside. It is estimated that at least two thirds of Vancouver’s intravenous drug users live in that area (Steffenhagen, 1997).
Although the NDP government had directed $3 million to Vancouver’s downtown eastside since the 1993 report of British Columbia Chief Coroner Vince Cain, it still takes many months to get addicts into detox or rehabilitation. And as previously discussed in Chapter 4, there are no ethnic specific services for, for example, people of Asians or Middle Eastern or Indo-Canadian ethnicity. According to John Turvey of the Downtown Eastside Youth Activities Services, the IV drug situation is worse than it has ever been (Steffenhagen, 1997). Drug addiction, poor health practices, poor nutrition are all compounded by poverty.

In a compelling article entitled “HIV Emergency Called in Downtown eastside,” Steffenhagen (1997) reported that people living in the downtown eastside of Vancouver were knowingly and willingly infecting themselves with HIV in the belief that this would get them higher social assistance benefits. If people are knowingly injecting themselves with HIV despite the education and knowledge currently available then the ineffectiveness of that education in reaching high-risk groups such as the IV drug users is apparent as is the desperation of these individuals.

Sharing needles, especially among cocaine addicts who inject drugs up to 20 times per day, is the leading risk factor in contracting AIDS in British Columbia. Other figures indicate that approximately 10,000 British Columbia residents are infected with HIV and the rate increases at about 1000 each year (Steffenhagen, 1997). Even for a government with a social conscience, more radical solutions to dire health problems affecting the eastside could not be seriously considered i.e. safe
houses in which drug addicts could "shoot up." Even if research demonstrated that funding safe houses would be prudent and lessen the risk of HIV infection, a decision to act on such a recommendation would be political suicide. The government would not be able to withstand the controversy such a position would create.

Dr. John Millar, the British Columbia Provincial Health Officer, in his 1996 report on the health of British Columbians reveals that HIV infection in the intravenous drug using population is rising faster in British Columbia than anywhere else on the continent. Millar estimated that one out of four people on "the strip"* were HIV infected and he estimated that the figure would be at 50% in two years. There is a parallel rising curve of drug affected babies born HIV infected. British Columbia statistics estimate that one in three babies born to moms with HIV have HIV. In 1994, published research demonstrated that the risk of perinatal transmission could be reduced by two thirds if the pregnant woman took antiretroviral therapy. With no pharmaceutical intervention, the risk of an HIV positive woman transmitting HIV to her fetus is about 25% (Silversides, 1998).

British Columbia now provides routine counselling about HIV for pregnant women. Testing is also routinely offered. British Columbia under the NDP government was the first province in Canada to act on these research findings and introduce a special initiative so that approximately 80% of pregnant women are agreeing to be tested (Silversides, 1998).

* The strip is an area in East Vancouver that is known to be inhabited by drug addicts, drug dealers, and sex trade workers.
In order to prevent the disease the cause of the disease, which more often than not is multifactorial, needs to be treated. It is ineffective to simply treat the symptom (drug use). The solution to preventing HIV/AIDS is early intervention. More resources and funding need to be funnelled into early childhood health services in order to break the cycle of poverty and its effects. There are numerous reasons why people become drug addicted—unemployment, poverty and abusive childhoods to name a few. For those who are drug addicted more emphasis should be placed on rehabilitation. More programs need to be set up and adequately resourced. All initiatives require funding and there are a limited amount of resources available. It comes down to what is seen as a priority by those in power.

Education Issues

It is imperative to recognise that within an educational paradigm, a set of values, ideas, assumptions are promulgated - the corollary being that there is a set of values, ideas, and assumptions elided. To exclude women from the AIDS equation as was done prior to 1989 makes one kind of political statement. To include women with seriousness and vision and with some attention to the perspective of those women affected is, put simply, another kind of political act. Education is a powerful political tool, which can serve to include or exclude and in doing so can control destinies giving some people hope while depriving others even of the most pedestrian expectations.

In British Columbia sex education programs for teens appear to be more concerned about protecting them from knowledge of alternate lifestyles than
protecting them from HIV/AIDS. We have seen a significant increase in pregnancies and STD's amongst teens in recent years. Additionally, poorly designed education has in some cases resulted in misconceptions about the seriousness of HIV/AIDS (McLellan, 1998).

In talking with young street kids, researchers have found most believe HIV/AIDS is curable (McLintock, 1997). Dr. Steven Genius, an Alberta doctor and expert on teen sexuality, spoke in Victoria about the alarming rates of unwanted pregnancies and sexually transmitted diseases in the teen population across Canada. Statistics also demonstrate an increase in the abortion rate among teens (McLellan, 1998). The "Just Say No" programs are not working. Current programs emphasising condom use and even "outercourse" (all sexual activities short of penetration) are not working either (McLintock, 1997). The Contraception Report, which provides comprehensive national guidelines for improving sexual health and birth control practices, found that adolescents, like adults, do not use contraceptives to prevent unintended pregnancies on a consistent basis. Although the overall birth rate among 15- to 19-year-olds has declined, the rate of induced abortions among them has risen by 51% since 1975. It is now 50% higher than the abortion rate among adult women (McLellan, 1998). Most teens know they should always wear a condom for sex, but few do consistently.

Teens are becoming sexually active at an earlier age; hence, are more likely to have multiple partners and are, therefore, at greater risk of contacting STDs. Medical research has linked STDs with an increased risk of contracting HIV possibly
because STDs tax the immune system and allow for a route of transmission i.e. the open sores associated with herpes that allow easy access into the system. According to Dr. Genius, some studies indicated that as many as 25% of sexually active teenage girls carry the latest sexually transmitted disease to be discovered, the human papilloma virus (HPV). The studies also found that the group now at greatest risk for STDs was heterosexuals aged 14 to 22 (McLintock, 1997).

Many sex education programs are not working because they do not address the underlying problems of those teens who become sexually active at an early age or the problems that lead them to exhibit other risky behaviours such as drug use, drinking, and running away. Again, early intervention is imperative. Genius recommends that parents, preferably, give teens complete information about sex and STDs and that the teens be told of the health benefits of delaying sexual activities.

In an ideal world, this would be great! What Genius' observations fail to recognise is the need to include open discussion on sexuality with that of anatomy and physiology. Adults, for the most part, are not comfortable with their own sexuality making it difficult for them to discuss sexuality with their children in a value free context. The subject is emotionally charged and aligned too closely with our “fit” in society.

Schools in British Columbia are required to provide sex education, but programs are subject to the approval of municipally elected School Board trustees. In British Columbia, sex education is taught in kindergarten but it is not until Grade 9 that students are introduced to factors that influence responsible decision-making.
The quality of the sex education programs varies from district to district. Some districts bring in consultants, experts in the area of teen sex education, while others rely on teachers. Some depend on the School Board and do not want their children introduced to "too much" sex-education. However, what children and teens need to learn are skills - how to say no and how to avoid situations where they have to say no (Proctor, 1998).

Research has also indicated that the education programs designed for school use were not explicit enough. Dr. Richard Boroditsky, Director of Family Planning Services at Winnipeg's Health Sciences Centre, states that sex is more than reproduction. He believes that no one has taken responsibility for sexual health education (McLellan, 1998). New strategies need to be developed. This is not an easy task for educators and curriculum developers. The public become extremely vocal and suspicious when faced with issues of sex and sexuality; hence, even if a government wanted to be proactive and design more effective AIDS prevention education programs, often their hands are tied.

In December 1995, for example, a public that clings to puritanical values vetoed candid advertising focusing on how AIDS is transmitted sexually. Similarly, a graphic pamphlet entitled "Great Sex Tonight," published by the Health Ministry and issued at a December 1995 student conference, evoked controversy and the pamphlet was pulled (Staley & Colebourn, 1996a, A5). There is a reluctance and unwillingness by the government, educators, and general public to address sexuality, sexual behaviours, specific sexual activities, sexual health, and relevant
psychosocial issues. Providing teens with age-appropriate, accurate information about sex and sexuality is met with suspicion and hostility by many parents, right wing politicians, and fundamentalists that fear education encourages experimentation and sexual “deviation.” Yet HIV and its relationship to sex demands we do exactly this. These groups fail to recognise the relationship of sexuality to both physical and mental health. They use their power to erode public acceptance of progressive, responsible sex education programs in schools.

Take for example, the Surrey School Board. A *Vancouver Sun* article dated February 2, 1996 reported on the banning of Planned Parenthood from Surrey Schools (Todd, 1996). The article demonstrates the significant influence of American values and fundamentalist propaganda in British Columbia. Mr. Robert Pickering, a right wing anti-abortionist and member of the militant US based (anti-abortion) “Operation Rescue” and the Surrey School Board Vice Chair, quelled an initiative to install condom machines in high school washrooms in Surrey and barred Planned Parenthood from continuing to be a resource in Surrey Schools. Planned Parenthood, known for its broad-based information approach to sex education, had been in British Columbia schools since 1986.

In a subsequent *Province* article dated February 9, 1996 entitled “Chastity on the Hot Seat” (Staley & Colebourn, 1996b), Mr. Pickering states that Planned Parenthood promotes sexual activity by promoting and increasing the use of birth control products. He has also attacked Planned Parenthood claiming that they endorse oral sex for teens and have what he perceives as strong ties to the abortion
movement. Like former Premier Vander Zalm, Pickering's personal values and agenda rather than the best interests of his charges influenced his position on sex education, condom machines in school washrooms, and Planned Parenthood. His publicly held position exposed the ideological underpinnings of a right wing discourse aimed at containing and controlling both diversity in the form of alternative sexualities and the sexuality of women by withholding education and access to prophylactics. Because of his position as Surrey School Board Vice-Chair, Mr. Pickering has been able to directly influence outcomes by using 'power over' in order to further his personal agenda and to control. Education, he believes should promote abstinence, which seems to equate to ignorance – if we don't talk about sex, the subject will just go away and teens won't engage in sexual experimentation. Unfortunately, the perpetuation of right wing hegemonic strategies such as these has resulted in inadequate education strategies and ever-increasing teen seroconversion rates.

In support of appropriate sexual health education, which would include HIV/AIDS prevention education, Dr. Dorothy Shaw, Obstetrician/Gynecologist at the British Columbia Women's Hospital believes the inconsistent approach to sexual health education is the problem. Most sex education programs do not deal with behaviour and relationship issues such as addressing the conversation on how to negotiate condom use with a boyfriend or how to have a sexual relationship but postpone intercourse (McLellan, 1998).
Dr. John Millar says that we don't have to look far to find places where sex education works; for example, teen pregnancies in Richmond and on the North Shore are among the lowest in the world. Teens in those districts have access to more resources and education than counterparts in isolated rural and northern communities (Proctor, 1998).

Notwithstanding that sex education programs are a contributing factor in the low pregnancy rate, I find this analysis somewhat simplistic. Other variables, which influence teen pregnancy rates in those school districts, could include but not be limited to family socio-economic level; family education level; cultural beliefs (Richmond has a high Chinese population); religious and personal values. To identify one variable as the sole reason for this situation would be erroneous.

For metro-Vancouver parents, as for most North American parents, sex and sexuality is a controversial subject and anything seen to possibly promote teen sexual behaviour makes people apprehensive. However, when objectively assessing the evidence, it becomes apparent that we need to talk more openly about sex and recognise that sexuality is a component, not an addendum, to healthy living (Easton, 1992). What people fail to recognise is that education will not infect the public or teens with thoughts and urges they don't already have. Research conducted in the Netherlands and Scandinavia, where teen pregnancy rates are low, show sex is talked about openly from a very young age. By establishing a comfort level with their children early in life, parents demonstrate to their children that it is okay to talk about sex and, as a result, children are more willing to discuss sex with their parents.
(Proctor, 1998). However, this analysis may be simplistic because other cultural factors and values may have influenced the findings.

Agencies such as YouthCO do visit schools and most likely positively influence the behaviours of some youth; however, because individual school boards control the flow of information and who is permitted access to students, not all British Columbia students will have the benefit of such initiatives. Access will be predicated on the particular bias of the school district.

**Adult Oriented Prevention Education Initiatives**

For the adult population, traditional public health information programs on HIV/AIDS consist primarily of pamphlet and poster campaigns, one-on-one counselling and education, and some workplace-related group education. The theme: know the facts and prevent transmission.

Social marketing strategists tell us there is a direct link between campaign effectiveness and its sensitivity to underlying beliefs and values of the audience being targeted. Of equal importance, the behaviour promoted must be achievable by the target population. The message must be repeated utilising various mediums so the message becomes rote. Finally and clearly the most difficult aspect of the campaign is to systematically measure behaviour change.

As discussed in Chapter 4, in 1990, PWN, the Women and AIDS Project (now defunct), and the Vancouver Health Department collaborated on an initiative to raise public awareness of the risk of HIV to women. The Vancouver Condom Awareness Campaign, "Condomania", was aimed at heterosexual women between
the ages of 19 and 30 who were based within the popular culture of Vancouver. The goal was to increase public awareness of the risk of HIV for women and to compensate for the dearth of educational resources specifically directed at women. Unfortunately, due to a funding shortage, the campaign, which was to consist of three parts, was never completed (Wagman, 1993). The project was terminated halfway through the second phase. The third phase—the evaluation of efficacy—did not occur. Yet community interventions need to be integrated with research evaluation methodologies so that ineffective approaches can be discarded and effective approaches widely disseminated. There is a paucity of published intervention studies of risk reduction behaviour (Kelly & Murphy, 1991).

The problem with behaviour change is that it is difficult to measure over short periods of time. With respect to condom use, quantitative assessments can be utilised, but in order to evaluate whether behaviour and attitude changes have resulted, highly personal questions have to be asked. Most people are uncomfortable engaging in honest, open dialogue about sex, let alone disclosing information about their personal sexual practices. Consequently, self-disclosure of personal sexual practices is not necessarily reliable. Again, the theme of power and funding and power and politics re-emerge.Politicians decide which projects will and will not receive funding.

PWN and Women's Outreach launched many community-based HIV/AIDS prevention initiatives. Ms Marcie Summers in an April 26, 1996 interview felt that the education interventions, outreach programs, and campaigns have had a limited
but positive impact especially around the area of some sexually transmitted diseases. The establishment of Sexually Transmitted Disease Clinics (STDC) was a positive step as these clinics were easily accessible to women and provided a safe environment where women could access both information and treatment. Medical evidence clearly supported a link between STD's and HIV; however, the efficacy of the STD program on HIV can only be demonstrated through a decline in case numbers. Currently, HIV is increasing in certain populations although STD's are decreasing. One possible explanation is that the route of transmission may be something other than sex, i.e. IV drug use.

Summers states that community based education programs are designed from a public health perspective, but relying solely on this perspective is too restrictive. An integrated intervention program targeting high-risk populations such as sex trade workers and IV drug users needed to be developed and delivered. AIDS prevention education in minority communities and with the socio-economically disadvantaged require the development of new, culturally relevant approaches that address HIV risk in the context of many competing life concerns, demands, and stressors associated with the disadvantaged. HIV, case management, condom promotion, and education needed to be integrated for maximum impact. Extensive and meaningful outreach programs coupled with research featuring quantifiable data on the efficacy of these programs on behaviour and attitudinal change needs to occur at the community level. In other words, long term change needs to be measured. But once again, research topics and funding are politically
driven. It is the politicians who decide which initiatives will receive backing. Although women may hold some government positions of importance, most politicians are men, so a male agenda is at the forefront.

On September 09, 1998, I met with and interviewed Jacqueline Barnett, Education Co-ordinator, for the Centre for Disease Control in Vancouver. The CDC has an education mandate. She described a peer education program done in association with British Columbia Multicultural Health Services. This initiative targets hard to access immigrant and refugee populations. The content of the program includes STD’s and related issues such as family violence, pregnancy, spousal assault and HIV. They work with women from ten ethnic groups. The program works on a train-the-trainer basis. Four peer educators access 5-7 women within her community and do a series of ten workshops. No formal evaluation of the program has been undertaken. However, since peers with the same ethnic and religious background provide the education, thereby ensuring that the information is relevant, it is believed to be fairly successful.

The CDC also does education for clients coming into the clinic. This education can be quite extensive including but not limited to collaboration with other agencies such as the University of British Columbia Health Services, Medical and Nursing Schools, Regional boards, and British Columbia Multicultural Services. The success of the education initiatives is measured informally by the awareness/lack of awareness of the clients and also by the sophistication of the questions being asked.
Jacqueline Barnett states that education for single, white upper and middle class women who are 35+ and just re-entering the dating scene is non existent. These women do not see themselves at risk and neither do others. Barnett states that Vancouver is seeing a significant increase in HIV in this population. This is based on anecdotal information from the Oaktree Clinic. Unfortunately, statistics that are kept do not identify demographic categories.

Barnett sees one of the significant problems of HIV/AIDS prevention education as the conspiracy of silence on the part of the medical establishment and the public to talk about women and anal sex. She believes open communication and dialogue on the topic of women and anal sex is necessary. This would enable women to be aware of the sexual health issues associated with having anal sex. Most physicians do not do rectal exams on women and rarely, if ever, ask women about anal sex practices when doing a physical examination. More scientific, medical, and qualitative research needs to be done on the subject.

Barnett believes one reason anal sex is not openly discussed is because of restrictive and distorted notions of sex and female sexuality. What is seen as “normal” or “abnormal” continues to be influenced by the dominant discourse on sexuality which has and continues to qualify both health and educational responses to HIV. Dominant opinions do not speak to a sexuality that extends beyond penile-vaginal contact that may include acts that society tells us are “dirty.” The dominant discourse on women’s sexuality needs to be challenged in order to develop relevant and credible HIV prevention materials.
The AIDS Discourse and "Family Values"

Right wing conservative morality was challenged by the emergence of the feminist movement in the 1960's. The women's movement brought to public attention such issues as non-procreative sex and women's autonomous sexual desires. Coincidental to the women's movement was the development of the birth control pill. Suddenly, women did not have to depend on men wearing condoms for birth control purposes and were able to engage in sex for pleasure without fear of pregnancy. This meant a separation of sex and reproduction and an implicit recognition of women's existence outside their functional roles. However, sexual liberation provided by "the pill" also placed the onus for birth control on women. With the coming of the AIDS crisis, the responsibility for safer sex still remained with women despite the fact that they do not ultimately control condom use.

In the face of the sexual revolution, the "moral majority" or the "new right" promoted a return to old fashioned and authoritarian family values linking these values to patriotism, national unity, and economic certainty. The AIDS epidemic, like past epidemics, was said to be God's judgement of the immoral and linked to the destabilisation of Canadian society. "In an era of panic sexuality, the family is being repackaged as a prophylactic social device. In the age of sexual epidemics, the family can be marketed as a strategic and prudential safe sex practice" (Singer, 1993, p. 85). A return to "traditional" values also equates with restrictive and inhibitive sexual mores. By equating "traditional" to that which society values (certainty,
stability) this propaganda campaign speaks to the core fears held by the general public and guarantee a buy-in at that level. Linda Singer (1993) goes on to state:

The population's panic in the face of contagion is often and differentially displaced and repeated in the form of a contagious proliferation of defensive strategies, aimed at combating this perceived threat to the health of the social body. Because the impetus for such strategies is defensive, the logic with which they operate tends to be conservative, i.e., aimed at preserving and protecting that which is seen as threatened by changes in the sexual political economy. Consequently, sexual epidemics provide occasion for the revivification of hegemonic forms of dominance, which now seem to have greater justification and utility, insofar as these can be mobilised in the name of health, safe sex, and the forces of life in a politics conceived as a struggle between life and death. (p. 85)

Faced with increased panic over the spread of HIV/AIDS to the general population, family values are promoted both as a defence against disease and perversion. The return to ultra conservatism is thus “justified” in the name of “public good”.

The family as sacrosanct and a haven of safety for women are questionable. As Singer (1993) points out:

Like the strategic marketing of condoms, the promotion of familial relations take on special irony when examined in light of women's historical experiences within the family. That history reveals that the family has never been a particularly safe place for women and children. Most violence against women occurs within the family, as does the sexual abuse of children. In families, women have been simultaneously subject to an institution, which exploits them economically, politically, and psychologically. When the rhetoric of family values is also used as a code word for a particular form of male control over the reproductive capacities of women, the prophylactic effect for women is questionable indeed. It may very well be that given the patriarchal organization of the family, women's sexual safety is substantially reduced by their participation in an institution structured to preserve male domination of women, and the product of their labour.
Within the confines of the family, some women have little say as to when, where and with whom they have sex and more often than not, are unable to negotiate safer sex with their partner. In many cases, women are afraid to negotiate safer sex with their partner for fear of violence or rejection. Further, women in monogamous relationships often do not perceive themselves “at risk” and, therefore, do not practice safe sex.

Conclusion

As I began writing this chapter, I started to think about what I meant when I used the word “sex” or “sexual” or “sexuality”. My meaning and understanding might be very different from someone else's. I decided to look up the text book definition of sex, sexual, and sexuality. When I read the words in the dictionary I realised that the definition did not begin to capture the diversity of experience or the needs that create a representative picture of women’s sexuality.

Sex noun 1. One of the two divisions of human beings, animals, etc....2. a. the character of being male or female...b. the physical quality in plants of having male or female functions ....3. the differences in structure and function between male and female.

Sexual adjective 1. Of or having to do with sex ...2. Of or between the sexes....3. having to do with the relations between the sexes

Sexuality noun 1. Sexual character; possession of sex....2. the possession of sexual powers or capability of sexual feelings

These clinical and sterile words lack emotion, connotation, values, and experience, which are all necessary parts to understanding and giving meaning. The words are far removed from the living reality of women's sexuality and experiences. Yet it is
these words that drive the dominant discourse on sexuality which in turn determine education initiatives.

Socialist feminist theory asserts that sexuality is socially constructed. Each society shapes members’ understanding of appropriate and inappropriate sexual practices, sexual beliefs, and attitudes. Men and women construct, experience, and define their sexuality and sexual practices based on societal norms (Holland et al, 1992). For example, in some societies such as Brazil, a male could engage in penetrative anal intercourse with another male and this would not be defined as homosexual behaviour provided that he played the active role in the sexual act (Herold, 1989).

In general, women are poorly served by both official and informal pedagogies on issues of sex. The ways in which women learn about sex and sexuality within social constructs continue to be confusing, contradictory and alienating. As women’s sexuality continues to be defined by the male perspective, there is little to offer women in the realm of a positive construction of female sexuality (Thomson & Scott, 1990).

Possibly the greatest obstacle that the HIV and AIDS prevention education for women must overcome is that practising safe sex calls into question trust and intimacy in relationships (Holland et al., 1992). Romantic love does not hold the view that sex and love are distinct from each other. Because sex and love are not viewed as quite different, romantic love is searched for in the interstices between sexual, procreational, friendly, and altruistic love. The general view seems to be that
romantic love is mysterious, mystical, even sacred, and not capable, apparently, of being subjected to the aloofness and the coldness of scientific inquiry (Tennov, 1981).

Like patriarchal mythology, which depicts the creation of woman by, from, and for men, the eternal female at her best, the aesthetic ideal, is that of contemplative purity – wholly passive, completely void of generative power – woman as mother and goddess, feminine symbols of transcendence. This “purity” signifies that these women are, of course, self-less, with all the moral and psychological implications that the word suggests. The culturally induced “love story” traditionally depicts two beautiful, young, flawless, heterosexual people drawn together by a strong physical attraction that transcends the pedestrian. This meeting of souls culminates in a sexual experience that completely satisfies the other’s erotic and affectionate needs. The lovers are caught up in the fury of passion, excitement, pain and fear. Obsessed with each other, they are willing to risk all to retain the feeling of being in love. They are scornful of reason or harsh realities; the two of them are in love with love (Tennov, 1981). If this defines love, then it becomes next to impossible for women to introduce a condom, which requires complex negotiation, into a sexual encounter that “should” by societal definition be spontaneous and requires that a woman relinquish control for passion (Holland et al., 1992).

The corollary of the woman as Madonna is her image as temptress and whore. If women assert their needs and demands for safe sex, they often are labelled whores with significant damage to their reputations. For a single woman,
carrying a condom equates with a lack of sexual innocence and the socially unacceptable identity of being a woman actively seeking sex. Further, women lack confidence in the sexual arena because they assume men are more sexually experienced (Holland et al., 1992). Women are socialised from early ages to accept and believe it is okay for men to "sow their wild oats" but not women – women must remain virginal.

In long term relationships, it is next to impossible for women to negotiate condom use as such a request would call into question trust and love (Holland et al., 1992). Women, even today, are defined in respect of their proximity to men and are, as a result, frequently reduced to mere properties of men in the marriage relationship. Not only do women relinquish control in the heat of passion but also their autonomy once in a committed relationship. For a woman, the essential process of self-definition is complicated by patriarchal definitions that intervene between who she believes she is and who society says she should be. She becomes this "otherness" which culture confronts with worship or fear, love or loathing. Only when women are permitted to have self-respecting sexual identities which are not solely predicated on being in a relationship, will they be in a stronger position to articulate their demands for safe sex.

Gendered power imbalances not only construct the rules around the encounter but also constrain a woman's ability to make sexual choices and decisions. If eroticism and desire are defined in terms of an inequality in power, (men take control, women relinquish control) then women are immediately disadvantaged in
terms of what they can negotiate around safe sex and condom use. Again, to reiterate, when love relationships are defined in terms of love and trust then sexual safety becomes a contradictory proactive.

For women, the implications of being defined from a patriarchal stance are far reaching. Patriarchal mythology defines women as the product of male brains, ribs and ingenuity. By having the female self defined within this context, it is no wonder that as women we experience confusion, anxiety, and ambivalence around sexuality. Looking at AIDS prevention education for women, this perspective provides an analytical tool by which traditional approaches to prevention education for women, who are enclosed in the architecture of an overwhelmingly male dominated society, can be judged. The results of the analysis are persuasive on the effects of being trapped in the constructs or images of what a patriarchal heterosexist society defines as “feminine,” “sexually acceptable” or deems as the “ideal.” One only has to look to the efficacy of an AIDS prevention education designed primarily by men for women. This complex of metaphors and aetiologies reflect the patriarchal structure of Western society and the rudiment of misogyny upon which it is founded.
CHAPTER 6:
CONCLUSION

In this chapter, I summarize the research by discussing three areas: initial focus, data analysis, and implications.

Initial Focus

The purpose of this research was to identify what prevention education programs existed in metro-Vancouver for women between 1981 and 1999; examine from a socialist feminist perspective the political ideology that framed the education; and, finally, insofar as possible, to evaluate the efficacy of that education. This research began with the questions, "What HIV/AIDS prevention education existed for metro-Vancouver women between 1981-1999? How accessible was this information? What kind of information was available? What factors influenced program development? How effective has this education been in preventing the transmission of HIV/AIDS in metro-Vancouver women?"

The literature examined the historical context from which North American HIV/AIDS and women discourse emerged. Within AIDS discourses, public policy was set, priorities established, and resources distributed (Boshier, 1992). The literature revealed that women were invisible in the epidemic until the early to mid-1990's despite mounting evidence that women were dying from HIV/AIDS. There were many impediments, which fettered the ability of activists to include women in the AIDS dialogue. Political, medical, social, and religious interests ensured that women remained disenfranchised, ignored, and underserved within the epidemic.
The conceptualisation of AIDS and the advice provided about prevention occurs in the context of deeply rooted and socio-culturally determined ways of construing the world (Boshier, 1992). AIDS prevention education for women can only be effective when tailored to specific experiences and needs identified in a particular constituency. Sex and sexuality need to be discussed in an open and honest forum and not defined solely in terms of male heterosexuality. Women cannot continue to be defined in terms of men’s sexual needs but rather as female sexual subjects who can negotiate with men (Holland et al., 1992). From a socialist feminist perspective, behaviour change is more likely when the education is framed in terms of images with which women can identify and strategies that are realistic in contradictory situations. Finally, and perhaps of most significance, the effectiveness of health education for women is dependent on the effectiveness of education for men (Holland et al., 1990).

The research process was arduous and the evidence daunting. My commitment to social and political change kept me motivated. Women’s voices, their diverse experiences, as well as their shared values must be incorporated into prevention education if it is to be valuable, credible, and effective. Women need to be heard. I do not hold these beliefs and principles in isolation. This perspective is shared and supported by the women I interviewed, my friends and colleagues. This project has extended beyond the confines of this research. Because of my involvement on various committees dealing with women’s issues, I have had the opportunity to bring forward my ideas and concerns.
Socialist feminist theory provided the theoretical foundation for this research. Patriarchal structures and androcentric biases disadvantage women. In terms of the AIDS epidemic this is seen, partially, in terms of misdiagnosis, lack of treatment protocols, and inadequate access to care. Like sexuality, gender relations are socially constructed. The primacy of extant gendered power relations needs to be challenged for a meaningful shift in male-female dynamics to occur. Simply adding women to existing patriarchal structures would not result in sufficiently significant changes.

The historical and the more recent HIV/AIDS prevention educational strategies for metro-Vancouver women were examined. There are many excellent programs, such as PWN, Women’s Outreach, ASIA, and DAMS, directed toward the needs of some women in the metro-Vancouver area. Notwithstanding having said this, however, I also saw how politicians directed and controlled the AIDS discourse and the education processes through the use of “power over.” The dilution and filtration of information by the media, politicians, and the medical establishment molded individual attitudes, collective behaviour as well as social policy.

"Power over" is traditionally masculine in nature. Education characterised by the “giving information” approach exemplifies use of “power over.” This type of education is imposed with no or little input from those affected. The educational campaigns that featured white, middle class doctors lecturing about the facts of HIV/AIDS or campaigns emphasising safe sex was solely women’s responsibility are examples of the use of separate power within the educational paradigm.
Separate power is predicated on the principles of rationality, objectivity, and authority. Behaviour change will result when citizens are made aware of the facts and defer to the opinions and values of the “greater” authority. For example, if the Bishop forbids the use of condoms, because of his authoritative position, he is able to influence people’s decisions about whether to use or not use prophylactics. Separate power typifies traditional men/women relationships and hinders a woman’s ability to negotiate within that relationship because she has surrendered her personal power to her partner who is perceived to be in the position of authority.

Connected power is “power with” and coterminous with collaborative and consultative decision making and empowerment. It espouses values of caring and connection. In relationships based on connected power, women participate as equals and thereby influence the final outcome of the negotiations. Although AIDS prevention education cannot change the power dynamic within a relationship, it is able to provide women with strategies to use in relationships based on separate power and, ideally, assist women in moving toward developing more balanced relationships and staying healthy. The principles underlying connected power are not as visible or as clearly articulated as those found in separate power and, therefore, are often less valued because they are considered “soft.”

The educators that I interviewed relied on both separate and connected power when delivering AIDS outreach education. This was evident in the materials that were developed as well as through discussion.
Leslie Remund from DAMS told me, “Just because the education I do is unconventional, doesn’t mean I’m easy on the women I work with. I’m actually tough on them. I tell it as it is.”

Socialist feminists would envision the ideal educational strategy as incorporating the positive qualities from separate and connected power to create a balanced structure. AIDS prevention education would include the “female” values of responsibility to self and others, nurturing and caring with the “masculine” values of efficiency, objectivity and personal authority thereby empowering the participants. The shared responsibility for sexual health would be emphasised.

**Data Analysis**

The data for this thesis came from primary and secondary sources. Primary sources included outreach workers, educators, and program co-ordinators from various organizations. Secondary sources included newspaper articles, magazines, journal articles and books.

This research has emphasised that at the onset of the AIDS epidemic, preventative educational strategies did not exist for metro-Vancouver women because sexism, heterosexism, racism and classism shaped and influenced women’s location in the AIDS discourse as well as within institutions such as the medical establishment thereby rendering women invisible. “Popular” AIDS discourse served to reinforce existing ideology despite evidence to the contrary. The government, the medical establishment, and the media chose not to challenge the reasoning that excluded women from AIDS discourses.
Subsequently, when some metro-Vancouver women were identified as “at risk,” AIDS prevention strategies were adapted from the educational information and materials used in the gay community. It was the gay male experience that was reflected, not the invisible experiences of women sex trade workers or IV drug users or white middle and upper-middle class women. At the start of the epidemic, metro-Vancouver education initiatives were generic, focusing on risk groups’ not risk behaviours. This reinforced that “ordinary” women who engaged in “ordinary” sex were not at risk – only “other” women were at risk – those who engaged in excessive behaviours with their bodies.

It was not until 1990, that the specific needs and experiences of HIV positive women gained some recognition through the establishment of the PWN and the Women and AIDS project. Notwithstanding that 1990 was the pivotal point for positive women in Vancouver, the mandate of the PWN was to support women with HIV/AIDS. Later the PWN expanded its mandate to include community outreach programs such as the Physicians Education Program.

The Vancouver Women and HIV/AIDS Support Network, a parallel initiative to PWN, had a prevention mandate. The prevention education initiatives incorporate women’s values and experiences but are population specific targeting the needs of women whose access to services is limited by a number of factors.

As the need for HIV/AIDS outreach education increased new and different initiatives were formed to meet the diverse needs of women at higher risk for contracting HIV/AIDS. But even with the multiple initiatives, not all women are
being educated about HIV/AIDS. I found no evidence of AIDS prevention education for Indo-Canadian women or Middle Eastern women or white middle and upper-middle class women. Are these women not dying of AIDS? Are they not at risk for contracting HIV?

In my interview with Barnett, she states, "No education for white upper and middle class women exists. The Oak Tree Clinic reports a dramatic increase of HIV in divorced professional women age 35+. These women still do not see themselves at risk and neither do others. White, professional middle and upper middle class women view AIDS as a combination socio-economic and social disease problem that affects sex trade workers and IV drug users or gay men. Occasionally, the disease is reported to have crossed socio-economic boundaries because of the misfortune of receiving tainted blood products. The depiction of women as innocent victims of HIV has served to further solidify the cognitive and social scripting of AIDS. These women did not do anything excessive with their bodies, they got the disease by accident. Therefore, many women who do not belong to a "risk group" believe they are protected by who they are not what they do. Like white middle- and upper-middle class women, white middle- and upper-middle class heterosexual men also do not perceive themselves at risk because of their membership in the heterosexual community."

When I began this research, I did not believe that I could be "at risk" for contracting HIV. I too believed the myth that only "other" women or gays or IV drug users acquired AIDS. I then looked at why I would believe this: The answer
was, "I only know 'respectable' men. I would only become intimate with men who hold the same values and occupy the same social class as I. I told myself that I do not know men who are bisexual or drug addicts or who buy sex." If I acknowledge that I could be at risk, what does this acknowledgement say about who I am? It calls into question my judgement, my intimate relationship, and the privileged position I hold in society.

I thought this research would support my beliefs as well as demonstrate that there was ample and adequate AIDS prevention education in metro-Vancouver and that the education was changing the behaviour of those "other" women. What I discovered was that every woman was at risk! - Albeit some women being at greater risk than others. I discovered that there was not enough education and many women continue to be elided from the HIV/AIDS discourse. The evidence tells me that AIDS prevention education strategies are only one piece of the solution. Belief systems, social scripting, and perceptions of ones' self and others are the more challenging and difficult pieces to change as are the underlying root causes of drug addiction and prostitution.

**Implications for Practice**

Again, I emphasise that education strategies are only one small part of the solution to the prevention of AIDS. As a society, we must become more woman-centred. For example, today's obsession with youth dictates how women are valued, viewed, and treated and has significant implications for child pornography and the child/adolescent sex trade. Exploitation of young bodies by advertisers
sends a clear message to the youth, men, and women in our society. Youth drives the consumer market, which in turn drives cultural values. We, as a society, are obliged to embrace all aspects of youth. For women growing old is viewed as an infirmity.

As a society we are hypocritical with regard to the position we take on sex with children. On the one hand society states that having sex with children is taboo but despite this, the practice is quietly condoned. It is estimated that 90% of the sex trade is conducted indoors by both adults and children. Prostitution is illegal yet the sex industry has become prolific in Vancouver through municipal licensing of massage parlours. The City of Vancouver actually profits from prostitution through the costs associated with licensing. A massage therapist pays $88.00 for a one-year license whereas a body rub parlour pays $6,788.00 (Shortt, 1998, p. 19).

Reflecting on the child sex-trade industry, I realise society must address the root causes of why children believe there are no alternatives to street life. This means dealing with issues of sexual abuse, poverty, and drug addiction. Most child abuse occurs within the family. Child abuse, like prostitution, occurs behind closed doors, making it difficult for police and social workers to combat but easy for the rest of us to ignore.

Sex education programs in schools need to talk candidly about sex and sexuality without shame, guilt, and stigma. Sexuality, especially women’s sexuality and homosexuality, are controversial topics. Right wing fundamentalists will view open and honest dialogue about sex and sexuality as promoting, encouraging, and
condoning alternative life styles. This type of dialogue will be met with hostility and resistance. Fundamentalists fail to recognise that education will not encourage promiscuity but rather will prevent STD infection and ultimately AIDS. Politicians must be willing to stand up to public pressure.

Implications for Research

This thesis provides a direction for other research. I did not survey or interview women who contracted HIV or who have AIDS. Their stories would be useful in formulating educational initiatives for women of similar experience.

It would also be useful to survey white professional divorced or separated women age 35+ with a view to understanding their experience and to determine if, on a regular and consistent basis, they use prophylactics. If not, why not? As there also is evidence suggesting that white, middle and upper middle class heterosexual men also do not perceive themselves at risk, it would be beneficial to do a comparative study on attitudes, beliefs, and sexual practices.

More work on merging the positives of connected and separate power in educational initiatives needs to be done and education needs to be developed for all women not just "certain" women. I do not mean that a generic or canned product be developed but rather that the education take into account the diverse needs of women depending on their life experiences.

The AIDS discourse is a place where politics, religion, belief systems, and social values overlap. The personal and the political interweave in a complex
pattern formed on the background of history. The historical events leading to the exclusion of women from the AIDS discourse are just a mirror in which we see our own concerns reflected.

To ensure that women’s needs are better met I recommend the following:

- More research should be funded to study the effects of HIV/AIDS on women’s bodies.
- A Sunday, August 29, 1999 Province article entitled “Patients needed in AIDS vaccine trial” reported that gay men in Toronto were being recruited to participate in the last stage of an international clinical trial involving an experimental HIV vaccine. The article went on to report that about 5000 volunteers at 61 sites in North America and Europe would be tracked for 36 months. The very last line reads “A small percentage of women in the US will be included in the study as well” (Province, p. A13). Women need to be included with seriousness and vision in drug trials so that the effects of the medications on women’s bodies are better understood.
- More educational strategies need to be developed that reach women in all sectors because ultimately all women are at risk for contracting HIV/AIDS.
- Finally, AIDS prevention education needs to be centralised for consistency and quality of product. The federal government should be responsible for developing a consistent HIV/AIDS prevention education policy to be used across Canada but not at the expense of accounting for diversity. This does not absolve provincial and municipal governments, community groups, parents and non-parents of their responsibility for promoting health from cradle to grave.

Nervous politicians and bureaucrats cannot allow their vision to become so restrictive that only specific needs of certain groups are met. The human dimension and cost of this myopic focus are too great.

Socialist feminism places women’s experiences and lives at the epicentre of, in the case of this research, HIV/AIDS prevention education rather than fitting women into existing structures. When developing HIV/AIDS prevention strategies it is necessary to understand and take into consideration gendered relations
including issues of power and social relationships between men and women. How
cwomen and men view sexuality and sexual relationships depends on the
construction of their individual experiences. To empower both women and men,
education must take the best attributes of both sexes' values to create a balanced
structure. Men and women need to work together, sharing power, so that
HIV/AIDS prevention education will achieve its intended outcome – prevention.

Conclusion

The pattern of AIDS in terms of distribution and outcome has always been
striking. Some people are at high risk while others are shielded from risk. Research
has placed too much emphasis on individual behaviour and excessive sexuality (gay
culture, IV drug use, African cultural practice). As was demonstrated by the
literature, the fields of medicine, anthropology and psychology ensure that the
epidemic remains "desocialized" in both research and medicine. Not enough effort
has been focused on the large-scale conditions which structure the epidemic
(Farmer, 1996).

Clearly, the statistics demonstrate that risk has changed. Worldwide, a
"feminisation" of the epidemic has occurred. Risk factors include inequality of
gender, age, class, and skin colour. These factors can't be looked at in isolation
because they are equally important and work in concert together. Poverty,
inequality, and oppression combine and inflate with cultural difference and enhance
the risk of contracting HIV/AIDS but ultimately every woman is at risk
(Farmer, 1996).
In many settings, HIV risk is not enhanced so much by poverty but by inequality. The commonality of what people with AIDS worldwide share is not culture, language, racial identity, sexual preference or income bracket. What they share is social position, the bottom rung of the ladder in an inegalitarian society (Farmer, 1996).
APPENDIX 1

INTERVIEW QUESTIONS

1. Tell me about the (organization).
   • How long have you been working for (organization)?
   • What is (organization's) mandate?
   • Who funds (organization)?
   • How many people staff (organization)?
   • Do you use volunteers?

2. Tell me about your work for (organization).
   • What prior programs/projects were you involved in?
   • What are you currently working on?
   • What kinds of materials do you use?
   • Where are these materials developed?
   • Do you use materials other than pamphlets? If yes, what?
   • What other techniques do you use when delivering prevention education?

3. Who is your audience?
   • How do you access your audience?

4. What is the greatest challenge you face in your role?
   • What is the greatest obstacle you face in doing (outreach/education/program development)? Why?
   • What obstacles do your audience face?

5. Behavior change is difficult to measure.
   • How do you define success?
   • What kind of evaluation and feedback do you incorporate into the programs/education to measure success?

6. If you could have funding for any initiative/project, what would that project be?

7. May I use your name and comments in my thesis?
APPENDIX 2

PERSONS TESTING POSITIVE FOR HIV BY GENDER, 1995 - 1998

Persons Testing Newly Positive for HIV by Gender and Year, 1985-1998

Rate per 100,000 Population

Year

Persons Testing Newly Positive for HIV by Risk Category and Year, 1985-1998

Number of Persons Testing Newly Positive for HIV

Year
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