Clinically Correct? AIDS Education in Ontario in the 1980s and 1990s

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Abstract. This paper reviews AIDS prevention initiatives in Canada and the United States in the 1980s and 1990s, and presents a content analysis of print materials used in Ontario during this period. Problems in public health publications included biased approaches, inaccessible or clinical language, anti-sex messages, and imprecise or ambiguous information. Community AIDS groups pioneered creative and effective pedagogical approaches that merit the careful attention of health educators. The Toronto case study showed how public health departments and schools collaborated successfully with community groups, most notably the AIDS Committee of Toronto.


From the beginnings of the AIDS (acquired immunodeficiency syndrome) epidemic in North America and Europe in the early 1980s, educational efforts to prevent the transmission of HIV (human immunodeficiency virus) were hindered by powerful societal prejudice against open discussion of sex in general and same-sex sexual activities in par-
ticular. At this time, in western countries, the disease was transmitted primarily through sexual contact, and gay men comprised the most vulnerable population.

Homophobic responses on the part of individuals, institutions, health departments, and governments in the face of the AIDS epidemic have been extensively documented (see for example, the work of Gary Kinsman, Randy Shilts, and Urvashi Vaid). In fact, homophobia itself was identified as a major “risk factor” for HIV/AIDS. In the United States and Canada, homophobic prejudice rendered homosexuality invisible in many AIDS education and prevention materials, and homophobic discrimination blocked gay men’s access to the full range of health care services. The Canadian AIDS Society was one of many community organizations that documented these barriers.

COMPETING PERSPECTIVES

In the United States, 1987 marked a turning point in AIDS education and prevention. In contrast to earlier moralizing about “the gay plague,” the Surgeon General’s 1987 Report on AIDS took a public health perspective by advocating condom use and AIDS education in the schools. Conservatives criticized what they saw as a pro-homosexuality stand and instead called for massive compulsory AIDS testing, especially among gay men. Within the framework for analysing AIDS policies developed by Dr. Mukesh Kapila, former deputy director of the UK National AIDS Program, the American situation in the 1980s could be described as a struggle between proponents of three broad approaches:

- the “expedient” approach where governments and key political figures determined policy direction;
- the “moralistic” approach where conservatives (in this case, the religious right) attempted to dictate the national agenda; and
- the “emancipation” approach (which I will term the “empowerment” approach) pioneered by and for gay communities to promote both individual sexual responsibility and community solidarity.

Throughout the 1980s, the US government funded a number of community-based AIDS groups working in partnerships with public health departments and for the most part adhering to a public health model of AIDS as an epidemic illness and AIDS prevention as modification of individual behaviour.

In Canada, while the moralistic agenda of conservative groups was not as powerful as in the US, official responses took longer to materialize and government agencies, particularly Health Canada, were accused of apathy and inactivity. Some community AIDS groups received funding from city, provincial, and federal governments in the mid-1980s, but it was not until 1990 that Health Canada responded to the crisis by devel-
opining a National AIDS Strategy. This document listed education and prevention as the primary goals and generally reflected the expedient approach. At the same time, the empowerment model had a long history in Canada, particularly in urban gay communities where AIDS prevention and education initiatives dated back to the early 1980s. However, while the National AIDS Strategy called for partnerships with community groups and initially provided adequate funding for their work, conservative swings in national and provincial governments resulted in major cutbacks. By 1998, these trends forced the AIDS Committee of Toronto (ACT) to generate one-third of its annual budget through fundraising, at a time when most non-profit, voluntary organizations in Canada averaged only 14% through fundraising.

Now, in the first decade of the 21st century, it is instructive to look back on the early developments in AIDS education and prevention in order to evaluate the long-term effectiveness of various approaches. By the late 1990s, with a variety of successful drug treatments accessible at least to those with the financial capacity to manage all their health needs, AIDS had come to be viewed as a chronic disease rather than a necessarily terminal one. However, the AIDS epidemic is by no means over, and there is a need for continuing education and prevention of this and other sexually transmitted diseases. In the light of two current global trends—economic recession and neo-conservative backlash—it is especially important to learn from past mistakes and to develop empowering AIDS prevention and sexuality education programs.

Health education campaigns organized in response to the AIDS epidemic in Canada fell into two main categories: those sponsored by public health departments and those mounted by community-based, predominantly gay and lesbian, AIDS groups. I will evaluate print materials for AIDS education and prevention from these two sources with a focus on publications that deal with actual sexual practices; information about intravenous drug use and other means of transmission will not be included. Specifically, I am interested in determining how successful these print materials were in presenting accurate, relevant, accessible, inclusive, and sex-affirming messages to specific target groups.

THEORETICAL APPROACHES

Sociolinguistic theories going back several decades, and more recently, neo-Marxist, feminist and postmodernist theories, have stressed the significance of language and discourse in shaping and delimiting human experience. The concepts, values, and meanings embedded in language play an important part in the social organization of knowledge and an analysis of texts provides key insights into the ways in which dominant groups organize and regulate knowledge—in other words, the "how" of ruling, as sociologist Dorothy Smith explains.
Michel Foucault’s analysis of 17th-century measures to control the plague, and his comparison of these with their 20th-century counterparts, have important implications for an examination of AIDS prevention texts (and it is not a coincidence that “plague” metaphors were often applied to the AIDS crisis). Building on Jeremy Bentham’s concept of the *Panopticon*, Foucault identified the key role of surveillance in creating and maintaining a disciplined and disciplinary society.¹⁴ A contemporary example may be seen in state authorities’ attempts to establish surveillance and control of gay men’s sexual practices, as evident in early proposals to enforce mandatory HIV testing of gay men and to close down gay bathhouses.

Much of the public discourse about AIDS reflected and reinforced individual and institutional homophobia (fear and hatred of gays and lesbians) and heterosexism (the assumption that heterosexuality is the only “natural” or “healthy” form of sexual expression). Additionally, AIDS discourses often supported ultra-conservative views about sex, and in this climate, AIDS educators faced a serious challenge when presenting a sex-positive rather than an anti-sex message.

Research and activism in three health-related areas—women’s health movements, disability advocacy movements, and community-based AIDS movements—have contributed to the analysis of AIDS-related literature presented here. “Movements” is used in the plural to indicate that none of these initiatives is monolithic. Issues of gender, race, class, sexual orientations, and political perspectives divide each movement in ways that are sometimes positive, producing heightened awareness and celebration of diversity among participants, and sometimes negative, resulting in internal rifts and struggles.

Along with the contemporary waves of feminist activism in North America, women’s community-based health movements had their beginnings in the 1960s, and focused on areas such as reproductive choice, mental health and violence against women. In the 1970s, disability activists began organizing to raise public awareness of the discrimination experienced by people with disabilities in housing, education, health services, and the workplace as well as in the private realm. And in the 1980s, as the AIDS threat escalated, gay and lesbian community activists and their allies began the long project of educating about AIDS and safer sex, caring for people living with AIDS, and lobbying governments to address the AIDS crisis.

Common goals of community health movements included the politicizing of health issues, especially in relation to women and disadvantaged minorities, and the demystifying of the medical system and medical knowledge. They shared an overarching goal of promoting health education for individual and collective empowerment so that all people could understand and take greater responsibility for the management of
their own health and well-being.\textsuperscript{15} These community initiatives also aimed at raising public awareness of the intersections between various forms of oppression—misogyny, racism, homophobia, economic oppression, ableism—and the implications for the health and welfare of women, people with disabilities, gays and lesbians, and people living with AIDS. \textsuperscript{16}

**HEALTH EDUCATION THROUGH THE PRINTED WORD**

Although activists in women’s health, disability rights, and AIDS prevention recognized the limitations of relying on the printed word, print materials on health issues remained a relatively cheap and widely accessible educational tool for distributing health information in the United States and Canada. Noting the range of reading ability in the target populations, producers of printed mass educational materials increasingly paid attention to readers’ English language skills and literacy levels. Many Canadian materials were produced in both official languages, French and English, and in large urban centres like Toronto, material was usually available in the languages of the major immigrant populations as well.

One fundamental limitation of print materials in health education should be noted. Research on health-related issues showed that knowledge was not necessarily accompanied by behavioural change. For example, a 1989 Canadian survey revealed that adults’ knowledge of AIDS did not decrease the incidence of high-risk sexual behaviour.\textsuperscript{17} Behavioural change requires learning that goes beyond the purely cognitive to involve the social and emotional domains.\textsuperscript{18} Drama and film, peer discussions, and public forums are likely to engage learners’ emotions more than a printed document alone, and these modes of education were employed extensively in community-based AIDS education.

However, it was unrealistic to assume that all sexually active men and women would participate in these more holistic AIDS education experiences. For many, reading a pamphlet on safer sex and picking up a free latex condom constituted the extent of their education. Thus it was crucial that print materials provided complete, accurate, and accessible directions for safer sex in language that was easily read and understood.

Effective print materials went beyond purely informational “facts and figures” to situate sexual activities in a meaningful human context. This approach enabled readers to identify with and gain validation from the characters and scenarios described. In their attempts to be relevant and meaningful, however, print materials sometimes resorted to scare tactics and anti-sex messages. Young people, in particular, were likely to hold the view that “it can’t happen to me” and hence, scare tactics were not effective.\textsuperscript{19} And when the target audience was probably sexually active,
or at the very least, sexually curious, as most young people were, many educators held the sensible view that it was unrealistic to advocate abstinence. In the face of the AIDS epidemic, the “ostrich position” about human sexuality in general, and young people’s sexuality in particular, was irresponsible and potentially dangerous.

LANGUAGE, CENSORSHIP AND THE POLITICS OF SEX EDUCATION

Debates concerning the language of sex education materials, especially those targeting youth, had serious implications for AIDS education. Sex educators working in schools traditionally called for the use of clinically correct terms to describe the human anatomy and physiology. This position was no doubt prompted, in part, by the precarious position that sex education occupied in the curriculum. Parents already uneasy with the perceived usurping of their role would have been even more outraged if their children were exposed to popular language in sex education classes. Similarly, public health literature for parents such as “Talk Sex” and “We Need to Know About AIDS” advised the teaching of “dictionary names” or “medical words” for parts of the body or sexual activity. (The term “popular language” is used here rather than the more common term “street language,” given its racist and classist implications that such words would never be uttered in middle-class, white homes.)

In the Canadian context, while some sex education was provided by publicly funded school boards, public health departments also did important AIDS prevention education in the schools including the distribution of print materials. At the same time, the more progressive boards, such as the Toronto Board of Education, maintained links with community-based AIDS prevention organizations such as the AIDS Committee of Toronto (ACT), and high school counsellors distributed ACT materials including publications for gay youth. Hence, it was possible for adolescents to be exposed to a variety of approaches through the school, the community, and the mass media.

The wisdom of reliance on clinical language in AIDS education with youth and adults has long been challenged by grassroots AIDS educators, especially those in gay communities. They argued that effective AIDS prevention work required the use of sexually explicit language, firstly so that there was no misunderstanding or ambiguity about the content and directions, and secondly, so that safer sex could be presented as exciting rather than as clinical, uncomfortable, or boring. These were compelling arguments for the use of everyday sexual language and unambiguous sexual images in all AIDS prevention work, as proposed by the Canadian AIDS Society and others.

Some of the specific problems with adherence to medical jargon and avoidance of popular language were identified by AIDS activists. For
example, the term “body fluids” in reference to HIV transmission was imprecise. Semen, blood, and vaginal secretions were the specific body fluids through which HIV was transmitted; according to medical knowledge in the 1980s and 1990s, sweat, saliva, and tears were probably not implicated.23 Many of the community-produced materials used terms like “cum” and “juices,” while public health publications tended to use the terms “semen” and “vaginal secretions.” It is interesting to note that one Toronto Public Health publication, “When you share, care about sexually transmitted diseases” provided an explanation of “abdomen” (“tummy”) and “urinating” (“peeing”) but failed to explain words that may have been equally obscure to some readers: vagina, vulva, rectum, and discharge. The terms condoms, rubbers, and safes were used interchangeably in all the literature.

AIDS activists identified certain terms describing HIV+ people or people living with AIDS as problematic. The term “carrier” was a dated, sexist, and classist concept which implied that those who spread the disease were not themselves affected. Historically, the term reflected a view of women, especially working-class women and prostitutes, as vessels of disease and sexual temptation—much like Typhoid Mary. Similarly, references to “catching AIDS” falsely implied that HIV+ people were “contagious” and should be avoided or isolated. When individuals lacked a clear understanding of the specific body fluids through which HIV was transmitted, the scene was set for avoidance, isolation, ostracism, and overt acts of discrimination against people who were HIV+.

The common label of “AIDS victim” implied passivity, helplessness, and inevitability. It also generated invidious comparisons between so-called “innocent” victims (children and hemophiliacs) and the rest, who were by implication guilty of bringing AIDS upon themselves by their sexual behaviour or drug use. “Person living with AIDS” was a more empowering concept that recognized the extent to which people managed their infection and their lives. The fact that HIV+ people often lived healthy lives for many years needed to be reflected in the terminology. The term “patient” was appropriate only in a medical context or in reference to a relationship with a medical practitioner. Even then, it was more appropriate to follow the example of some consumer groups who used the term “client.”

The term “risk group” was inaccurate; in relation to transmission through sexual contact, it was the behaviour, not membership in a particular group, that contributed to the risk of HIV infection. However, in the North American context, gay males remained the group most affected, and therefore AIDS education materials needed to validate gay sexuality and to identify how specific gay male sexual acts could be practiced more safely.
MAINSTREAMING AIDS

There were ongoing debates within gay communities about the “ownership” of AIDS, especially in relation to AIDS activism and fund-raising. Gays and lesbians in some instances demanded recognition from non-gay communities for their longstanding record of activism, education and care-giving, as well as fundraising, in the struggle to deal with the epidemic. Gay men were justifiably proud of the success of grassroots safer sex campaigns, evident in the changed sexual practices of significant numbers of gay men. However, given the pressing need for funds for AIDS research, education and medical services, support from governments and non-gay communities was critical.

The “mainstreaming of AIDS philanthropy,” as one critic called it, inevitably called for the mainstreaming of the disease. In other words, fundraising in privileged, white, heterosexual circles was more effective when the threat to the heterosexual population was stressed. In addition to the homophobia at work here, this strategy had serious implications for disadvantaged minorities whose specific health risks were likely to be rendered invisible by slogans such as “AIDS is an equal opportunity disease.”

The “equal opportunity” message was conveyed in a number of publications. For example, the public health pamphlets “AIDS and the Black Community” and “AIDS and people of color” and the community-produced pamphlets “You don’t have to be white” and “AIDS: you’ve heard a lot about it” all stated that AIDS does not discriminate: “HIV does not care if you are: straight or gay, male or female, old or young, rich or poor, doing drugs or not.” Similarly, Health and Welfare’s “Women and AIDS” pamphlet stated: “The virus doesn’t care about age, sex or race.” However, these messages were misleading because they implied that a virus acted like a human, and that it had the capacity to “care” or to “discriminate.” Human agency was thus obliterated.

In their attempts to signal to female, Black or non-gay populations that they were not immune to HIV, these materials ignored the social-cultural context of health and disease. Women, especially minority women, were at greater risk by virtue of being female in a society where men’s sexual violence was an everyday threat, with the result that many women lacked the power to negotiate safer sex practices with male partners. Furthermore, a number of social-cultural factors contributed to the overall health and life chances of an individual, and hence, their vulnerability to HIV. Discrimination on the basis of sex, socioeconomic status, race and ethnicity, sexual orientation, religion, region, literacy, and disability restricted access to health promotion information, sexuality education, and health care services, as well as affecting people’s capacity to change their health behaviours or to adopt a health-enhancing lifestyle.
COMMUNITY-BASED AIDS MOVEMENTS

By the 1990s, over 70 community-based AIDS organizations in Canada were members of the Canadian AIDS Society, a national coalition formed in 1986. Their members, predominantly gay men and lesbians, provided most of the education, support, and advocacy for people and communities affected by AIDS across Canada. In Ontario, a provincial coalition, the Ontario AIDS Network, comprised over 30 community organizations. Metropolitan Toronto, the largest urban centre in Ontario, had a culturally and sexually diverse population and an extensive network of gay and lesbian groups engaged in AIDS education.

The first community-based AIDS group in Canada, AIDS Vancouver, began operating in 1983. In 1985, the Canadian Department of National Health and Welfare initiated partial funding of community AIDS organizations, which by 1990 numbered about 48. However, it was not until 1990 that Health and Welfare Canada produced a national policy on AIDS. It was in response to the slowness of governments, the medical profession and the social services to address the AIDS crisis that gay and lesbian activists mobilized to form a network of autonomous support and advocacy groups. Such groups, run mostly by volunteers and free from the constraints of government funding, engaged in more radical AIDS-related work including sit-ins and direct action. Thus, references to “community groups” covered a spectrum of political positions. In terms of print materials, obviously the funded groups had a greater capacity to engage in educational campaigns and to produce and distribute print materials in large quantities. Most of the community materials discussed here were produced and/or distributed by the AIDS Committee of Toronto.

ACT was Canada’s largest non-profit community AIDS organization, providing support, education, and advocacy. Like the other groups in the Canadian AIDS Society, it received funding from government grants, business, and personal donations. Its staff included over 20 paid workers and over 400 volunteers, and its work encompassed Deaf Outreach, the Women and AIDS Project, and community outreach. Also in Toronto, the Black Coalition for AIDS Prevention (BLACKCAP), Africans United to Control AIDS, the Gay Asians AIDS Project and the Alliance for South Asian AIDS Prevention were among the many culturally specific, largely volunteer, AIDS organizations established in the 1980s and early 1990s.

Another key Toronto-based community group was AIDS Action Now!, an activist group run entirely by volunteers with no government funding. This group, founded in 1988, worked towards improved treatment, care and support for people living with HIV and AIDS. AAN!’s political agenda was reflected in its subcommittee structure, which included Provincial Lobbying and Direct Action, Prison, Women’s Cau-
CONTENT ANALYSIS OF PRINT MATERIALS

Appendix A provides a listing of all the public health and community-produced publications reviewed below. A small number of these pamphlets originated in the United States, but all were widely distributed in the Toronto area. The listing represents publications that I collected between 1987 and 1992, as well as those collected by two research assistants in 1992/93. Most materials were picked up at easily accessible distribution points including public health department offices, public health centres, women’s health centres, medical clinics, and the offices of community-based AIDS groups. Also included were materials from information tables at fairs organized for Toronto Lesbian and Gay Pride Days and International Women’s Days. A comparison of the lists of publications produced by provincial/federal public health agencies and those collected here shows that the sample included most materials available in the Toronto area at the time. Similarly, the sample covered most community-generated materials produced and/or distributed in Toronto. I analyzed the text and illustrations in all of the listed materials in order to determine to what extent their messages were inclusive, accessible, pro-sex, gay-positive, and relevant to the target group.

Publications for Heterosexuals

Almost all the public health publications fell in this category, even though many used gender-neutral language and attempted to be sexually inclusive. Failure to use explicit language was a recurring problem. Euphemisms such as “having sex” or “making love” were imprecise and likely to be misunderstood. Similarly, statements about transmission of HIV through sexual intercourse often omitted the crucial word “unprotected” and thus implied that intercourse was always dangerous, a message that many critics saw as anti-sex. Some publications were more forthright in their anti-sex stance. A number of public health materials put sexual abstinence at the top of the list of safer behaviours, followed by monogamous sex with an uninfected partner, with safer sex as a third or fourth option. The 1989 community publication for Blacks, “You don’t have to be white” also listed sexual abstinence as the first choice, followed by protected sex and then monogamy.

The high-risk heterosexual practices that needed to be identified specifically in these educational materials were unprotected anal or vaginal intercourse, that is, intercourse without a latex condom. Anal intercourse between heterosexual partners is not uncommon in North America and should have been mentioned specifically in these publications,
but the 1991 Health and Welfare publication "Women and AIDS" was one of the few to do so.

The emphasis on sex within marriage or monogamous relationships may not have reflected the reality of many heterosexual men and women for whom AIDS publications were intended. For example, many public health publications included references to "your love life," "lovers" and "couples," with illustrations that reinforced ideas of seduction and romance. Repeatedly, these texts reinforced the assumption that heterosexual sex occurred between two consenting adults who liked and respected each other. Other possibilities—casual sex, or coercive sex experienced by women—were rarely considered.

The terminology used to describe penetrative heterosexual sex in public health literature was, for the most part, clinical and male-centred. The City of Toronto pamphlet "Latex is for lovers" advised men to "Put on a condom before entering." Many publications spoke of the "entry" of the penis, as if the male was the only active partner in a heterosexual encounter. Among the many appeals to self-interest regarding condom use was the statement that an erection might last longer with a condom. The 1992 Ministry of Health publication "Condom Sense" took a less clinical approach, achieved by humorous, cartoon-type illustrations, although these portrayed only heterosexual activity.

Sexually Inclusive Publications

Publications that presented sexually inclusive language, concepts and illustrations were all produced by community AIDS groups. Pamphlets developed by the Prostitutes' Safe Sex Project in 1987 and 1989 explained the risk factors associated with a wide range of sexual practices involving same-sex or heterosexual partners, used popular language and included cartoons. As "How to have safer sex" explained: "This pamphlet was made by prostitutes. Safer sex is our business." Clearly, the target audience for these publications was not only male and female prostitutes, but any sexually active man or woman.

Another example of a sexually inclusive publication was the BLACKCAP pamphlet "A decision has to be made," which identified all the risky same-sex and heterosexual practices, with explicit illustrations. Like the gay men’s pamphlets produced by ACT and the Prostitutes' Safe Sex Project pamphlets, the BLACKCAP pamphlet discussed the need to use a latex barrier for rimming (tongue on anus). And ACT publications, such as the 1987 pamphlet "AIDS: get the facts," were sexually inclusive, identified high-risk sexual activities and stated clearly: "It doesn’t matter who you are...it matters what you do."

It should be noted that some of the public health publications, like the 1988 Ministry of Health pamphlet "AIDS: let’s talk," were so general that
they could be regarded as sexually inclusive simply by default, and their use of gender-neutral language exacerbated the problem of lack of specificity. Gender-neutral language is often appropriate, but, in the context of AIDS education, it obscures some key differences in practices and risks based on sex and sexuality.

Publications for Parents

Public health publications for parents included Health and Welfare’s “We need to know about AIDS” (1991) and Planned Parenthood’s “Talking openly about AIDS” (1988). In these, parents were advised to discuss the use of latex condoms with sexually active teenagers, and to correct misinformation about AIDS as an exclusively gay male disease. The 1989 Toronto Public Health pamphlet, “Talk Sex,” made no mention of STDs, AIDS, condoms, or gay sexuality, and the Ministry of Health 1986 fact sheet for parents and teachers, perhaps reflecting the more cautious attitudes of the mid-1980s, also failed to discuss condoms or gay sexuality.

These publications for parents showed some effects of the conservative backlash against sex education. For example, a statement on the first page of “We need to know” explained: “This material is not meant to promote any values (sic) or lifestyle.” It appears that government agencies did not want to be perceived as too “pro-sex.” There were similar disclaimers on behalf of the government funders of community AIDS education initiatives, assuring readers that the views or policies expressed were not necessarily those of the public health department which funded the community group.

Publications for Youth

Materials for young people reviewed here included approximately equal numbers of public health and community publications. On a positive note, all of these publications portrayed people from a variety of racial and ethnic backgrounds.

Public health materials for youth rarely mentioned the possibility of gay or lesbian relationships. In one exception, the Toronto Public Health 1990 pamphlet, “Deciding About Sex: it’s okay to say no,” the text listed as one of the “poor reasons to have sex” the possibility that “you’re worried (sic) that sex is the only way not to appear homosexual.” This well-intentioned but poorly worded statement did little to address the concerns of a young gay or lesbian reader, and in fact may have contributed to a homophobic response. Equally disturbing was the total absence of advice about condom use for young people who did decide to say “yes”—for example, almost 50% of Grade 11 students in Canada. 28

The Ontario Women’s Directorate (Government of Ontario) pamphlet for youth, “Talking Sex,” provided a more realistic range of sexual
options for young people, gave advice on pregnancy and disease prevention, and talked briefly about sexual assault. However, there was again no recognition of same-sex relationships.

In addition to the problem of heterosexist content, the Ministry of Health’s 1989 booklet “Decisions, Decisions” presented incomplete information. It made at least five references to the ways one can “get AIDS” through “sexual intercourse with an infected person.” The missing word “unprotected,” in reference to risky sexual intercourse, did not appear until the last page of the booklet, and there was no reference at all to the use of latex condoms. The message to young readers was that they should not become sexually active in response to peer pressure, but there was little relevant information for those who had already done so. Again, it appeared that the government agency was trying to avoid a hostile response from conservative parents who either did not hold with the concept of “safer sex” for religious reasons, or believed that information about condoms would “put ideas into children’s heads.”

In contrast, the community publications for youth conveyed clear messages and accurate information about risky practices. YouthLink’s comic book “To test or not to test?” began with a scene of a young man and woman in bed, and focused on the importance of safer sex practices, especially latex condom use. Similarly, the 1988 photo-story “So you want to do it?” showed young men and women buying condoms at the drugstore and talking to each other about safer sex. Both these publications included detailed directions for using condoms and for cleaning needles. Even the comic book “You can’t catch AIDS,” written for children of public school age (up to about 12 years of age) made clear statements about HIV transmission and the need for latex condoms. And, outside of educational contexts, gay characters and discussions of AIDS were increasingly appearing in mainstream comic books aimed at young audiences.

In light of the general neglect of gay sexuality in publications for youth, ACT’s 1991 pamphlet for young gay men, “Safer sex generation,” part of its larger campaign on the same theme, filled a void. It first of all validated the choice to be gay: “just like being gay, having sex with men is natural.” It went on to explain which sexual practices were safer and which were not, and made repeated reference to the need for latex condom use. This pamphlet, together with ACT’s other publications for gay men, was the focus of heated debate at the Toronto Board of Education in the fall of 1992, one outcome being the board’s decision to restrict the “general distribution” of these materials in Toronto schools. However, school counsellors were still free to distribute these pamphlets on an individual basis to students who, in their view, needed this kind of information.
Publications for Women

There had been widespread neglect and considerable misinformation regarding women and AIDS. The Ontario Ministry of Health included only one fact sheet on women in its 1986 set of AIDS prevention materials, recommending monogamy first, followed by protected sex. By 1989, the Ministry’s pamphlet for women was promoting abstinence first, then monogamy and safer sex. Toronto Public Health’s booklet for women, “How’s your love life” referred to having sex only in the context of a heterosexual relationship. And, as noted above, sexual abstinence and monogamy were the most common recommendations in public health materials intended for heterosexual readers of both sexes.

An AIDS Action Now! fact sheet, “Women Get AIDS,” presented a compelling critique of these recommendations: “A large majority of HIV positive women were infected through unsafe sex with their male partners, often in long term relationships. The pristine monogamy that public health departments and the Federal Centre for AIDS promotes as safe sex for women is a lethal lie.”

Health and Welfare’s 1990 booklet “Women and AIDS” was somewhat more open about the range of sexual possibilities for women, and was one of the few public health publications to mention “woman-to-woman” transmission of HIV (although it did not use the word “lesbian”). The text used more realistic language than some publications of this kind, with references to “sex lives,” “shooting drugs,” etc. The illustration of condom use was unusually explicit, in that the condom and lubrication were shown being put on the man’s penis by the woman. Instructions for cleaning needles were also included.

Public health information for women frequently recommended saying “no” to unsafe sex, with little recognition of the constraints on women’s ability to do so. The Health and Welfare booklet was sensitive to women’s difficulties in negotiating safer sex with men, but observed that “some women always let the man do as he pleases” without recognizing that threatened or actual violence might have explained this behaviour.

The community publications “Women need to know about AIDS” (AAN!) and “Women and AIDS” (ACT) assumed that women were sexually active and wanted to learn about safer sex, rather than recommending abstinence or monogamy. Both publications dealt briefly with the possible risks to lesbians.

AAN! produced a pamphlet that asked “What do sexism, racism, poverty, homophobia, reproductive rights, access to health care, marginalization have in common? Women and AIDS/HIV.” It identified the political implications of AIDS for women, especially minority women, in relation to HIV testing, symptoms, treatment and reproductive rights.

Two pamphlets for lesbians, “Lesbians and AIDS” (1986) and “Take the test” (1991), distributed by ACT, gave explicit details of safer and unsafe
sex practices for lesbians; the latter reflected the pro-sex humour that characterized some of the gay male publications.

There were debates about the risks of various kinds of lesbian sexual practices. On the one hand, lesbians, like heterosexual women, were generally neglected in AIDS education and research, and so it was important to consider lesbian-specific health issues. Furthermore, it could not be assumed that lesbians never had sexual intercourse with men. On the other hand, there was evidence to suggest that oral sex between women was a very low risk activity, and some lesbian sex educators believed that there was undue attention paid to the use of dental dams.30

Publications for Gay Men

Except for the publications of community AIDS groups, there were very few materials that validated the existence of gay men or addressed their specific sex practices and associated health risks. One 1990 publication from Toronto Public Health on STDs was specifically “A guide for gay men.” In strictly clinical terms, it described ten common STDs (excluding HIV/AIDS) and preventive measures. In dramatic contrast, the gay male pamphlet “Cum Clean” presented virtually the same information in a thoroughly irreverent manner, perhaps best described as “in-group humour.” For example, the discussion of removal of venereal warts concluded by stating: “Dynamite is reserved for extreme cases.” As well as the use of humour here, this pamphlet added one additional STD—guilt—which it attributed, in large part, to the Judeo-Christian tradition of morality. This publication was unique in its recognition that low self-esteem, chronic guilt and anxiety about sexual activity in the face of the AIDS epidemic constituted a mental health threat for gay men, and one that needed to be named and discussed within gay communities. In the same vein, as noted earlier, ACT’s “Safer Sex Generation” validated young men’s gay identities while providing accurate advice about sexual practices and emphasizing the importance of condom use, as did ACT’s pamphlets on oral and anal sex.

Publications about Hemophilia

The Canadian Hemophilia Association published two guides, one for women partners of hemophiliacs and one for both men and women. The latter, “Hemophilia, HIV and Safer Sex” provided relatively realistic portrayals of some aspects of (hetero) sexuality. For example, it referred to “sex lives” rather than “love lives” and had explicit and light-hearted graphics showing heterosexual sex and male masturbation. The emphasis was on exploring new and imaginative safer sex practices, including alternatives to penetration, that at the same time enhanced sexual pleasure, a concept often missing from mainstream advice literature.
However, there was almost no recognition that men with hemophilia might have male sex partners. In the section on “Safer Sex”, there was a gender-neutral reference to penetrative sex practices—“the penis enters the partner’s vagina, rectum or mouth”—but the subsequent discussion about lubrication not only assumed that the man’s partner was female but also blamed her for possible problems: “A woman’s lubrication may not be enough.” The section dealing with anal sex contained information on allergies to latex condoms and recommended the use of a lambskin condom “next to the penis or vagina of the allergic partner” (as well as a latex condom)—but did not mention the rectum.

CONCLUSION

This analysis of print materials used in AIDS prevention work demonstrated the shortcomings of much of the public health material, when evaluated in terms of its relevance and accessibility to specific target groups. In an apparent attempt to avoid conservative backlash, public health materials ran the risk of presenting imprecise or ambiguous information. The androcentric and heterosexist approaches, the clinical language and the anti-sex messages of many publications seriously hampered individual and collective empowerment in the realm of sexuality. More importantly, the failure to convey complete and accurate information about safer sex had potentially fatal outcomes.

The Toronto case study showed the possibilities for collaboration between public health departments and community groups. Materials produced by the AIDS Committee of Toronto, in particular, were effectively used in the educational work of public health departments and publicly funded educational institutions. Community AIDS groups, free of many of the constraints imposed on public health departments, pioneered creative and effective pedagogical approaches that merited the careful attention of public health professionals.

APPENDIX A: LISTING OF PRINT MATERIALS, BY TARGET GROUP

Women

How’s your lovelife? (City of Toronto: Department of Public Health, n.d.).
Take the test, (Toronto: AIDS Committee of Toronto (ACT), n.d.).
Women get AIDS (Toronto: AIDS Action Now! n.d.)
Clinically Correct?

Lesbians


Black People and People of Colour

A decision has to be made (Black Coalition for AIDS Prevention [Black C.A.P.], n.d.).
AIDS and people of color (Massachusetts: Department of Public Health, 1988).
AIDS and the Black community (Massachusetts: Department of Public Health, 1988).
You don’t have to be white or gay to get AIDS (Baltimore: Health Education Resource Organization, 1989). Distributed by North York Public Health Department.

Gay Men

Condom Sense (Toronto: ACT, 1987).
Cum clean (San Francisco and Toronto: Sisters of Perpetual Indulgence, n.d.).

Prostitutes

How to have safer sex (Toronto: Prostitutes’ Safe Sex Project, 1989).
Safer sex: make it your business (Toronto: Prostitutes’ Safe Sex Project and ACT, 1987).

Youth

Deciding about sex (City of Toronto: Department of Public Health, 1990).
To test or not to test [comic] (YouthLink - Inner City, n.d.).
Teen talk on AIDS and So you want to do it [photostory] (Toronto: Davenport-Perth Neighbourhood Centre Youth Programme, 1988).
Talking Sex (Toronto: Ontario Women’s Directorate, n.d.).

Parents

AIDS Information for parents and teachers (Toronto: Ontario Ministry of Health, 1986).
Talk sex (Toronto: City of Toronto Department of Public Health, 1989).

Non-specific Audience

AIDS: Get the facts (Toronto: ACT, 1987).
AIDS: You’ve heard a lot about it (Toronto: Ontario AIDS Network, n.d.).

Latex is for lovers (Toronto: City of Toronto Department of Public Health, n.d.).
Use Condoms: make them part of your love life (Toronto: City of Toronto Department of Public Health, 1988).  
*What do you know about sex in the 90’s?* (Toronto: City of Toronto Department of Public Health, n.d.).  
*When you share, care about sexually transmitted diseases* (Toronto: City of Toronto Department of Public Health, 1989).  

**People with Hemophilia**  
*Hemophilia, HIV and safer sex* (Ottawa: Canadian Hemophilia Society and Health and Welfare Canada, n.d.).  
*What women should know about AIDS and hemophilia* (Ottawa: Canadian Hemophilia Society and Health and Welfare Canada, 1988).

**NOTES**

Clinically Correct?

28 Queen’s University, Canada Youth and AIDS Study, Kingston (1989).