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**FACULTY OF GRADUATE AND
POSTDOCTORAL STUDIES**

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HIV/AIDS and Gendered Prevention Education in Ontario

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HIV/AIDS and Gendered Prevention Education in Ontario

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no news. nothing new. no one pays attention if it's not new.
no new angle. nothing new to show. more of the same.
nothing new to report. no breakthroughs. no new
perspectives. no one brought back from the dead. no illusions
about a cure. science has failed us. twenty two years into the
epidemic the only people who seem to still be around in the
same form they were in 1985 are the AIDS bashers. the rest
of us are transfigured, transformed, disfigured, or dead. stiff
upper lip. chin up. smile. there's always tomorrow except
when there isn't.

cynthia madansky

Safe sex doesn't mean no sex, it just means use your imagination...

Sexuality, Billy Bragg

For my dad.

With special thanks to my sister, Geneviève, for innumerable meals and unending love and encouragement, to my mother for her support, and to my advisor, Dr. Sharon Cook, for her perseverance and encouragement.

Abstract

Thesis: HIV/AIDS and Gendered Prevention Education in Ontario

Program: Master of Arts in Education, Specialization in Women's Studies

Candidate: Monica Brown

Thesis Advisor: Dr. Sharon Cook

Thesis Committee: Dr. Lorna McLean and Dr. Judith Robertson

Defence: September 18th, 2008

Final Submission: October 22nd, 2008

Young women in Canada are increasingly at risk for contracting HIV through heterosexual transmission, which represents the most common mode of HIV transmission worldwide. In Canada, women now comprise a quarter of all HIV prevalent people, and the number of young women aged 15-29 who have tested positive for HIV has increased dramatically despite over twenty years of health and education programming. Women's gendered vulnerabilities are not well understood in the Canadian context, nor is women's risk (especially that of young women engaging in supposedly safer 'hetero'-sexual practices). The purpose of this study is to analyse how young Canadian women's prevention needs are represented in HIV/AIDS discourse and to determine whether and how those needs are being met in the current public health and formal educational contexts. This has been accomplished through a feminist content analysis of the relevant epidemiological, social, legal, educational and operational documents related to HIV prevention. This analysis addresses young women's representation in HIV/AIDS discourse; normative understandings of risk (primarily risk behaviours and categories in light of prevalence and incidence rates); and the inclusion of a gendered perspective in current Canadian policies, guidelines and public health prevention and formal education programs. The results show that all of these elements are lacking in current HIV prevention research, policies and programs. The intent of the study is to reflect this information back to researchers and educators, highlighting absences and silences in the representations of women in HIV/AIDS discourse and prevention efforts; it is also meant to provide a baseline understanding from which to undertake future research. This ongoing work largely consists of the development of evidence-based, gendered HIV prevention interventions in schools and communities. It also includes further analysis of issues relating to women's representation in HIV/AIDS discourse, particularly from a queer perspective; Foucault's exploration of power and knowledge, of the pedagogization of children's sex and the hysterization of women's bodies, and Butler's exploration of compulsory heterosexuality and the performativity of gender are presented as important ideas for informing analyses of young women's representation in the HIV epidemic. Hopefully this study serves to highlight young women's increasing vulnerability to HIV, clarify some of the issues impacting on that vulnerability, and inform the future development of effective, gendered prevention interventions.

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1. Introduction

Young women in Canada are increasingly at risk for contracting HIV through what are normally understood to be heterosexual modes of transmission, modes which represent the most common means of HIV transmission worldwide (UNFPA, February 2003). In Canada, women now comprise over a quarter of all HIV prevalent people, a more than 20% increase since the 1980s (Health Canada, 2003). In addition, the number of young women among all those aged 15-29 who have tested positive for HIV has increased by at least 30% since 1985 (Gatali and Archibald, 2004) despite over twenty years of health and education programming; young women in this age cohort now represent close to half of all new reported HIV infections. Though the absolute numbers of HIV positive women are still relatively low in Canada, particularly in comparison to those of the global epidemic (10,218 women had tested positive for HIV between 1985 and June 2007, in comparison to 50,656 men, PHAC 2007c), the increase in rates of other sexually transmitted infections (human papilloma virus, chlamydia, gonorrhoea, syphilis and Hepatitis C) (CFSH 2007) in combination with the overall decline in the use of condoms (Fisher, Boroditsky and Morris, 2004) and the seemingly widespread belief that HIV/AIDS is curable to some degree (CFSH 2007 and CME 2003), all point to the potential for a growing and devastating spread.

There are various factors at work in women's vulnerability. Women are at risk because of their physiology, involving a greater interior mucosal surface which facilitates the uptake of HIV, particularly for younger, less physically mature women (Commonwealth Secretariat, 2002). Women are also at risk due to their gender and sexual socialization (Burger and Clow 2006; and Lenskyj 2007), inadequate public health prevention programming (CAS 2004b) and inconsistent (or non-existent) public school education programs and practices (Gahagan and Rehman, 2004; and CAAH 2006). Women's vulnerability is increased by socio-economic factors as well, such as gender-based violence, poverty, sex work and citizenship issues (Rao Gupta, Whelan and

Allendorf, 2003; and CAS, 2004b). In addition, the rates of HIV incidence and prevalence among new Canadians is one of the fastest growing in Canada, though this may in part be due to mandatory HIV screening for new arrivals implemented in 2002 (PHAC 2007a). For female immigrants to Canada, the risk is often compounded by endemic HIV prevalence in the home country; prevalence rates and cultural practices are transposed to Canada where increased marginalization, language and cultural barriers make prevention or treatment even more difficult to access (Husbands & Soje, 2007).

Unfortunately, a person's sex or gender has rarely been cited as a cause for concern in HIV programming except in terms of homosexual populations risk groups (gay, lesbian, bisexual, transgender, transsexual and queer - GLBTQ). Women's sex and sexuality in particular are rarely made manifest except in discussions of intravenous drug users (IDUs), prostitutes, Aboriginal women and immigrant women; always marked and "othered", HIV has long been perceived as *someone else's* problem (and that someone else has largely been perceived as non-white and/or homosexual). HIV/AIDS is also perceived to be more of a threat based on the identities and behaviours of vulnerable populations rather than focussed on specific activities or on the underlying socio-economic conditions that make certain groups vulnerable (CAS 2004b). Compounding this issue for women is the fact that women's vulnerabilities are poorly understood by the majority of Canadians. A concrete discussion of womanhood in terms of the HIV/AIDS epidemic is therefore lacking in the Canadian context. The nature of the problem and past experiences with prevention initiatives however, suggests that effective, gendered prevention programs for young Canadian women, which encompass but do not privilege issues of sexuality, race, ethnicity, class and socio-economic status; which address risk activities rather than behaviours and identities; and which celebrate sex and sexuality rather than deny or debase them through fear mongering and conservative agenda setting, will not be easily developed or implemented.

Various studies in Canada have shown that prevention interventions geared to women need to address the gendered dimensions of womanhood as well as the particularities of women's lived experiences, whether as middle-class suburban teenagers or sex workers or recent immigrants (see Brown & Garcia, 1999; Langille, McKinnon, Marshall and Graham, 2001). Interventions also need to be developed in the context of an overall sexual and reproductive health framework, as the interplay between contraception and safer sex practices, pregnancy and STIs (including HIV) are significant, and women's ability to negotiate the outcomes of their sex lives is strongly linked to their lived, gendered experiences (Gahagan and Rehman, 2004; Rao Gupta et al., 2003).

This study begins with the assumption that public health policies and programs at the federal and provincial levels, as well as the provincial educational programs and guidelines (specifically in Ontario) possess the capacity to provide these kind of effective, gendered, HIV-prevention education programs within the context of a broader sexual and reproductive health framework. Whether and how this might be occurring is unclear. The 'add women and stir' approach to HIV prevention is seen as "ineffectual tokenism" (Roth & Hogan, 1998, p. xv), however there is very little to suggest that this is not the prevailing model for prevention. Based on the steadily increasing rates of HIV incidence and prevalence evident among young, Canadian women (PHAC, 2007a), particularly in Ontario (Remis et al, 2008), this model is failing. The questions this study seeks to resolve are therefore these: How are the sexual and reproductive health needs of young women in Canada represented in HIV/AIDS discourse? Are these needs being met in the current HIV prevention context, from either a public health or formal educational perspective – and if not, why not?

2. Researcher Perspective

I am undertaking this research from multiple though complementary perspectives. I am an

outcomes, but in learning about HIV/AIDS specifically and in understanding their distinctive place in the epidemic, their particular risk factors and the steps that can be taken to mitigate those risks.

This study will hopefully contribute to the slowly growing body of research that deals with women's vulnerabilities to HIV and the requirements of effective prevention and education programs in Canada that address those vulnerabilities. General guidelines for gendered prevention programs may be derived from this study as well as directions for future research, which in turn can be applied to the development of public health and /or formal education HIV prevention initiatives. The improvement of these initiatives works not only to the benefit of young Canadian women, but will also contribute to an increase in positive sexual and reproductive health outcomes for all young people, as well as an increased understanding of the role of gender and sexuality in other areas relating to health and education.

4. Limitations

The limitations of this study relate primarily to the scope of the project. Preliminary prevention research has highlighted the weaknesses of many educational and intervention programs (Remis, 2007; and CAS 2004), however because this study is limited to a documentary analysis, a true measurement of the operationalization of the programs is not possible, nor is a rigorous testing of the guidelines for a theoretical prevention model that is addressed throughout this analysis. Implementation and operationalization of programs followed by meticulous observation, data gathering, evaluation and analytical assessment are effective means of measuring prevention and education programs, however these will not be possible within the scope of this study. Given that these are limitations currently experienced in almost every domain of HIV prevention research however – there has never been a comprehensive assessment and evaluation or even database

development of prevention and intervention programs in Canada (Remis, 2008), this is not a limitation that can be overcome given the parameters of this study.

5. Statement of the Problem

Despite over twenty years of research, educational programming and medical-scientific advances, HIV/AIDS remains incurable and deadly. Though in comparison to other regions Canada could be considered one of the more fortunate nations in terms of the HIV/AIDS epidemic, despite occasional intermissions or pauses in the advance of the epidemic, the rates of incidence and prevalence have been steadily increasing among every sub-population in every region over the course of the past two decades.

Some might question the designation of HIV/AIDS as an epidemic in the Canadian context given the relatively low incidence and prevalence rates overall (based on 2003 estimates Canada's total prevalence is calculated at 0.3%, CIA 2008). The fact is that HIV is prevalent in such diverse populations and regions throughout the country and that there are several insidious means, some of which are not easily detectable or avoidable, by which HIV transmission can be achieved; there are so many socio-cultural and discursive barriers limiting discussion and action and the potential for a devastating increase in incidence is a very real possibility. All point to the fact that 'epidemic' is not a misnomer. In addition, the very fact that Canada is so closely linked to nations where HIV has wrought a great deal more devastation, including the United States which has "one of the largest HIV epidemics in the world" (UNAIDS, 2008), in conjunction with the fact that worldwide HIV is one of the fundamental challenges facing mankind, means that Canada is not dealing with HIV in isolation; it *is* a global epidemic.

In the following pages I outline the problem in detail, from a discussion of the specific number of Canadians affected, to a questioning of the normative understanding of risk, to an

overview of the HIV/AIDS-related knowledge and attitudes of Canadians, women and youth in particular. The picture that develops is grim, and will serve to illuminate further discussion of the weaknesses and strengths in federal sexual and reproductive health (SRH) and HIV/AIDS policies and guidelines; the lack in provincial (specifically Ontario) programs and services; and the deficiencies in the educational programs and prevention interventions offered by public health services and the public education system. More importantly, it will serve to highlight the ways in which women are misrepresented in the epidemic, and how the lack of dedicated, integrated and gendered SRH and HIV/AIDS policies, education, programs and services contributes to young women's discursive and socio-medical marginalization.

5.a) Sexual and Reproductive Health in Canada and Ontario:

In 2007 the Canadian Federation for Sexual Health (CFSH¹) prepared the *Sexual Health in Canada: Baseline 2007* report, the “first ever comprehensive, national, statistical portrait of Canadians’ sexual and reproductive health...[which] amasses current research on key health indicators including contraceptive use, sexually transmitted infections, sexual violence and pregnancy outcomes” (CFSH, 2007, p.2). This report confirms and reiterates the results and conclusions of studies and surveys undertaken primarily since 2000 (several of which are addressed in this study as well), thereby providing a broad, detailed and up-to-date picture of the overall sexual and reproductive health of Canadians. The working definition² of SRH as presented in the CFSH study was prepared by an international working group convened by the World Health Organization.

Sexual and reproductive health (SRH) is influenced by a complex web of factors ranging from individual behaviours, societal attitudes, gender, poverty and access to health services. SRH is a state of physical, emotional, mental and social wellbeing [*sic*] in relation to sexuality,

¹ Formerly the Planned Parenthood Federation of Canada (CFSH, 2008)

² The World Health Organization states that this definition represents a contribution to ongoing discussions of SRH, and should not be misconstrued as an officially stated position of the WHO (2004).

encompassing sex gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (2004).

Unfortunately, overall, Canadians are demonstrating increasing inadequacy in areas related to determinants of health such as poverty and homelessness, and increasingly poor sexual health outcomes, particularly with regards to sexually transmitted infections (STIs³). In the mid-nineties Health Canada developed the *National Goals for the Prevention and Control of Sexually Transmitted Diseases in Canada* (1996), with the stated objective of reducing rates of infection nationwide between 2000-2010. In a comparison of the goals to SRH-related studies and literature however, the CFSH (2007) found that in Ontario alone since 1997, the rate of chlamydia has risen more than 70% and is more than double the goal set for 2000 (the national rate is almost triple); the rate of gonorrhoea is increasing steadily and is higher in Ontario compared to the national rate (the goal was elimination by 2010); and syphilis, especially among men, has increased to more than six times the goal of 0.5 per 100,000 set for 2000 (total elimination of congenital and infectious syphilis is the goal for 2010) (CFSH 2007 and Patrick, 1997).

According to CFSH (2007) findings, the majority of Ontario youth have engaged in sexual intercourse by the time they reach approximately 20 years of age, though at a lower rate than nationally, and slightly more young women than men report sexual experience and activities. Though Ontario youth used condoms more frequently than at the national rate, 35% of “sexually active 15-24 year-olds who were single and/or had sex with more than one partner in the past year” (CFSH, 2007, p. 91) did not use condoms; and 38% of young women alone in Ontario did not use condoms in 2003 (*Ibid.*). This is problematic because “youth are disproportionately affected by STIs...[and] rates of STIs are significantly higher among young women than among young men”

³ The term sexually transmitted diseases (STDs) is no longer commonly used in this context as the term STI “is more encompassing, including infections that may be asymptomatic” (Health Canada, 2006) and which are not necessarily in and of themselves diseases. “The infection comes first and is what needs to be prevented. The disease starts after a person has been infected” (SOGC, 2008).

(*Ibid.*, pp.19-20). The highest rates of gonorrhoea infection are among young women, in addition, over two thirds of all reported cases of chlamydia are attributed to those aged 14-24, and among 15-19 year olds alone, “women represented 84% of all reported cases in 2004” (*Ibid.*). Not only are these numbers a problem because they signal inconsistent condom use, but the possibility of co-infection with other STIs substantially increases susceptibility to HIV (Remis et al., 2008); in particular, “chlamydia infection...significantly increases the risk of HIV transmission” (CFSH, 2007, p. 30). Poor overall SRH health outcomes, particularly in relation to STI prevention, signal even greater risks ahead for young women in particular if steps are not taken to improve Canadians’ knowledge, behaviour and attitudes with regards to sexual and reproductive health and HIV prevention practices.

5.b) HIV Prevalence and Incidence in Canada and Ontario:

The Public Health Agency of Canada’s (PHAC) Centre for Infectious Disease Prevention and Control *HIV/AIDS Epi Updates* (2007a) has found that Ontario, Quebec, British Columbia and Alberta (comprising 85% of Canada’s total population) together account for 95% of reported HIV and AIDS diagnoses. The PHAC *HIV and AIDS in Canada: Surveillance Report to December 2006* (2007b) states that the prevalence rate in Canada, the number of Canadians currently *living* with HIV⁴, is estimated at 58,000 (anywhere from 48,000-68,000), a substantial increase from the estimate of 50,000 in 2002 (PHAC, 2007a). Among this number, there are approximately 15,800, or 27%, who remain undiagnosed (PHAC, 2007b). Both HIV incidence (the number of *new* diagnoses in a given time period) and prevalence (the *total* number of people living with HIV) have steadily increased in Canada since 2000, though the incidence rate has remained relatively stable at approximately 2,500 new diagnoses per year since 2002 (*Ibid.*). What has definitely increased

⁴ The total prevalence rate for Canada includes all diagnoses between 1985 and 2005, and also includes those who have died of HIV/AIDS-related causes. Total HIV prevalence is therefore 62,800 (plus 20,669 AIDS cases). Of these it is estimated that approximately 20,800 people have died (PHAC 2007a). For the purposes of current epidemiological surveillance reporting, “prevalence” is used to indicate only those currently living with HIV.

however is the estimated *range* of new infections, from an estimated range of 2,100 to 4,000 new infections in 2002 as compared with an estimate of 2,300 to 4,500 new infections in 2005 (PHAC, 2007a). Unfortunately these estimates, though inexact and bounded by a conservative degree of uncertainty⁵, are frequently borne out by epidemiological monitoring data which is continuously updated, even in retrospect (for example older or modified data sets are newly evaluated or re-assessed for years following initial development, often due to delayed reporting, late diagnoses, new data, improved analysis, etc., [*Ibid.*]). HIV/AIDS continues to spread.

Overall in Canada, there are four major categories of Canadian sub-populations accounted for in HIV/AIDS monitoring: men who have sex with men (MSM), intravenous drug users (IDU), heterosexual/non-endemic (people from regions where HIV/AIDS is not endemic, such as Europe or North America) or heterosexual/endemic (i.e. Sub-Saharan Africa)(PHAC, 2007a). Depending on regional or organizational differences and priorities in monitoring and surveillance, the categories are often expanded to include MSM/IDU, blood product recipients, Aboriginals and mother-to-child transmission, as well as being broken out by age cohort (child, youth, adult, senior) and sex/gender (male, female and occasionally transgender or no gender reported). The age spans of the categories of youth and young adults varies somewhat depending on the organization, for example the term “youth” is variously used to encompass those aged 10-19, 14-19 or 15-29. If one of the former two age cohorts is used, the term young adult is generally applied to those aged 20-24 or 20-29. For the purposes of this study and in line with the Public Health Agency’s national-level categories (*Ibid.*) ‘youth’ encompasses the notion of young adulthood and is used to refer to all people aged 15-29 (unless otherwise indicated) in accordance with the most common usage; in reference to females only, the term ‘young women’ may also be applied.

⁵ According to the Public Health Agency (2007a), though the analytical methodology has improved significantly for this year’s report, incomplete and / or insufficient surveillance data may have led to some misclassifications or missing information with respect to risk factors, ethnicity, age cohort, etc.; “the [specific] increase cannot be stated with certainty...a firmer conclusion is that overall incidence is not decreasing” (p.6).

A particular sub-set of the heterosexual risk or exposure category used in some monitoring initiatives (including that of the federal Public Health Agency and of the Ontario HIV Epidemiologic Monitoring Unit) is organized according to high risk (origin from an HIV endemic region and/or sexual contact with someone at a high risk) and low risk, for example where heterosexual sexual contact with another low-risk individual is the only indicator of risk (PHAC, 2007b; and Remis et al., 2008). Though the notion of “low risk” and “high risk” as categories of exposure and the normative binary of hetero/homo-sexuality are both problematic in terms of effective, gendered HIV prevention and education initiatives (these issues are addressed in the following section), at present there are no alternative classification labels that are actively applied in medical-epidemiological monitoring and research. There are however three more recently identified sub-categories which will be used in this study in discussions of populations affected by heterosexual modes of transmission: HIV endemic (origin from a region where HIV is endemic, i.e. Sub-Saharan Africa), high risk (sexual contact with a person who is HIV+ or at increased risk of infection, i.e. MSM, IDU, endemic origin, prostitute, etc.), and low risk or no-identified-risk (NIR – where sexual contact with a person of the opposite sex is the only indicator of risk activity (PHAC, 2007a).

According to the most recent published epidemiological data, the incidence patterns of HIV/AIDS have shifted from those of the original epidemic, which in Canada in the 1980s was concentrated among MSM, and to a much lesser extent among recipients of blood products (PHAC, 2007a). Women, Aboriginals and IDU now represent significant HIV/AIDS sub-populations. However, while the incidence rates among IDU have been decreasing for the past few years, the number of new infections among women (especially younger women) and Aboriginals (especially Aboriginal women) continues to increase (*Ibid.*). Significantly, while the primary exposure category in the Aboriginal population is injection drug use, among non-Aboriginal women new

infections are primarily attributed to the heterosexual category (endemic, low risk and high risk) (*Ibid.*).

Women in Canada now account for one fifth of the national prevalence total and for over a quarter (27%) of the incidence rate. Significantly, more than three-quarters (76%) of new infections among women in Canada are attributed to heterosexual modes of transmission; the remainder are primarily attributed to injection drug use, and a small number to the “other” category (i.e. blood products) (PHAC, 2007a). Unfortunately, age is a major indicator of risk for women, “the proportion of positive HIV test reports accounted for by women...is highest among young adults” (*Ibid.*, p. 28). Of the total HIV incidence among youth aged 15-29 years in 2006, 40.9%⁶ were women. In 2001 alone there was a 30% increase over the 1995 rate of prevalence among women aged 15-29 years (Gatali and Archibald, 2004). Currently, 71% of HIV prevalence among women in Canada is among women aged 15-39, and incidence in 2006 is almost evenly split between women in the 15-29 age cohort and those in the 30-39 age cohort (PHAC, 2007b) (see *Table A*). In other words, young women are fast approaching the rates of incidence of young men, they are far outstripping the incidence rates of older women and those in the IDU exposure category, and heterosexual transmission (endemic, high risk *and* low risk) is by far the most significant among the exposure categories for women.

More specifically, in Ontario as of June 2007, HIV prevalence has been estimated at 28,134 cases (PHAC, 2007c). As the most populous province by far this is not surprising, however Ontario encompasses just over a third of the population of Canada overall (Statistics Canada, 2008), yet accounts for nearly half of the HIV prevalence. The only other province with a similarly inflated rate of infection is British Columbia, with 20% of the national prevalence (PHAC, 2007c), yet only 13% of the population (Statistics Canada, 2008). However, Ontario’s rate of HIV incidence alone

⁶ Or between 36% and 45% - the degree of uncertainty reflected in this range of incidence is due to incomplete data, i.e. age unknown in some reports (PHAC, 2007a).

between 2002 and June 2007 is twice or more that of any other province (PHAC, 2007c). These figures highlight a significant problem overall; when women's HIV incidence and prevalence rates are factored in, the problem is magnified.

The Ontario HIV Epidemiologic Monitoring Unit's *Report on HIV/AIDS in Ontario 2006* (Remis, Swantee, Schiedel, and Liu, 2008) shows that HIV incidence has increased markedly (21%) among all population sub-categories in the five years between 2001 and 2006. As previously stated, Ontario consistently reports the highest number (controlled for population) of HIV prevalence and incidence rates in the country (PHAC, 2007c). Until recently, MSM and IDUs had also consistently accounted for the highest number of reported cases of HIV (Remis et al., 2006). More recently however, the incidence rate of all three major heterosexual exposure categories, endemic, low risk and high risk, have increased to second, third and fourth highest categories respectively, both nationally and at the provincial level (PHAC, 2007a; and Remis et al., 2008).

The proportion of positive diagnoses attributed to women is substantially less stable, rising to 30% of all diagnoses in Ontario in 2006 (Remis et al., 2008). This represents a 44% increase in HIV incidence among women in Ontario between 2001 and 2006 (*Ibid.*), and a 71% increase since 1999 (Ministry of Health and Long Term Care, 2008)! This is extremely significant given that overall, between 1985 and 2006, women's prevalence in relation to all diagnoses in Ontario has been calculated at approximately 15% (*Ibid.*); the rate of incidence far outstrips the prevalence rates, clearly highlighting a steady increase. This is borne out by an analysis of the statistics at the national level as well. Among Canadian women aged 15 to 39 between 1985 and 2000, there were 4,356 positive HIV test reports, and yet between 2001 and 2006, there were 2,685 positive reports (PHAC, 2007a). In other words, it took just five and a half years to achieve 62% of the prevalence rates of the previous *fifteen* years (see *Table B*).

Among young women, 2006 was a banner year for diagnoses both nationally and provincially, with 344 positive diagnoses, the highest ever recorded in all three of the major heterosexual exposure categories. In Ontario alone, “heterosexual transmission accounted for 91% of cases among females in 2006” (Remis et al., 2008, p.10), a substantial increase over the 83% rate of heterosexual modes of transmission in 2004 (Remis et al., 2006). In addition, as with the national averages, exposure categories in Ontario defined by age show that the majority of people diagnosed with HIV were between 20 and 44 years of age; among women 57% of cases are from HIV endemic regions, and 25% were exposed through *low-risk* heterosexual transmission (*Ibid.*)! Even though the actual numbers might be low, the rate of increase signals a rupture between knowledge, behaviour and sexual and reproductive health outcomes for young women.

5.c) Knowledge, Attitudes and Behaviour in Canada:

There are several surveys and baseline reports which have been developed in recent years addressing issues related to HIV/AIDS, sexual and reproductive health knowledge and behaviours, targeted both at Canadians as a whole or youth and women more specifically. The most comprehensive among these are the *Canadian Youth, Sexual Health and HIV/AIDS Study* (Council of Ministers of Education, Canada, 2003) the *Sexual Health in Canada: Baseline 2007* (Canadian Federation for Sexual Health, 2007) study, and to a lesser extent the *Canadian Contraception Study* (Fisher et al., 2002). They provide an important perspective in terms of what youth, specifically young women, know, think, do and feel about sex and sexuality, safety and risk. These and other studies are examined in more detail below and will serve to provide insight into the type, accessibility, and to some extent quality of the information, education and interventions currently available in Canada and Ontario.

In 2003, a national, randomized survey was undertaken for the Public Health Agency of Canada titled *HIV/AIDS – An Attitudinal Survey*. The purpose of the survey was to acquire a

baseline measurement for informing future health activities geared towards awareness and a reduction in the risk of HIV transmission (PHAC, 2003). The first follow-up survey to the baseline, the *HIV/AIDS Attitudinal Tracking Survey 2006: Final Report* (PHAC, 2006a) is intended to “help inform the PHAC-led HIV/AIDS social marketing campaign that is currently being developed” (p.2). What this campaign constitutes exactly is unclear, however it is listed as an expected result of the horizontal government initiative: *The Federal Initiative to Address HIV/AIDS in Canada* (PWGSC, 2004) in the Public Health Agency’s *Report on Plans and Priorities 2008/09* (PHAC, 2008). This means that specific monies have been allocated and that Treasury Board of Canada will be monitoring progress on work undertaken. According to the Agency there is a concrete communications product currently in development, and despite some delays release is tentatively slated for sometime in the next year (PHAC, personal communication, 2008).

The results of the two attitudinal tracking surveys clearly indicate the need for such a campaign. While Canadians are generally adequately informed with regards to HIV/AIDS issues, there has been some erosion of knowledge since 2003 (PHAC, 2006a), both minor and considerable, and there are indicators of poor knowledge levels, attitudes and practices. The most significant of these indicators is the marked difference between self-reported, perceived knowledge levels of Canadians compared with their actual knowledge. Among those with low knowledge, (primarily youth, seniors and those characterized by lower educational attainment), 23% believe themselves to be very knowledgeable and 66% to be moderately knowledgeable; 28% of moderately knowledgeable people also believe themselves to be highly knowledgeable (*Ibid.*). In contrast, only 34% of highly knowledgeable people believe themselves to be so (*Ibid.*). Obviously inconsistent and mixed messages over the course of the past twenty years have led to ramified perceptions and misunderstandings among the general populace.

Overall, results between the 2003 baseline and the 2006 tracking surveys remain fairly constant. Most Canadians know that HIV is transmitted through “unsafe intercourse...blood to blood contact...sharing needles and unsafe oral sex” (PHAC, 2006a, p.iii) (what exactly is ‘unsafe’ about these activities is never specified – it would have been more accurate to talk about *unprotected* intercourse, oral sex, etc.). However, a significant minority still believe that kissing (32%), mosquitoes (29%), coughing (11%), and fountains and toilets (10%) transmit the virus as well (*Ibid.*, p.12). In an analysis of the results of the surveys that compared responses according to age (there are few references to sex and gender overall and no gendered data), there were some differences found regionally as well as in a comparison of youth and adults. Almost all Canadians believe HIV/AIDS to be a serious problem, however they also believe that HIV is not a problem for *themselves*; as in 2003 however, slightly more youth than adults perceive themselves to be at risk of exposure (*Ibid.*).

Overall youth are more likely to have reported two or more and/or casual sexual partners in the previous year, but they are also more likely to have practiced safer sex. Despite this, and despite self-reported high levels of knowledge, 50-69% of young people did not use a condom the last time they had sex, with many reporting monogamy as the reason for this choice (the notion of serial monogamy as a significant risk activity for youth, young women in particular, is not addressed), while too many others perceived no risk of infection, or simply *didn't know* why they did not use protection (PHAC, 2006a). Finally and most interestingly, throughout the survey women generally display more tolerance towards those affected by HIV, are least likely to distance themselves from risk for HIV and are likely to be more knowledgeable in general about HIV/AIDS-related issues (*Ibid.*). Women’s knowledge is better than men’s overall, however the higher rates of STIs, including HIV among young women, signals a rupture between what women know and what

they do; a clarification and possible explanation of this breakdown will be explored in the coming pages.

The Society of Obstetricians and Gynaecologists of Canada's (SOGC) 2002 *Canadian Contraception Study* (Fisher et al., 2004) also echoes and substantiates a number of the attitudinal survey findings. Overall Canadian women aged 15-44 were most familiar with oral contraceptives and condoms as methods of birth control, though more women in Ontario and those with a higher educational attainment were more familiar with condoms (*Ibid.*). Unmarried women were more likely to use condoms than married women (32% vs. 15%), however withdrawal is the third most commonly employed contraceptive method (*Ibid.*). In addition, only 2% of respondents cited protection from STIs as a reason for contraceptive choice, 2% of respondents believed that oral contraceptives protect against STIs, and despite the rarity of specific sexual health testing such as mutually negative HIV tests, the majority of women cited monogamy, trust in the partner and a lack of perceived risk as reasons for discontinuing condom use (*Ibid.*). Among adolescent women (15-18), condom use is inconsistent though also the most frequently used method of contraception for 44% of young women; multiple partners were reported by 40% of young women and fewer than 20% have had negative HIV tests (understood as any HIV test at all); and overall, the rate of condom use had declined in Canada up to 2002, and was the lowest reported rate since 1993 (*Ibid.*).

A survey undertaken by the Canadian Association for Adolescent Health (CAAH), *Sexual Behaviours and Attitudes – Canadian Teenagers and Mothers* (2006) also reveals a clearer, if grimmer, picture than that presented in the attitudinal and contraception studies in terms of HIV and youth. It was found that though sexually active 14-17 year olds in Canada have had an average of three sexual partners, 24% did not engage in safer sex practices the last time they had sex; 68% engaged in unprotected oral sex; nearly 40% engage in casual sex; and half of condom users never check the integrity of the condom after use (CAAH, 2006). In direct opposition to these

behavioural statistics, 90% of teens believe themselves to be knowledgeable about sex and sexual health (*Ibid.*), and yet fewer than a fifth can answer questions relating to STIs, including HIV, with any accuracy.

From a public health perspective, it is significant that 62% of teens overall encountered difficulties gaining information about sexual health, 31% are uncomfortable seeking or acquiring the information and 90% found it difficult to find information on the internet or from a healthcare professional (CAAH, 2006). Additionally, fewer than a quarter of Canadian teens (though this number increased slightly to 30% in Ontario) find the formal sexual health education they receive in school to be very useful, though an additional 20% (approximately) find it somewhat useful (*Ibid.*). Parents and friends are cited as the next most valuable sources (43% and 29% respectively), yet health professionals, teachers, literature, the Internet and traditional media are all listed at well below 20% (*Ibid.*). In contrast, school sex education paved the way for “74% of mothers to discuss sexuality and sexual health with their teenager” (*Ibid.*, p.12). However when it comes to discussing STIs and condom use, fewer than 50% of teenagers stated that these issues had been addressed with parents (*Ibid.*). Provincial school health programs are also evidently insufficient, and public health alternatives at the federal or provincial level are also lacking; only 38% of teens claimed they encountered no obstacles to gaining relevant information (*Ibid.*).

The most comprehensive of the three surveys targeting youth to date⁷ is that undertaken by the Council of Ministers of Education (CME) of Canada in a follow-up to the 1989 *Canada Youth and AIDS Study*. The 2003 *Canadian Youth, Sexual Health and HIV/AIDS Study* (CME) was implemented in schools across the country and was administered to students in grades 7, 9 and 11 (approximately between the ages of 12 and 17). The study explores factors influencing the

⁷ The *Toronto Teen Survey* (Flicker, Larkin, Travers, Pole and Palmer, 2008), administered in 2007, is another excellent example of youth-oriented research, however it is focussed very narrowly on Toronto youth and only preliminary results have been released to date. Some references to the research are still made in this study however.

knowledge, attitudes and behaviours of Canadian teens (broken down by grade and sex) and situates them in the context of the World Health Organization's approach to sexual and reproductive health (WHO, 2004), specifically regarding sexual health and healthy sexuality.

[Sexual health and healthy sexuality] are intended to invoke a holistic image of sexual being, one which integrates the emotional, physical, cognitive, and social aspects of sexuality. Attaining sexual health implies much more than simply avoiding diseases and unintended pregnancies (CFSH, 2007).

This relates directly to the purpose of the study, which was to “increase understanding of the factors that contribute to the sexual health of youth by examining the socio-cultural, socio-environmental and interpersonal determinants of adolescent sexual activity” (CME, 2003, p.6).

While the authors acknowledge that HIV prevalence is currently low among youth (CME, 2003), as is shown in prevalence and incidence statistics (PHAC, 2007a; and Remis, 2008), risky sexual behaviour and the belief among respondents that HIV is not relevant are cause for concern. These factors “clearly indicate that the potential for HIV spread exists among young Canadians” (CME, 2003, p.6). Determinants of adolescent sexual health and indicators of early sexual initiation and risky sexual behaviour were linked to family structures, parental income and education, degree of family/personal religiosity, gender identity, coping skills, peer interactions and the presence of community health and social organizations, among others (*Ibid.*). Overall results indicate that students were generally less knowledgeable about HIV prevention and transmission than they had been in the 1989 study, and perceived themselves to be less susceptible to HIV. Among sexually active youth however, intercourse is occurring more often and only a quarter of grade 9 students and a third of grade 11 students reported using condoms the last time they had intercourse (*Ibid.*). Given that 36% of grade 11 boys and 28% of grade 11 girls have had 3 or more sexual partners and that 14% of grade 9 and 11 students have had 4 to 10 sexual partners⁸, the

⁸ These high numbers could be the result of serial monogamy as well as multiple casual partners. While 14% of grade 9 girls and 24% of grade 11 girls report faithful partnerships as the reason for eschewing condom use (only 4% and 10%

apparent lack of condom use in combination with rising STI and HIV rates highlights the potential for a serious problem!

Some of the most worrying results relate directly to knowledge of STIs and HIV, to the ability to perceive and mitigate the risk of HIV transmission, and many involved a considerable gender component as well. Compared to the 1989 results, student knowledge had eroded considerably by 2003. In the two years preceding the study, one-tenth to one-quarter of students (depending on grade and geographic location) did not receive any instruction about HIV/AIDS, sexuality, puberty or birth control (CME, 2003). Only 62% (down from 83%) of grade 7 students knew that sharing needles is a risk activity for HIV transmission (grade 9 and 11 student results also decreased though only by a few percentage points); 80% of grade 9 students (down from 95%) and 86% of grade 11 students (down from 96%) knew that multiple partners put one at risk of HIV; and only 53% of grade 7 students (down from 79%) knew that a condom helps prevent the transmission of HIV (*Ibid.*).

With respect to adolescent girls, they are far more likely to feel pressured into sexual intercourse, and a quarter of girls in grades 9 and 11 are either too embarrassed to buy condoms and/or to address condom use with a partner (CME 2003). Drug and alcohol use, poor self-esteem, peer pressure, and an inability to say no are among the most significant indicators of poor sexual health outcomes for girls (*Ibid.*). In addition, 46% of girls who have been pregnant had also had four or more sexual partners and two to five times more girls than boys (depending on age) with multiple partners reported having an STI (*Ibid.*). Taken in conjunction with the data on women's incidence and prevalence garnered from the national and provincial HIV epidemiological reports, it is clear that current prevention interventions are ineffective. "New ways of talking and doing safe sex by acknowledging and accounting for the various forms of being sexual"(Erni, 1998, p.23) and

of boys in each category do so) (CME 2003), they seemingly fail to recognize multiple sequential relationships as being similar to a more generalized kind of 'promiscuity' in terms of risk of HIV transmission.

which reference the multiplicities of young women's lived experiences (gendered, sexual and social) must be addressed for prevention efforts to succeed. "[Developing] innovative activities targeting boys and girls that will promote more equitable and mutually respectful attitudes and behaviour" (Spigelman, 2002, p.27) is key. Prevention programs clearly must also be integrated with sexual and reproductive health as a whole in order to encompass the many factors affecting adolescent and youth development.

5.d) Risks Groups and Activities:

The population characteristics of those who are diagnosed with HIV are central to monitoring and tracking the epidemic, not only among groups traditionally perceived to be at risk of HIV transmission but also for tracking infections in sub-populations previously believed to be unaffected. It is in this way that health professionals, activists and governments address changing incidence patterns and are occasionally required to reassess the epidemic. This information contributes to the development of new approaches and responses to dealing with the epidemic, and explains in part why the response has expanded beyond the original focus on MSM, to IDUs, sex workers, Aboriginals, women and youth (never mind that the monolithic categories of women and youth intersect in various ways with the other categories). Unfortunately, this population focus has resulted in an emphasis on identity and behaviour as markers of risk, rather than as indicators of a more comprehensive assemblage of risk activities and health determinants interacting in multifaceted ways. In the case of Aboriginals in Canada for example, it should be emphasized that "Aboriginal people are at increased risk of HIV infection not because they are Aboriginal but because of the social determinants [i.e. racism, poverty, low educational attainment] associated with risk of infection" (Spigelman, 2002, p.24). More generally, it is "important not to confuse race with racism or attribute HIV vulnerability to race and gender rather than to the discrimination so often associated with [them]" (*Ibid.*, p.27).

Understanding the centrality of formulations of risk in epidemiological monitoring is necessary for elucidating the factors contributing to an increase in risk. People who are at a high risk of HIV transmission have inhabited specific sites (i.e. endemic regions such as Sub-Saharan Africa, bathhouses, crack houses) and undertaken specific activities (i.e. needle sharing and/or unprotected sexual contact with someone of unknown or uncertain or HIV+ status) (PHAC, 2007a; and Remis et al., 2008). People who are at a low risk of transmission engage in none or few of the afore-mentioned activities with anyone who does engage in them, or they are skilled at negotiating risky activities. However, people from non-endemic regions (i.e. *not* from areas with extremely high incidence and prevalence rates such as sub-Saharan Africa or parts of South East Asia or Eastern Europe) who were exposed either through high-risk heterosexual sexual activities (described as sexual contact with a person living with HIV, IDU or someone of origin from an HIV-endemic region), or those exposed through low-risk heterosexual sexual activities (no identified risk occurrence), represent 22% of the total HIV prevalence in Ontario and 46.3% of the incidence rate (Remis et al., 2008). Most notable is the 91% heterosexual exposure rate among women in Ontario in 2006, including a 30.4% increase among women in the low risk exposure category (*Ibid*); in fact, the so-called low risk category has shown consistently higher rates of incidence for the past several years than either the IDU or high risk exposure categories!

This delineation between risk categories is obviously flawed if women in a perceived lower risk category are actually experiencing a higher rate of exposure. This group is composed of women who likely do not perceive themselves to be at risk; they are *not* engaging in what is commonly understood to be high-risk behaviour with individuals who are themselves in high-risk categories, making the distinction between high and low-risk, as normalized in medical scientific discourse, increasingly muddled, if not meaningless. In purely sexual terms “risk categories do not reflect people’s ‘real world’ thinking about sexuality, nor do they reflect the ‘continuum’ along which

sexual activity occurs (the flow and ebb of sex, with one act stimulating or leading into another)” (CAS, 2004b, p.9). HIV transmission is occurring in ways and between people that are poorly, if at all perceived and understood. Feminist and queer scholars argue that normalized notions of gender and sexuality, particularly in HIV/AIDS discourse, contribute in some ways to an erasure of the fluidity of sexuality and sexual behaviours, leading to a “[failure] to apprehend real zones of risk” (Erni, 1998, p.17).

For the most part, risk is not a well-articulated or sophisticated concept in relation to HIV/AIDS research, surveillance or prevention and education initiatives. It is most commonly understood in terms of a high risk / low risk binary and as a marker of the identities, behaviour and characteristics of specific populations. For example, men-who-have-sex-with-men and intravenous-drug-users are groups of people defined by one aspect of their identities, gay⁹ and addict respectively, and by specific behaviours, in this instance gay sex and shooting up. In order for risk to be more relevant to the majority of people, all of whom negotiate risks of varying order in their daily lives (CAS, 2004b), the discussion of the many HIV-related risks must be specific and detailed (even graphic) and activity-oriented (for example broadly speaking, the risk should be ascribed to *unprotected* penile-anal intercourse and unprotected oral sex on the one hand and needle sharing on the other – the activities involved in engaging in so-called gay sex and injecting drugs in and of themselves are not responsible for the transmission of HIV; other conditions must be met).

Another problem inherent in risk designations involves the over-arching risk categories dealing with sex and sexuality characteristic of the medical-epidemiological perspective which largely informs high level policy and prevention guidelines, namely MSM, heterosexual endemic, heterosexual high-risk and heterosexual low-risk. The single most problematic element of these

⁹ Though clinically speaking MSM refers to any man who engages in sexual activity with another man regardless of whether he might self-identify as gay, bi or straight, of whether he is “closeted” or not, or of the number or type of encounters he might enjoy with men (CAS, 2000).

designations is the hetero-homo binary suggested by the categories and the misclassifications in transmission data that might (and probably do) result. This issue has been addressed in limited fashion with the designation of a 'new' risk group, namely MSM/IDU, meaning that transmission could have occurred by one or the other of these means, however other sub-categories among more monolithic groups are also likely lost or glossed over, particularly for 'women' and 'youth'. Demarcating rigid sexual boundaries along lines that do not reflect the realities of people's experiences are ultimately self-defeating in terms of using them to help understand patterns of transmission and to develop effective prevention education and interventions.

Defining sexuality can be a deeply personal process, albeit one that is also discursive in nature and profoundly influenced by cultural norms and gendered socialization; most people are unlikely to conceive of sexuality as encompassing anything beyond heterosexuality and homosexuality (other than perhaps a nod to bisexuality, which is commonly disparaged either as a layover before coming out as 'truly' gay or as a special kind of sexual greed and promiscuity) even when their own preferences and activities do not fit neatly within that normative binary. Many people who engage in same-sex sexual activities do not self-identify as homosexual, or even bisexual, and many people who identify as homosexual have engaged in sexual activities with members of the opposite sex (CAS, 2004b). Instead of adhering rigidly to a clearly delineated category of activity = identity, people often negotiate, whether consciously or not, their understanding of their own sexuality in relation to a broad spectrum of sexual identities and behaviours, situating their own preferences and activities within a range of such options. When risk is ascribed to specific identities, it is therefore in danger of becoming a meaningless term of reference. This permits young people in particular to rationalize their safety on the basis of the designation of a risk group not aligning with their own self-identity (i.e. I'm not gay, therefore the anal/oral/other sexual activities I'm enjoying with this same-sex partner are safe...).

Some advances in understanding and defining risk categorizations have occurred, for example MSM as a category includes any and all men who have sex with men, regardless of how they self-identify (CAS, 2004b). Unfortunately, age, gender issues and other health determinants (such as socio-economic status and educational attainment) are often overlooked in discussions of HIV and MSM (Spigelman, 2002). Even more problematic from a surveillance and prevention perspective is the fact that a single occurrence of same-sex sexual activity, for men at least, is a higher level risk occurrence than a lifetime of other sexual activities. By the same token, a single occurrence of sexual activity with a man is a higher level risk occurrence for women who might normally engage only in lesbian sex. In fact, the complete invisibility in HIV epidemiology and prevention in Canada of lesbians and other women who have sex with women might suggest that these women are not in any way at risk of HIV transmission. Yet there is a slowly growing awareness that woman-to-woman transmission occurs, but it is as yet poorly understood and under-researched (Vazquez, 1998). The fact that many women who identify as lesbians still engage in sexual activity, protected and unprotected, with men, and that many young women who identify as heterosexual engage in sexual activity with other young women is not addressed; “the variety of sexual behaviours we engage in are shrouded...in mystery” (*Ibid*, p.76). These and other issues tend to be obscured by the focus on unprotected penile-anal and penile-vaginal intercourse; certain identities and behaviours are emphasized over others, and while that emphasis is in some respects valid, it does not help to understand other modes and routes of HIV transmission, avenues to sickness which are increasingly, disproportionately affecting young women.

Finally, by designating women as a risk group and subdividing that into high and low risk categories without clearly defining what exactly is involved beyond prostitution and promiscuity means that far too many young women do not see even their own ‘vanilla’ heterosexual activities reflected in risk designations. “In the limited understanding we have of women’s sexuality and

AIDS [what we hear] is that women living with AIDS are bad heterosexuals or innocent heterosexuals” (Vazquez, 1998, p.74), and only the bad heterosexuals (the hookers and junkies) get HIV... Yet studies have shown that 38% of youth have casual sex (CAAH, 2006) and young women are frequently involved in serially monogamous relationships (Fisher et al., 2004)¹⁰ which put them equally at risk.

Multiple sexual partnerships and serial monogamy are common among single young [Canadian] women and the tendency for condom use with a current partner decreases with increased duration of a relationship. If condoms are not used in these serially monogamous relationships, the net effect is multiple partners without protection against STIs (CFSH 2007).

For the most part, risk groups are simplistically designated. Though not inaccurate, those designations do not adequately convey the multiplicities and breadth of risk or speak to all those who share in a given activity, and can be highly problematic in terms of further marginalizing individuals and groups. Gender, sexuality, race, level of education and socio-economic status (among others) are markers of vulnerability, and it is these that should be correlated with risk of infection for the ways in which they marginalize people differentiated along these lines. HIV transmission is *not* “narrowly the result of personal shortcomings and group dynamics” (Spigelman, 2002, p.38).

A thorough re-evaluation of sexual risk behaviours and risk categorizations is clearly needed (in addition to an analysis which problematizes women’s marginal place in HIV/AIDS discourse) before effective prevention efforts can be developed. “Universalizing and predestined conceptual categories...employed to inform epidemiological...and behavioural research about the classification and formation of sexual risks” (Spigelman, 2002, p.16) must be critically reassessed. Rigid categorizations ignore real zones of risk as experienced by women (and men) in all their

¹⁰ Monogamy within multiple sequential relationships.

interacting multiplicities, whether defined or framed by the sex, sexuality, gender, socio-economic status, desires, habits and/or practices of the various actors.

Sexual...activities do not occur in discreet [*sic*] packages of performance. Individual behaviours are often difficult to isolate when documenting cases of HIV infection and their behavioural causes...it should be stressed that one activity often leads to another higher-risk activity, making it difficult to pinpoint which activities are specifically responsible for infection (CAS, 2004b, p.10).

Measuring risk merely according to identity and behaviour limits the effectiveness of epidemiological monitoring and the usefulness of the data generated through surveillance. This in turn hinders the development of a genuinely representative and accessible conception of risk activities and the connections between them, and of prevention interventions that can be appropriately targeted to speak to all people.

6. Literature Review

6. a) HIV Prevention and Education

Literature specific to the Canadian context regarding HIV prevention and education is somewhat lacking, despite some very pointed critiques of both the public health and formal educational approaches in Canada which have been published in recent years (for example see Spigelman, 2002; Burger and Clow, 2006) Whether regarding youth generally or young women in particular, formal research on prevention and education is only sporadically undertaken and lags in significant ways behind the gender and youth-centred foci of international organizations such as various United Nations bodies (i.e. UNAIDS, UNIFEM, UNDP), the World Health Organization, the International Planned Parenthood Federation and others. The very recent, and slight, increase in attention given to heterosexual incidence and prevalence in Canada and the recognition that young women face particular challenges and barriers means that this is likely, however slowly, to change, as evidenced by a review of the following analyses and studies.

The health education of youth in Canada has been a contentious topic for decades, shifting, as do provincial curricula in general, along a scale (if a very stunted one) between liberal and conservative approaches to education (Lenskyj, 2007). According to Lenskyj (1991), as far back as the 1940s “75% of Canadian adults favoured sex education in the schools” (p.284). In practice however messages or programs which transcend boundaries of explicitness or heteronormativity frequently give rise to community and parental objections (for example high school condom or safe sex pamphlet distribution). Whether due to conservative school leadership, pressure from vocal minorities or “moral” and religious grounds, schools in Ontario have consistently under-delivered in terms of conveying effective, accurate, detailed and progressive sexual and reproductive health education programs to youth, and young women in particular. HIV prevention and education in particular has been deficient, and despite knowledge gained in public health and community AIDS programming, school curricula continue to be hampered by heteronormative, fear-based, anti-sex messaging.

Lenskyj (1991) argues that conservative sex education curricula, with their focus on only plumbing and biology, fail to challenge sexism, homophobia and violence; her assessment of Ontario’s sexual health education curriculum is still valid today.

The problems resulting from unprotected heterosexual intercourse – pregnancy and sexually transmitted diseases – have a central place in most existing sex education programs, evidence of the generally reactive rather than proactive approach. Yet even in teaching the mechanics of contraception, a program that fails to recognize power relations between the sexes is unlikely to succeed (Lenskyj, 1991, p.287).

In Lenskyj’s (1991) estimation an “anti-sexist and anti-heterosexist sex education program” (p.295) would validate sexual preferences and recognize the differences and commonalities between the male, female, homosexual and heterosexual experiences of sex, as well as being ‘woman-centred’ (acknowledging and addressing the socio-political context of women’s lived

experiences)(*Ibid.*); taken a step further today it would be centred on a gendered approach which would challenge heteronormative assumptions and the hetero/homo binary. She cites the Ontario Ministry of Education's AIDS education program curricular guidelines, released in 1987, as a laudable step forward at the time (*Ibid.*); unfortunately, the *Health and Physical Education* program has since been supplanted by new curricula developed in the late 1990s, and the Ministry's AIDS education guidelines have not been replicated or replaced¹¹. The Ministry's resource document, *Education About AIDS: Materials for Use in the Mandatory Health Education Units* (1987) has never been updated.

The Ontario Ministry of Education's lack of attention to HIV/AIDS is problematic in large part due to the fact that education is seen as the most effective vaccine against transmission of HIV. Researchers consistently find a link between a lack of knowledge or incomplete knowledge about HIV and HIV incidence rates (Gahagan and Rehman, 2004). The Canadian AIDS Society argues that "prevention and education remains [*sic*] our strongest weapon in the fight against these diseases" (p.3). Vandemoortele and Delamonica (2000) argue that a correlation between HIV infection and levels of education exists, and both AIDS-specific sex education as well as basic education are key. Education functions as a vaccine in the context of providing relevant, timely, detailed information in school sex education classes, but also in the context of basic literacy which helps to combat "silence, shame, stigma and superstition...which thrive in a climate of ignorance and illiteracy" (*Ibid.*, p.7). In addition, the authors argue that girls' education is an "absolute priority" (*Ibid.*, p.11), though further discussion of gendered prevention or gendered inequalities is lacking.

Unfortunately, there are also studies that show that knowledge of HIV risk and transmission is unlikely on its own to have an impact on changing behaviours or alleviating risk. Several studies

¹¹ A thorough search of the Ministry of Education and Training's website brought up only one link relevant to sexuality education, and that was a component of a Healthy Sexuality curriculum for students with disabilities (OME, 2008).

(explored in further detail in Section 9) such as the *Canadian Youth, Sexual Health and HIV/AIDS Study* (CME 2003) and the *Sexual Health in Canada Baseline* (CFSH, 2007) reveal that knowledge alone is unlikely to have an impact on HIV prevention. “Research...showed that knowledge was not necessarily accompanied by behavioural change” (Lenskyj, 2007, p.407). The increase in HIV incidence among young gay men alone (PHAC, 2007a) clearly signals a rupture between knowledge and behaviour. More disturbingly, Viner, Hart and James (2007) have also found that though young *heterosexual*¹² university students are knowledgeable about HIV/AIDS, a significant percentage engage in unprotected vaginal intercourse. They found that high HIV knowledge, specifically “worrying directly about contracting HIV via sexual activities” (*Ibid.*, ¶16) is associated with unprotected vaginal intercourse (though the directionality of causality remains unclear). The Canadian Public Health Association (2001) argues a similar point in a discussion paper on safer sex fatigue.

A large investment in knowledge, rationality and reason as key components of HIV prevention and education strategies is substantially limited...there appears to be no reliable guarantee that such ‘knowledge’ ensures the desire and practice of safe sex (Wenger, in CPHA, 2001, p.5).

Safer sex fatigue is presented as one of the most significant drivers behind increased risk behaviours despite high levels of knowledge about HIV/AIDS, and current prevention practices and education programs are not doing enough to mitigate the effects of this fatigue. The CPHA argues that the public, those at risk and HIV prevention educators and researchers are all potentially affected to some degree or another by safer sex fatigue, and there are many issues that need to be addressed to reinvigorate HIV prevention messages. These include understanding how women address gender inequality and negotiate safe sex simultaneously as well as how to target prevention

¹² Whether the students self-identified as heterosexual, or whether the researchers determined heterosexuality on the basis of a scale of sexual preferences, an either/or option, on the experience of heterosexual sexual activity or on some other means of classification is unclear.

messages effectively and appropriately, for example by avoiding fear-tactics generally, but specifically with youth – they don't work! (CPHA, 2001, and Lenskyj, 2007).

In the 1980s and 1990s, "AIDS educators faced a serious challenge when presenting a sex-positive rather than an anti-sex message" (Lenskyj, 2007, p.406). This has not changed significantly over the course of the last decade. The fault does not lie merely with educators themselves, but also with the tools at their disposal. In an assessment of prevention and education material (primarily pamphlets), Lenskyj found that those print materials which were the most effective situated sexual activities in a meaningful and relatable context, avoided scare tactics and did not advocate abstinence above other methods of protection. The use of clinical-medical language in favour of more explicit popular language in the classroom and in prevention material is also problematic: "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 clinical, uncomfortable or boring*¹³" (*Ibid.*, p.408). Making sex education interesting, explicit, even erotic is a very effective approach, unfortunately it is one that is unlikely to be made manifest in Ontario schools in the near future. As Lenskyj argues, "behavioural change requires learning that goes beyond the purely cognitive to involve the social and emotional domains" (*Ibid.*, p.407), however this is not an easy (or often popularly accepted) approach to develop or implement.

When exploring barriers to learning about sexual health and HIV prevention in schools, it is clear that education and prevention programs which ignore the social and emotional domains, or socio-political context, of young women's lived, gendered experiences, are not effective in providing these young women with the tools needed to ensure their continued sexual and reproductive health, let alone protect them from the risk of HIV. A study undertaken in Nova

¹³ My emphasis.

Scotia sought to clarify just what such barriers might entail and how they might be reproduced in the sex education classroom. Langille et al. (2001) found that gender roles, sexual pressures and coercion, power dynamics in relationships and the overt sexualization of young women (both in the media and in ‘real life’) all lead to negative sexual and reproductive health outcomes. Specific barriers in the classroom are associated with the curriculum itself¹⁴ which is largely centred on questions of biological function rather than on the emotional or lustful aspects of sex; on teachers who lack the knowledge, comfort levels, experience and teaching strategies to convey the material effectively, and who are perceived to be old and judgemental; and on the gendered experiences of students themselves, specifically girls who are silenced by the subversive and disruptive behaviour of the boys in sex education classes (mockery, machismo and immaturity are frequently identified as problem behaviours throughout) (*Ibid.*).

Research has shown that effective sexual and reproductive health education for youth is likely best delivered in a combined approach of concurrent or sequential teacher led and peer led programs. The advantages of peer education include youth “bringing to bear their own knowledge of the situation and their peers...[and] the opportunity for more detailed and in-depth discussion” (Backett-Milburn and Wilson, 2000). Peer education is also being promoted by international organizations such as the United Nations and the World Health Organization as effective means of teaching and learning about HIV/AIDS, particularly for young women, though evaluations of peer-led programs in a western setting are scarce (Wight and Abraham, 2000; and Mellanby, Newcombe, Rees and Tripp, 2001). Teacher-led HIV education on the other hand has the potential for implementing theoretically-based psycho-social prevention programs (Wight and Abraham, 2000) which could address in more systematic fashion the barriers undermining sexual and reproductive health for young women especially. Both of these approaches necessitate training for the peer

¹⁴ In this study the curriculum in question is that of Nova Scotia, however the results are transferable to the Ontario context in many ways.

facilitators and teachers, however the educational and sexual and reproductive health education outcomes of youth are more likely to be positive. Peer-led education is likely to be “more successful in dealing with teenage relationships...and may be a more effective method of assisting teenagers to develop skills and set their own standards of behaviour than instruction from adults” (Mellanby et al., 2001, p.491). Teachers however are more likely to impart factual information with greater success (*Ibid.*), and in a classroom environment defined by trust could take on valuable support and mentorship roles which might be outside of the experience and capacity of peers; “the aims of sex education are ambitious” (*Ibid.*), and therefore no one single approach can work every time in every context.

6. b) Condom Use

Teaching about condoms, whether in schools or in alternative prevention intervention settings, has been one of the most enduring approaches to safer sex education for many years. Condoms in schools remain controversial however, and teaching about condoms, whether merely discussing them in an abstract context or getting students involved in practical demonstrations of the mechanics of their use, continues to be unevenly implemented. As argued by Davis and Weller (1999), “current evidence indicates that the use of condoms for each and every sexual contact reduces the rate of heterosexually transmitted infection” (p.276). Though the authors estimate that condoms are unlikely to perform as well for HIV prevention as for pregnancy prevention (they estimate a likely efficacy rate of 85-90% HIV transmission prevention as compared to 97% pregnancy prevention), consistent use is nonetheless likely to greatly reduce the risk of transmission of HIV (*Ibid.*). More recent research has found that condoms offer almost complete protection against HIV (in one study showing a 0% seroconversion rate when condoms are consistently and properly used between sero-discordant¹⁵ heterosexual couples) (McKay, 2007). This holds true for

¹⁵ Only one of the partners is HIV+.

other STIs as well (co-infection is another risk given youth rates of chlamydia and gonorrhoea) (*Ibid.*), therefore the use and function of condoms (male, female, dental dams, etc.) should be taught to young women and men alike in consistent and explicit fashion.

It is evident that a significant increase in proper and consistent condom use, particularly among adolescents, young adults, and other at-risk groups would result in a substantial reduction in the incidence of STI/HIV and in the negative health outcomes that result from them. Health promotion education and counselling should strongly emphasize the health benefits of proper and consistent condom use (*Ibid.*, p.59).

Unfortunately, merely learning about condoms and knowing how (and intending) to use them do not guarantee their effectiveness. In addition to school-based and politically motivated barriers to learning about condoms, youth themselves experience socio-cultural barriers to condom use in particular ways. Bauman, Karasz and Hamilton (2007) found that the use of drugs or alcohol, the lack of access to or availability of condoms and ‘the heat of the moment’ all contribute to a failure of condom-use intention, however these barriers alone did not solely define this failure. “Participants engaged in unsafe sex because, in an important sense, they actively intended to” (*Ibid.*, p.267). The authors found that there was also a significant gender dimension to this failure to use condoms. Both boys and girls in long-term relationships perceived sex without condoms as safe and desirable. For boys more generally condom use competed with masculine notions of control and leadership in the sexual act, and for girls “avoidance of HIV or STDs competed with the goal of finding and keeping a mate” (*Ibid.*). The authors go on to argue that “the effects of gender roles and their interactions with culture [must] be made clear to adolescents so they can examine how [gendered] expectations about their behaviour may increase their risk... HIV prevention programs should include substantial gender content” (*Ibid.*).

One way in which condom use can be increased among youth is by addressing the difficulties youth have in discussing contraception and safer sex practices, as well as by addressing

the issue of condom availability. Many young people (and not so young people...) find it difficult to initiate discussions about sex and contraception despite a desire to do so; young women are even more apt to experience problems (Coleman and Ingham, 1999). Fear of disrupting a 'romantic' moment or of a hostile reaction from a partner; discomfort expressing an intention to have sex¹⁶ (therefore being 'forward' or only interested in sex); and the association of condoms with disease prevention over pregnancy prevention¹⁷ (therefore the discussion can potentially be misconstrued as a comment upon the promiscuity, health and 'cleanliness' of the partner) (*Ibid.*) are all considerations. Interestingly, when the student respondents in this study were asked how they themselves would respond to a partner initiating a discussion about contraception, reactions were overwhelmingly positive. This suggests that gender roles and socialization in conjunction with negative discourses surrounding condoms and HIV (and perhaps in addition to teenagers' penchant for melodrama and angst in relationships) are significant contributing factors to young people's reluctance to discuss contraception and safer sex practices.

Finally, the availability of condoms plays a significant role in their use. The cost of condoms, the associated 'trauma' or embarrassment of buying condoms and the perception that condoms reduce pleasure (Bauman et al., 2007; and Gahagan and Rehman, 2004) are important both for youth intention to use condoms and adherence to condom use. In a high school condom availability program undertaken in Los Angeles (Schuster, Bell, Berry and Kanouse, 1998), the researchers found no change in the percentage of young men and women who had engaged in vaginal intercourse over the course of the year-long study. With condoms readily available on campus however, the rates of other sexual activities among young women increased, and the general use of condoms among young men every time they had vaginal intercourse increased significantly; the increase in condom use was less encouraging among young women (*Ibid.*). Most

¹⁶ Interestingly more young men than young women reported this as a concern (Coleman and Ingham, 1999)

¹⁷ More girls than boys believed that a discussion of condoms could be perceived as a veiled accusation of sorts (*Ibid.*)

importantly however, the condom availability program was found to have “greatest impact on adolescents who have the least [or no] experience with vaginal intercourse” (*Ibid.*, p.72), suggesting that effective condom education programs targeted at younger students could have the greatest impact on positive sexual and reproductive health outcomes and the prevention of HIV transmission.

6. c) Gender and HIV

As previously noted, gender roles and socialization play a significant role in young women’s ability to acquire knowledge about sexual and reproductive health and on their ability to negotiate safer sex. Effective gendered education and prevention programs must recognize the discursive structures in which this gendered socialization occurs, but they must also take into account boys’ socialization as well; empowering young women is only half the battle in striving to achieve positive sexual and reproductive health outcomes for youth. Unfortunately, in Canada, gendered approaches which encompass young women and young men’s differential experiences of sex, sexuality and sexual and reproductive health are sadly lacking.

While gender blindness is beginning to recede with respect to high-incidence regions [such as in Sub-Saharan Africa], for many low-incidence countries – including Canada – it continues to confound the management of HIV/AIDS. Unless we recognize gender as a crucial factor in the spread of HIV, low-incidence countries may soon be transformed into high-incidence countries (Clow, 2006, p.4).

Many researchers and activists argue that there are many reasons why HIV remains invisible to the majority of Canadians, including perceptions that HIV is a gay or urban disease (Gahagan and Rehman, 2004); or that it primarily affects the sexually promiscuous or perverse and users of hard drugs, and therefore is not relevant to the lives of most people (CME, 2003, and CFSH, 2007). Clow (2006) argues that one of the major reasons that HIV is ignored in Canada is precisely because the incidence and prevalence rates are low, that HIV is a threat only to a small proportion

of the population who behave in perceived risky ways, and that we are believed to have the means to deal with the epidemic (reliance on medical treatments, or, as demonstrated in the *Canadian Youth and Sexual Health Study*, the erroneous belief that there is already a cure [CME, 2003]). She also argues however that “changing patterns of HIV infection should sound an alarm for Canadians” (Clow, 2006, p.4), because the history of the epidemic in Canada mirrors that in other countries. In South Africa in particular the HIV epidemic also started out affecting homosexual populations before shifting to and overtaking the heterosexual population (*Ibid.*).

The shift from MSM and IDU to the so-called heterosexual population has been much slower in Canada, likely due to such factors as fewer or less extreme disparities and inequities dividing the privileged and under-privileged members of society than in South Africa. However the increasing rates of heterosexual transmission, the steadily growing HIV incidence and prevalence rates among young women and the lack of gender mainstreaming in either sexual and reproductive health or HIV prevention programming¹⁸ means that the potential for a widespread epidemic clearly exists (Clow, 2006). The case of Aboriginal women supports this argument; as one of the most vulnerable and under-privileged Canadian sub-populations, one which makes up only a small proportion of the overall Canadian population, Aboriginal women’s incidence and prevalence has been estimated at approximately 50% of all Aboriginal HIV/AIDS cases (PHAC, 2007a); this feminized rate of incidence and prevalence is much the same as for women in Sub-Saharan Africa and far exceeds the rates of non-Aboriginal women! The potential for an increase in HIV in Canada therefore has significant implications for women’s health, not only due to increased vulnerability to

¹⁸ Confirming my own impressions of and frustrations with the state of HIV prevention research in the Canadian context, Clow (2006) cites the clear lack of gendered approaches at the annual Canadian Association of HIV/AIDS Research (CAHR) conference, where fewer than 10% of presentations in the few years preceding her assessment addressed women’s health or gender issues. The theme of the 2008 conference which I attended was prevention (CAHR 2008), yet there was still a marked absence of research dealing with women, gender and heterosexual transmission issues. Even when sex or gender was addressed, it was in the context of discussions around very specific issues, such as condom use among Canadians of Middle Eastern descent (Schoueri and Bullock, 2008), or the link between religion and unprotected vaginal intercourse (James, Lima, Hart, Roberts & Ghai, 2008).

HIV, but also due to poor prevention and treatment options – HIV in women is poorly understood and under-researched (Clow and Pederson, 2006), and this in combination with socio-cultural inequities means that women’s place in the HIV epidemic is unique, and uniquely deadly.

Merely extending improved sexual and reproductive health and HIV prevention programs and services to women alone however will not serve to stem the tide of new infections. The sexual and reproductive health of young men in Canada is also a key consideration. In *The Buddy Study* (2004) Gahagan and Rehman found that young men’s gender socialization played a primary role in putting themselves and their female partners at considerable risk for negative sexual and reproductive health outcomes, including the potential for HIV transmission. The authors found that risk-taking behaviours; low comfort levels surrounding discussion of ‘taboo’ topics such as sex and sexuality; and the roles, responsibilities and expectations surrounding sexual relationships are demarcated along strictly gendered boundaries. Two major issues which reappeared throughout the study deal with gender stereotypes surrounding desirable male and female knowledge and experience levels (the stud versus slut problematic) and young men’s desire or need to present themselves as sexual experts. “Males feel sociocultural pressures to appear ‘instinctively knowledgeable’ about sex” (*Ibid.*, p.17). The feminization of contraception and protection is another key problem, “the majority of young males appear to lack interest in issues related to sexual and reproductive health” (*Ibid.*, p.8).

Though young women’s incidence and prevalence are increasingly a direct result of transmission from their male partners, *The Buddy Study* demonstrates that young men are unlikely to see HIV as a cause for concern, are unlikely to think about sexual and reproductive health in general as having any impact on their lives and are highly unlikely to seek out information on what are viewed as essentially women’s issues. “Many of the male participants regarded HIV and ‘sex

talk' more generally as female topics of conversation...sexual health is a woman's issue" (Gahagan and Rehman, 2004, p.17). This is unfortunately not uncommon.

The barriers that men face in using [sexual and reproductive health] services are often related to sociocultural norms that ascribe reproductive responsibilities entirely to women... because HIV/AIDS information and services are provided primarily in [family planning] clinics, men are less likely to benefit from those services and are thus less likely to be fully informed about HIV/AIDS prevention (Rao Gupta et al., 2003, p.16).

Some of the recommendations for developing strategies to address these issues include a gender-based approach to HIV prevention messages, creating effective education programs and youth fora for discussion of relevant sexual and reproductive health and HIV prevention, and distributing condoms and effective and detailed information on HIV and other STIs.

There are also considerations related to normative understandings of lived and sexual experience and risk when undertaking an effective gendered approach to HIV prevention.

The serious incongruence between people's concrete and varied experiences in the [HIV/AIDS] epidemic and the dominant social and scientific practices operating on narrow and deadly cultural assumptions about sexual and gendered realities [exists]...the social acceptance of the common knowledge and definition about the epidemic, most notably in the areas of epidemiology and safe sex education, masks the continuing and escalating instability exactly in those same areas (Erni, 1998, p.3).

Education and prevention programs should not, as they currently do in Ontario (see Section 10 for further discussion), operate along binary constructions of male / female, gay / straight, safe / unsafe. They should not be, as they are in schools, focused on biology and characterized by euphemism; "HIV transmission does not occur in a vacuum" (CAS, 2004b, p.3) though many formally approved government curricular materials might have some students think so. Even some recent studies and research projects have failed to clearly identify the variability and multiplicity of identities and behaviours that exist and which offer potential for HIV transmission. Sex, gender and sexuality have been shown to be infinitely malleable and varied, and gendered and sexual identities

are more likely to be multiple and variable than monolithic and absolute (Gahagan and Rehman, 2004; and CAS, 2004b). This must be considered when developing and delivering effective sexual and reproductive health and HIV prevention programs, in order that the message not be overlooked – if youth are not visible in HIV/AIDS discourse and in the prevention messaging that is disseminated, they will continue to ignore its relevance to their own lives (CME, 2003).

Making HIV prevention relevant and interesting to youth is a challenge, particularly the development of a program that encompasses gendered, age-appropriate and targeted approaches. “Educators must realize that to prevent HIV transmission successfully they must incorporate prevention information within the reality of an individual’s life” (CAS, 2004b, p.3), and for many youth in Ontario and Canada this means addressing on the one hand the discursive and gendered structures which frame their lived experiences, and on the other the basic practicalities of prevention, like accessibility of condoms and the ability to use them effectively.

One of the most important messages that can be disseminated in support of innovative, gendered HIV prevention interventions and education is simply that “effective prevention and sexual pleasure are compatible” (CAS, 2004b, p.8), in direct opposition to the fears of many young people (and the assertions of those older) that condoms (male condoms, female condoms and dental dams) reduce pleasure and spoil the mood (Gahagan and Rehman, 2004; and CFSH, 2007). First of all there needs to be a clear recognition of the mutability of sexual acts undertaken by people who identify themselves as heterosexual – limiting discussions of HIV risk, safer sex or risk reduction to penile-vaginal sex erases other forms of erotic congress (anything from mutual masturbation, anal and oral sex to BDSM – bondage & discipline, domination & submission and sadism & masochism – Wikipedia 2008). Secondly there needs to be a rethinking of sex in general and safer sex in particular, as there are a number of sexual activities beyond vaginal penetration that can be safe and extremely pleasurable for women. “If sexual pleasure were the goal, as teenagers usually say it is,

then young women in particular would opt for alternative sexual practices” (Lenskyj, 1991, p.289). Schooling which includes some discussion of arousal and techniques for pleasure might be beneficial to all. However, girls are unlikely to have the power necessary in a relationship to insist on other sexual activities (*Ibid.*), let alone the power to insist on condom use, therefore learning that focusses on empowerment, negotiation and self-assertion must also be provided. “Women will be able to protect themselves from HIV infection when they have power in their relationships and an independent sense of self-worth...[then] women can reject roles of passivity, and claim their own sexual pleasure and identity” (Banzhaf and Bellamy, 1998, p.104).

In a fundamental way, it must be recognized that “HIV/AIDS is more than a health matter” (Rao Gupta et al., 2003, p.45). It is also about sex and reproduction, human rights, equality and equity. Gendered interventions must empower women, be tailored to subvert and disrupt gender and sex norms, engage men in reproductive health practices, be clear and detailed about risk activities to emphasize relevance, and provide women with the tools necessary to be able to negotiate safer sex (Lewis, 2002). “The effectiveness of HIV/AIDS programmes and policies is greatly enhanced when gender differences are acknowledged, the gender-specific concerns and needs of women and men are addressed, and gender inequalities are reduced” (Rao Gupta et al., 2003, p.6).

7. Analytical Framework

The methodological impetus of this study is qualitative, given the need to present a detailed view of the topic (Creswell, 1998) and will be manifested largely as a critical content analysis of HIV prevention and education initiatives in Canada, undertaken from a feminist perspective. A feminist perspective is in fact fundamental to this study; by highlighting young women’s increasing risk and identifying and stressing the links between gender, sexuality and HIV prevalence, a

gendered perspective is marked as a central component of effective HIV prevention for women. Gender is a “basic organizing principle that shapes the conditions of [women’s] lives” (Fox-Keller in Creswell, 1998, p.83); when gender is not acknowledged or addressed in HIV education and prevention initiatives, women’s risk is compounded (UNAIDS, 2007). Simply adapting prevention initiatives to women or tacking a gender component onto an existing program (which in Canada have for the most part been developed with discrete groups such as gay men, see **Annex 1**, or minority populations in mind, see **Annex 2**) will not benefit most young Canadian women. Perceptions of risk are weakened when ethnicity or sexuality are privileged over gender as markers of risk. After all, those who are “encouraged to see themselves as ‘ordinary’ or as members of the ‘heterosexual community’”(Patton, 2002, p.xiv) have often been ignored, marginalized or deemed irrelevant in HIV/AIDS discourse (i.e. HIV as the gay man’s / drug user’s / prostitute’s disease) whether in early safe-sex campaigns in the United States, as Patton argues, or in current prevention research and initiatives. In fact, women are too often misrepresented in every aspect of the epidemic; this understanding profoundly affects prevention efforts.

‘Woman’ is too many things in the epidemic: epidemiology’s partner’s of, communities’ other half...They are either a demographic exception (not gay men) or the idealized case where we see the unbiased (by sexuality) truth of the pathos of the epidemic. Simultaneously passive, innocent victim and monstrous, infectious sex organ, women do not yet have a voice that gives them purchase on the...systems that engulf them (Patton, 1998, p.xiii).

A feminist critique of the various documents is thus a necessary exercise for beginning the process of implementing change and for challenging existing norms. This kind of change, in the context of a gendering of HIV discourse through inclusion in prevention policies, programs and practices, is largely a political exercise and as Chris Weedon (1987) argues, “feminism is a politics. It is a politics directed at changing existing power relations...[which] structure all areas of life, family, education and welfare, the worlds of work and politics, culture and leisure” (p.1). These

power relations, embedded as they are in education, health, scientific and medical systems (Patton, 2002), are certainly reflected in HIV/AIDS discourse and are therefore certainly also embedded in prevention and education initiatives. It is in the analysis of these relations and other elements of latent content that the feminist perspective will prove particularly relevant. Latent content is found in “the meaning underlying what is said or shown” (Fraenkel & Wallen, 2003, p.487), and therefore involves interpretation. As Belsey and Moore (1997) argue, “all interpretation is political” (p.1), lending itself very well to a feminist approach.

To interpret a work is always to address, whether explicitly or implicitly, certain kinds of issues about what it says. The feminist reader might ask...how the text represents women, what it says about gender relations, how it defines sexual difference. (A few texts...do not depict any women at all, and say nothing about gender relations, and...that too signifies.)(*Ibid.*).

The presence or absence of women in HIV/AIDS discourse and particularly in prevention research, guidelines and programs; their representation and the representations and definitions of gender, gender relations and sexual difference are all profoundly important issues to be addressed in this study. “Representation can be the product of ideology, that vast scheme for...justifying [the world’s] dealings” (Stimpson in Lincoln & Guba, 2000, p.184). By interpreting women’s representation in HIV/AIDS discourse, particularly relating to HIV prevention, this study is engaging in a necessary political feminist exercise.

Finally, by drawing on one element of a queer perspective within this feminist approach, even in limited fashion, the potential for a deeper analysis (and hence a strengthened response) is afforded; *sexuality* has been a “guiding term of analysis”(Erni, 1998, p.10) for queer theory as *gender* has been for feminism. With that in mind, heteronormative assumptions about women’s sex and sexuality present in HIV epidemiological and prevention documents, particularly in relation to risk, are identified and addressed in some respects throughout this study¹⁹; further analysis in this

¹⁹ Though I do not claim that this aspect of the analysis is comprehensive.

area is needed however. As HIV/AIDS sets about disrupting an infinitely variable array of gendered and sexualized bodies and behaviours, prevention efforts and other responses cannot isolate gender and sexuality from one another. “Epidemiological knowledge...is notoriously universalizing in its production of gender and sexual groupings defining risks...[and] is notoriously fragile in the face of the shifting particularities of yet unnamed gender and sexual formations” (*Ibid.*, p.16). Gender and sexuality are messy and fluid states; in terms of HIV/AIDS discourse, they must be addressed simultaneously and in relation to one another in order to assess young women’s place in the epidemic and to facilitate the provision of effective prevention tools.

8. Methodology

This study addresses the documentary component of the problem of increasing HIV incidence and prevalence among young Canadian women, first by reviewing relevant education and public health policies and programs; secondly through an analysis of their content. A documentary analysis is an important first step for understanding young women’s representation in HIV/AIDS discourse and assessing their prevention needs; once the scope and nature of the issues are clearly laid out, this understanding can be applied to the future development of subject research involving young women which encompasses their own experiences and understanding. Taken together, both the documentary and subject research will serve to inform the eventual development of effective, practical and theoretically sound gendered prevention initiatives.

A qualitative content analysis of relevant documents lends itself very well to a critical feminist research study: “Content analysis is a technique that enables researchers to study human behaviour...through an analysis of their communications” (Fraenkel & Wallen, 2003, p.482). A feminist review and critique of ‘communications’ documents is therefore a useful enterprise. This has been accomplished first of all through the provision of a “detailed thick description” (Creswell,

1998, p.201) of the topic, thereby facilitating the acquisition of descriptive information and the formulation of themes (Fraenkel & Wallen, 2003) around HIV/AIDS discourse and prevention. Policy documents, curricular guidelines, epidemiological data and research studies of the last ten years are representative of a documentary cross-section of the state of HIV prevention in Canada, and have provided the necessary level of detail for a descriptive approach (Neuendorf, 2001) to content analysis.

The analysis is bounded by time (approximately 1996 – 2008) and within this timeframe, further sampling of documents has occurred through an assessment of their specific applicability to the Canadian context (i.e. curricula, policies), or their generalizability in terms of gender and prevention issues (i.e. national or international studies). It is important to note that in a few instances, though only where necessary, a few older documents (for example prevention guidelines and health or education frameworks from the 1980s) have been addressed. Except where indicated or specifically discussed however, the terminology used throughout analysis conforms to contemporary usage (for example, HIV/AIDS rather than AIDS, HIV rather than ARC²⁰, STIs rather than STDs, etc.). The detailed, thick description has therefore emerged from an analysis of a wide variety of documents taken from international, national, provincial and regional sources. Canadian epidemiological monitoring reports and surveys (necessary for statistical data regarding prevalence and knowledge levels); funded and peer-reviewed studies (for insight into young women's representation in HIV/AIDS discourse, prevention guidelines and practices, etc); and HIV prevention guidelines and public health and formal educational programs, including learning materials (for understanding current iterations of representation and prevention) have all been assessed in light of young Canadian women's perceived needs.

²⁰ AIDS Related Complex – used in the 1980s to refer to early symptoms experienced by those who were HIV positive, including reduced T-cell counts, but who had not yet developed AIDS. HIV+ individuals who were asymptomatic were merely referred to as 'carriers' (OME, 1987). Now the terminology has been simplified to differentiate only between those who have seroconverted (are HIV+), and those who have developed full-blown AIDS.

Though there is a reliance on funded research over peer-reviewed research evident (given that that is what is primarily available in the Canadian context at present), the epidemiological, socio-cultural, educational and operational elements of HIV prevention have all been addressed in this study to the extent possible, and have allowed for the development of an understanding of the current state of gendered HIV prevention and education initiatives in Canada, particularly Ontario; of young women's prevention needs, as conceived of by epidemiologists, educators and researchers; of the current state of their HIV knowledge, as assessed through various studies; and of their HIV risk 'status', as understood in both medical-scientific discourse and critical feminist discourses.

The analysis also takes into consideration both the manifest and latent content of the legal and operational documents (i.e. policies and curricula), enriching the description of the problem further by adding a quantitative as well as a qualitative dimension to the research, if only in limited fashion. The manifest content has been assessed in a straightforward manner, by applying a checklist template to existing federal and provincial policies, guidelines, program frameworks and curricular documents. Through a simplistic method of coding (i.e. counting occurrences of words such as gender and women as they appear in specific contexts, or noting the dedicated HIV/AIDS-related focus of various documents – see **Annex 3**) the checklist has been used to determine the degree of inclusion of a gendered perspective in Canadian HIV prevention programming. The latent content on the other hand has been assessed through a more holistic, qualitative form of 'coding' or analysis. This has been accomplished through an analysis of the integration of gender into a program based on responses to a series of 'questions' or criteria derived from credible sources (i.e. UNAIDS, Commonwealth Secretariat and Maritime Centre of Excellence for Women's Health gender mainstreaming guidelines – see **Annex 4**) and filtered through a critical feminist lens. This has aided in determining the existence and scope of a gendered perspective with a view to reflecting

this information back to researchers and educators, highlighting absences and silences in representations of women in HIV/AIDS discourse and prevention efforts.

The actual Ontario Ministry of Education curriculum documents have undergone an analytical review distinct from other source materials, guidelines, learning tools and programs. The manifest and latent content assessment tools were developed prior to a complete reading of the relevant senior secondary curricular guidelines. Though still applicable to other texts, the paucity of HIV and sexual and reproductive health-related issues discussed and terminology used in the curricula, in combination with the lack of any dedicated HIV and SRH expectations and outcomes, means that an alternative approach to reading had to be devised. The few instances where *HIV/AIDS*, *sex*, *sexuality* and *gender* are mentioned have been counted and assessed in terms of their context, whether they contribute to a normative understanding of issues related to the HIV epidemic in particular and gender and SRH in general, and whether any meaningful approach to or discussion of the issues can be construed; in that sense a modified, simplistic use of the manifest and latent assessment guides has been made.

With regards to the remainder of the curricula, only the following questions have been asked: is there potential for the inclusion of gendered HIV/AIDS prevention education to take place in the context of the guidelines? Which determinants and indicators of overall sexual and reproductive health (i.e. health / social justice determinants such as gender, sex, sexuality, socio-economic status, employment, religiosity, coping skills, health choices, etc.) could be addressed to support the achievement of specific expectations and outcomes?

Finally, the formulation of themes derived from formal education or public health policies, guidelines and practices have helped to categorize the descriptive information, obtained with the help of the checklist and criteria templates, for ease of analysis. Formulating themes “[helps] to...make sense out of large amounts of descriptive information”(Fraenkel & Wallen, 2003, p.484),

and has been particularly useful given the number and variety (and occasional incohesiveness...) of the documents that were assessed. Some of the themes addressed are young women's representation and inclusion, the inclusion of gendered approaches and consideration of gender issues, sex and sexuality, and normative understandings of risk. The subsequent comparison and analysis has revealed facets of current HIV prevention and education initiatives in Canada generally and Ontario in particular, and highlights both their strengths and inadequacies in light of young women's perceived needs.

8.a) Instrumentation:

Because this study is largely qualitative in its development and implementation, the procedure for instrumentation design is fairly straightforward and the tools themselves relatively simplistic. As indicated, a checklist template (**Annex 3**) for manifest content has been developed that has been applied to the various documents (the only element of quantitative assessment). The results that derived from this analysis are presented as a simple sum (for example the number of times the word "gender" or "HIV" appears in a curriculum outline, in relation to the length of the document or relevant sub-section), or if the document is focussed specifically on HIV, young women's sexual and reproductive health, etc., rather than counting off hundreds of occurrences, the dedicated nature of the material has been noted instead.

A criteria or questions template (**Annex 4**) for qualitative assessment of the latent content has also been developed, though the structure of the template is based on research into already existing international and national frameworks for effective gendered HIV prevention. Slight modifications in the approach to or use of this assessment tool were required depending on whether the questions were applied to a research study, policy document, or formal curricular document, however overall the same general considerations applied to every individual analysis. Overall, the templates helped to ensure that relevant data, themes and categories were consistently if not

universally addressed.

This method of instrumentation also served to ensure ease of analysis, as the data was in most cases simultaneously identified and categorized. Common themes, categories and phrases helped with the identification of types of representation, of the inclusion or exclusion of a gendered perspective and other important issues. In addition, the coding and categorization of data which resulted from the use of these templates has helped to ensure the trustworthiness of the results garnered by the study, as they function as the baseline assessment upon which the analysis has been based.

8.b) Verification:

Verification is necessary for establishing the reliability of this study (Creswell, 1998). By assessing the Canadian response to HIV/AIDS in light of local, national and international studies, the richness of data necessary for ensuring trustworthiness and authenticity (Lincoln & Guba, 2000) has been provided. As described earlier, one of the primary methods for facilitating verification is through the use of the rich and detailed description, achieved through the consultation and analysis of documents from a wide variety of sources, disciplines and perspectives. A comparison and contrast between the manifest and latent content, combined with an analysis of that content in comparison to other studies has also served to verify results (Fraenkel & Wallen, 2003). Finally, verification can be applied to the coding process due to its clarity and simplicity and to the formulation of thematic categories derived from the analyses of the manifest and latent content; “the categories [are] so explicit that another researcher could use them to examine the same material and obtain substantially the same results” (Fraenkel & Wallen, 2003, p.486).

9. Research Context

As demonstrated in the statement of the problem and in the literature review, there is a growing body of HIV/AIDS-related research and analysis focussing on prevention issues as well as on the gendered or sexualized dimensions of the epidemic, though not often both at the same time. Given young women's increasing risk in Canada, particularly in the face of ignorance or misunderstandings, research that focusses on effective gendered education and prevention initiatives is especially timely. In order to effect change, it is first necessary to establish the scope of the problem in Canada, which by many accounts, as demonstrated, is increasingly urgent if not yet catastrophic. Several studies involving young Canadian women, in conjunction with a review of available epidemiological data, legal documents such as the *Federal Initiative to Address HIV/AIDS in Canada* (PHAC, 2005a) and the Ontario Ministry of Education curricula all provide insight into the problem of increased HIV incidence and prevalence. It is clearly a significant issue facing young women, yet one which garners astonishingly little attention in public health and educational research, policies, guidelines and practices. It is therefore necessary to assess the manner in which women are represented in the relevant documents and to determine what exactly it is that they are saying about young women and prevention in HIV/AIDS discourse in Canada.

9.a) Federal SRH and HIV/AIDS Policies and Guidelines – The Canadian Context:

Nationally, Health Canada and the Public Health Agency of Canada are responsible for developing and administering SRH and HIV/AIDS policies and guidelines, as well as for coordinating epidemiological surveillance at the national level (CFSH, 2007). Specifically, the Federal Government is responsible for health policy, research and funding; the provinces and territories are responsible for organizing and delivering health services and distributing federal funding according to program needs and priorities; and regional health organizations are responsible for delivering health services (CPHA, 2005). Each plays a distinct role in developing,

implementing and monitoring health guidelines and programs, however federal leadership in the area of HIV prevention and research is particularly important as “the stigma and discrimination associated with HIV and... the resources and leadership [needed] in this area” (*Ibid*, p.21) can make information and services in some regions (or contexts) more difficult to access than in others. For example the Durham Catholic Board of Education in Ontario is known for conservatism and reactive sex ed policies (i.e. insisting on teaching only abstinence for prevention, and in another instance threatening to suspend an openly gay student who wanted to bring his male partner to his high school formal – CBC, 2002).

In the past, federal policy on HIV/AIDS research and education has been criticized as reactive and penny-pinching, and marked by a lack of political will (Rayside and Lindquist, 1992). Today, though federal leadership is weakened and explicit SRH and HIV health policies are still lacking, specific strategies in Canada concerning HIV/AIDS (if not SRH as a whole) are stronger, if still far from ideal. The *Canadian Strategy on HIV/AIDS* (Health Canada, 1997) was first developed in the mid-nineties and was characterized by partnerships, a focus on research, surveillance and epidemiological monitoring, and international collaboration (Mulvihill and Jacino, 2001). Goals related to prevention and education in this earlier incarnation were to “prevent the spread of HIV infection [and] to counter the social and economic factors that increase individual and collective risk of HIV infection” (*Ibid.*, p.89), an early model of a determinants of health approach. Youth and heterosexuality were already identified as indicators of risk groups (albeit seemingly as discrete and un-gendered populations) and complacency (i.e. misperceptions of risk, safe sex fatigue, etc.) was already marked as a significant issue in terms of prevention.

In 1999, partly in support of the *Canadian Strategy on HIV/AIDS*, Health Canada sought to strengthen and promote overall strategies for advancing the sexual and reproductive health of Canadians (including through the prevention of STIs and HIV). The *Report from Consultations on*

a Framework for Sexual and Reproductive Health (Health Canada, 1999) was developed in concert with stakeholders across Canada with the intention of providing governments, NGOs, health care providers, educators and activists with tools for collaboratively developing policies, and with the “principles [needed] to guide action, seven strategic directions focusing on the major determinants of sexual and reproductive health, and suggested initiatives for each of the seven directions”(p.1). The purpose of the report was to work towards maintaining, protecting and promoting SRH, and the eight principles guiding the work affirm individual sexuality and autonomy, access to information and prevention, the right to knowledge, supportive and safe physical and social environments and safe, effective, prevention interventions. Specific determinants of SRH are related to socio-economic status (income, social supports, education, employment, etc); physical environment; individual capacities, coping skills and health practices (health and lifestyle choices, and psychological and biological characteristics); and health services (access to health promotion, protection and recovery services) (*Ibid.*). The authors also found that gender and culture are cross-cutting, over-arching determinants of health that interact in complex ways with the others.

Of the many initiatives proposed in the addendum to the report, improving education (child, family and professional), addressing gender-based inequities and discrimination, contributing to healthy and open attitudes to sex and sexuality, enabling access to services, facilitating economic development and employment opportunities, and enhancing information and research are core (Health Canada, 1999). Unfortunately, any momentum gained from the consultations was not sustained apart from initiatives relating to sub-elements of SRH, such as HIV prevention and research (CFSH, 2007). Though this is not to be dismissed, particularly in the context of this study, the integration of HIV prevention and education initiatives into a sustained and comprehensive SRH framework is the preferred approach for most concerned parties, whether it is referred to explicitly

as an SRH approach (WHO 2004; and CFSH 2007) as a population health approach (FPT AIDS, 2004), or a social justice or determinants of health approach (UNFPA, 2003).

In the most recent iteration of a federal HIV strategy, the *Federal Initiative to Address HIV/AIDS in Canada* (PHAC, 2005a), the focus on determinants of health and prevention as paramount is significant. The newer initiative is linked to the *Canadian Strategy on HIV/AIDS* (Health Canada, 1997) by an interim report, *The Federal Initiative to Address HIV/AIDS in Canada - Strengthening Federal Action in the Canadian Response to HIV/AIDS* (PWGSC, 2004) which lays out in detail the roles and responsibilities, planned funding, areas of action and examples of activities. Many of the activities are reiterated in the federal framework *Leading Together* (CPHA 2005) discussed below.

The federal initiative states that through program and policy interventions, coordination, global engagement etc., the federal government will work towards “[preventing] the acquisition and transmission of new infections... [contributing] to the global effort to reduce the spread of HIV and [mitigating] the impact of the disease” (PWGSC 2004, p.7). The initiative involves a partnership between the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research (CIHR) and Correctional Service Canada (*Ibid.*). Their actions are meant to be guided by three policy directions: partnerships and engagement for a coherent, aligned approach with a focus on determinants of health to be implemented and maintained; an integrated approach to program implementation; and mutual accountability among the federal government and its partners (*Ibid.*).

In support of the strategy, a national framework was developed. *Leading Together: Canada Takes Action on HIV/AIDS 2005-2010* (CPHA, 2005) is fairly robust in theory, though its use and application by provinces, AIDS Service Organizations (ASOs) and other stakeholder groups is encouraged rather than mandated (PHAC, 2005a), and it relies somewhat on a ‘canonical’ (Erni, 1998) understanding of sex, sexuality, gender and risk. It is however characterized by a global

approach and outlook; by calls for sustained and dedicated funding; by innovation in research and prevention; and by a focus on the socio-economic, social justice and human rights (or integrated SRH) components of the epidemic. One of the most significant advances in the current strategy is the identification of women between the ages of 15 and 29 as being among those populations most at-risk; age is a considerable factor in women's vulnerability (CPHA, 2005), particularly given the interplay and impact of social determinants such as peer pressure and popular culture on young women's development, knowledge and risk behaviours (Ward & Waters, 1999; Tolson and Kellington, 2001).

Leading Together is intended as a call to action, and it does so with zeal, if not complete accuracy. For example in the opening vision statement, it is claimed that in Canada "the racism, discrimination, poverty, and homelessness that fuel the epidemic have been reduced or eliminated" (CPHA, 2005, p.5). Presumably sexism is another form of oppression that is considered to have been eliminated, however if that were the case, there would be little need to undertake the present study; unfortunately the erroneous nature of that claim will be borne out by the conclusions drawn in the coming pages. Regardless, through an approach that values social justice, human rights, diversity, participation and empowerment of the disadvantaged, and a sense of global responsibility and mutual accountability, the framework sets out to achieve four goals by the year 2010:

1. Reduce the social inequities, stigma and discrimination that threaten people's health and well-being.
2. Prevent the spread of HIV.
3. Provide timely, safe and effective diagnosis, care, treatment and support for all people living in Canada with HIV/AIDS.
4. Contribute to global efforts to fight the epidemic and find a cure (*Ibid.*).

The emphasis on prevention is reiterated throughout the framework, and is echoed in the first of six key strategies discussed, specifically through sustained funding and increasing awareness of HIV. This is largely to be accomplished through education, media coverage and campaigns, etc.,

despite the fact that research has consistently shown that media, particularly the internet, are not accessed by Canadians, youth especially, in their quest for information on sex and sexuality (CAAH 2006; Gahagan and Rehman, 2004; CME 2003, etc.). Most importantly, the third initiative deals specifically with ramping up prevention efforts through “targeted programs that use culture / gender-sensitive and age-appropriate prevention strategies” (CPHA, 2005, p.30). At-risk youth are identified as a sub-population of significant concern; peer programming is highlighted as an effective mechanism for prevention interventions. Finally, women and heterosexuals generally, particularly young women aged 15-29, are also highlighted as significant sub-populations at risk of HIV transmission. The framework calls for gender-sensitive and empowering prevention programming that will provide women with the tools (biological, medical, economic, social, educational and cultural) needed to stave off risk. Overall, it provides the potential for effective policy and program development and implementation.

Unfortunately for the last few years the federal leadership role has weakened substantially. Most of the targets of *Leading Together: Canada Takes Action on HIV/AIDS 2005-2010* (CPHA 2005) have not yet been achieved despite four years of work. What became one of the most widely discussed among these targets was for the Prime Minister of Canada to open the 2006 International AIDS Conference in Toronto; Harper simply refused to attend, citing previous commitments (CBC, 2006). In addition, for the past two years there has been no federal political representation at the annual Canadian Association for HIV/AIDS Research Conference (CAHR2008), unless a two-minute, pre-recorded speech by Minister Clement (played over the sound system in the main auditorium in Montreal in 2008) can be construed as attendance or adequate political representation and support. Policy and program initiatives called for within Health Canada’s *Report from Consultations on a Framework for Sexual and Reproductive Health* (1999) “were never drafted and national objectives and standards were not set” (CFSH, 2007, p.10).

Finally, the majority of federal funding allocated to HIV/AIDS programs is based on the commitments of previous governments (FPT AIDS, 2004), and that funding is steadily eroding (Ontario AIDS Network, 2008b). The *Federal Initiative to Address HIV/AIDS* promised to double funding from \$42.2M in 2003/2004 to \$84.5M by 2008/2009 (PWGSC, 2004), yet that ultimate target has not been reached and in the past year the Conservative government has *cut* \$1M from front line prevention and treatment programs, and will likely cut at least another \$7M over the next few years (Cress, Pinault and Kennedy, 2008). For Ontario alone this equals 30% of annual funding, and its prevention and health promotion programs were the first to suffer from funding cuts (van Veen and Kennedy, 2007). The situation is much more dire in Alberta, where the funding expired in March 2008; Alberta has still not received a commitment from the Conservative government to renew that funding (Cress et al., 2008). The worst part is the political *léger-de-main* at work in this situation. The Conservative government has been touting their “up-to-\$111M” pledge (made in concert with the Bill and Melinda Gates Foundation) to HIV vaccine research as a boon to HIV/AIDS research worldwide (PMO, 2007). While this is a more than worthy initiative, the cuts to provincial and regional HIV programming (primarily education and treatment programs) are being redirected to vaccine research (Cress et al., 2008); in the meantime, more people will become infected and those already infected will suffer from poor care and reduced services, all so that Harper can be, potentially, forever remembered for his role in the sexy cure initiative, rather than be forced to endure being perceived to care about the safety and lives of addicts and queers.

9.b) SRH and HIV/AIDS Strategies and Programs in Ontario – The Provincial Context:

Ontario’s response to the HIV/AIDS epidemic precedes that of the federal government (Ontario Advisory Committee on HIV/AIDS [OACHA], 2002). The first provincial HIV/AIDS strategy was developed in 1995 (two years before the first Canadian strategy), and focussed on preventing the spread of HIV and caring for those already infected (*Ibid.*). The strategy was

updated in 2002 according to proposals made by the Ontario Advisory Committee on HIV/AIDS (FPT AIDS, 2004) and aligned for consistency with the then federal Canadian Strategy on HIV/AIDS (OACHA, 2002). The new strategy calls for a comprehensive approach based on social justice, which recognizes diversity and difference, encourages self-esteem (i.e. coping skills), ensures access to medical and information services, meets basic needs (i.e. housing), reduces inequities and encourages equitable participation of the disadvantaged (*Ibid.*); all of these elements of social justice echo and complement an overall sexual and reproductive health approach.

The two overarching goals for the strategy are first, to prevent the spread of HIV, and second, to “improve the health and well-being of people living with HIV and their communities” (OACHA, 2002, p.43). Prevention is to be accomplished through four key policies, most notably by adopting a determinants of health / social justice approach (social, economic, environmental and health factors); and focussing on integrated, sustainable, targeted responses (Ministry of Health and Long-Term Care, 2008). The strategies for accomplishing Ministry goals and implementing these policies include the development and dissemination of knowledge, fostering leadership at the provincial, regional and community levels and engaging in prevention efforts (OACHA, 2002).

The primary office responsible for implementing the Strategy is the Ministry of Health and Long-Term Care (MOH). The Ministry coordinates its efforts with several stakeholder groups responsible for monitoring and surveillance (the Ontario HIV Epidemiologic Monitoring Unit and regional public health offices), and prevention, education, research and support programs (i.e. Ontario AIDS Network, Ontario HIV Treatment Network, etc.) (MOH, 2008); disturbingly, neither the Ontario Ministry of Education nor organizations such as the Ontario Physical Health and Education Association (Ophea) or the Canadian Federation for Sexual Health are mentioned anywhere as education partners.

Not including physician and drug costs, the province spends \$55M annually on HIV initiatives; on more than 90 programs including prevention strategies geared towards primary at-risk groups, including women; on anonymous and rapid HIV testing; on a province-wide pre-natal testing program; and on information hotlines, clinics and hospices (MOH, 2008). In addition, the Ministry is taking steps to address women's increasing vulnerability to HIV exposure.

A strategy to address the growing rates of HIV infection among women in Ontario is being developed by a working group of ministry staff, researchers, community representatives and people infected and affected by HIV/AIDS. The Ontario Women's Study, an Ontario-wide research program, is currently being designed that will take into account the varied life experiences of women who are vulnerable to HIV infection (*Ibid.*).

What that study might entail is however unclear – there have been indications for the past two years only that it is in development.

In a further assessment of governments' response to the HIV/AIDS epidemic, in 2004 the Federal/Provincial/Territorial Advisory Committee on AIDS (FPT AIDS) prepared *A National Portrait: A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada*. Overall the report found that "governments across Canada...are responding to the epidemic in a manner appropriate to their circumstances" (FPT AIDS, 2004, p.ii). As with other reports cited in this study, the authors provide a broad overview of epidemiological data, national and provincial programs and services and considerations for future direction, however it also details the responses of governments at the provincial level. In addition, it is one of the few reports that cites "conservatism surrounding sexual health education and harm reduction" (*Ibid.*, p.iv) as a barrier to responding to the HIV/AIDS epidemic (though oddly, throughout the document the related stigma are consistently attributed to so-called *small* communities; discrimination and conservatism in Canada's metropolitan areas, or among the political leadership, are not discussed).

The *National Portrait* report also provides an assessment of the strengths and weaknesses of Ontario's response to HIV/AIDS, including prevention services. The strengths identified in the province's initiatives include "variety and comprehensiveness of prevention programs, availability of anonymous HIV testing [and] community expertise" (FPT AIDS, 2004, p.36). Weaknesses are attributed to the "fragmentation of services, lack of co-ordination...*lack of sustained, high profile information campaigns, lack of focus on determinants of health...and lack of education for youth*"²¹ (*Ibid.*). Though prevention efforts have been stepped up somewhat since 2004, there are still many weaknesses and omissions apparent, particularly with regards to information campaigns and public education programs (addressed in further detail in the following sections).

As highlighted in the *National Portrait* and as made clear through a review of programs currently in operation, prevention initiatives continue to be lacking in important ways, despite their presumed importance. Of the eight research programs that are currently underway and funded in whole or in part by the provincial government, only the "Women and HIV/AIDS Working Group", which is one of the groups working on the as-yet-to-be-released woman-oriented HIV strategy, deals with women or even references gender as an issue (MOH 2008). Very little information on the working group is available however and to date only a literature review has been published (McWilliam, 2006). Current provincial public health campaigns highlight this lack as well; there are only two HIV-related sexual health campaigns operating and these are targeted to specific communities (in this case MSM and the Toronto Afro-Caribbean community, see Annexes 1 and 2). The intersection of vulnerabilities and risk activities for women is ignored in favour of ascribing a broader risk identity to these communities.

This lack of a focus on a gendered perspective in research and prevention initiatives is problematic for various reasons; when individual risk factors such as race, ethnicity and sexuality

²¹ My emphasis.

are privileged in identity-based categorizations of risk rather than understood as intersecting elements affecting behaviour and attitudes with regard to risk activities (Erni, 1998), “risk markers that correlate with other more fundamental determinants of health status such as poverty” (CDC, in Spigelman, 2002, p.24) (fundamental precisely because, like gender, poverty *transcends* categories) are lost.

In terms of formal sexual health education in the schools, the Ministry of Health and Long-Term Care, as well as the newer Ministry of Health Promotion (MHP, 2008) have very little to say. The goals of the primary and secondary sexual health education curricula were listed on the Health Ontario website as recently as 2007, however the site has been updated and the goals have now been removed²². There also were and continue to be no links made between Ministry of Education and Ministry of Health outcomes and strategies. The fact that young women specifically and youth generally are increasingly at-risk makes this omission highly problematic.

9.c) Prevention and Education:

According to researchers, educators and health practitioners (Remis 2007; Remis 2008; and UNAIDS & WHO, 2000), research on and development of HIV prevention and intervention strategies are urgently needed in the Canadian context. This is particularly true for understanding at-risk groups, and currently among those increasingly at-risk are young Canadian women (PHAC, 2007a). Gendered prevention initiatives which do not either categorize women as a monolithic risk group or privilege one manifestation of vulnerability over another are necessary.

9. c) i: International

There is a growing international consensus on just what gendered prevention programs might entail. The World Health Organization (WHO) provides a detailed description in the

²² When I attempt to use the link I referenced in the proposal for this thesis prepared in 2007, an error message appears indicating that the content is no longer available. I have still cited it in the reference list however as I refer to it several times (http://www.health.gov.on.ca/english/public/updates/archives/hu_06/aids06/flash/index.html).

document *Integrating Gender into HIV/AIDS Programmes* (2003). The importance of understanding norms of femininity and masculinity; poverty and dependency; and the special vulnerabilities of youth, particularly in terms of gender relations and socialization, risk behaviour, alternative sexual practices and peer pressure, is fundamental for effective program development (WHO, 2003). Integrating gender is essential for increasing the effectiveness of interventions and for ensuring gender equity and equality (*Ibid.*)

The UNFPA *HIV Prevention Now* (2003) collection of programme briefs cite similar policy guidelines and program perspectives. Because heterosexual HIV transmission represents 75% of all transmissions worldwide, “sexual and reproductive health programmes...serve as entry points for addressing the social and behavioural changes that can slow the spread of [HIV]” (UNFPA, 2003, p.2). The UNFPA calls for “gender-responsive sexual and reproductive health programmes to achieve HIV prevention among young people” (*Ibid.*, February, p.4). This will be accomplished by “[strengthening] HIV/AIDS and sexual and reproductive health education programmes for young people both in and out of school” (*Ibid.*, December, p.3). A multisectoral, gendered and age-appropriate prevention strategy is therefore likely to be the most useful model for facilitating HIV prevention among women and youth worldwide, as well as among young women in Canada.

9. c) ii: Canada

Over and over again the Canadian federal, provincial and municipal governments have failed in one respect or another to implement or maintain a coherent, sustained, well-funded, integrated and gendered approach to HIV/AIDS prevention and education, to implement a consistent response to the epidemic, and to promote and maintain the sexual and reproductive health of Canadians. “Canada needs a better approach to HIV/AIDS and to health” (Spigelman, 2002, p.39). One such better approach includes integrating HIV prevention and education into a sexual and reproductive health framework, to reinforce the linkages between contraception, protection and

favourable sexual health outcomes. “The more sexual partners that young Canadian women report having, the more likely they are to be using oral contraception, the less likely they are to use condoms, and the more likely they are to have an STI” (Black, Francoeur and Rowe, 2004, p.150). The best way to achieve this and reach the most young women possible is through public sexual health education.

Schools represent the only formal institution to have meaningful contact with nearly every young person in Canada and are therefore in a unique position to equip youth with the knowledge and skills necessary to exercise healthy sexuality throughout their lives (CFSH, 2007, p.10).

The *Canadian Guidelines for Sexual Health Education* (Health Canada, 2003) provide a concrete barometer for the development and assessment of curricular models of sexual health education (though one that is applicable to public health initiatives as well). The guidelines are intended as an overarching uniting principle for policy-makers and practitioners, to provide a “framework for evaluating existing sexual health education programs and policies [and] to guide...the development of new and effective programs” (*Ibid.*, p.v). The authors state that intervention and education programs that take into account environmental (i.e. socio-economic) determinants, and are “designed in partnership with communities [and] tailored to meet...social, economic and cultural circumstances” (*Ibid.*, p.42) are more likely to contribute to sexual health.

The authors of the *Canadian Youth, Sexual Health and HIV/AIDS Study* (CME, 2003) make similar recommendations (though as with the *Guidelines*, the specifics of how to develop this kind of program are unclear).

Policy makers and implementers across Canada within local, regional, provincial, territorial and national governments need to take the lead in ensuring that Canadian adolescents have access to education, information, services and communities that will enable them to develop into sexually healthy adults (*Ibid.*, p.136).

They also argue that the formal education curricular content as well as public health programming of HIV prevention interventions must address underlying issues that influence behaviour, such as socio-economic, gender and cultural issues and other developmental and personal characteristics that impact on beliefs and knowledge (CME, 2003).

The Ministerial Council on AIDS' discussion paper, *HIV/AIDS and Health Determinants, Lessons for Coordinating Policy and Action* (Spigelman, 2002), offers a final perspective. The author begins by stating that since HIV/AIDS has, in Canada as in the rest of the world, become firmly entrenched in the most vulnerable communities and is slowly spreading outwards from there, it is evident that no one anywhere is entirely immune to its impact. The study also finds that literature relating to population health and health determinants "frequently offers recommendations for influencing individual and community behaviour...distributing condoms and clean needles, and encouraging less risky sexual behaviour..." (*Ibid.*, p.38). Most significantly, Spigelman argues that Canada needs a better approach to HIV/AIDS and health. Increased "income and personal security, stability, self-esteem and social support" (*Ibid.*, p.39) is needed in order to mitigate the spread of HIV. The strongest critique yet of government commitment derives from this argument:

It is not clear why Canada and other countries have not built more [support systems]. Given the research and the advice of those undertaking the research, given the experience of those living with HIV/AIDS, and given the intuitive logic of the population health approach, it is perplexing that 'so much evidence apparently generate[s] so little action'(McInnis in Spigelman, 2002, p.39).

Finally, the Ministerial Council states that the 'unsexy' nature of prevention has led to less emphasis on prevention in policy and program initiatives. They argue that the "results of prevention are inherently invisible since their success is measured by the absence of a problem...[that] the rescue is more dramatic than prevention...[and that] prevention must address multiple causes whereas medical care focuses only on visible manifestations" (Spigelman, 2002, pp.39-40). The study concludes by stating that "without efforts to fundamentally improve

(Health Canada, 2003). Sexual health education should be accessible, comprehensive, educationally sound and methodologically effective, delivered by trained individuals and carefully planned, evaluated and updated (*Ibid.*). The goals of the guidelines are “to help people achieve positive outcomes (e.g. self-esteem, respect for self and others, non-exploitive sexual relations, rewarding sexual relationships, desired parenthood); and avoid negative outcomes (e.g. unintended pregnancy, HIV/STIs, sexual coercion, sexual dysfunction)” (*Ibid.*, p. 1). The components of a successful sexual health educational program facilitate the acquisition of knowledge; the development of motivation and personal insight (self-esteem and awareness); the development of skills (i.e. negotiation, setting limits, using condoms, etc.); and the creation of an environment conducive to sexual health (challenging gender roles, sexism, racism and normative understanding of sex, sexuality and risk) (*Ibid.*). The public school system, with access to millions of children and youth every year, is one of the most viable spaces in which to achieve these goals and outcomes.

10.b) HIV, Gender and Sexual Health Education in Ontario:

Ontario was once at the forefront of public health and education programs and prevention intervention initiatives in terms of the Canadian response to HIV/AIDS. The provincial government implemented many policies and programs, frequently in advance of the federal government and other provinces. It was one of the first provinces to implement a public health program and to incorporate HIV/AIDS in the health curriculum in the public education system (Rayside & Lindquist, 1992). Unfortunately, while federal initiatives, at least on paper have become increasingly robust since the mid-1980's (PWGSC, 2004) despite the vagaries, interests and actions – or inaction – of the controlling political parties, the momentum that once drove provincial public health and education prevention efforts, in Canada as a whole and in Ontario in particular, appears to have weakened (or at least has not advanced in line with the changing nature of the epidemic). The education systems that are meant to be responsible for at least a portion of

young women's HIV/AIDS-related knowledge, as well as their capacity for ensuring their own sexual and reproductive health have in part abrogated their duties; public health initiatives have not always met with greater success than formal education programs, despite increased innovation and fewer constraints in terms of content.

This lack in Ontario is especially clear in comparison to the health-related curricula of Quebec and British Columbia, which are far more explicit and specific; sexual and reproductive health education and HIV/AIDS prevention information is more detailed in British Columbia and much richer and more innovative in Quebec. In the Healthy Living strand of the grades 8 and 9 *Health and Career Education* (BCME, 2005) and the Health Decisions strand of the grade 10 *Planning* (BCME, 2007) curricula, sexual and reproductive health issues, including HIV/AIDS, are addressed in a much more comprehensive way than in Ontario. Several determinants of health are addressed in both documents, including the emotional, physical and psycho-social aspects of relationships, decision-making and choices related to nutrition, drugs, alcohol, and sex and sexuality. In terms of HIV information and prevention, some of the expected outcomes do not differ significantly from those found in the Ontario curricular documents (i.e. demonstrate an understanding of the consequences of contracting sexually transmitted infections including HIV/AIDS [BCME, 2005, p.43]) and are based rather more on a prohibitive approach to sex than not (this is echoed in repeated discussions of abstinence). Still, the fact that the curriculum seeks to enhance students' decision-making capacity and to critically reflect on healthy relationships, peer pressure and media stereotypes in relation to sexual and reproductive health (BCME, 2007) means that in terms of a whole health approach, health education in British Columbia is somewhat more innovative than in Ontario.

The Quebec Ministry of Education (QME) curricula are even stronger, and considering that the two course programs discussed here were developed in 1989 (and yet are still relevant in several

respects), this signals an approach to sexual and reproductive health education that is likely by far the strongest in Canada. In the secondary *Human Biology* curriculum (QME, 1989a), the physiological and biological aspects of puberty, anatomy, hygiene and sexual relations are addressed. While the discussion of sexual relations is rooted in a heteronormative perspective, it demystifies the human body in its frank and detailed discussion of various parts and their function, and it is not coy about defining sex or its purpose (*Ibid.*). In the secondary *Personal and Social Education* (QME, 1989b) curriculum however, is where the fundamental strengths and differences lie. Though there are occasional fallacies, such as the assertion that adolescence is the “time for the first intimacies, flirting, the *first expressions of sexuality*”²³ (*Ibid.*, p. 16) (if expressions of sexuality means feeling or desiring sexual contact and pleasure, onset is much earlier, even infancy [CFSH, 2007]), overall the expectations in this course are well in line with a gendered approach to sexual and reproductive health and overall well-being, and account for the socio-cultural as well as personal domains.

Health, sexuality and relationships are three of the core elements of this program, wherein human sexual development; masturbation; adolescent sexual relationships; sexual orientation; sex roles and sex-role stereotypes; pleasure; contraception; and sexually transmitted diseases (QME, 1989b) are all addressed, signalling a vastly more complex and comprehensive approach. This is the only curricular program which specifically identifies knowledge of prevention and avoidance of STIs in its expectations, including a discussion of effects, symptoms and responsibilities relating to STIs. The primary weakness which emerges is again with regards to a heteronormative approach, though the guidelines are quite frank about this: “while encouraging respect and understanding of each person, whatever his/her sexual orientation, this course gives priority to heterosexuality as a path of evolution toward full psychosexual maturity” (*Ibid.*, p.129). Unfortunately this statement

²³ My emphasis.

undermines a great deal of the progressive narrative which precedes it. The fact that this document is almost twenty years old is also problematic, as there is no mention made of HIV at all, and while there is discussion regarding *sex* roles and stereotypes, it is not representative of a truly gendered approach.

10. b) i: Formal Curriculum

In comparison to the stated goals and action items of the *Federal Initiative to Address HIV/AIDS in Canada* (PHAC, 2005a) and the Ontario Ministry of Health (OMH) emphasis on HIV prevention, the Ontario Ministry of Education (OME) guidelines are lacking in several respects. The secondary school *Health and Physical Education Curriculum* (OME HPE, 1999; and OME HPE, 2000²⁴) requirements for studying HIV/AIDS are limited to a discussion of characteristics of current treatment programs and prevention behaviours such as abstinence. Given the flexibility or lack of understanding most teenagers evince towards abstinence (approximately 26% of 14-17 year olds believe oral sex is compatible with abstinence [CAAH, 2006]), and the common failures of abstinence-only education for the prevention of HIV (Ward & Waters, 1999), this represents a distinct weakness. The curriculum also consistently links HIV/AIDS and STIs to pregnancy (OME HPE, 1999). This conflation of HIV and pregnancy simultaneously lessens the significance of the virus, suggesting it is transitory and curable; feminizes it – girls and women traditionally take responsibility for contraception (Langille, Gahagan & Flowerdew, 2002), now HIV prevention has been relegated to women’s reproductive sphere as well; and sexualizes it – HIV transmission through other means (i.e. needle-sharing, blood transfusion, etc.) is not discussed.

Though HIV/AIDS is referenced several times in the secondary school curricular guidelines, there are many more opportunities present for discussion of HIV in various subject streams than are

²⁴ See Annex 5 for complete course list reviewed. Because there are minimum two course descriptions in each curriculum document, and because there are several curricula discussed in this study, the only distinction that will be drawn between them in the body of the study is with regards to the overall subject matter and year of publication.

seized; the Ministry of Health's assertion that "courses such as Biology, Science and Social Sciences and Humanities also provide opportunities to learn about sexual health and AIDS" (MOH, 2006) is not borne out. For example, an examination of the representations of HIV, sex and sexuality would be extremely relevant in the context of popular culture in media-related studies in many of the subject areas including *English, French and Native Studies*, particularly given the relevance of pop culture to youth (Gould, 2007), yet nowhere is this addressed.

As previously discussed, the original intention for assessing the curricular documents had been to evaluate the manifest and latent content using a prescribed set of guidelines (as laid out in Annexes 3 and 4). However the sparse nature of the text in combination with an almost complete lack of HIV or gender-related terminology has led to an alternative approach (as outlined in the discussion of the methodology). Instead of applying distinct or more stringent analytical criteria to a reading of the *Health and Physical Education* curricular documents, the modified approach used for reading the other curricular documents was applied. The following questions have therefore been asked:

1. What relevant terminology is used, how often and in what context?
2. Is there potential for the inclusion of gendered HIV/AIDS prevention education to take place in the context of the curriculum guidelines?
3. Which determinants and indicators of overall sexual and reproductive health could be addressed to support the achievement of specific expectations and outcomes?

10. b) ii: Health and Physical Education

The Ontario *Health and Physical Education* (OME HPE, 1999; and OME HPE, 2000) curriculum at the secondary school level has the greatest potential for providing youth with a comprehensive, integrated approach to achieving strong sexual and reproductive health outcomes in general, and for providing them with the knowledge, psycho-social skills and analytical tools

necessary for the prevention of HIV in particular. Designed to provide students with abilities and information regarding “an understanding of the importance of physical fitness, health and well-being and the factors that contribute to them” (OME HPE, 1999, p.2), the intent is to help students “develop a commitment and positive attitude to lifelong healthy active living and the capacity to live satisfying, productive lives” (*Ibid.*; and OME HPE, 2000, p.2). The Ministry of Education goes on to claim in both the junior and senior secondary curricular guidelines that competence, skills, knowledge and attitudes needed to deal with personal, social and workplace demands will be achieved through the development of physical, social and personal skills, primarily through the Healthy Living and Living Skills strands (OME HPE, 1999; and OME HPE, 2000).

In essence the curriculum appears to support overall health determinants in line with sexual and reproductive health. The benefits of the programme include “reducing health-care costs, improved psychological well-being...self-esteem and the ability to cope with stress” (OME HPE, 1999, p.2). Most importantly for the purposes of this study, “informed decision making related to healthy sexuality [is] central to this curriculum” (*Ibid.*). The grade 11-12 curriculum takes this a step further and states that the expectations will also serve to “develop additional skills and knowledge relating to healthy growth and sexuality” (OME HPE, 2000, p.3). Unfortunately, there are very few expectations and outcomes in any of the course outlines which support this assertion.

Though *Health and Physical Education* course outlines do include some references to HIV/AIDS-related issues, they are limited in number and scope. In both the Grades 9 and 10 courses in the Healthy Living strand, there is a specific expectation titled: Healthy Growth and Sexuality. Though some of the key words from the manifest content assessment tool appear under this heading, this is the ‘richest’ source of these terms anywhere in any of the curricula, and they appear in a very particular context. HIV is referenced in relation to prevention and social and coping skills, to environmental factors (health and social determinants) and to responsible sexuality.

One of the overall expectations for the Healthy Living strand for the ninth grade course is that students will be able to “explain the consequences of sexual decisions on the individual, family and community” (OME HPE, 1999, p.10). The term ‘consequences’ is problematic, as it suggests that there could only be negative outcomes from any such decisions taken. The reference to drug and alcohol use is in contrast much more positive and pro-active, as students are meant to “demonstrate personal strategies to deal effectively with the social influences that contribute to... use and abuse” (*Ibid.*).

The remainder of the sexual health-related expectations are much weaker and deal with *describing* “factors that lead to responsible sexual relationships... and the effectiveness of methods of preventing pregnancies and sexually transmitted diseases” (OME HPE, 1999, p.10), and how to *demonstrate* “understanding of how to use decision-making and assertiveness skills effectively to promote healthy sexuality [i.e. avoiding STDs such as HIV/AIDS]; [and] understanding of the pressures on teens to be sexually active” (*Ibid.*). These are feeble expectations, and could prove very difficult to measure in the classroom (are the students being asked to demonstrate understanding and/or use and/or promotion and/or actual positive sexual health outcomes?!). Probably the most useful of the expectations to students’ own needs is the final one, where students are expected to be able to “identify community support services related to sexual health concerns” (*Ibid.*), as youth are thereby likelier to have access to more information and the ability to acquire further knowledge necessary for the prevention of HIV transmission. Overall, HIV/AIDS only appears once in the curriculum guideline, STDs appears twice, and variations on sexuality, healthy sexuality and sexual relationships appear ten times. In addition, the terms: pressure, prevention, condom and abstinence appear once each.

The overall and specific expectations differ only slightly for the tenth grade course (OME HPE, 1999); they are no worse in their vagueness, and there continues to be a negative connotation

in some descriptions. Overall, students are expected to “demonstrate an understanding of the factors affecting human sexuality as it relates to themselves and others” (*Ibid.*, p.15). There is nothing however to clarify exactly what is meant by this, as those factors could encompass anything from the biological, to the emotional and the social. Two of the specific expectations are clearer and could present interesting opportunities for discussion. Students are expected to be able to “describe environmental influences on sexuality (e.g. cultural, social and media influences); [and] identify available information and support services related to sexual health concerns”(*Ibid.*). This presents students with an opportunity to critically assess stereotypes and media images and texts regarding human sexuality, and identify (and potentially access) uncensored and detailed information regarding sexual and reproductive health issues, including HIV/AIDS.

One odd sub-topic listed in the tenth grade curriculum asks that students be able to “explain the effects (e.g. STDs, HIV/AIDS) of choices related to sexual intimacy (e.g. abstinence, using birth control)” (OME HPE, 1999, p.15). There is no further elaboration of abstinence or birth control and prevention of HIV/AIDS (other methods of transmission are never addressed) and prevention through safer sex practices is never clearly delineated. This expectation is also highly problematic for the fear tactics it suggests. First of all, STDs (or STIs) and HIV/AIDS are not an effect, result or consequence of a choice regarding sexual intimacy (to be or not to be...), but rather regarding the means by which that intimacy is achieved (i.e. unprotected sexual intercourse, oral, vaginal, anal, etc.). Secondly, ‘using birth control’ will do nothing to protect students from STIs, including HIV, unless their chosen method involves condoms (and even then, condoms are too frequently used inconsistently and incorrectly – the curriculum does not address adherence to or correct use of contraception or protective barriers). Finally, regarding the overall use of relevant terminology, sexuality / responsible sexuality (what that exactly entails is not made clear) appear five times, STDs and HIV/AIDS twice, and sexual health, pressure/influence, abstinence and birth control each

appear once. It can be presumed from this that the topic of sexual health (and to a lesser extent, HIV) is mandated, but the nature, frequency and effectiveness of related discussions and lessons is unclear.

In the Healthy Living strand of both the grades 11 and 12 “Healthy Active Living Education” courses, there is a Healthy Growth and Sexuality expectation as well (OME HPE, 2000) which builds on those in the junior grades and which also suggests the potential for a broader, more integrated approach to SRH education. Of the three course curricula assessed at this level, there were overall quite a few references to terminology relevant to HIV prevention. To begin with, gender and HIV/AIDS and STDs appear three times each; sexuality/healthy sexuality appear eight times; prevention, pressure/influence, health determinants (i.e. socio-economic status, education), mental health/social skills and healthy relationships appear four times each; and reproductive health and culture appear twice (OME HPE, 2000).

In the eleventh grade students are expected to be able to describe “factors (e.g. environmental, hormonal, nutritional) affecting reproductive health in males and females; [and] information and services related to sexual and reproductive health” (OME HPE, 2000, p.11). First of all, it is important to note that this is the *only* reference to male reproductive health in the *Health and Physical Education* curriculum, signalling once again the feminization of sexual and reproductive health – there is very little in any of the documents that challenges normative gender socializations. That said, requiring students to understand the role of more sophisticated determinants of health and how they interact with, for example, gender norms and risk of HIV transmission would be one way of encompassing a broader SRH perspective; at least the potential for this discussion is present. This would also provide a stronger perspective from which to build in order to achieve two of the other expectations, which require that students “demonstrate the skills

needed to sustain honest, respectful and responsible relationships; [and] assess reproductive and sexual health care information and services” (*Ibid.*).

The grade 11 course, “Health For Life” (OME HPE, 2000) is best suited for an in-depth exploration of gender and HIV in the context of overall sexual and reproductive health. The Determinants of Health strand explores both the personal and social factors that influence health; with guidance, teachers could be encouraged to use STIs, in particular HIV, as one of the major topics when addressing the issue. Students are required to describe “the interrelationship of physical, social and mental health in enhancing personal health; how family, peers and community influence personal health; [and] the influence of culture on health (e.g. ...*gender roles*²⁵)” (*Ibid.*, p.14). Finally, students are also required to analyse the social factors influencing health (i.e. education, socio-economic status, access to services, etc.). Unfortunately, there is no mention made of the *differences* inherent in sex, sexuality and gender in curriculum, leading to the omission of integral elements of other health indicators. However, the emphasis on healthy living and safe, healthy lives; the engendering of personal responsibility, self-esteem and well-being in youth; and the development of decision-making, social and personal skills are all vital over-arching tools for maintaining and promoting SRH and should not be dismissed despite their limited presence here.

These are all determinants of health which are inherent to an approach to prevention education based on sexual and reproductive health (Spigelman, 2002). Though HIV/AIDS and other STIs are not mentioned anywhere in this particular course guideline (except once in the context of evaluating the effectiveness of different treatments for HIV and STIs), HIV incidence and prevalence in Canada is an issue which is best understood in light of determinants of health. The one really problematic expectation in this strand which could undermine an SRH approach is that which requires students to “analyse how various lifestyle choices...affect health” (OME HPE,

²⁵ My emphasis.

2000, p.14); there is a danger of essentializing risk categories and reducing them to personal ignorance and weakness, rather than to the factors that contributed to ignorance and weakness (i.e. blaming it on race rather than racism [Spigelman, 2002]). That is not to say that individuals cannot and should not ever be held accountable for their own problems and misfortunes (sometimes people do make bad choices), but it must be recognized there are often subtler and more pervasive influences and discursive pressures being brought to bear on a situation.

Finally, in the twelfth grade “Healthy and Active Living Education” (OME HPE, 2000) course, the expectations in the Healthy Living strand have been rendered somewhat more specific than those in the earlier grades (and perhaps more easily measurable for teachers). In addition to being required to understand the characteristics of healthy relationships and the skills needed to maintain them, students must “describe the communication skills needed to discuss sexual intimacy and sexuality in a relationship; analyse the factors (e.g. culture, media) that affect gender roles and sexuality; [and] demonstrate an understanding of the factors (e.g. attitudes, values, and beliefs about gender roles and sexuality) that affect the prevention of behaviour related to STD, AIDS and pregnancy” (*Ibid.*, p.22). While understanding factors that affect the mitigation of high-risk behaviour is important, as a stand-alone outcome it is unlikely to improve youth understanding, beliefs, risk behaviours or risk perception. Despite this and some inconsistencies in terminology (HIV/AIDS and AIDS used interchangeably, emphasis on “long-lasting” relationships, as opposed to *just* relationships – what does a long-lasting relationship entail from an adolescent perspective?), there are opportunities to address some very real behavioural and social issues specific to youth and young women (risk-taking, gendered interactions, influences and pressures) that could prove to be valuable in providing HIV prevention education.

In terms of overall health and social justice related outcomes, there is potential in many of the *Health and Physical Education* courses for achieving a coherent and integrated approach to

teaching sexual and reproductive health, though it is unclear from the expectations and outcomes discussed how exactly the goal of “informed decision making related to healthy sexuality” (OME HPE, 1999, p.2) in particular is really being instilled in Ontario youth. Whether or not it is occurring is unfortunately not possible to measure in the context of this study. Both relationship skills and the skills and knowledge needed to assess SRH information and services need more than the average amount of health education classroom time to develop however (Ophea, 2008a). It is no wonder that instruction time is so inconsistently and poorly allotted; the *Annual Report on Ontario’s Schools 2008* (People For Education, 2008), while limited in analytical scope (an evaluation of the *Health and Physical Education* program yielded only results relevant to *physical education*), found that health and physical education classes were frequently cut in favour of other course programs. Other examples which support this assertion come from other studies. Youth in the *Canadian Youth, Sexual Health and HIV/AIDS Study* (CME, 2003) claimed only 4-8 hours of health instruction in the six months leading up to the survey, and only 62% of youth in Toronto claimed they received sexual and reproductive health education in school (Flicker et al., 2008).

Though not simple in design or execution, curricular modifications could be applied in an effort to improve sexual and reproductive health education as well as HIV prevention education more specifically. Learning strands, outcomes and expectations from other curricula could be integrated to support an approach that is less fragmented, as issues relating to reproductive health and well-being, sexual and relationship violence, stress management, decision-making, risk-taking, and social skills (such as maintaining positive relationships) could be addressed in a variety of ways in many programs. The potential is there, if nothing else, however these curricular requirements need to be further (even extensively) developed.

The OASPHE survey was conducted in partnership with Ophea and was administered to elementary and secondary educators responsible for teaching *Health and Physical Education* courses. Some of the primary results which relate to this study are the fact that 72% of respondents indicated that “the curriculum does an above average job...in addressing...current societal concepts and issues” (OASPHE, 2006, p.3). However, 20% of respondents felt the expectations were only “somewhat better than average” (*Ibid.*). Overall, 53% of respondents feel that there is too much overlap of expectations from grades 9 through 12, and 97% respondents felt that there are too many expectations, especially in the Healthy Living strand in the ninth grade (*Ibid.*) – this is significant given that this is one of the few courses where expectations specifically relating to HIV/AIDS have been developed. However, teachers also felt that “there is a good relationship between healthy living and living skills, e.g. decision-making as it relates to human sexuality and substance use and abuse; [and] very pertinent topics, address the challenges that teenagers face primarily related to relationships, and substance use” (*Ibid.*, p.5).

In light of research results like those in the HIV/AIDS attitudinal surveys (PHAC, 2006a; and PHAC, 2003) that reveal a less than ideal degree of understanding of sexual and reproductive health and HIV among Canadians, it is understandable that teachers might feel that they are being asked to address too many irrelevant or overly contentious issues, however, it is also clear that too many people are ignoring the links between sexual and reproductive health and overall well-being. It is not clear that *Health and Physical Education* teachers at any rate have made that connection. One encouraging finding however was that 97% of respondents indicated that there should be a second mandatory HPE credit to address healthy growth and physical activity (OASPHE, 2006). This approach could also provide the opportunity for further sexual health education as well, though this was not cited as a priority for teachers.

Following the OASPHE survey, Ophea (2008a) submitted recommendations to the Ministry of Education for consideration in the curriculum review process. One of the strengths of the *Health and Physical Education* curriculum that they cite deals with the focus on developing life skills “skills that are not covered in any other subject area” (*Ibid.*, p.3). Sexuality and sexual health are highlighted as a continuing emerging issue, and given the already overstretched schedules and budgets of most schools, Ophea recommends that the Ministry of Education perhaps reassess the place of some topics in the *Health and Physical Education* curriculum (for example in the OASPHE survey, teachers recommended leaving pollution issues, addressed in the grade 11 “Health for Life” course, to the *Science* curricula [2008]; changes like these could free time and space for other issues in the health classes). In addition, they recommend more integrated education and public health services as well as “training for educators and others who will support curriculum implementation such as public health. A key focus of this support will be on strategies to integrate HPE expectations into other subject areas” (Ophea, 2008a, p.5). Finally, Ophea also recommends that the Ministry ensure linkages to other federal and provincial initiatives are made to help educators implement and support the HPE curricula; a number of such strategies are listed, though any related to sexual and reproductive health have been overlooked (*Ibid.*). There is no mention made of *Leading Together* (CPHA, 2005) and the *Canadian Guidelines for Sexual Health Education* (Health Canada, 2003), or to Ontario Ministry of Health and Long-Term Care or Ontario AIDS Network (2008a) initiatives.

10. b) iv: Other Curricula

Throughout the remainder of the relevant curricular guidelines (subjects such as mathematics and physics are not addressed), many opportunities for discussion of HIV/AIDS, gender, sex and sexuality are present, though rarely specifically cited as a timely or pertinent topic. Of course, what teachers do in the context of specific course programs is unclear, but depending on

Board of Education policies or individual teacher knowledge, inclination and comfort level with the subject matter, it is likely that some people at least are addressing these issues, particularly in relation to Aboriginal and world studies, history and social science programs and media studies. The Ministry of Education's antiracism and ethnocultural equity policy (OME, 1993) in combination with newly implemented anti-discrimination principles (such as those cited in the senior *English* [OME ENG, 2007] curriculum) encourage school boards and teachers to be thoughtful in their approach to teaching and learning materials, with the intention of making students aware of the "historical, cultural and political contexts for both the traditional and non-traditional gender and social roles represented in the materials they are studying" (OME ENG, 2007, p.33).

The *Native Studies* (OME NS, 1999; and OME NS, 2000) and *English* (OME ENG, 1999; and OME ENG, 2007) curricula in particular (as well as the French Immersion or French literature/media curricula where applicable) allow the most flexibility in terms of choice of materials and topics related to sex and sexuality, including HIV/AIDS. The nature of the courses allows for an approach to the topic that can eschew the clinical in favour of the analytical or emotive. Stories about HIV/AIDS, whether fictional, biographical or news-oriented will do much more to focus youth attention on the matter than a recitation of risk behaviours and consequences (too often couched in a 'don't have sex yet' rhetoric). Media Studies strands in particular provide a rich source of materials for analysis, as well as a far reaching opportunity for prevention education. In 2005, UNAIDS assessed media education programs in Africa with a focus on HIV/AIDS (including the South African version of *Sesame Street*, *Takalani Sesame*, which includes an HIV+ muppet character). The analysis showed that rigorously researched, high quality, targeted media campaigns and programmes allow the mass media "rich opportunities for effectively responding to HIV/AIDS" (*Ibid.*, p.51). In particular, encouraging interaction with media (or even encouraging

students to analyse, discuss and produce media products themselves) “can be very effective in encouraging awareness, debate and personal identification with the issues [related to HIV/AIDS]” (*Ibid.*, p.53). Though there is a dearth of such targeted and dedicated programming in Canada, the media could still be used effectively as a teaching tool for HIV prevention education (i.e. through a critical analysis of HIV/AIDS awareness campaigns or news stories).

There is some room for this kind of approach in Ontario curricular guidelines. In a grade 11 *English* “Media Studies” (OME ENG, 2007) course, one of the suggested guidelines for teachers in the Media and Society strand asks that students assess racist or homophobic statements in a comparison of traditional versus alternative media (p.154). Other media-oriented guidelines provide other opportunities for critical reflection, however specific topics are not generally addressed. While this is a long way from more innovative curricular guidelines (such as those in British Columbia or Quebec, as previously discussed), it could provide teachers with direction in terms of choosing more controversial subjects to address.

The *Native Studies* (OME NS, 1999; and OME NS, 2000) curricula are even stronger in this regard. Though HIV/AIDS is an increasingly urgent issue for Aboriginal people in Canada, particularly women (PHAC, 2007a) it is only mentioned twice in the context of current Aboriginal issues, once each in the junior and senior curricula, yet identification of challenges faced by Aboriginal women are cited repeatedly as expectations (OME NS, 1999; and OME NS 2000). However, the focus on the socio-political perspective and on gender roles and socialization in Aboriginal communities means that there are many opportunities, whether through literature, media, history texts, art and drama, to address issues affecting Aboriginals in Canada today. In particular, the oft-repeated references to the work of Tomson Highway (OME NS, 2000) are one avenue by which HIV/AIDS, sex and gender issues can be addressed; though better known for his stage plays, Highway also wrote a semi-autobiographical book, *Kiss of the Fur Queen* (1998). The

book deals with his and his brother's lives, both of whom were abused as children in the Residential School system; his brother also died of AIDS in 1990 (Methot, 1998).

Other curricular documents which provide guidelines relevant to HIV/AIDS and SRH education are the senior *Science* curriculum (OME SCI, 2000), the *Social Sciences and Humanities* curricula (OME SSH, 1999; and OME SSH, 2000) and the *Canadian and World Studies* curricula (OME CWS, 2005a; and OME CWS, 2005b). HIV/AIDS is mentioned specifically three times in the *Science* curricular guidelines (STDs are cited once)(OME SCI, 2000), however all references are incidental to the topic at hand. Specifically, students are asked to analyse how social needs have influenced science and led to technological advances (i.e. detecting and treating AIDS), and to identify causes, treatments and effects of immune-related *diseases*²⁶ such as AIDS (*Ibid.*). An in-depth exploration of HIV/AIDS, such as tracking and analysing progress of HIV to AIDS, or a study which looks into the co-infective relationship between Hepatitis C or chlamydia (as previously stated, the most common STI in Canada and one which disproportionately affects young women – CFSH 2008) and HIV is not addressed.

The *Social Sciences and Humanities* (OME SSH, 1999 and 2000) curricula also present many opportunities for discussion of sexual and reproductive health and HIV/AIDS. In fact, many of the expectations in each of the strands in the junior curriculum deal with issues related to determinants of health with a focus on overall well-being, “individual and family development, relationships...decision making...and health sciences” (OME SSH, 1999, p.6). One important element of the “Individual and Family Living” (*Ibid.*) course is its focus on “strategies to develop and maintain effective relationships”(*Ibid.*, p.15), peer, familial, work and romantic. These are important areas to address, especially in relation to one another, as it has been shown that “a person’s ability to incorporate safer sex practices is closely associated with high self-esteem [and]

²⁶ This is an error on the part of the curriculum authors, as AIDS is not a disease but a syndrome which leads to the acquisition of disease.

solid social supports” (Spigelman, 2002, p.20). Unfortunately, this curriculum appears to be somewhat of a repackaging of traditional home economics or family studies courses, and is unlikely to appeal to male youth given their seeming disparagement of women’s issues (Gahagan and Rehman, 2004), thereby missing out on an important demographic. In addition, many of the more innovative expectations (i.e. negotiating conflict, building self-confidence, research-based decision making, etc.) are dishearteningly haphazard in their distribution and detail; far too much is likely to depend on specific school and classroom environments, teacher interests and awareness, the degree of or potential for open dialogue in the classroom, etc. Specific references to sexuality, sex and gender (except once very broadly in the context of analysing “the impact of gender roles within families”, OME SSH, 1999, p.20) or HIV/AIDS are also completely lacking.

The senior level curriculum offers more room for flexibility, although HIV/AIDS is only mentioned once in the descriptions for sixteen separate courses (OME SSH, 2000)! Notably among all the curricular guidelines, feminism is identified several times, if in slightly ambiguous contexts: for example as a factor in reconstructing the family as a psychological rather than economic unit (*Ibid.*, p.71); and simultaneously as “terminology” (p.104), “theory” (p.109) and “philosophy” (p.123) related to sociological modes of inquiry. Gender is also continuously referenced in the context of roles, expectations, difference, socialization and stereotyping, often in surprising ways. For example in the “Fashion and Creative Expression” (*Ibid.*) course, students are expected to “demonstrate an understanding of the effects that clothing can have on social interaction (e.g., as it signals the wearer’s individuality or conformity to group behaviour, occupation, gender, social role, status)” (p.39). Gender is also referenced in terms of its impact on “personal and social development” (p.101) in “Introduction to Anthropology, Psychology and Sociology”; and in terms of gender stereotypes related to the development of religion (p.130), in “World Religions: Beliefs, Issues and Traditions”. These topics could generate discussion on normalizations and assumptions about gendered

roles and identities, and contribute to an understanding of these norms in relation to individual development and overall well-being.

The term 'gender' is however frequently misused in the *Social Sciences and Humanities* guidelines as well, signifying a lack of understanding on the part of the education professionals and teachers who worked to develop the curriculum guidelines in the first place (and possibly contributing to further confusion in the classroom). In some instances gender (masculine, feminine) is used where sex (male, female) should be, for example in expectations relating to "gender differences in intellectual development" (OME SSH, 2000. p.86) and "gender differences in communication patterns" (*Ibid.*, p.88) in the "Parenting and Human Development" course. As with other curricular guidelines however, there is potential for HIV/AIDS to be addressed. In the "Living and Working with Children" (*Ibid.*) course in the eleventh grade, and the twelfth grade "Individuals and Families in a Diverse Society" and "Issues in Human Growth and Development" (*Ibid.*) courses, discussion of HIV in the context of personal well-being and healthy decision-making, child and adolescent development and socialization, and social structures and challenges would be appropriate.

These issues are taken a step further in the humanities courses in the *Social Sciences and Humanities* curriculum, as students are expected to be able to think critically about socialization and structural and discursive barriers to equity. The course with the greatest potential in this subject stream is the grade 12: "Challenge and Change in Society" (OME, SSH 2000). Students are expected to be able to "appraise the differences and similarities in the approaches taken by anthropology, psychology, and sociology to the study of social challenges *pertaining to health, social injustice and global concerns*²⁷; [and] demonstrate an understanding of the social forces that shape such challenges" (*Ibid.*, p.108). The issue of HIV/AIDS and gendered prevention and

²⁷ My emphasis.

education is virtually tailored to meet this overall expectation as well as other specific expectations relating to fertility, poverty, gender relations, women's roles, etc. (*Ibid.*). Unfortunately, HIV or sexual and reproductive health more generally are not identified as topics of interest at all. They could however contribute in significant ways to addressing issues of gender, race and poverty in the context of the HIV epidemic and to achieving the stated need in Canada to:

Ensure that women, Aboriginal people and other stigmatized and marginalized groups are free of discrimination...[and] develop innovative activities targeting boys and girls that will promote more equitable and mutually respectful attitudes and behaviour [in support of HIV prevention initiatives] (Spigelman, 2002, p.27).

The *Canadian and World Studies* (OME CWS, 2005a) curricula also retain potential for addressing HIV-related topics. Oddly enough however, in the grade 10 history courses, "Canadian History Since World War I" (applied and academic) (*Ibid.*), the context in which HIV/AIDS appears is problematic. A specific expectation for both courses is that students be able to "analyse Canada's responses to some of the major human tragedies since World War I (e.g. genocide...the Holocaust...*the AIDS crisis in Africa*²⁸)" (*Ibid.*, p.49). Whatever happened to HIV/AIDS in Canada? Though describing it as a crisis in the Canadian context would be misleading, particularly in comparison to the situation in Sub-Saharan Africa, it is approaching crisis-level in some communities. It is clear for example that among Aboriginal women, incidence and prevalence rates are approaching those of women in Sub-Saharan Africa (PHAC, 2007a; and WHO, 2008), despite the fact that they make up only a small proportion of the Canadian population overall!

Finally, the senior curricular guidelines in *Canadian and World Studies* (OME CWS, 2005b) also provide many potential opportunities to address issues related to HIV/AIDS, yet the failure to do so is highly notable. In the guidelines for *twenty-seven* separate courses, HIV/AIDS is cited only once overall, in the grade 11 "Travel and Tourism" course, and that is in relation to how

²⁸ My emphasis.

a *disease*²⁹ such as HIV contributes to “the growth or decline of tourism around the world” (OME CWS, 2005b, p.83). Even economics courses such as “Analysing Current Economic Issues” (*Ibid.*) could include discussions of HIV/AIDS in terms of poverty, employment and health, as “a nation’s economic structure and commitment to income equity may be the most important determinant of health” (Spigelman, 2002, p.12), and studies consistently show that “every HIV infection that is prevented saves approximately three quarters of a million dollars in direct and indirect [treatment-related] costs” (Cress et al., 2008, p.2).

Law courses such as “Understanding Canadian Law” (OME CWS, 2005b) could also reference HIV in terms of the criminalization of sex work or barriers based on sexual orientation and gender identity (Canadian HIV/AIDS Legal Network, 2007) or legal cases wherein non-disclosure of seropositive status has led to the prosecution of HIV+ individuals³⁰. There is also the issue of harm reduction programs such as Vancouver’s InSite safe injection facility, a highly contentious legal issue given the current government’s intractable stance on harm reduction; “the new National Anti-Drug Strategy focuses exclusively on punishment” (Canadian HIV/AIDS Legal Network, 2008, p.2). Harm reduction strategies are however of paramount importance to health professionals and researchers working on HIV prevention among drug addicts, particularly among women, who have fewer options in terms of negotiating safety and access to support (*Ibid.*).

This failure to address HIV in curricular guidelines for *Canadian and World Studies* is compounded by the fact that related topics are addressed throughout the curriculum in listed expectations and course descriptions. Several issues are repeatedly identified, such as sex and gender issues (twenty-two times overall), particularly in terms of gender inequality in the work

²⁹ Once again, HIV/AIDS is mistakenly classified as a disease.

³⁰ Some of these cases have resulted in legal travesties, such as one case discussed anecdotally at the Canadian Association of HIV/AIDS Research Conference (CAHR 2008). In this instance a Canadian woman who is HIV+ and in an abusive relationship charged her partner with abuse. When he was found guilty, he based his appeal on the fact that she was equally guilty of abuse, as the first time they had had sexual intercourse four years previously, she had not disclosed her seropositive status. The appeal court ruled in her partner’s favour, dismissing all charges of abuse against him and sentencing her to several years in prison (*Ibid.*)!

place in the geography courses “The Americas: Geographic Patterns and Issues” and “World Geography: Urban Patterns and Interactions” (OME CWS 2005b). Sex and sexuality also appear in terms of sexual orientation, same-sex relationships and parents, sexual discrimination and sexual assault (nine times overall), in discussions of human rights and family structures in the “World History” (*Ibid.*) course. Health-related issues are also addressed, though epidemics, pandemics, medicine patents and so on are overlooked (health is addressed more in terms of environmental health, health organizations and consumer health) (*Ibid.*). A final specific example of HIV being overlooked occurs in the *Canadian History and Politics since 1945* (*Ibid.*) course. At one point there is a discussion of individual rights in the context of “alternative lifestyles” (*Ibid.*, p.156), yet the description is limited and the context and scope unclear; HIV/AIDS having played such a significant role (since the early eighties) among people who live so-called *alternative* lifestyles (i.e. queer communities, MSM, sex-workers, IDUs, etc.), the absence of a discussion of HIV/AIDS appears as a glaring omission.

10. b) v: Formal Educational Resource Material

In 1987 the Ontario Ministry of Education implemented a mandatory HIV/AIDS program to be included as part of the health education courses in Ontario schools. The Ministry’s resource document for teachers, *Education About AIDS* (OME, 1987) was developed for health education in grades seven, eight and nine, and provides teachers with information, guidelines and suggested lesson plans for implementing AIDS education in the classroom. Though now more than twenty years out of date and developed as a guideline for curricula that no longer exist (the current Ontario *Health and Physical Education* curricula – OME HPE, 1999; and OME HPE, 2000 – at the secondary level contain no reference to mandatory AIDS education and the Ministry resource

materials have never been updated or replicated³¹), it is important first of all because it is the only Ministry developed HIV/AIDS specific program. In addition, it is possible that this resource is still in some use, and there is some important information contained in the document. As will be shown, there is also a great deal that is inaccurate and out-of-date and even potentially misleading, presuming that some teachers might still be making use of this resource in some capacity. Though there is a great deal of valuable and useful reference, guideline and educational materials (some of which is examined in further detail in the following pages) available to teachers, none have been developed (or are clearly mandated) by the Ministry of Education other than *Education About AIDS* (1987), suggesting that the Ministry itself has taken a significant step back from innovative approaches to sexual and reproductive health education, thereby abrogating in certain respects its duty to contribute to the health and education of Ontario youth.

Some of the strengths of *Education About AIDS* (OME, 1987) include fairly detailed bio-medical information about AIDS; an approach to AIDS education that includes discussion of other STIs and encompasses a health promotion perspective (a precursor to a public health or overall sexual and reproductive health approach, including elements of physical, intellectual, emotional and social health as well as a positive outlook on sexuality); the inclusion of parents in the health education program through adult courses, parents' night AIDS information sessions, and homework assignments that focus on parent-child communication; and a fairly complete list of additional resources (print, video, audio and organizations) which address HIV/AIDS in various contexts, including epidemiological, formal research and public health and education materials (*Ibid.*) – though this information was of course more useful in 1987 when it was current.

In terms of an assessment of the manifest content, given the focus on AIDS in the resource

³¹ In a quick perusal of the University of Ottawa library due date stamp sheet in the book, it is clear that *Education About AIDS* is growing increasingly obsolete, and is, in fact, likely not referred to anymore now that there is no dedicated HIV/AIDS education in Ontario – it appears that it was last borrowed from the library in December of 1999.

document it becomes meaningless to simply note the number of times that HIV/AIDS is referenced, as HIV, AIDS and STDs appear on virtually every page. Prevention is discussed but is largely focussed on abstinence first, monogamy second, and condoms last; and needle sharing, peer pressure and mother-to-child AIDS transmission are presented as some of the most relevant issues for youth to address (OME 1987). Likely due to the fact that this document is over twenty years old, a gendered perspective or an in-depth discussion of alternative prevention measures (dental dams, microbicides) or even a real exploration of health determinants such as socio-economic status, ethnicity, religion, etc., are completely overlooked (*Ibid.*), therefore this terminology, representative of a more innovative, gendered SRH perspective, is lacking.

In considering the questions for assessing the latent content of the material in the context of the late 1980s, the results are fairly positive. There is statistical, medical and epidemiological data present in the guidelines; prevention data is included as an integral component throughout the curricular guidelines and lesson plans; for the most part HIV/AIDS is represented as an equal opportunity epidemic; and despite some prejudices inherent in the material, most people affected by HIV are represented fairly (OME, 1987). Unfortunately, what is more important to note is that there is an overarching heteronormative perspective as men are almost uniformly responsible for women's seroconversion (even where drug use is a viable factor), and when not entirely absent from discussion, homosexuals are cited in terms of being 'carriers' of the virus, therefore vectors of disease as well as members of the largest risk group. There is also an odd emphasis on anal sex, though never specifically ascribed to homosexual preferences or behaviours; the prohibitive and negative way it is addressed however (tears in the anus facilitating the uptake of HIV, anal sex described as the easiest way of transmitting HIV [*Ibid.*, p.11]) suggests that it is predominantly associated with illness, risky behaviour, bad choices, etc. (and perhaps by association with some element of homophobia). Finally, there is a gender neutral approach that avoids discussing women

as sexual beings, but which nonetheless suggests a misogynistic perspective which categorizes women as innocent and passive or infectious and sordid. Women are discussed solely in terms of being recipients of blood transfusions, as naïve partners of homosexual, bisexual or promiscuous men, or as prostitutes, drug users and mothers who have transmitted the AIDS virus to their children (*Ibid.*). Questions regarding gender as a factor in women's inability to negotiate sex and sexuality, of women's choices and their role in their own illness and challenges to the presumed, normative heterosexuality of all women are entirely absent from the various issues addressed.

The most problematic elements of the gender discourse at work in the resource document appear in the case study lesson guidelines for the grades 7, 8 and 9 programs. There are stereotypes quite clearly at work in each of the (presumably) fictional cases presented, though those suggested for use in grades 7 and 8 are less controversial in nature than those for the ninth grade. The first case study involves a fourteen year-old girl who was infected with AIDS after a blood transfusion, and against whose presence in schools many parents protested. Because her transfusion was a medical necessity (OME 1987), hers is a 'clear' case of victimization. In the second case study, a fourteen month old baby has AIDS, contracted from her mother, an "intravenous drug user... [who] had AIDS when she became pregnant" (*Ibid.*, p.29). Rose is quite obviously in the innocent victim category, though with her mother the situation is less clear. Oddly enough, in the discussion section the authors state that Rose's mother could have contracted AIDS from either her husband or from infected needles – the reader is unsure whether she is a victim or a vector.

The ninth grade cases both deal with sex as the mode of HIV transmission, though women are still clearly the victims of promiscuous men. In the first case, a gay man married to a woman is diagnosed with AIDS, yet does not reveal either his status or his sexuality and sexual history (or ongoing homosexual sexual activities) to his wife (OME 1987). In the second, a young heterosexual man becomes infected with HIV after a blood transfusion (victim), yet he failed to

take precautions and proceeded to infect at least four other women (vector), which also resulted in a child of his being born with AIDS (*Ibid.*). Women are victims in both of these scenarios, only able to be receptive to infection and illness with little agency of their own. Though it is likely that this resource document is no longer in common usage, the fact that it is the only Ministry of Education publication which so specifically addresses HIV/AIDS, and which was at one time, fairly recently, widely available across the province, means that it is still relevant to current HIV prevention education; this is problematic.

Another officially sanctioned teacher resource document which is mandated in Ontario is the Institute for Catholic Education's (ICE) HIV/AIDS program guidelines, *AIDS: A Catholic Educational Approach to HIV* (1999). As with the Ministry of Education's AIDS resource document, an assessment of the manifest content (terminology usage, specific discussion of issues related to health determinants) becomes largely meaningless given the guidelines' focus on HIV/AIDS. Gender socialization, racism and socio-economic inequities however are not addressed, nor are prevention issues other than abstinence and monogamy (good...) and condoms (bad...) (*Ibid.*).

Interestingly enough, it is worth noting that in two separate instances the malleability of sexuality is referenced (and the authors are careful to condemn only same-sex sexual activities, not homosexual people themselves). First, in reference to youth, "it is not uncommon for young people to experience strong feelings or crushes on individuals of the same sex... Identity is particularly fluid during adolescence" (ICE 1999, p.5). Secondly, in a treatise on Catholic teachings about homosexuality included in the teacher's manual, Cardinal Basil Hume states that "an individual's sexual orientation can be unclear, even complex. Also, it may vary over the years" (*Ibid.*, p.161). This is virtually the only complexity that is acknowledged with regards to sex and sexuality however, as only abstinence outside of marriage and heterosexual, procreative monogamy within

marriage are acceptable options; these are centrally situated as the focus of the manual, and are the two only acceptable means of preventing the sexual transmission of HIV according to Catholic teachings.

In the Catholic manual the ICE only address four highly simplified means by which HIV is transmitted: sexual contact with an HIV-infected person, sharing needles, mother-to-child transmission and blood transfusions (ICE 1999). Though not inaccurate, this simplistic focus becomes highly questionable in terms of education and HIV prevention, particularly as other sexual activities and condoms are quite systematically condemned. Oral sex is moderately acceptable, but only if it takes place between a husband and wife as a precursor to “life-giving...sexual intercourse” (*Ibid.*, p.139). In and of itself it is a dangerous activity, “if one of the partners should be infected with HIV, the other could absorb the virus into the bloodstream; e.g. through infected semen or vaginal fluids entering slight cuts or lesions in the mouth or gums” (*Ibid.*). The authors fail to address how so-called life-giving sexual intercourse differs from oral sex as a risky activity for a sero-discordant couple; if a man and woman are engaging in unprotected oral and penile-vaginal sex, the chances of transmitting HIV (male to female especially) are similar enough to make either activity risky.

Anal sex on the other hand is described as “an extremely dangerous sexual practice... which can severely damage the tissue [so] the virus can pass...through even small, invisible lesions or tears in anal tissue or on the penis” (ICE 1999, p.139). These messages are made even more problematic by the Church’s stance on condoms, which are described as “morally wrong” (*Ibid.*) and are the central object of fear-based messaging (which has already been roundly discounted as an ineffective approach to HIV prevention education). The authors take their objections a step further and make claims based on inconclusive evidence about the safety of condoms, claiming a pregnancy failure rate for male condoms of 8-10%, a general male condom failure rate of 20-50%

and female condom failure rate of 15-20% (*Ibid.*). This is of course in direct opposition to recent research, addressed previously, which shows that condoms, if used correctly and consistently, are highly effective for preventing pregnancy *and* STIs, including HIV. There are no citations to research listed nor is it clarified as to exactly in what context or to what end the ‘success’ or ‘failure’ of condoms was being assessed. Taken altogether, the fear-based messages in conjunction with abstinence-only education (also found to be ineffective) means that the Church, as a whole, is more invested in proselytizing about sex and sexual health than in providing complete, accurate and detailed information. In light of the number of youth who are sexually active (CME 2003), this also means that Catholic schools in Ontario are most likely failing to provide youth with effective skills and tools to ensure positive sexual and reproductive health outcomes for themselves and others.

The most complete and useful resource document available for teacher use is the Canadian Federation for Sexual Health’s (CFSH) manual, *Beyond the Basics: A Sourcebook on Sexuality and Reproductive Health Education* (2005). Referenced by various organizations including the Public Health Agency of Canada (2005b), the Society of Obstetricians and Gynaecologists of Canada (2008) and the Ontario Physical and Health Education Network (Ophea, 2008b) in their own teacher resource materials (though Ophea does not cite the second edition discussed here), it is widely accessible and available for free download, an important consideration for teachers and schools dealing with limited budgets or other prohibitions. The sourcebook was designed to complement provincial curricula (including Catholic education programs) (CFSH 2005), and is distinctive for its inclusiveness, its adherence to overall sexual health education, its goals for educating teachers and students, and its commitment to ensuring healthy growth and sexuality for Canadian youth (*Ibid.*). The book was developed for use in sexual and reproductive health education programs in grades 4 to 12, and contains references and tools for teacher preparation, topic outlines and resources, discussion guidelines and lesson plans geared to specific age groups

and grade levels (i.e. level 1 is for students in grades 4 to 7, level 2 for grades 7 to 9 and level 3 for grades 10 to 12). Though the sourcebook addresses issues ranging from values and self-esteem to contraception and HIV, the focus of this assessment is on modules 7 (“Contraception and Safer Sex”) and 8 (“STIs and HIV”), though modules 1 (“Getting Started”), 2 (“Values and Sexuality”), and 5 (“Sexual Identity”) are also briefly addressed.

The first module of the sourcebook is intended as a training and information manual for teachers, providing them with tools and strategies for delivering effective sexual and reproductive health education in the classroom. Given that teachers at the primary and junior levels are more often than not generalists (or not specialists in physical and health education at any rate), the inclusion of guidance materials (i.e. garnering support for sex ed, building teacher confidence and assessing teacher values, as well as how to create a safe environment for open and honest discussion) (CFSH 2005) is an integral consideration. The most important of the guidelines and strategies addressed are those dealing with building support for the curriculum in the school itself as well as among parents and the community at large, including school administration. Strategies include the creation of a formal philosophy and mission statement that clearly communicates the nature, values, purpose and principles behind sexual and reproductive health education; the implementation of a committee comprised of educators, students, parents and health agencies; and ensuring communication with parents and the community to facilitate their involvement and support (*Ibid.*).

Two other fundamentally important guidelines ask teachers to use teachable moments, “using current events or topics...to initiate a larger discussion of SRH issues” (CFSH 2005, p.24); and “[*incorporating*] SRH issues into other subjects”³²(*Ibid.*). As previously discussed in the assessment of Ontario curricular documents, this can be undertaken in various subject areas.

³² My emphasis.

Examples identified in the sourcebook include incorporating SRH in math (i.e. calculating STI and HIV rates), science (transmission, pathogenesis and treatment of STIs and HIV), language arts and social studies (media literacy, social construction of sexuality and gender roles, and economics of unprotected sex)(*Ibid.*). In addition, throughout the sourcebook, lesson plans and activities require that students complete assignments that involve working and communicating with an “adult support person”³³ (*Ibid.*, p.39). These are all highly innovative strategies which if carefully developed and implemented could potentially serve to normalize sexual and reproductive health education and bring about some fundamental changes, perhaps even significant improvements, in the knowledge, behaviours and overall health of youth in general, and young women in particular. As young women are traditionally silenced in sexual health education classes (Lenskyj 1991; and Langille et al., 2001), and demonstrably more affected by rates of STI and HIV transmission (PHAC, 2007a), classrooms where sexual health issues are consistently and effectively addressed could serve as important sites for the development of skills and knowledge to ensure positive health outcomes. This could also serve to deconstruct taboos around sex and sexuality, making it easier for young women to access information and to speak openly with parents, teachers, peers and partners about sex and sexual health.

If the sourcebook is used consistently and in its entirety for a dedicated sexual and reproductive health education program, the topics covered address many fundamental elements necessary for promoting sexual health, such as puberty, values, beliefs, relationships, culture and so on. For example, the objectives of the second module, “Values and Sexuality”, require that students be able to “define and explore personal...and democratic values; describe how the media depicts and influences our values; and identify values related to relationships, sexuality [etc.]” (CFSH 2005, p.33). The values of honesty, equality, responsibility, social justice and respect (*Ibid.*) are explored

³³ An ‘adult support person’ is the politically correct term used to describe parents, guardians, or some other adult (relative, minister, teacher etc.) with whom the student might have a supportive relationship.

throughout the lessons presented in this module, in the context of anti-homophobia, sex and sexuality, safer sex, sexual violence, and so on. Module 5 deals with sexual identity, and requires that students be able to “identify and explore gender stereotypes and...equality; explain how sexuality develops and changes...; describe media portrayals of sexuality; and examine sexual orientation”(Ibid., p.183). These outcomes are to be achieved by addressing stereotypes, social and religious views about homosexuality, coming out, sexuality in the media, and the biological, emotional and psychological dimensions of sex and sexuality. Though these two modules are not specifically related to HIV prevention, they are integral in that they require critical thought about gender roles, sex and sexuality, and values, beliefs and behaviours, fundamental for developing knowledge and abilities related to positive sexual health outcomes.

The two most relevant sections of the sourcebook, for the purposes of this study, are modules 7, “Contraception and Safer Sex”, and 8 “STIs and HIV”. All of the lessons in these modules are geared to older youth (primarily level 3 but also some level 2, therefore grades 7 to 12). The objectives of module 7 include requirements that students be able to “identify risks of [unprotected] sex; describe various methods of birth control; and identify ways to negotiate condom use”(CFSH, 2005, p.291). Each of the suggested lessons deals with decision-making and coping strategies for talking about sex and using contraception to reduce the risk of pregnancy or transmission of STIs and HIV. They are also inclusive in that gender roles and issues relating to sexuality are openly addressed; the authors are careful to note that teachers should avoid normalizing particular behaviours or identities, and account for the presence of GLBTQ youth in their classrooms (i.e. by referring to partners rather than girlfriends/boyfriends), as well as youth who are both sexually experienced and inexperienced (Ibid.).

In terms of HIV-specific lessons or discussions, HIV is frequently identified throughout this module in the context of risk, prevention, condom use, attitudes to condoms, safer sex, alternative

sexual activities to intercourse and basic biological-medical information. One of the most important statements made in the context of contraceptive responsibility is that young men “should also be knowledgeable about the range of methods of pregnancy and disease prevention in order to support their partner’s effective use of a method and to effectively decrease the risk of STIs and unintended pregnancy” (CFSH 2005, p.297). The goal of ‘de-feminizing’ contraception and of highlighting the importance of disease prevention as well is integral to effective, gendered sexual health education.

Finally, in module 8, STIs and HIV represent the sole focus of the lessons. In addition to general statistics, definitions and descriptions, there are extensive plans for addressing transmission and prevention. The message to use condoms (in addition to the right to choose to abstain from or postpone sexual activity) is clearly rearticulated throughout the lessons, as the only viable options for preventing transmission of HIV and STIs. One weakness that is immediately apparent in discussions of sexual health however is the frequent reference to sexually active women being required to get pap tests – any discussion of young men having to get regular medical exams is overlooked. There is no such similar recommendation in place for young sexually active men, but there is an opportunity in sexual health education classes to normalize regular check-ups related to reproduction and sexual health for men as well, rather than leaving that in the realm of ‘merely’ women’s issues. For the most part however, the sourcebook as a whole is intrinsically concerned with social justice issues, sexism, homophobia and peer pressure. It is quite clearly geared towards imparting effective sexual and reproductive health education, and as such should be widely used in schools in support of the *Health and Physical Education* curricula, particularly for preventing the transmission of HIV and other STIs among young Canadians.

10. b) vi: Public Health Education Resources (Online)

In addition to more traditional resources, the internet also contains information and tools to

facilitate sexual health education and HIV prevention. Two of the most relevant sites for accurate information are the Canadian AIDS Treatment Information Exchange (CATIE) and the Public Health Agency of Canada, both of which provide timely and accurate statistical, epidemiological and prevention information on HIV geared towards health and education professionals as well as the general public. CATIE (2008) is a national organization committed to providing free information, knowledge exchange and services related to HIV/AIDS. Part of CATIE's mandate includes the operation of a virtual library and the provision of links to other sites and electronic versions of books, teaching manuals, reports, and pamphlets, thereby serving as a valuable information resource (*Ibid.*).

The Public Health Agency of Canada, as the responsible federal authority dealing with sexual health and HIV-related issues, also provides links to online information and electronic documents (2005b), including lesson plans and guided workshops. Though the lesson plans and workshops have not been updated recently (the site makes reference to lesson plans up to grade 13, which was eliminated from the Ontario secondary school program five years ago), some interesting topics are addressed, including workshops on male/female relationships, birth control and STIs, specifically gonorrhoea, chlamydia and herpes (*Ibid.*). The workshops are preceded by an introductory section with pointers for teachers for broaching the topic of sex with students. Some of the suggestions for undertaking sexual health education in the classroom are useful, whether as reminders for experienced teachers or for capacity building for younger or more inexperienced teachers. For example, being sincere (teachers should be honest with students if they experience reservations or are lacking in knowledge on the topic under discussion); expressing discomfort (again for the purpose of creating a more honest, and hopefully relaxed atmosphere); and practicing talking about sex and sexuality prior to presenting in the classroom (*Ibid.*). Other recommendations that are made however suggest that the authors are not familiar with educational norms and

standards. Teachers are enjoined to:

[Avoid] openly criticizing any students' opinions. This attitude may lead the student(s) to become aggressive and will shut down any further communication; [avoid] lecturing. For example: "In my day we would not have thought/done those kinds of things!"; [and avoid] laughing at an opinion or a comment, even if it is naïve or amusing (*Ibid.*)

While it is true that teachers are fallible and there are individuals who might ridicule or belittle students in the classroom, given that these are fairly basic tenets of teacher-student interactions, it seems redundant (and perhaps condescending?) to direct teachers to avoid making fun of their students. In addition, the introduction to the lesson plans concludes with an optional activity which addresses embarrassment and discomfort surrounding discussions of sex. The teacher is meant to initiate a five-minute discussion (as though that might be sufficient!) guided by three questions (why do we feel uncomfortable, why is it embarrassing, and what makes you laugh?) and to be concluded with an explanation of sex and sexuality as taboo (PHAC, 2005). Both the students' and the teacher's capacity for an informed discussion and critical analysis seem to be underestimated in this activity.

The actual workshop lesson plan materials are more practical. The workshops dedicated to chlamydia, gonorrhoea and herpes are good resources (though a real evaluation of their effectiveness in the classroom has not been made here) and are very important both in and of themselves and in relation to HIV/AIDS, given increasing rates of STIs among young women and the probability of co-infections (PHAC 2007a; CFSH 2007). HIV/AIDS is not discussed however apart from brief references in two of the workshop plans. The term AIDS appears once in an aside in the "Workshop on Chlamydia and Gonorrhoea" (PHAC 2005) (in reference to a statement a teacher might hear in the classroom: I only know about AIDS!); no actual discussion of HIV prevention is incorporated or encouraged. In the "Workshop on Birth Control Methods and the Prevention of Unplanned Pregnancy" (PHAC, 2005), HIV appears repeatedly lumped together with

other STIs, and as a secondary issue to pregnancy. While the conflation with other STIs or the focus on pregnancy is not a hugely significant problem in and of itself (more youth are after all more often affected by unintended pregnancy and by STIs other than HIV), still a dedicated lesson on HIV is of paramount importance, particularly as it represents a cross-cutting issue and would be relevant in the relationship and STI workshops as well.

The most significant problem appears in a more careful reading of the part of the workshop plan which addresses contraception. First of all, abstinence is the first of the ‘contraceptive’ options listed, and barrier methods (condoms) are *third* (following hormonal methods such as the patch and the pill) (*Ibid.*). Given the increases in rates of STIs and HIV, particularly among young women, oral / hormonal contraceptives should never be privileged above condoms! Secondly, the teacher is meant to conclude the lesson by reiterating effective contraceptive methods, however as it is phrased in the lesson plan a potentially lethal error is made: “The teacher ends this activity by specifying that abstinence, male and female condoms, *and in some cases spermicide, are the only methods protecting not only against unplanned pregnancies but also against STIs, including HIV/AIDS*³⁴” (*Ibid.*). Spermicides do not protect against HIV, no more so than the pill (SOGC 2007). While it is possible that this involves merely a syntactical error rather than a lack of knowledge on the part of the authors, it is careless and potentially significant. If this lesson plan is used by a teacher not well-versed in sexual and reproductive health and HIV, or who does not engage in further research before implementing these lessons, youth could be on the receiving end of some deathly inaccurate data.

In terms of classroom specific resources, the Society of Obstetricians and Gynaecologists of Canada (SOGC) has developed one of the most comprehensive online resources for teaching about sexual and reproductive health. The *SexualityandU* (SOGC 2008) website has been designed to

³⁴ My emphasis.

provide information and education for the promotion of sexual health. Within the site there are pages specifically geared towards health professionals, adults, parents, teens (discussed in the following section) and teachers. The section for teachers is quite detailed and offers a variety of links both internally and externally to additional sources of information. Most importantly, in addition to providing teachers with sexual health information and statistics, the SOGC has developed guidelines for teachers for dealing with sexual health education in the classroom as well as specific tools including lesson plans, presentations and student webquests (major projects that involve a significant online component). The lesson plans are derived from *Beyond The Basics* (CFSH, 2003) discussed previously. The presentations however are original documents available for download free of charge and in various formats; more importantly, the SOGC also provides a complete editable text-only copy for teachers to adjust as necessary, important for teachers who might be constrained by school, board or religious policies.

The complete presentation, *Choosing a Contraception That's Right For U* (SOGC 2007) is divided into several different sub-presentations according to clearly delineated issues, making it easy for teachers to organize lessons around specific topics (though also possibly to eliminate or limit some discussions). While the information contained in the presentation is valuable and fairly detailed, HIV is not discussed anywhere. The information on contraceptive methods however – barrier, hormonal, intrauterine and sterilization (nowhere does abstinence appear) – are all fairly complete including advantages, disadvantages and effects of the many options as well as an outline of the ways in which each works (*Ibid.*). Most importantly, the details offered for each and every method include a statement regarding its effectiveness for preventing STIs in general; it is quite clearly stated throughout the presentation that only latex condoms (male and female) provide complete STI transmission protection (*Ibid.*).

In addition, though further discussion is needed in the context of lesson implementation, in

relation to “Myths and Misconceptions About Hormonal Contraception” (SOGC 2007, slide 24), one of the myths addresses the belief that condoms are unnecessary if oral contraceptives are used. Further research is needed on the part of the teachers to adequately address this issue (additional information within this presentation is not provided, but there is sufficient data available on the *SexualityandU* site to supplement teacher knowledge), but it provides another opportunity for discussion of STIs and HIV. One final interesting element of the presentation is the discussion of contraceptive options open to men (condom use and vasectomy). One of the advantages listed for choosing one of these options is that they “allow the male partner to assume some responsibility for birth control” (*Ibid.*, slide 45). This is significant given the feminization of reproductive health and contraceptive responsibilities. Depending on the teacher’s ability and knowledge, this could lead to further discussions centred on challenging gender norms in sexual and reproductive health.

Finally, the teacher resource documents that are provided will likely serve to adequately support or increase teachers’ capacity to effectively convey the subject matter. These include *A Primer For Teaching Sexual Health Education* (teacher preparation, tools, better practices and lesson plans)(McCall, n.d., a); guidelines for managing controversy and dealing with student questions (SOGC 2007); and a sexual health communications kit for managing communication with and engendering the support of parents, other teachers, school administration, school board authorities and the community at large (McCall, n.d., b); this last especially is a very useful tool for engaging the community in the sexual health education of youth and for establishing a supportive, open and trusting environment. Its success is not guaranteed, but the potential for public support and engagement is significant.

Finally, the SOGC also offers teachers guidelines for webquest projects to implement in the sexual health education classroom. A webquest is described as:

An inquiry-based, group learning activity that motivates students to use the

Internet to learn about an issue and to apply or demonstrate that new knowledge through an assigned set of activities such as research reports, writing letters to designated agencies, conducting class/school surveys, setting personal health goals, interviewing experts, evaluating their own health and preparing materials such as posters and displays for school-based activities (SOGC 2006).

Given that the internet is a rich source of sexual and reproductive health and HIV prevention data, guided activities such as these allow students to access information that might not otherwise be readily available or disseminated in the classroom.

At the secondary level (grades 9-12) there are two webquests already developed for teachers, although a template and guide for designing an original assignment are also available. The two developed webquests are “Contraception Basics” and “Creating a Board Game on Postponing Sex” (Shannon and McCall, n.d.). The guidelines for the contraception project are innovative in that they include a socio-cultural perspective (barriers, access, informed choice, the use of barrier methods in combination with other forms of contraception for optimum effectiveness) as well as a requirement that students keep a personal health journal. The project undermines some important goals of effective gendered sexual and reproductive health education from the very start however, as it requires students to read three documents and respond to questions dealing only with the use of condoms and other contraceptives by *young women* in Canada (*Ibid.*). No mention is made of data concerning young men’s use of contraceptive and STI/HIV prevention methods.

The second webquest is somewhat more problematic as it emphasizes abstinence in several ways, and abstinence education is largely ineffective among youth (McKay, 2004). It is not defined solely by exhortations to abstinence however; it also focusses on postponement (Shannon and McCall, n.d.), which incorporates less of an anti-sex perspective, making it more palatable (and realistic) as an approach. Students who are already sexually active might not gain much from the exercise, though the guidelines for this webquest also include links to sites such as the Peel Region Public Health site (Peel, 2008) which provides in-depth information into alternative sexual activities

to intercourse for youth. This is significant from both an HIV prevention and a gendered perspective. Sexual activities such as masturbation, 'outercourse' and protected oral sex not only decrease the risk of transmission of HIV and other STIs, the message is also more sex-positive, more likely to increase interest in sexual health education, and more likely to help youth learn more about their own and others' bodies. Some of the net effects of this learning could also include greater gender equity in sexual and romantic relationships, increased mutual respect and potentially the increased personal agency, sexual comfort and sexual pleasure of young women. While this might be ascribing more influence to web media and school projects than is perhaps warranted, these are potential outcomes and even partial positive results should not be discounted.

10. c) Public Health Programs in Ontario for Youth:

In addition to formal education initiatives, there are many public health, peer-led and AIDS Service Organization (ASO) prevention and education initiatives geared to youth in Ontario. The Canadian AIDS Society (CAS) compiled a list of such programs in *Connecting Youth with Youth: A Guide to Youth and HIV/AIDS-Related Programs and Projects across Canada* (2004a). Despite the fact that the document is four years old, it is evident that there are many ongoing initiatives throughout Ontario and Canada that target youth; in Ontario alone in 2004 there were thirty-three such HIV/AIDS programs (*Ibid.*). CAS also provides several links to other provincial, municipal and ASO-driven programs, however there is also a great deal of information lacking, particularly inasmuch as specifically gendered prevention initiatives are seemingly non-existent and no programs in Ontario outside of Toronto are linked. For example, the Youth Services Bureau of Ottawa (2007) offers HIV/AIDS education and counselling services, as does the Access AIDS Network of Sudbury (2006). None of these programs however highlight risk groups other than street youth, IDUs and GLBTQ youth, and only the Access AIDS Network (*Ibid.*) appears to conduct some of its work within the formal as well as informal education systems.

Unfortunately, this limited approach is not uncommon. In practice, while public health HIV/AIDS prevention initiatives are much stronger overall than in the formal education system, they are still largely inadequate – one of the most notable weaknesses of public health initiatives includes their failure to make effective and widespread use of the media; the ubiquity of popular culture in teen development and interactions makes it an extremely accessible forum with vast educative potential (UNAIDS, 2005). Finally, many public health programs are seen as problematic in their inception, too narrow in focus, limited in scope, unconnected to lived realities (Langille et al., 2001) or not based on adequate research and not rigorously evaluated (Remis, 2007). They are also largely designed for communities defined and delineated only by sexuality and/or ethnicity. Of the initiatives listed in the CAS report, only one is described as a program for women, and that is actually a support group for positive women (CAS, 2004a). There are however many peer-led programs, an important consideration for delivering effective HIV prevention education to youth. In addition, many organizations such as Planned Parenthood Toronto (2007a), the Kawartha Pineridge Children's Aid Society (through their *Rainbow Youth Coalition* [2007] program) and the Aboriginal Youth Network (2007) also engage in outreach and program delivery in the schools, supplementing and augmenting (and sometimes entirely replacing) formal education programs in an important way. None of these programs is marked by a gendered approach to HIV prevention or sexual and reproductive health education programs however.

10. c) i: Online initiatives

Many regional, provincial and national organizations have all developed interactive and highly informative websites for youth to access information about sexual and reproductive health issues, including a significant component on HIV/AIDS prevention. Taken in conjunction with formal sexual health education in the schools and with public outreach programs such as those discussed in the previous section, it is clear that there is a great deal of information available to

youth. This is particularly important for young women given the lack of a focus on gendered prevention in many of the formal and public health outreach programs. Unfortunately, whether youth, and young women in particular are accessing the available electronic resources is unclear, though the *Canadian Youth, Sexual Health and HIV/AIDS Study* (CME, 2003), the *Sexual Behaviours and Attitudes* (CAAH, 2006) teen survey and the *Toronto Teen Survey* (Flicker et al., 2007) all suggest that only about a quarter to a third of youth seek (or find) sexual health information online. While not alarming on its own, the fact that youth have so little access to information and education through other channels supports findings that reveal a decline in sexual and reproductive health knowledge and positive outcomes among youth.

Though there are any number of websites administered by public health and AIDS Service Organizations (ASO) dedicated to youth and sexual and reproductive health, many focus either on GLBTQ youth or other issues relating to sexuality, or on counselling and support services. The best Canadian sites however are those which are highly accessible (two of the three offer information in English and French); innovative and detailed in terms of their approach to sexual and reproductive health education, gender, sex and sexuality among youth; and which provide more than a regional or community-specific focus. In addition, they are for the most part linked to regional and/or ASO sites, so even if a young woman started out trying to find information in London or Sudbury or Ottawa, the following sites are consistently and clearly referenced and easy to access. They are also distinctive in that they have information and activities dedicated to youth in general and young women in particular, and include information for teachers and parents or guardians as well. Significantly, these sites have included information on basic anatomy, relationships, love, sex and sexuality for youth, demonstrating an approach to sexual and reproductive health education that considers many, if not all determinants of health, from the psycho-emotional to the socio-economic, and this is highly laudable. Finally, though HIV is not the primary focus of any of these sites (as

previously discussed, HIV public health programs dedicated to young, hetero-sexually active women are distinctly lacking), still there is a significant component on each site dedicated to HIV and other STIs, including symptoms, modes of transmission and means of prevention.

In addition to providing valuable information for teachers and parents, the Society of Obstetricians and Gynaecologists of Canada's website, *SexualityandU* (SOGC, 2008) is one of the strongest examples of an information and learning resource for youth. The tone is informal, the language inclusive and sex-positive (for example talking about condom use for sexually active teens while also reassuring youth that abstinence or delaying sexual activity are also viable choices) and the information detailed without being too technical (i.e. "HIV is transmitted through contact with infected body fluids such as vaginal secretions, semen, pre-semen, breast milk, and blood" [*Ibid.*]).

The site is also interactive, providing files to download such as videos, computer screensavers, television and radio advertisements, and audio files for those with lower literacy levels (SOGC 2008). A further example of the interactive nature of the site is the inclusion of a game called *Sex-Fu* (which is a play on Kung-Fu and is quite entertaining) and several virtual scenarios available for play (including one called 'War of the Condoms'); these last are set up like a choose-your-own-adventure story in which the choices made by participants lead to different scenario conclusions. There is one significant element lacking from the game and scenario plays however, and that is a section dedicated to women who have sex with women – this is especially remarkable in the virtual scenarios, with specific storylines developed for heterosexual girls ("It's Party Time", "Chlamydia in Your Corner"; and "War of the Condoms"), heterosexual boys ("Chlamydia in Your Corner" and "War of the Condoms") and gay boys ("It's Party Time" and "War of the Condoms") (*Ibid.*); there is no mention made of girl-on-girl play of any kind.

In terms of the STI and HIV-specific information available to youth on the *SexualityandU* site, it is very comprehensive, including detailed instructions and explicit diagrams (and a short

video) on how to use and dispose of male and female condoms and dental dams, as well as how to turn a male condom into a dental dam. Most importantly, even though the approach is distinctly hetero-normative in relation to young women, there is also a brief section for girls on raising the issue of condoms with their male (though not female) partners, and provides suggestions for addressing various responses to the condom question (for example, if the male partner claims that condoms reduce sexual pleasure, signal a lack of distrust, and/or are 'lame' or boring) (SOGC 2008). The information provided which relates specifically to HIV, while accurate and useful, is also unfortunately marked by a normative understanding of risk. For example, it states that blood-related infections are unlikely in Canada unless needle-sharing is involved (*Ibid.*); this ignores the issue of violent or coercive sex, or even of more extreme forms of BDSM which could involve cutting for example. The site also reinforces racialization inherent in HIV discourse, by suggesting that sex in foreign countries (i.e. the Caribbean region) should be contemplated with more care and attention to protection (*Ibid.*). While this is true in the strictest sense when considering the increased likelihood of transmission in the face of prevalence and incidence rates in some regions, it is important to note that this could also reinforce perceived lack of risk among young Canadian women (I'm not at risk because I won't have sex in the Caribbean, or I won't have sex with 'a local'...).

As with *SexualityandU*, the Planned Parenthood Toronto's *Spiderbytes* (PPT, 2008b) includes information on sex, sexuality, gender, relationships and overall health. Two unique elements of this site are the highly descriptive (and sex-positive) pages detailing various sexual acts as well as the stages of physical arousal, from initiation to post-orgasm (including discussion of female arousal, lubrication, male erections, positions for oral sex, potential bleeding due to a ruptured hymen, and so on – *Ibid.*). Another interesting point is that the authors are careful not to normalize sensation or reactions, differing between girls' and boys' reactions and adding caveats

about the reactions of people who suffer from nerve damage or paralysis, as well as the effects of different moods, medications, stress, smoking, drugs and alcohol on physical responses (*Ibid.*). In addition, the description of various sex acts (from oral sex to fisting, using sex toys and cyber sex) include guidelines for relaxing, encouraging partner discussion and even a note that not every act is pleasurable for every person, thereby avoiding normalizing sexual activity, or even pleasure: “It may not be for you. People have sex acts they like and those they don't. Sometimes your preferences will change over time”(*Ibid.*).

In terms of HIV-related information, there is a section on STIs that includes references to HIV dealing with symptoms and means of transmission and methods of prevention. More interestingly, there is a section which discusses risk called the ‘Risk Rater’ (PPT 2008b). Using a small diagram of a temperature gauge, various activities including vaginal, anal and oral sex, as well as kissing, touching, rimming, fingering, fisting and using sex toys, are assessed for risk. Each activity is described in a gender and ‘sexuality-neutral’ way (referring to partners generally, and genitals being inserted or penetrated rather than speaking always about penis to vagina, etc.). Safer sex options are also presented for each activity (i.e. using a male or female condom, dental dam, or not undertaking a particular act – ‘skipping it’) (*Ibid.*). The major downfall of this site is that the information is available only in English, which in Canada is problematic for issues of access. Even though it is administered by an organization based in Toronto, there is still a significant Francophone presence, particularly among the Afro-Caribbean community in Toronto (let alone the rest of Ontario), to warrant translation.

Finally, the Canadian Association for Adolescent Health’s site, *YoungandHealthy* (CAAH 2008), is another strong online resource, including information on sex, sexual orientation, relationships (including violence), STIs, contraception and pregnancy; on communicating with partners, medical professionals and parents; and on overall health and wellness. Like

SexualityandU, there are also games and quizzes, in addition to contests (such as the STI-HPV Vaccine video contest), youth picture, music and story publications, and e-cards to send to friends (*Ibid.*). The two quizzes relate to STIs and contraception, though the majority of the games appear to be included merely to lure youth to the site, with the exception of one game, 'SOS STI'. This game can be played at three different levels (easy to expert) and involves many questions about prevention, transmission and symptoms of STIs including HIV (*Ibid.*). In the information section dedicated to STIs, including HIV, there is also some useful data, though it is more limited than the previous sites assessed and encompasses only very basic descriptive information, with none focussed on risk assessment or young women.

11. Conclusion

Having sought in this study to understand how the sexual and reproductive health needs of young women in Canada might be represented in HIV/AIDS discourse, the most accurate response at this time is that the representation is largely inadequate. While the actual numbers of young Canadian women becoming infected with HIV are still relatively low (with the noted exception of some minority populations such as Aboriginal women), their rates of HIV prevalence and incidence are increasing steadily (PHAC 2007a; Remis et al., 2008). In addition, in epidemiological reporting, except in the context of monitoring reports focussed on Aboriginal populations, women are not clearly identified as drug users or sex workers, as belonging to ethnic, religious or racialized communities, or, most importantly, as anything other than sexualized bodies that engage only in 'hetero'-sexual activities with men (PHAC 2007a; Remis et al., 2008). 'Woman' as a major monitoring category presupposes heterosexuality (the major risk categories applied to current policy, prevention, monitoring and treatment initiatives underscore this), and reinforces notions of

women's sexual health and sexual nature in terms of what they do with, and what is done to them by, men.

In discussions of risk in Canada, women are treated as a monolithic risk group separate from (or merely a subset of) youth and IDU, and of only a few very specific ethnic or racialized populations, limited to Aboriginal and Afro-Caribbean women (CAS, 2004b; PHAC 2007a; Remis et al., 2008). Real sites of risk for young women are poorly grasped, meaning prevention and education initiatives cannot be appropriately targeted to female populations. Epidemiology ignores too many differences among women, therefore the many ways in which various kinds of women, particularly younger women, in Canada are at risk of HIV or of other sexual and reproductive health-related problems more generally, will continue to be misunderstood.

Based on this study, it is also clear that young women's sexual and reproductive health needs are not being met in the current HIV prevention context, from either a public health or formal educational perspective. The fact is that except at the policy level; except for some very isolated research projects; and except in relation to specific risk populations such as Aboriginal women, an evidence-based, informed discussion of sex and gender is not brought to bear on monitoring or prevention initiatives. Neither public health nor formal education initiatives assessed in this study seriously or strenuously address gender issues which impact on women's sexual and reproductive health, or contemplate a gendered perspective which might serve to redress imbalances and omissions. This lack has been noted elsewhere in a few instances (Clow, 2006; Langille et al., 2001), however a sustained, dedicated response is yet to be forthcoming.

While there are some very strong policy documents and guidelines for dealing with HIV/AIDS in Canada from medical-epidemiological, monitoring, prevention and treatment standpoints, and while the *Canadian Guidelines for Sexual Health Education* (Health Canada, 2003) provide a very strong point of departure, implementation of sexual and reproductive health

education and HIV prevention is uneven and fragmented, and frequently bounded by conservative politics and a lack of funding (Spigelman, 2002). Within the *Guidelines* and other documents and policies addressed, there are elements of a gendered perspective, but little evidence that they are being translated into concrete programming. The public health and education systems in Ontario are a clear case in point, as outlined previously; HIV is only sporadically addressed in formal educational curricula, guidelines and resource documents. There is also little that is innovative in public health prevention initiatives, and nothing that employs a fully gendered approach to sexual and reproductive health, let alone anything that deals fully with all the variability inherent to women's health and sexuality. While there is excellent and detailed information available for young women willing and able to search the web (particularly *SexualityandU*, SOGC 2008; and *Spiderbytes*, Planned Parenthood Toronto, 2008b), or for teachers knowledgeable enough to find and request materials (the *Canadian Guidelines for Sexual Health Education*, Health Canada, 2003; and *Beyond the Basics: A Sourcebook on Sexual and Reproductive Health Education*, CFSH 2005), too much depends on individual knowledge, capacity and agency, traits not always nurtured through other avenues or by other means (i.e. teacher in-service training or student outreach efforts). Even if teachers or young women were to take the initiative in acquiring information, there is too little targeted HIV prevention programming in existence and what little there is suffers from an 'add-women-and-stir' approach, one that fails to address or encompass real differences, real zones of risk, or real lived experiences.

For educators, researchers and health practitioners, the idea of working towards the eradication of HIV/AIDS should be a universal goal, one which fits well within a gendered approach to sexual and reproductive health education. As addressed earlier in the study, the significant impact and effects of the HIV/AIDS epidemic in Canada also fit well within a host of other subject areas; these effects are manifested in a variety of contexts, from the medical-scientific

(PHAC 2007a) and legal (Canadian HIV/AIDS Legal Network, 2007), to the socio-economic (Cress et al., 2008) and socio-cultural (CAS, 2004b; CME 2003) dimensions of life in Canada. As a subject for courses in Ontario schools such as “Healthy Active Living” (OME HPE, 1999); “Biology” (OME SCI, 2000); “Understanding Canadian Law” and “Analysing Current Economic Issues” (OME CWS, 2005); “Aboriginal Governance: Emerging Directions” (OME NS 2000); and “Media Studies” (OME ENG, 2007), the HIV/AIDS epidemic contributes in many ways to illuminating inequities based on gender, sex, sexuality, race and poverty. An evidence-based, gendered approach to learning about and preventing HIV potentially benefits all young people by imparting the tools and abilities needed to achieve not only positive sexual and reproductive health outcomes but overall well-being as well.

11. a) Next Steps:

Further research into effective, gendered HIV prevention is needed in Canada. Although clearly some important work has been undertaken (by government agencies, academic researchers and the like) the issue of gender and of young women’s gendered risks are still not clearly or effectively addressed in the Canadian context. Existing research must be translated into effective action, meaning that educators, health practitioners and researchers must come together to devise a prevention response that encompasses a gendered perspective and makes effective and meaningful HIV prevention, both nationally and specifically in Ontario schools and communities, practical and feasible. To that end, this study has served to provide a baseline understanding from which to undertake future research, and to reflect this information back to researchers and educators, highlighting absences and silences in the representations of women in HIV/AIDS discourse and prevention efforts. Further efforts in this regard include exploring the possibility of condensing the findings of this study and presenting them to educators and researchers in professional and academic journals. Hopefully this will serve to generate ongoing efforts towards the development

of evidence-based, gendered HIV prevention interventions in Canada, including the design and implementation of pilot programs in schools.

One significant issue which also requires further study, which could contribute to the development of HIV prevention programs and which relates to young women's risk of HIV transmission (one of the most poorly understood issues in Canada), is that the variability and mutability of young women's experiences of sex and sexuality have yet to be legitimized and thoroughly researched, something that was not possible within the scope of this study. In addition to incorporating a more explicit feminist perspective in prevention initiatives, a richer theoretical understanding might be achieved in future studies by incorporating a queer perspective as well (beyond merely identifying and questioning heteronormative approaches and perspectives in existing material, as I have done here). In a small way this study represents a first step in that direction, in that it is marked in part by an attempt to "discover who does the speaking [about sex], the positions and viewpoints from which they speak, the institutions which prompt people to speak about it and which store and distribute the things that are said"(Foucault, 1978, p.11). It is important to understand the discursive structures around sex and sexuality, particularly relating to young women, before being able to conceive of how those structures might affect their behaviours and contribute to their risk of HIV transmission. Foucault's work on discursive knowledge and power could contribute to that understanding. More specifically the notions of the "hysterization of women's bodies" (*Ibid.*, p.104) (the hyper-sexualization of women and the pathologization of their bodies); and of the "pedagogization of children's sex" (*Ibid.*) (that all children are intrinsically sexually indulgent, and childhood sexual activity poses "physical, moral, individual and collective dangers", *Ibid.*) would be of particular value in unravelling the "discursive production...the production of power...[and] the propagation of knowledge"(p.12) surrounding young women's sexual and reproductive health in HIV/AIDS discourse.

Another theorist whose work would be of tremendous value in undertaking a gendered analysis from a queer perspective is Judith Butler (who also builds on and critiques Foucault's analyses in some of her writing). Butler's (1990) notion of the performativity of gender, the "repetition and [the] ritual [of a gendered identity]...[naturalized] in the context of a body [and]...culturally sustained" (p.xv) is especially interesting in light of the monolithic nature and presumed universality of women's gendered experiences in HIV/AIDS discourse. Her discussion of compulsory heterosexuality and of the overlap between homosexual and heterosexual structures, behaviours and relationships (*Ibid.*) could serve to deconstruct categories and classifications of women's gendered and sexual representation which are limited to a binary model of heterosexual/homosexual, male/female, masculine/feminine (and which in turn serve to limit understanding of safe and unsafe behaviours, of real sites of risk). In addition, Butler's assertion that "heterosexuality offers normative sexual positions that are intrinsically impossible to embody, and the persistent failure to identify fully and without incoherence with these positions reveals heterosexuality itself not only as a compulsory law, but as an inevitable comedy" (*Ibid.*, p.166) might serve to illuminate some reasons for and mechanisms by which women's sexuality and sexual behaviours are so often obscured and misrepresented in HIV/AIDS discourse.

Given the increasing rates of young women's HIV prevalence and incidence in Canada, despite over twenty years of research into prevention, treatment, vaccination, or even a cure, this study has proven both timely and useful, particularly in terms of future iterations of HIV prevention research, program development, implementation and assessment. Developing an understanding of the current state of sexual and reproductive health education and HIV prevention initiatives in Canada at the present time serves to clarify many of the barriers experienced by young women, and provides guidance for addressing the omissions and distortions which characterize women's representation in HIV/AIDS discourse. Young women's sexual and reproductive health needs are

not adequately represented in HIV/AIDS discourse or sufficiently or effectively addressed in formal education or public health programming, and this needs to be addressed.

Coda:

Love and lust, anger and stupidity, poverty and boredom, coercion and ignorance and depression all can play a role in determining the nature, context and outcome of sexual activity, so why do we imagine that some people are more careful and sane about safer sex practices than others, or less at-risk for making uninformed (or risky or even stupid) choices about sex? Why are only certain groups targeted for HIV/AIDS-related interventions? And why are those interventions, in schools, in public health organizations and in the media, so weak when directed at young women, of any stripe (of differing socio-economic backgrounds, ethnicities, sexualities and so on)? “Woman” is not a singular entity in any context, yet any suggestion of complexity in ascribing an identity or set of behaviours (sexual or otherwise) to women is largely effaced, omitted, silenced in HIV/AIDS discourse. “Straight” women have sex with women, lesbians have sex with men, women have sex with addicts (women *are* addicts), women have sex with transsexuals or with men who have sex with men and so on; so why aren’t women at risk for what they do to themselves or with each other, or with any other people than supposedly ‘hetero’-sexual men? Once the multiplicity and variability of gender, sexuality and sexual activities are fully understood (if not embraced), a real discussion of women’s risks of HIV transmission and of effective gendered prevention can begin.

“...adolescents aren’t the problem, adults are...”

(Haffner, 1998, in Langille et al., 2001)

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Why don't we always use condoms?



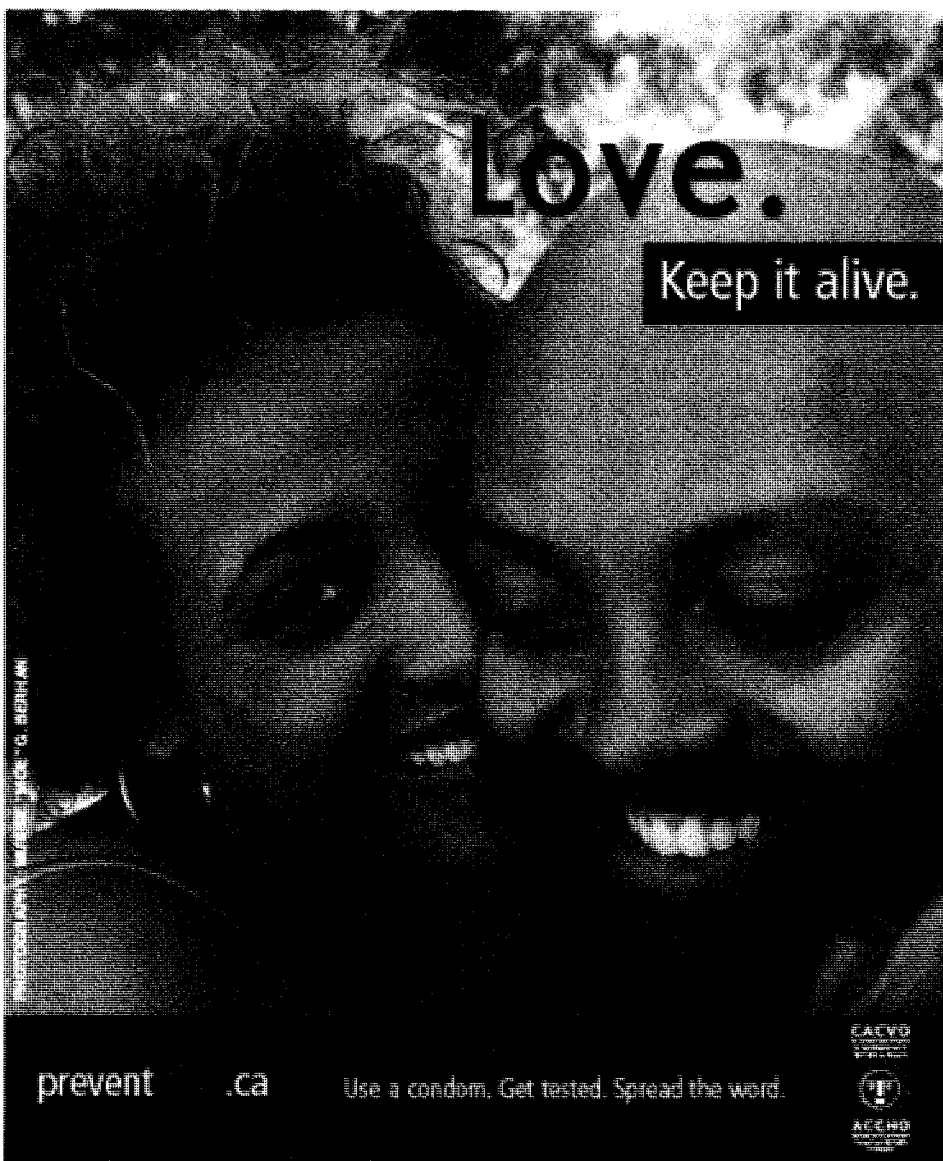
Reality check: Most of the time we do. When we don't, there are a lot of reasons — some are yours, some are his.

HIV Prevention Strategy Working Group
668.2437. free anonymous counselling

Retrieved on June 30, 2007, from:

http://www.health.gov.on.ca/english/public/updates/archives/hu_06/aids06/flash/index.html

Annex 2 – *Keep It Alive* (Ontario Ministry of Health and Long-Term Care, 2007)



Retrieved on June 30, 2007, from:

http://www.health.gov.on.ca/english/public/updates/archives/hu_06/aids06/flash/index.html

Annex 3 – Manifest Content: Assessing Prevention Effectiveness

Document title:

Document type:

Publication date:

Author(s):

Authorized / intended function or use:

Intended Audience:

Total length:

Sub-section length:

Word Occurrences (including noted variations, where applicable, and page references):

HIV/AIDS / HIV and AIDS / STIs / STDs _____

Sexual practices (heterosexual, homosexual, bisexual, queer, oral, anal, vaginal, etc) _____

Sex / casual sex / love / pleasure / choice, etc. _____

Woman / girl / lesbian / female etc. _____

Gender (perspective, relations, socialization, norms etc.) _____

Prevention / condom / dental dam / microbicide etc. _____

Abstinence / Monogamy / Multiple partners _____

Health Determinants:

Drugs / IDU / needle-sharing / pipes / addicts / casual users etc. _____

Coercion / peer pressure / negotiation _____

Socio-economic status / poverty / class _____

Culture / religion / ethnicity / racialization. _____

Other? _____

Total Number : _____

Results: In a _____ page document, _____ appears X times, suggesting the inclusion / exclusion of a useful gender / prevention perspective...

Annex 4 – Latent Content: Assessing Prevention Effectiveness

HIV/AIDS Policies and Strategies (Federal / Provincial)

1. How is risk defined? Are young women identified as a risk group? Are heterosexual practices identified as risk practices?
2. In what context do the words woman / gender / prevention, etc. (see checklist template for relevant words and word occurrences) appear?
3. How are women categorized? i.e. as a monolithic risk group, or as a group with varying lived experiences and needs?
4. Is gender integrated in policies and strategies or included as an ‘add-on’?
5. How are women represented? i.e. at-risk because of occupation or race? Deserving (i.e. prostitute, IDU) or innocent bystanders / victims (i.e. blood donors, rape victims, or simply passive, receptive), sexualized / pathologized bodies (i.e. physiologically weaker, carriers, ‘breeding grounds’), etc.

HIV/AIDS Public Health and Formal Educational Programs (Provincial / Municipal)

1. Is HIV/AIDS information (i.e. transmission, statistics) provided? Is it useful, detailed, accurate and neutral?
2. Are prevention data included as an integral component of the HIV/AIDS prevention / education program? Is it complete and detailed? (i.e. prevention addresses real fluidity of risk, sex, drugs, blood products, sexual negotiation and variability, etc.)
3. How are the epidemic and the virus represented? How are HIV+ individuals and groups represented?
4. How are women represented? How are women’s risks and vulnerabilities represented?
5. Is gender integrated in programs or included as an ‘add-on’?
6. Based on the inclusion / lack of the following requirements, how effective is the _____ program likely to be at incorporating gender into its prevention efforts?
 - i. Multisectoral
 - ii. Social justice
 - iii. Peer pressure
 - iv. Education
 - v. Socio-economic (poverty, prostitution, IDU, etc)

Annex 5 – Ontario Ministry of Education, Secondary School Curricula Course List³⁵

Canadian and World Studies (CWS), Grades 9-10:

- Canadian History Since World War I, Grade 10, Academic (CHC2D)
- Canadian History Since World War I, Grade 10, Applied (CHC2P)

Canadian and World Studies (CWS), Grades 11-12

- Analysing Current Economic Issues, Grade 12, University Preparation (CIA4U)
- Travel and Tourism: A Regional Geographic Perspective, Grade 11, Open (CGG3O)
- Canadian History and Politics Since 1945, Grade 11, College Preparation (CHH3C)
- Canadian History and Politics Since 1945, Grade 11, Workplace Preparation (CHH3E)
- Understanding Canadian Law, Grade 11, University/College Preparation (CLU3M)

English (ENG), Grades 9-10

- English, Grade 9, Academic (ENG1D)
- English, Grade 9, Applied (ENG1P)
- English, Grade 10, Academic (ENG2D)
- English, Grade 10, Applied (ENG2P)

English (ENG), Grades 11-12

- Media Studies, Grade 11 Open (EMS3O)

Health and Physical Education (HPE), Grades 9-10

- Healthy Active Living Education, Grade 9, Open (PPL1O)
- Healthy Active Living Education, Grade 10, Open (PPL2O)

Health and Physical Education (HPE), Grades 11-12

- Healthy Active Living Education, Grade 11, Open (PPL3O)
- Health for Life, Grade 11, Open (PPZ3O)
- Healthy Active Living Education, Grade 12, Open (PPL4O)

Native Studies (NS), Grades 9-10

- Aboriginal Peoples in Canada, Grade 10, Open (NAC2O)

Native Studies (NS), Grades 11-12

- English: Contemporary Aboriginal Voices, Grade 11, University Preparation (NBE3U)
- Current Aboriginal Issues in Canada, Grade 11, University/College Preparation (NDA3M)
- English: Contemporary Aboriginal Voices, Grade 11, College Preparation (NBE3C)

Science, Grades 11-12

- Biology, Grade 11, University Preparation (SBI3U)
- Science, Grade 11, Workplace Preparation (SNC3E)
- Science, Grade 12, University/College Preparation (SNC4M)

³⁵ Note: Only courses specifically or indirectly referenced in the text are identified here. For a full course list, please see the Ministry of Education and Training at: <http://www.edu.gov.on.ca/eng/curriculum/secondary/subjects.html>.

Social Sciences and Humanities, Grades 9-10

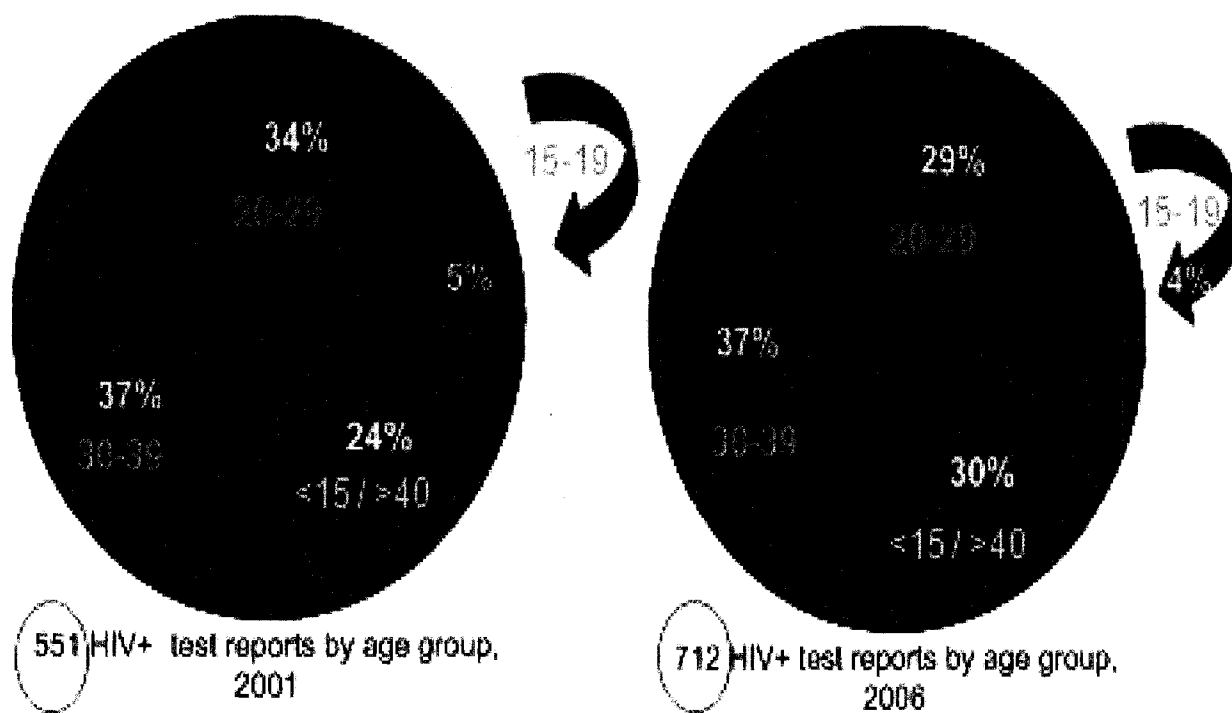
- **Individual and Family Living, Grade 9 or 10, Open (HIF1O / HIF2O)**

Social Sciences and Humanities, Grades 11-12

- **Living and Working With Children, Grade 11, College Preparation (HPW3C)**
- **Individuals and Families in a Diverse Society, Grade 12, University/College Preparation (HHS4M)**
- **Issues in Human Growth and Development, Grade 12, University/College Preparation (HHG4M)**
- **Challenge and Change in Society, Grade 12, University/College Preparation (HSB4M)**

TABLE A

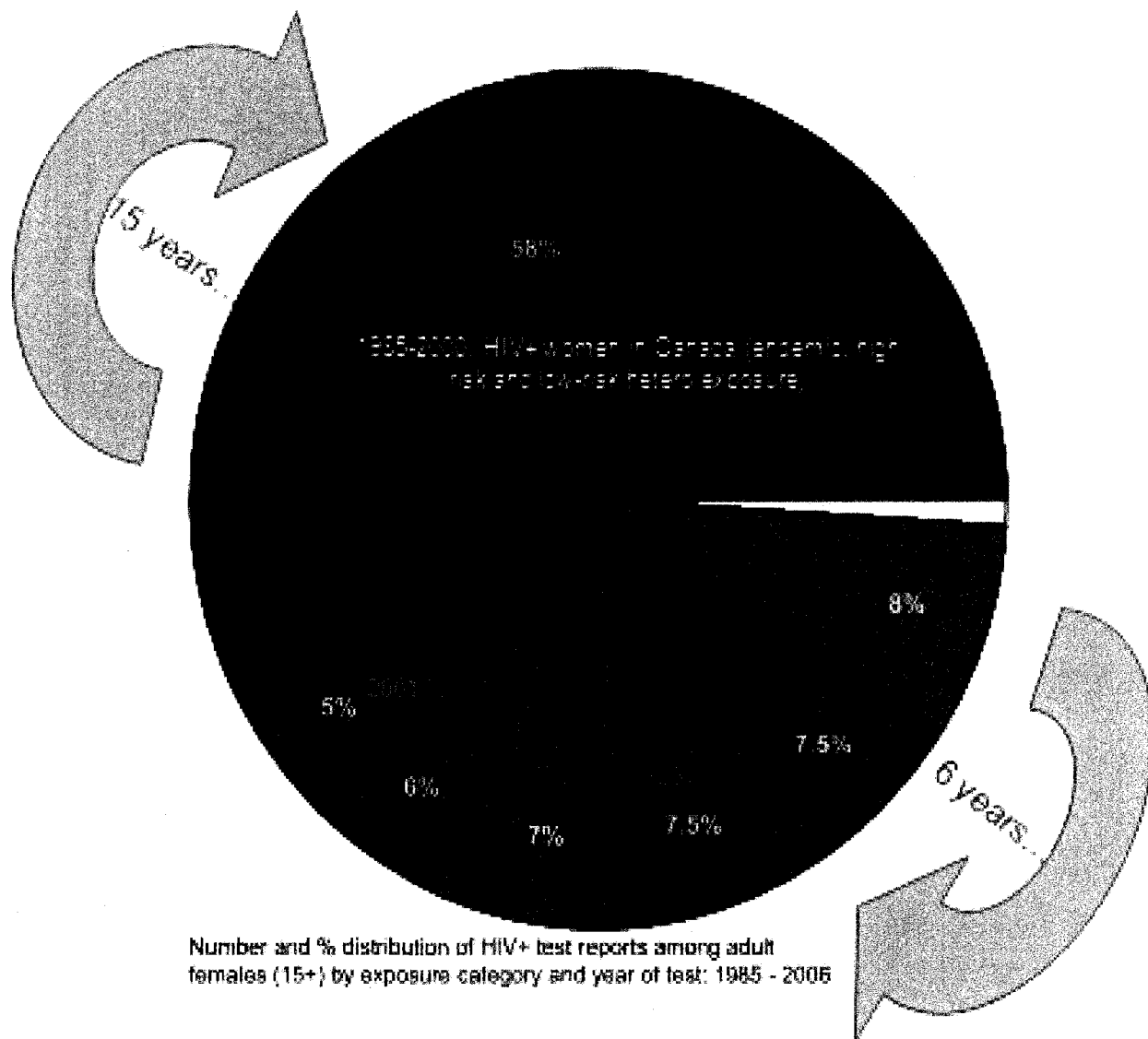
Women's HIV incidence by age cohort – a snapshot



Based on epidemiological data garnered from the *HIV and AIDS in Canada: Surveillance Report to December 30 2006* (PHAC 2007b).

TABLE B

INCREASES IN WOMEN'S HIV PREVALENCE RATES SINCE 1985



Based on epidemiological data garnered from the *HIV and AIDS in Canada: Surveillance Report to December 30 2006* (PHAC 2007b).

GLOSSARY OF TERMS³⁶

Abstinence – Not engaging in sexual activity voluntarily. Highly individual definition of what constitutes abstinence, i.e. everything-but-intercourse or no sexual activity at all both qualify**

AIDS – Acquired Immunodeficiency Syndrome

Bisexual – sexual orientation/preference focussed equally or to various degrees on members of both same and opposite sex.

Condom (male, female) – a sheath of thin latex that either covers the penis or is inserted into the vagina and cervix to prevent conception and transmission of STIs**

Dental Dam – a sheet of thin latex used to cover the anus and/or vagina during oral sex, rimming, etc. to prevent transmission of STIs.

Endemic – disease which is common in a certain area, region, etc.*

Epidemic – disease which is widespread in a particular community in a particular time period*

Gender – psycho-social, masculinity or femininity.

GLBTQ – gay, lesbian, bisexual, transgender/transsexual and queer

Heteronormative – assumption or normalization only of heterosexuality

Heterosexual – sexual orientation/preference primarily or only focussed on members of the opposite sex (straight).

HIV – Human Immunodeficiency Virus

Homosexual – sexual orientation/preference primarily or only focussed on members of the same sex (gay, lesbian, queer).

IDU – intravenous drug user, addict.

Incidence (HIV/AIDS) – the number of new infections in a given region during a specific time-period.

MSM – men who have sex with men, whether self-identified as gay, bi or straight.

Pandemic – disease which is prevalent throughout a country, region, continent or world-wide*

Prevalence (HIV/AIDS) – the total number of people in a given region to be infected.

Reproductive Health – state of complete physical, mental and social well-being with regards to reproductive system**

Sex – physical-biological, male or female.

Sex – the physical act, anal, oral, vaginal, masturbation, etc.

Sexual Health – achievement of positive outcomes (i.e. self-esteem, pleasure, choice, relationships etc.) and avoidance of negative outcomes (i.e. STIs, unintended pregnancy, assault, etc.)**

Sexuality – emotional, psychological, physical expression / interaction with others (ranging from asexual, to bisexual, to partially or fully heterosexual or homosexual – sexuality is fluid and changeable, self-identification as one or the other most valid expression, but not necessarily most accurate).

SRH – Sexual and Reproductive Health

STI – sexually transmitted infection (previously sexually transmitted disease)

Transgender – gender identity does not correspond with biological sex**

Transsexual – a person who presents him/herself and lives as the opposite sex, up to and including surgical/hormonal alteration**

³⁶ References:

* The Canadian Oxford Dictionary (2001). Toronto: Oxford University Press.

** CFSH, 2007