

Bridging the Gap

Integrating HIV Prevention into

BY ERIN CONNELL

Cet article explore le clivage historique entre le VIH et la santé sexuelle et de la reproduction, les programmes et les services, c'est-à-dire entre les origines du planning familial, de l'idéologie autour de la sexualité féminine, de l'association du virus avec la communauté gaie, de l'homophobie et de la honte. Elle conclut avec des études récentes qui font le lien entre ces pôles.

Planned Parenthood Federation of Canada (PPFC) is the only non-governmental organization (NGO) in Canada that provides services, information, and counselling exclusively on sexual and reproductive health. In December 2000, PPFC received project funding from the HIV/AIDS Prevention and Community Action Program (ACAP) at Health Canada. The project goal is to develop a resource that would allow Planned Parenthood affiliates to better recognize and serve both women at risk for HIV as well as HIV positive women.

The first phase of this project involves an examination of the historical separation of HIV and sexual and reproductive health promotion and the recent attempts to reintegrate HIV prevention under the broader umbrella of sexual and reproductive health. This article will explore the reasons for the split between HIV and sexual and reproductive health planning, programming and services, namely the origins of the family planning movement, ideology around female sexuality, the association of HIV with the gay community as well as homophobia and stigma. It will conclude by examining some of the recent research that supports bridging this gap.

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The Origins of the Family Planning Movement

Sexual and reproductive health programs and services grew out of the family planning movement, a movement that historically focused only on birth control. Within this context, social, economic, and eugenic factors were emphasized as was a tendency to uphold traditional family values. Birth control was promoted as a solution to economic problems and as a means to world peace since over-population was hypothesized as a cause of war (Bishop). In fact, most attention was directed to the poorer sections of the working class since it was believed that the birth rate of the middle class was too low. The target population of the first birth control clinics in Canada was poor women (Bishop). This (heterosexist) focus on birth control often excluded discussions about sexually transmitted infections (STIs) and any acknowledgement of the

needs of women who have sex with women.

The goal of many "birth controllers" was wanted children, better marriages, and freedom for married women (McLaren and McLaren). Feminist perspectives as a rationale for birth control, operating on the premise that women should be able to control their childbearing function, were in the minority until the Second Wave of feminism in the 1970s. Throughout much of the 1970s and 1980s, the women's health movement was largely preoccupied with issues of reproductive rights (e.g., resulting in the decriminalization of abortion in 1988) and control over one's body (e.g., reclaiming the female orgasm; new sexual assault and sexual harassment laws). These priorities and resulting ideological shift left the goals of the family planning movement unchallenged until the 1980s where STI prevention was increasingly becoming a part of the work of Planned Parenthood and other like-minded organizations.

Female Sexuality

Since the target population of the family planning movement was women, it is also important to examine the values and beliefs around female sexuality that have informed programs and services dealing with women and STIs. In fact, in the late eighteenth and nineteenth centuries, biological essentialism prevailed in the West: women were perceived as passionless and asexual beings while sex for men was a "conquest" and badge of masculinity. The stereotypes applied to women tended to distinguish between the "madonna" (good

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woman and moral custodian) and the “whore” (bad woman, morally corrupt).

While women’s roles have expanded to recognizing (and therefore giving some degree of respectability to) unmarried and non-procreative heterosexuality, this double standard still exists, particularly for women who engage in “excessive” sexual activity (Dubinsky and Belyea). There has been a tendency to blame women for STIs: women are seen as vectors of disease and sources of infection. Even though it is biologically easier for men to transmit STIs to women, women have been blamed for the transmission of STIs to men and children (Manthorne). Indeed, “good girls” don’t get STIs and prevention programs and services have been largely preoccupied with women’s reproductive function as opposed to their sexuality and range of sexual behaviour.

Clearly, female sexuality is socially constructed and shaped by prevailing systems of gender, racial, and economic relations and hierarchies as well as social institutions (e.g. compulsory heterosexuality). Recognizing women’s risk of HIV means dealing “with a morality which still does not really accept women’s sexual appetite and their enjoyment of sex” (Manthorne 35). As a result, women’s limited sexual knowledge, their alienation from their desire (which is socially constructed and objectified) and concomitant lack of control in sexual encounters places them at particular risk for HIV (Holland, Ramazanoglu, Scott and Thompson). Moreover, safer sex has often focused on the responsibility of women to negotiate condom use and

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this concept has more to do with how appropriate sexual behaviour among women is socially constructed rather than with practical considerations of risk. Indeed, women are encouraged to purchase, carry, and insist on the use of condoms and to take responsibility for sex in a world that constructs women as passive receptors of men’s sexuality (Dubinsky and Belyea).

HIV and the Gay Community

HIV was politicized, and leadership in the AIDS movement in North America, came from the gay community because of their direct interest in the issue: survival. It was certainly also politicized because it was a terminal illness affecting a particular community with certain beliefs around sexuality and sexual behaviour. While the epidemiology of AIDS is changing in Canada (e.g. HIV rates have increased amongst both women and injection drug users) the gay

community and men who have sex with men have been hardest hit by the epidemic and this was the context within which HIV programs and services were developed.

The mobilization around HIV was both positive and remarkable: ideological links were made between sex and identity as well as pleasure and equality. Educational resources that were pro-gay/lesbian, sex positive, explicit and clear were developed (Canadian AIDS Society). Positive images of gay male sexuality have become more widely available and include the legitimization of male desire and a concept of pleasurable sex (Holland *et al.*). “Safer sex,” as a new terminology, ideology, and approach, emerged from the AIDS movement and has contributed to more sex-positive, pro-active, and comprehensive programs and services.

This contribution of the gay community was also effective and essential in the development of housing and hospices, self-help groups, buddy programs, and advocacy around treatment issues. However, the unification and mobilization of the gay community meant creating focused services in a particular way for a particular group that resulted in a sense of exclusion for other groups. The target population of AIDS programs and services was largely gay men while the target population for the rest of sexual and reproductive health (in this case, family planning programs and services) was largely women. In addition, some AIDS service organizations have been slow to change to meet the needs of newly infected groups, particularly women (Cameron and Lee). This certainly contributed to the split between HIV



Rochelle Rubinstein, *untitled*, woodblock print and photograph, 8.5 x 11", 2001.

and the rest of sexual and reproductive health. Similarly, given the epidemiology of the virus, the "general public" has been slow to personalize their risk of HIV, which is further exacerbated by homophobia and stigma.

Homophobia, the hatred of, or aversion to, people engaging in same-sex relationships, and stigma have prevented an open dialogue on HIV/AIDS and served as a barrier to some sexual and reproductive health programs and services incorporating HIV issues (Manthorne). Indeed, the family planning movement certainly reflected society's latent homophobia as its programs and services targeted and aimed to maintain the heterosexual, nuclear family. This, combined with issues of chronic lack of funding and understaffing, often served to isolate HIV from the rest of

sexual and reproductive health promotion.

The HIV crisis further perpetuated myths and stereotypes about gay people (as promiscuous, irresponsible, deviant, etc.) that resulted not only in a slow response from government and other institutions, but also in internalized homophobia within the gay community (Canadian AIDS Society). In addition, the popular equation of AIDS with gay men makes many heterosexuals resistant to identifying their own risk behaviour. For women who have sex with women, expectations of heterosexuality, and negative social or cultural attitudes towards homosexuality, may serve to increase risk behaviours among some women who have sex with women and perpetuate a lack of prevention and support services (DeCarlo and Gomez).

Homophobia and stigma was also reinforced when, in the 1980s, AIDS was medically classified as the Gay-Related Immuno-Deficiency Syndrome (GRID) and the media coined the term "gay plague." This "AIDSphobia" perpetuated stereotypes about gay people and entrenched the link between HIV and the gay community in the public's eye. Here, the emphasis was on a particular type of person who contracted AIDS (e.g. gay/bisexual men, injection drug users, Canada's Haitian population) rather than behaviours that put people at risk for HIV. This resulted in a heterosexist moral focus on controlling a risk group based on sexual orientation as opposed to addressing the risk behaviour that leads to infection (Canadian AIDS Society). Attitudes toward sexually transmitted infections are often judgmental and may involve a

great deal of speculation and assumption about the behaviours that led to infection. Within this context, HIV affects two groups: the "guilty" (e.g. men who have sex with men, injection drug users) and the "innocent" (e.g. hemophiliacs, newborns).

Bridging the Gap

Despite the ideological underpinnings that have supported a split between HIV and the rest of sexual and reproductive health, recent research demonstrates an awareness of the need to incorporate HIV issues into the broader rubric of sexual and reproductive health planning, programming and services.

The Centers for Disease Control (CDC) in the U.S. supports STI testing and treatment as an effective HIV prevention strategy. Moreover, they suggest that HIV and STI prevention programs should not only develop strong linkages, but that it is especially important for programs to target sexually active young women who represent one of the fastest growing population with AIDS (CDC). Funding grants from the Comprehensive STD Prevention Systems require all state and local programs to address the intersection of HIV with other STIs. And the Sex Information and Education Council of the U.S. (SEICUS) *Guidelines for Comprehensive Sexuality Education* recommend education programs that include STI and HIV prevention with other sexual and reproductive health issues such as unintended pregnancy prevention, sexual orientation, self esteem, sexual decision-making, etc. (SEICUS).

In addition, the Joint United Nations Programme on HIV/AIDS (UNAIDS) also recommends that HIV and STI prevention programs be collaborative and integrate with other relevant prevention programs, such as pregnancy prevention programs and programs that discuss condom use and risk reduction (UNAIDS).

In Canada, while there is no national strategy on sexual and reproductive health, there is increasing

recognition that comprehensive sexual health education involves far more than the prevention of unintended pregnancies and sexually transmitted infections. Both Health Canada's *Guidelines for Sexual Health Education* and the Sex Information and Education Council of Canada (SIECCAN) call for programs to include HIV and other STIs as well as issues such as human and intimate relationships, sexual assault, sexual orientation, body image, reproductive health, and gender roles (SIECCAN). In addition, Canada's AIDS Strategy notes that "HIV-prevention initiatives are being positioned more clearly within the context of sexual health and social environments" (Health Canada 1999: 17).

Although HIV is a sexually transmitted infection (STI), it has, through its politicization and professionalization, become a stand-alone issue largely divorced from the rest of sexual and reproductive health. This split has been exacerbated by access and outreach issues; strategies, messages, and language used as well as organizational policies and institutional structures. However, there is growing recognition that, in order to ensure effective and successful programs and services, HIV issues need to be integrated into sexual and reproductive health. Given the changing epidemiology of HIV and PFFC's unique position as an agency serving primarily women, it is important that we work with the AIDS community in order to integrate HIV issues into our daily work. Including HIV into sexual and reproductive health programs and services ensures a broad, comprehensive and effective approach to sexuality and is in-line with research documenting the same. In order to do this, however, we must recognize and challenge the ideological underpinnings that have supported this split between programs and services as well as challenge our own biases and the biases of society at large.

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Planned Parenthood Federation of Canada (PPFC) is the only non-governmental organization in Canada that provides services, information and counselling exclusively on sexual and reproductive health. Our goals are to create awareness and support among policy makers and the general public regarding sexual health needs and family planning issues of Canadians. Twenty-seven independent Planned Parenthood affiliates in 68 communities across Canada provide clinical services, education, and counseling to over 310,000 Canadians every year; 90 percent of these clients are under 30, the vast majority of which are women.

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