INTERDICTIONS AND BENEDICTIONS: A DISCURSIVE ANALYSIS OF AIDS PREVENTION MATERIALS FROM VANCOUVER CANADA 1983-1999[1,2]

John Egan[3]
University of New South Wales

Abstract

This study identifies differing interests that have impacted how Acquired Immune Deficiency Syndrome (AIDS) prevention programs in Vancouver have evolved. Drawing largely upon the writings of Michel Foucault with respect to power, knowledge and sexuality, discursive trends in materials are identified, categorized and compared to consider how pertinent subjugated knowledges have developed. The interplay between knowledge-regimes (the benedicted) and subjugated knowledges (the interdicted) are explicated through textual analyses of the materials collected. The findings suggest that knowledges cultivated within the male gay communities of Vancouver ensured the implementation of prevention programs contextually relevant to their own milieu. These strategies were eventually integrated into broader prevention initiatives designed for mainstream society, once their efficacy was apparent. Implications for community education and public health education are discussed, and areas for future research are identified.

Résumé

La présente étude identifie des intérêts distincts qui ont influencé l'évolution des programmes de prévention du syndrome d'immuno-

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[3] National Centre in HIV Social Research University of New South Wales, Webster Building, 2nd Level, Sydney NSW 2052 Australia. e-mail: john.egan@gmail.com

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déficience acquise (sida) à Vancouver. L'étude, qui s'appuie en grande partie sur des écrits de Michel Foucault se rapportant au pouvoir, à la connaissance et à la sexualité, identifie, classe par catégories et compare les tendances discursives trouvées dans la documentation. Ceci permet d'examiner la manière dont les connaissances subjuguées se sont développées. L'interaction entre les régimes de la connaissance (le bénit) et les connaissances subjuguées (l'interdit) est expliquée par des analyses textuelles portant sur les documents qui ont été amassés. Selon les résultats, les connaissances cultivées au sein des communautés d'hommes homosexuels de Vancouver ont permis la mise en œuvre de programmes de prévention adaptés au milieu. Une fois leur efficacité éprouvée, ces stratégies ont également été intégrées à des initiatives de prévention plus larges et destinées à l'ensemble de la société. En outre, cette étude discute des répercussions de ces programmes pour la formation communautaire et la formation en matière de santé publique, et identifie de possibles avenues de recherche.

When Acquired Immune Deficiency Syndrome (AIDS) first appeared in Vancouver, the question posed by public health officials was "how can we prevent gay men from spreading AIDS?" Some years later, re/searching technical strategies for preventing the sexual transmission of AIDS would not be particularly elucidating; the answers to this technical, "how to" question haven't changed in the last 15 years. But how these strategies are articulated certainly has. And explication of changes in communicative strategies help us better understand how knowledges related to AIDS and sexuality might have been re/constructed.

AIDS prevention for (and often, by) gay men in Vancouver has been largely a grassroots endeavour. In discussing *grassroots* prevention/ education, I do not, in a generalized sense, refer to community education activities instigated by established non-governmental organizations (NGOs). Grassroots education, as a specific mode of community education, have their origins outside existing public or private institutions. Quite often those who initiate these programmes are "ordinary" people, whose shared concerns bring them together on an *ad hoc* basis. From such seemingly amorphous beginnings, highly effective educational projects take form. These activities often develop in response to unique, context-specific issues for which institutional responses are absent or perceived to be inadequate. Grassroots adult education is local in action and orientation, and puts local concerns first. AIDS prevention programmes for gay men in Vancouver—and arguably, throughout the US and Canada—evolved in precisely this manner.

And these particular grassroots adult education endeavours are unusually well-documented, allowing for a rich and detailed analysis.

The first AIDS diagnosis in Vancouver was in 1981 (Health Canada, 1988b). As per Majoribanks (1995), Vancouver's early AIDS prevention activities focused on person-to-person peer education, and the distribution of printed prevention materials. While the first sets of materials distributed were developed in other milieus (including San Francisco and New York), within two years, flyers and pamphlets created by a group of local gay men were in circulation in the city's gay bars, bathhouses, and other businesses known to be gay-supportive. Many of the men initially active in what was to AIDS Vancouver[4] had tertiary educations; several were primary care physicians. Not surprisingly, the first materials created by this group articulated their prevention messages in medical terms. But as the scientific and medical understanding about AIDS improved, grassroots activists also saw that medically-identified "how-to" strategies to prevent the spread of AIDS seemed to be having limited impact. The implications were that many gay men either saw themselves as invulnerable to AIDS, felt that AIDS infection was inevitable, or viewed the prevention information being proffered was not relevant to their lived experiences as gay men.

Context

To understand the context in which AIDS appeared requires an awareness of the socio-political climate in which many urban gay men in Canada and the US lived, circa 1980. In the years immediately preceding the appearance of AIDS, dramatic changes had occurred in the lives of many gay men in North America. Since the late 1960s, the gay liberation movement had gained significant strides, barely a decade before AIDS appeared. Despite substantive increases in visibility in many major cities (often in gay 'ghettos" like San Francisco's Castro, New York's West Village, and Vancouver's West End), relatively few gay men were living *wholly* open gay lives. Most remained reticent to disclosing their sexual preference, particularly in interactions with institutions like corporations, the academy and the state. For many, job security and its related economic implications served as a powerful impediment to complete candour regarding one's sexual orientation. At the same time, many gay men had acquired professional

[4] The first and largest AIDS service NGO in Vancouver.

credentials and tertiary educations, and had attained significant financial resources by "passing" as heterosexual in society—either unconsciously or strategically. The resources acquired by many of these (closeted) gay men—in terms of professional skills and financial resources—were to play an integral role in the evolution of AIDS prevention in North America (Shilts, 1987; Seidman, 1993).

These resources, combined with a burgeoning market of both local and national gay-owned magazines and newspapers, laid the groundwork for the production of localized AIDS prevention materials. Access to typesetting and personal computers through these media outlets allowed activists to produce their own publications quickly and inexpensively. Also, as access to personal computing technology broadened, so too were financial constraints experienced by local groups mitigated, allowing for wider production of printed materials. This unique combination of financial resources, professional skills, and access to technology allowed gay men to use locally created, context-specific printed materials as a primary mode of prevention information dissemination.

Purpose

Among those who worked in grassroots AIDS prevention in the beginning of the epidemic, the veracity of these claims is common knowledge. But what has not been documented is the extent to which the printed, disseminated materials created for use in Vancouver's AIDS prevention programs demarcate distinct knowledges regarding AIDS, sexuality, and desire. More precisely, what sorts of different knowledges are contained therein? The findings of this study speak to the specifics of effective AIDS prevention strategies in one context (viz., gay men in Vancouver Canada), but also contribute to our understanding of the interactivity of different knowledges in general. The materials examined here were created to educate adults how to avoid contracting AIDS. Thus for this research, AIDS prevention is examined as a realm of adult education practice. In analyzing the materials used in AIDS prevention, we garner not only a better understanding of how a particular grassroots adult education response to a health crisis has unfolded; those concerned with grassroots adult education (health-related and not) in other contexts should also find the specifics of this account highly informative.

Literature Review

There have been innumerable epidemiological studies of AIDS transmission among gay men in North America; Stokes, Vanable and McKirnan's study (1997), and Strathdee's Vancouver-based report (1997) are but two examples. But the normative, almost wholly quantitative practices of epidemiological research limit the areas investigated by such studies: their shared focus is to understand the pathology of AIDS, with an aim of creating prevention programs focused on changes in risk behaviours. The social context in which the activities occur are frequently acknowledged, but not critically examined; neither is how the strategies used have been influenced and shaped by the context. Social research on the Western gay male experience (in general), and the impact of AIDS on said experience (in particular) each inform the motivation for this study. Jeffrey Weeks (1991) offers insightful and critical sociological examinations of Western discourses on homosexuality, both pre- and post-AIDS. He has substantively contributed to our understanding of the influence of the social context in relation to AIDS, but his work does not examine practical aspects of prevention programs. Cindy Patton (1985; 1990) has examined the discourses embedded in AIDS prevention programs. Her critiques of prevention programs' objectives and strategies largely excludes the materials used in prevention activities; instead, she looks at issues of how dominant, mainstream discourses about sexuality in the public sphere have influenced AIDS prevention.

In adult education literature, Boshier's (1992; 1993) popular culture analyses about AIDS offer some insight into discourses in the public sphere regarding AIDS, but do not speak specifically to AIDS prevention *as a practice*. Sessions & Cervero (1999) examine the public discourses on AIDS prevention in the US over nearly two decades. Their findings are not rooted in prevent practices per se, as much as in the values and ideals embedded in program priorities. Though the question of values' influence on prevention programs is important, their study uses a critical perspective on program planning (Cervero and Wilson, 1994; 1996) as a theoretical framework for its analysis. Archie-Booker, Cervero and Langone (1998) studied the practice of AIDS prevention at an AIDS NGO in a southern US city. They determined that most AIDS prevention information available in that context lacked critical nuances or adaptations, particularly for African-American women; they deftly mapped the different materials used locally, and integrated them into the experiences of African-American women seeking information and

support regarding their own risk for AIDS. But their research is more an analysis of the experience of accessing programs, than of the materials used, and does not consider the discursive implications contained therein.

This study seeks to assuage gaps in grassroots adult education literature. Together, while these sources identify issues at both the macro and micro levels, and integrate a plurality of contexts, strategies and practices, they do not address how competing sets of knowledge have interacted in the shaping of AIDS prevention strategies. Here a *discursive analysis* is used to elucidate how different knowledges have—oppositionally and interactively—shaped AIDS prevention strategies implemented in Vancouver in the first two decades of AIDS. This study identifies the printed materials produced and used as direct (to the public) information sources in AIDS prevention programmes in Vancouver between 1983 and 1999 as a veritable discourse on AIDS prevention – particularly with regards to sexuality. It particular, it considers how materials conceived and created by gay men for their peers differ from mainstream materials, with respect to discussions of desire, sex and love. What is interdicted—excluded, silenced or refuted – or benedicted —permitted and celebrated—is delineated and described. The importance of these discourses with regards to these findings will also be discussed.

Methods

Michel Foucault wrote at-length about the intersection of knowledge, power and sexuality in *The History of Sexuality Volume One: an Introduction* (1990). Foucault posited that institutional knowledges—reified by the academy and the state—are benedicted, usually at the expense of local—subjugated—knowledges. Such knowledges are often interdicted—excluded or silenced—when proffered outside their local milieus, usually for not meeting inappropriate, proscribed rigours of "validity". Foucault saw this dynamic as being in no one's best interest. As a researcher committed to grassroots activism, Foucault's ideas regarding this interactivity intrigued me. With significant animus between early gay male AIDS activists and public health officials during the nascent epidemic (Shilts, 1987; Majoribanks, 1995), an examination of artefacts from AIDS prevention strategies could explicate to what extent any subjugated, gay-male knowledge regarding sexuality existed. In delineating different knowledges, the nature of their interaction with the knowledge-regime (manifest as medicine, specifically public health) could then be examined. What power relations were at work in AIDS prevention education in Vancouver, as evident in artefacts used in local AIDS prevention programs?

Research Design

For this study, over 200 publications used in grassroots AIDS prevention programs between 1981 and 1999 were analyzed. Data collection occurred at venues throughout the City of Vancouver, including gay bars and bathhouses, private physician's offices, public health clinics, and community centres; sites where one could reasonable expect to secure AIDS prevention materials. Using an emergent design, document analysis was initiated with the classification of materials, in terms of why, when, by whom and for whom each was created. Materials were coded for format (pamphlet, poster, wallet card, display kiosk, booklet, pamphlet, web site, or sticker) and origins (grassroots groups versus medical/public health entities). Both graphic images and text were analyzed to identify representations and discussions of sexuality, AIDS transmission, and prevention methods. Given the brevity of most documents (usually less than 100 words), quantifying words, phrases or concepts within individual documents was not particularly illuminating. Instead, the entire collection of materials was considered a singular "canon" of AIDS prevention literature. Discursive trends thus were identified.

Findings

These publications were examined both for their articulations of technical prevention strategies, and as "instances of discursive practice" (Foucault, 1990a, p.12). Their content—and the ideas and values embedded in them, as discerned from the context from which each emerged—revealed two distinct perspectives on gay male desire, that of gay men themselves, and that of mainstream society. Publications were created by a public health entity (medical association, or municipal, regional or national public health ministry/department), or by gay men working (initially) at the grassroots level (and later as staff in AIDS-specific NGOs). Though the evolution of the discourses analyzed has not been linear, trends that appeared over two different phases of the AIDS prevention movement are differentiated chronologically, to represent how discursive trends have evolved. Two periods, each representing roughly 10 years of HIV prevention in Vancouver, emerged.

The 1980s

Early in the epidemic (1981-84), all AIDS prevention materials used in Vancouver adhered to the dominant medical paradigm for disease prevention: a harm reduction approach that encouraged changing behaviour to mitigate risk of infection. Since physicians have largely shaped this

paradigm, and several gay male physicians were involved in planning the initial grassroots response to AIDS among gay men in Vancouver, their having chosen medical terms to explicate their prevention messages makes sense. Thus an existing *medical* discourse about disease prevention was uncritically transferred to AIDS prevention programmes, from other disease prevention strategies; this medical discourse would remain prominent in public health-produced materials for most of the 1980s.

However, within this *medical* discourse, terms related to the candid discussion of the precise nature of sexual expression—oral, vaginal or anal sex—were interdicted in favour of euphemistic phrases like "sexual contact", or "having sex". In doing so, public health professionals perhaps sought to avoid accusations of superimposing any sorts moral judgements onto outreach programmes, and instead endeavoured towards *neutral*, or non-judgemental language. This common pursuit of "neutrality" avoided any contextualized discussions of AIDS transmission. In the pamphlet *AIDS Antibody Testing: What It's All About* (Province of British Columbia, Ministry of Health, 1987), readers learn that, "the AIDS virus is transmitted from person to person most commonly through sexual contact in the same manner as other sexually transmitted diseases." No differentiation between sexual practices' different risk levels is found. Those unwilling to acknowledge the specifics of Vancouver's AIDS epidemic—as a condition which almost exclusively affected gay men—likely did so as much due to ignorance of (and discomfort with) gay male sexual health issues. By not addressing gay male sexuality specifically, these materials were of questionable efficacy in preventing transmission. Yet they were quite effective in perpetuating the existing silence in the public sphere about normalized gay male sexual relations.

Early in the epidemic, grassroots educators chose a different tack. In the early 1980s, their materials incorporated a different strategy, as shown the following excerpts from the pamphlet *Fight Fear with the Facts*. A move away from a neutral discourse is apparent: The activity which is seen by many as most capable of transmitting AIDS is taking the passive role in sexual intercourse, especially anal intercourse, which includes ejaculation. (AIDS Vancouver, 1984, p.7) Rather than speaking in vagaries, precise sexual practices are named, using medical terms to describe sexual activities. Public health's materials did not embrace this candour until 1987—six years after AIDS first appeared in Vancouver.

Local knowledges about gay male sexuality began to supplement (but not supersede) the dominant medical paradigm of public health/health

promotion. Virtually every publication had aligned itself with the dominant medical framework: AIDS was a communicable disease, a presumption in place before HIV was identified as the cause of AIDS. It posited the most obvious means by which to avoid getting AIDS was to avoid the activities through which AIDS was most likely transmitted: blood-to-blood contact from blood products or by sharing injection drug paraphernalia, or through sexual activity. But it was another framework that would constitute the cornerstone of Vancouver AIDS prevention materials: assuming an inability or unwillingness to forego perceived risk behaviours, these behaviours can be adapted to greatly reduce exposure risk. Hence injection drug users were admonished to avoid sharing their injecting equipment, and those who were not sexually abstinent were advised to use condoms during anal and vaginal sex. This *harm reduction* strategy was reified in the prevention discourse. Identification of these frameworks helped to isolate the perspectives in which they were embedded.

As the medical discourse began to be supplemented with candid discussions of gay male sexual practices (viz., a gay discourse), gay male-affirming perspectives began to influence new publications. This naming of exact sexual practices was a challenge to public health's interdicting silence about the realities of sexual desire. In "AIDS, Acquired Immune Deficiency Syndrome" (AIDS Committee of Toronto, 1983), a difference in levels of risk associated with anal intercourse and "swallowing semen" (p. 5) is cited: the discourse moves beyond a mere acknowledgement of male-male desire. In explicating how gay men act upon their desires for other men, gay men are not only giving themselves more precise and accurate prevention information, they are affirming—benedicting—the value and importance of their sexual desires. In advising "sexually active men" (p. 7) to access medical care, especially regarding their sexual health, those who created and distributed this publication take an unequivocal position which validates male-male desire. Even so, in directing gay men to seek care from "a physician familiar with gay health problems" (p. 7), a perceived general anti-gay prejudice in the delivery of health care is acknowledged. Among gay men, a perspective already existed which did not see any neutrality in healthcare delivery. Fighting AIDS meant speaking against, interdicting, homophobia.

Also beginning in 1983, a *quotidian* (or everyday) discourse—one which used common vernacular terms to describe sex between men—began to be used in community-created AIDS prevention materials. A shift away from

using anatomical or behaviourist medical terminology paralleled the incorporation of words and phrases which were perceived as common in everyday discussions about sex between gay men. This change in perspectives was manifest in two ways. Initially, words like "intercourse", "penis" and "fellatio" were replaced with "fucking", "dick", and "cocksucking". One AIDS Vancouver pamphlet (*Information about AIDS from AIDS Vancouver*, 1983) discussed finding a "fuck buddy", or ongoing non-romantic sexual partner (p. 2). This shift towards using the quotidian language gay men use with one another when discussing sexual matters demonstrates an effort to make the materials more relevant to the lived experiences of gay men in Vancouver, taking a more peer-based, collegial tone.

One of the earliest materials located in this study was created by members of AIDS Vancouver in 1983. It is an excellent example of this transition from a wholly medical discourse on sexuality, towards one which integrates both medical and quotidian terms to elucidate risk reduction schemes for HIV exposure. In *What are my chances?* (AIDS Vancouver 1982), men are warned that, "In particular, rimming and anal-receptive contact with semen increases risk" (p.2). "Analingus" is the medical equivalent of "rimming", the quotidian term for the stimulation of a sexual partner's anal with the lips or tongue. Few gay men would understand what "analingus" means, whereas "rimming" appears commonly in the gay vernacular. Whether the equivalent medical term is esoteric, or, where there is no equivalent term within the medical discourse, using quotidian terms should not have seemed an innovative strategy—yet it was. This shift represents a concrete refutation of the knowledge regime, in favour of a local knowledge. Gay men were creating a discourse based on their own values, a discourse that benedicted male-male desire.

In conducting this study, it was also useful to read *behind* the words, looking for reasons why ideas were explicated and contextualized differently in certain ways in the grassroots materials. In doing so, an additional discourse was uncovered: a *celebration discourse*. In this discourse, materials moved more concretely towards the re/estimation of male-male desire, particularly in light of a sexually-transmitted pandemic. In *Information about AIDS from AIDS Vancouver* (AIDS Vancouver, 1983), gay men are advised to not "waste valuable energies on negative reactions to sex. Now more than ever, ignorance, arrogance and hypocrisy about sex are to be repudiated. If anything, be even more genuinely affirmative about your sexuality" (p. 6).

These materials began to speak to the social context in which risk for transmission occurs, as much as to the pathology of transmission.

Paradoxically, some materials produced by AIDS Vancouver between 1984 and 1987, their "AIDS Update" series, seem to avoid both the specifics of how HIV is transmitted and techniques for reducing transmission. Phrases such as "homosexual and bi-sexual men" do not reflect the social contexts presented in earlier materials via the quotidian discourse. In excluding specific harm reduction information (the phrases "contact AIDS Vancouver for specific information"; "if unfamiliar with condoms, learn how to use one" appear in each issue of the Updates for this period, were the staff and volunteers of AIDS Vancouver reverting to the dominant discourses of mainstream society? To some extent perhaps; a more accurate assessment would be that this period was marked by rapid expansion in program resources (i.e. government funding) and staffing. As AIDS Vancouver grew, the evolution of prevention materials was not linear: the reassertion of the more normative discourses probably reflects the tensions between those whose perspectives were shaped by medical training and those whose perspectives were based on a grassroots, peer approach.

Between 1987 and 1990, numerous Health Canada, City of Vancouver and BC Ministry of Health pamphlets were disseminated; as well, the BC Medical Association (BCMA, whose members are physicians licensed to practice medicine in BC) used its membership to distribute a pamphlet on AIDS. Despite evidence that contextually-focussed, community-specific (viz. gay male) materials were more efficacious than generic ones, the medical discourse held sway; in two instances this discourse is awkwardly used to conceal homophobia. *AIDS antibody testing: What it's all about* (BC Ministry of Health, 1987) encourages persons to "abstain from anal sex (and) use a condom properly for oral or vaginal sex" (p.6). The BCMA's (1988) *AIDS: This information could save your life* defines safe sex as "you should not perform anal intercourse, and you should always use condoms for all other forms of intercourse" (p.4). While the pathology of HIV does make anal intercourse a greater risk for transmission than oral sex, at the time of this pamphlet's writing there was no substantive evidence that anal intercourse was higher risk than vaginal intercourse. These "neutral" admonishment are thinly veiled attempts to frame anal intercourse *between two men* as unhealthy. Further, no suggestion that heterosexuals forgo vaginal sex entirely can be found in *any* of the materials analyzed. Yet gay men are admonished for pursuing what is for many the *equivalent* sexual

expression of love and desire. Were a public health official to suggest abstinence from vaginal intercourse by *all* heterosexual persons, whether in committed relationships or not, the suggestion would be considered ludicrous and unrealistic. Yet similar pronouncements against anal intercourse appeared in public health-created materials nearly ten years into the Vancouver epidemic. These interdictions are as much against any representation of love between men—and the concomitant sexual expression of that love—as they are about disease prevention. And these two publications were still in circulation in some Vancouver-area health facilities, as late as 2002.

The 1990s

In the second decade of HIV prevention targeting gay men in Vancouver, an integration between these two discourse—medical and quotidian—took shape. Materials often used both scientific and vernacular words to describe gay male sexuality. More and more publications began to include bisexual men explicitly, broadening their messages beyond gay-identified men. And many publications from grassroots organizations addressed the context of gay men's sexual and romantic lives, further cementing the importance of contextually-specific prevention information. In public health materials however, little changed.

In many instances, the medical discourse was used to describe ways to mitigate transmission risk, but the design of the materials firmly contextualized this information as being targeted towards gay men. In *In control* (AIDS Committee of Thunder Bay, 1994), each of 16 pages includes a photographic showing gay men in their support/friendship circles (p. 2), having sex with one another (pp. 1, 7, 12, 13), and in romantic but not overtly sexual situations (pp. 3-7, 9, 10, 12). Communication, AIDS denial, substance use, and monogamy are also discussed, in terms of how these issues affect one's ability to negotiate sexual safety. AIDS Vancouver's Man2Man project's 1995 wallet card on condom use, combines the medical ("penis"; "anal intercourse") and quotidian ("cum") discourses with drawings of how to apply a condom to an erect penis. Similar material was used in 1996 as a condom carrier/wallet card, for distribution with free condoms in bars, bathhouses and in other outreach programs.

Two AIDS Committee of Toronto (ACT) pamphlets were in circulation in Vancouver around the same time. *Safer Sex Guide for men having sex with men* (ACT, 1996a) used stylized photos and drawings as supplements to a detailed technical explanation of HIV transmission and ways to reduce

infection risk. Both the quotidian and medical discourses appear, as in the following excerpt:

> Anal sex (fucking) is a very easy way for HIV to pass from one person to another, whether you are fucking or getting fucked. It's a high risk activity. The rectum (ass) is very tender inside, and small tears can occur during anal sex. This lets HIV get into the bloodstream. Small cuts or sores on the penis that you might not be able to see can also let the virus in, or HIV can get in through the lining of the urethra (peehole). You can get other STDs from anal sex too. It isn't enough to pullout before ejaculating (cumming) as HIV is found in pre-cum too. (ACT 1996a, p. 4, emphasis original).

The shifts between the quotidian and medical discourses seem appropriate and natural. The message, both in terms of technique and intended audience is quite clear. This style of prevention message both validates gay male local knowledge and adds to it, by adapting the knowledge regime's understanding of HIV pathology to the language of the gay male community being addressed.

Throughout the 1990s, this notion of community also gained fluidity. NGOs like Atish (South Asian), Healing our Spirit (Aboriginal) and Asian Society for AIDS Prevention (now Asian Society for the Intervention of AIDS, or ASIA) asserted the need to go beyond Western notions of gay male reality. The South Asian, Aboriginal and Asian communities (within the larger gay male community, and in a broader sense) produced their own materials, often in languages other than English. Yet this notion of culture can be broadened to include those (including, but not exclusively gay men) whose sexual expression includes sadomasochism (SM). In *Safer SM* (ACT, 1996b), a detailed discussion of how the rectum/ass (p.5) and vagina/cunt (p.6) can be irritated or injured, resulting in greater risk for HIV infection; strangely, the penis is not mentioned. How the use of sex toys (p. 7), piercing and shaving (p. 9), whipping (p. 9), and electricity (p.10) in sex play can be risky (or not) for HIV transmission constitutes the balance of the materials. Similarly, the AIDS Committee of Thunder Bay identifies its gay male community as consisting of "men who express our sexuality in a healthy way. We can feel good about ourselves as we take *control* of our lives" (1994, p.3, emphasis original). In 1997, a new gay bath house opened in Vancouver for the first time in nearly 20 years. F212 encouraged local AIDS NGOs and public health workers to use their venue for sexual health services for gay men. Additionally, they created their own HIV prevention

information card, which is placed on the pillow of every private room, exhorting patrons to "play safely—You're worth it" (F212, 1997, p.1). Except for information about the facilities available and the safer sex techniques, clients are only advised to "have fun and play safe" (p.2).

Subjugated Knowledges

Homosexual desires were consummated long before they were permitted under the Criminal Code of Canada. But with the acquisition of some civil rights for homosexuals, these desires were discussed more candidly. Immediately prior to AIDS, gay men in Vancouver were exploring sexual activities, customs and relationships without and within the monogamous norms of mainstream society, as were many of their peers across North America were (Shilts, 1987; Seidman, 1993). The candour with which issues relating to sex and sexual relations were discussed among gay men did not substantively change as the AIDS pandemic manifested itself. Today in Vancouver, this discourse on sexuality continues to transgress the mainstream medical discourse on sexuality.

Whereas the knowledge-regime critiqued, ghettoized and silenced homosexuality in the public sphere, its medical discourse on sex was unable to subvert the local knowledge about sexuality which had already taken root among gay men (Foucault, 1980b, p.81). Pre-AIDS, this local knowledge's most fundamental component was that male homosexual desire was to be celebrated, not loathed. In challenging mainstream interdictions against homosexuality, a subsequent examination about many other aspects of romantic and sexual relations was a reasonable next step taken by many gay men. Many men's assumptions about love, relationships, monogamy, promiscuity, intimacy, and other aspects of sexuality were subject to scrutiny, adaptation, acceptance or rejection. The resulting articulations of unique and individual moralities about sex and relationships was an integral component of "coming out" (e.g. revealing oneself to be homosexual) for many gay men. Under the shadow of AIDS, its resilience is remarkable.

The successful integration of this local knowledge into gay male specific AIDS prevention strategies necessitated the development of risk reduction strategies which were non-judgmental about the various contexts in which sex between men occurs. The overall message was that gay men needn't abhor their sexuality in the age of AIDS, regardless of how their desires for other men were expressed. Men were instead encouraged to protect themselves and their sex partners from AIDS—always. Any mainstream discourses in which AIDS was inferred to be a punishment for

homosexuality's immorality were rejected. Entreatments within the gay male constituency to ignore homophobic mainstream messages were indeed "insurrection(s) of subjugated knowledges" (Foucault, 1980b, p. 81), particularly in their refusal to moralize about sex.

Interdictions and Benedictions

These materials offer substantive evidence to support Foucault's postulations on the interactivity of the knowledge-regime and subjugated knowledges. In the mainstream, the reality of those whose lives do not conform to what is considered "normal" is often maligned, silenced or ignored. To most, "those people" do not, or should not, exist. The dismissal, silencing and vilification of their local knowledges all seek to interdict any discourse that might challenge this dominant perspective. In juxtaposing the materials which were from the gay male milieu, with those from society at-large, critiques of male homosexual desire are easily discerned. These critiques, which often operate in collusion with a broad silence about homosexuality, permeate the public sphere. Heteronormative content, images and text which frame heterosexual desires as normal (and superior to homosexual desires), specify what is the benedicted desire in the mainstream. Interdictions against homosexual desires, or the absence of any acknowledgement of their existence, serve as further de facto benedictions of heterosexuality. But members of a subjugated group often priorize their local knowledge over the knowledge-regime—especially when faced with a crisis like AIDS (Foucault, 1980b, p.81).

Foucault offers a new mode of inquiry related to analyses of competing knowledges which he himself employed to examine discourses about sexuality. "Instead of looking for basic interdictions that were hidden or manifested .... it was necessary to locate the areas of experience and the forms in which sexual behaviour was problematized, becoming an object of concern", he recounts from his own research in *The Use of Pleasure: The History of Sexuality, Volume Three* (1988, pp. 23-24). For some, AIDS represented an opportunity to re-assert belief systems characterizing homosexuality as evil. Ironically, within the gay male milieu this served to reify local knowledges about desire and sexuality, and to disseminate them more widely: it can now be argued that male homosexual desires are less interdicted in the public sphere than they were prior to AIDS. Though explication of the specific practices inspired by male-male sexual desire remain largely excluded, tolerance of diversity with respect to sexuality in

principle has diffused into the mainstream. This also supports Foucault's theory that local criticism's character is not limited to the local, but can impact upon other locales, or the mainstream (1980b, p.81).

A gay disease?

One discursive trend deserving further examination was the public-health-driven "not a gay disease" discourse. To many gay men this discourse was seen to challenge an AIDS-related homophobic backlash in the mid-1980s. But for heterosexuals this discourse was intended to clarify that AIDS is a disease which can affect anyone, not only gay men. In using this discourse to challenge notions of AIDS only affecting homosexual men (and later, people in the Third World, and injection drug users)—to what extent does this discourse perpetuate homophobia? Should AIDS prevention strategies that do not challenge such biases be permitted?

Consider this: It is now apparent that AIDS was already endemic in much of sub-Saharan Africa by the early-1970s, more than ten years before AIDS exploded among gay men in North America. Had AIDS's early impact in Africa garnered the sort of media attention it had merited, what discourses might have occurred regarding AIDS in North America? Would AIDS have been perceived as a legitimate threat to (largely Caucasian) gay male constituencies in Canada and the United States? Had a prescient epidemiologist predicted how AIDS would travel from Africa to North America and kills hundreds of young gay men, would many of these men have considered their risk for exposure to AIDS important enough to foster an immediate change in sexual behaviour? In such a scenario, as the number of gay men with AIDS began to rise, might not an "AIDS is not an African (or Black) disease" discourse have developed?

While the tension here is somewhat conjectured, doubtless the anti-gay and anti-African trends are rooted in prejudice (homophobia in the former, and racism in the latter). Discourses such as these do not demonize the constituencies named in them; instead they serve to challenge notions which are perceived to be significant barriers to many persons taking seriously their risk for contract AIDS. The "not a gay disease" discourse is of merit for mainstream prevention strategies because it reflects a contextual reality of the society in which it appears: homophobia was (and still is) used by heterosexuals to delude themselves about their risks for contracting AIDS. Just as strategies integrated into gay-milieu prevention programs were seen as offensive and disturbing elsewhere, so too must gay men (and lesbians) permit those who plan mainstream programs to include elements which may

offend some, but which are purposefully chosen for their perceived efficacy in reducing new HIV infections.

A Praxis for Effective Grassroots Education.

Foucault's theories of knowledge speak directly to the grassroots constituency worker experience. As a research method, discursive textual analysis has few operational barriers for activist/researchers, and marginal significant operational costs. Thus a greater potential for voicing these grassroots experiences is achieved. Most adult educators, particularly practitioners whose work is extra-institutional, can adapt these methods to a variety of contexts. In identifying more accessible research paradigms, these local knowledges can be integrated more readily into the knowledge-regime, enhancing the larger body of adult education literature.

Foucault described Western society's normative discursive practices around sexuality as "restrained, mute and hypocritical" (1990a, p.3). In its efforts to prevent the spread of a sexually transmitted and largely fatal disease, governments continued to resist any implementation of more candid discourses about sex. Since HIV has been transmitted in Canada mostly via sexual relations, why have the publications used in government prevention programs remained so vague in their discussions of sexuality? In seeking to prevent further spread of a fatal malady like AIDS, this continued pursuance of a "neutral" discourse is spurious.

Sonia Nieto (1992) stated that "all good education connects theory with reflection and action...defined as praxis". Reflection on one's actions, one's position in the setting of practice, and one's relationship with those being assisted is complemented by consideration of theoretical and ideological underpinnings related to self and society. This integration allows grassroots educators to pursue local change as part of a broader agenda for a better society. In helping to improve the circumstances under which those on the margins of society live, benefits are realized by society as a whole.

Transferability of Study

These materials are instances of discursive production from a particular community (gay men in Vancouver), in response to a particular health crisis (AIDS). The opportunities of these men granted them access to material and social opportunities that have doubtlessly afforded gay men fighting AIDS in Vancouver particular opportunities to foment a local response to a local concern: AIDS is certainly much bigger than the Vancouver epidemic among

gay men. Currently in Vancouver, an equally devastation epidemic rages on among injection drug users (IDUs); the difficulties of the IDU community transferring the strategies (and replicating the successes) of gay men demonstrates how grassroots adult educational endeavours acquire their validity from their local origins. The AIDS pandemic in Africa, the Caribbean, Asia and Eastern Europe contain a multiplicity of local contexts and local epidemics. If we can learn anything from the Vancouver experience, it is that those at-risk for AIDS are the custodians of unique and vitally important local knowledges. As long as these knowledges are subjugated, change at the local level is difficult. Conversely, until these local efforts—successes and failures—are shared with those facing similar challenges, grassroots adult educators will have only their own resources upon which to build, and from which to learn. Sharing these local experiences between adult grassroots educators could save time, resources and lives.

The findings of this study are of merit to any context where local knowledges are of importance in the planning of grassroots educational programs. How these local, subjugated knowledges can be differentiated from the knowledge-regime—and the potential merit of any such determinations to one's practices—is to be determined by those living in the context, not outside "experts." But these findings should also be considered by those who direct public policy related to health promotion activities of government. In the last few years, a climate of fiscal austerity has seen a trend towards government support being channelled through a decreasing number of NGOs. This strategic action has been undertaken to reduce administrative expense incurred when organizations with similar mandates deliver overlapping programs.

This is not a policy direction we need our governments to take. According to a study from the BC Centre for Excellence in HIV/AIDS, the expected average expense to provide medical care to each new person infected with AIDS in British Columbia is anticipated to be $150,000. Concurrent estimates of per capita prevention expenditures for each averted AIDS transmission are approximately $82,500 (Meagher et al, 1998). Grassroots, constituency-specific interventions have proven effective in preventing HIV infections (Health Canada LCDC, 1998), and are wholly inexpensive in comparison to the treatment costs associated with AIDS. For each infection that occurs due to this "economizing" of grassroots prevention programs, money will be lost, not saved.

And more women, men and children will become infected with AIDS and die.

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