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Messages of responsibility: HIV/ AIDS prevention materials in England

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ABSTRACT This article investigates messages of responsibility expressed in HIV/AIDS health promotion literature produced in England. Critical academic literature provides an analysis of the impact of overly individualized approaches to responsibility for health, which lead to victim blaming. While some of the materials in this sample demonstrate the type of simplistic approach to responsibility addressed by this literature, there are also some expressing shared social and organizational responsibility for AIDS prevention. These complex differences will be discussed in the article with reference to specific examples of image and text from prevention materials. I argue that isolated messages of individual responsibility alone do not encourage readers to identify with the broader social context of the epidemic. It is not only possible but imperative to integrate notions of broader shared responsibilities into public health efforts in order to generate a community response that includes attempts to reduce social vulnerability among those most at risk of contracting the virus. This has implications for the success of future HIV prevention efforts both in England and globally.

KEYWORDS *AIDS; HIV; public health; responsibility*

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Introduction

> AIDS is still almost entirely a disease passed on by poofters and junkies. Only their promiscuity and stupidity has spread it like wildfire. (*Daily Star*, 18 December 1990)

This newspaper quotation, with its pathologization of the victim, reminds us that the production of HIV education materials does not take place in a social vacuum. The intent of this article is to open a dialogue about the ways in which messages of responsibility in HIV prevention materials impact upon cultural perceptions of the epidemic and those it affects. The core of this discussion is an exploration of messages of responsibility contained in printed material produced by five English organizations concerned with HIV prevention. While the goal of prevention organizations is to reduce the spread of HIV through increased education and decreased stigmatization, such efforts take place within a social context that contains contradictory values and attitudes in relation to AIDS.

A central question running through this article is the relationship between efforts to engender personal responsibility in relation to 'risk behaviour', and the negative impact of individuating responsibility and victim blaming. The issue raised here has wider pertinence to the field of health promotion, as many of the tactics discussed are utilized beyond the field of HIV/AIDS campaigning. While the social context of AIDS gives perhaps a complexity to the situation unparalleled by other modern illnesses, we can apply the lessons drawn from this instance to a range of other health promotion areas. The move towards the individualization of responsibility is evident in all areas of health and calls for critical assessment (Moran, 1997).

Public health emerged in the UK as a means of protecting the well being of the population against the harmful effects of industrial pollution, unmanaged sewage, contaminated water supplies, malnutrition, etc. (Ashton and Seymour, 1988). Public health organizations took responsibility for the welfare of the population on behalf of a nascent welfare state. This has in time been 'eclipsed by a more individualistic approach' (Ashton and Seymour, 1988: 17), whose rhetoric speaks of the individual's responsibility to the self through healthy 'lifestyle' choices. This simultaneously implies that society is better off when its citizens are well and that the individual is therefore responsible for the 'greater good'.

One signpost of this shift was Canada's 1974 Lalonde Report (see Crawford, 1977 and Leichter, 1980). This report indicated a new stage in contemporary public health in that it emphasized prevention and took a keen interest in the lifestyles of individuals as a cause of illness. It introduced the 'health field concept', an approach taking human biology, environment, lifestyle and health care organization into account as a unified means for government, communities and individuals to work towards improved health while at the same time saving costs.

In 1992, the UK government's *Health of the nation* White Paper extended the mildly veiled attack on individual lifestyle choices which lay below the surface of the Lalonde Report. Although the Health Secretary's (Virginia Bottomley) introduction spoke of balancing responsibilities between the government, other agencies and individuals, most specific strategies in the document were directed towards individual behavioural change. In the case of sexual health it stated: 'If the spread of HIV infection and other STDs (sexually transmitted diseases) is to be curbed, behaviour change on a wide scale is needed. . . . Success lies in: information and education; monitoring and surveillance; development of comprehensive local services' (Department of Health, 1992: 23).[1] There was no emphasis on the preventive health benefits of a more supportive, egalitarian social context or of the Government's role in creating this kind of environment.

The UK government's more recent White Paper, *Our healthier nation* (1999), uses the notion of partnership to make the same arguments 25 years after Lalonde: 'It is the Government's job to spell out the facts and quantify the risks on which individuals can make informed decisions'.[2] Like the Lalonde Report it prescribes the role of government, communities and individuals on the assumption that these partners are operating on equal ground and that no conflicts exist between them. It is clear when looking at the sections outlining the roles allocated for these three partners, that the burden of responsibility rests with individual citizens. Their responsibilities include items like increased exercise, healthy eating and reduction in tobacco and alcohol consumption.[3] The White Paper improved upon its Green Paper predecessor in that it recognized the role of social inequality; yet the document opens with 'Ten Tips for Better Health' aimed at the individual, such as: don't smoke; reduce stress; exercise regularly.

Our healthier nation excludes sexual health from its four main target areas, but says that a separate strategy for sexual health is under consultation. Poor statistics on teenage pregnancy and sexually transmitted infections in the UK alerted the Government to deficiencies in this area giving great impetus to the development of a combined sexual health and HIV/AIDS policy. It is perhaps, however, a sign of the contradictory messages given by the Government on the importance of sexual health that this topic is not at the centre of the national health strategy.

The use of the term 'partnership' in *Our healthier nation* refers to partnership between government, communities and individuals and doubtless plays a necessary role in improving health. However, the idea of 'partnership' has to be reassessed in light of the state's own inactivity in restructuring the unequal social conditions of health. This partnership does not operate on the understanding that the most powerful and resourceful partner, the state, has the greatest responsibility for social change – beyond health reform rhetoric. The inverse is true in that the individuals who are most vulnerable and possess the least power have the greatest obligation to 'take responsibility' and change their 'lifestyles' in order to become healthier citizens.

While health promotion professionals have tended to argue that the primary way to prevent AIDS is to encourage individuals to change risky behaviour that can lead to HIV transmission,[4] a number of critics have contended that isolating individual responsibility in this way serves to blame those who are most vulnerable to infection (see Crawford, 1977, 1994; Veatch, 1980; Kennedy, 1993; Frankenberg, 1994; Daykin and Naidoo, 1995; Brandt, 1997; Gastaldo, 1997; UNAIDS, 1998).[5]

Robert Crawford's work focuses on the historical reasons for the turn towards victim blaming near the end of the 20th century. He connects this to the difficulties faced by traditional biomedicine in the 1970s, when it was no longer able to satisfy the increasing public hunger for breakthrough cures which it had been responsible for creating (Crawford, 1977). From an economic standpoint, welfare states and large employers felt that they could no longer afford to provide high quality health care with its exponential rate of growth. At this point, he argues, health policy began to shift its focus onto the good and bad practices of individuals:

> The language of health came to signify those middle class persons who were responsible from those who were not, those who were respectable from those who were disreputable, those who were safe from those who were dangerous, and ultimately, those who had the right to rule from those who needed supervision, guidance, reform or incarceration. (Crawford, 1994: 1349)

Writing about the way in which these understandings of responsibility began to fashion identity in the age of AIDS, Crawford says: 'The loss of health or simply the characterisation of a person as "high risk" entails a setting apart. Thus, the claim of health is simultaneously a declaration of identity: "I am responsible and rational" ' (Crawford, 1994: 1356).

Crawford and Brandt both draw attention to the role of the most important advocate of individual responsibility in the 1970s in relation to health care, John Knowles, President of the Rockefeller Foundation (now one of the leading funders of global AIDS research). Knowles' attitude may be illustrated by the following statement:

> The next major advances in the health of the American people will be determined by what the individual is willing to do for himself and for society-at-large. . . . If he is unwilling to do these things, he should stop complaining about the steadily rising costs of medical care and the disproportionate share of the GNP that is consumed by health care. This is his primary critical choice: to change his personal bad habits or stop complaining. (Knowles, 1977: 78)

Here we have an example of rhetoric which mentions social factors contributing to public health, yet places the onus of responsibility on the individual. As he says in the same article: 'I believe the idea of a "right" to health should be replaced by the idea of an individual moral obligation to preserve one's own health – a public duty if you will' (Knowles, 1977: 59). It was not long before Knowles' approach became part of the political mainstream in the USA and influenced most affluent democracies which were all facing financial crises in their health care sectors (Brandt, 1997).

Echoes of this approach persist in *Our healthier nation's* image of the 'healthy citizen' (Department of Health, 1999).

Both the health promotion concepts of individual responsibility and the ideas of their critics have had a strong impact on the production and interpretation of HIV/AIDS prevention materials. Allan Brandt warns about negative impact of AIDS prevention which simplifies transmission of the virus into a matter of personal choice. He summarizes this simplistic approach in the following way:

> If one 'merely' avoids the risk behaviours associated with transmission of the virus – unprotected sexual intercourse and sharing needles for intravenous drug use – one can avoid AIDS. Therefore, infection is a clear – and usually terminal – marker of individual risk taking, of engaging in behaviours typically held to be deviant or criminal. According to this view, those who are infected are responsible for their plight. AIDS is caused by a moral failure of the individual. (Brandt, 1997: 69)

There is a fine line between addressing the need for behaviour change in health education and the danger of such efforts lapsing into, or being understood as, victim blaming. Crawford, Brandt and others can be interpreted as supporting the argument that all approaches which employ individual responsibility lead to isolation and stigmatization.[6] In this article I argue that in some cases AIDS education has this potential, but that we cannot characterize all prevention materials in the same way. In some instances education materials have clearly worked to contextualize HIV/AIDS in its social and political setting rather than simply blaming isolated individuals.

An alternative reading of Crawford's work would regard it as a critique of specific styles of health promotion which place an *inordinate amount* of responsibility on the individual. Viewed in this light, it would be possible to see that not all health promotion materials necessarily take an extreme approach towards individual responsibility or lead to victim blaming. Indeed, some materials that I have collected include reference to organizational, governmental and social issues that contribute to the continuing spread of HIV, while also referring to individual responsibilities for change. Many offer a direct challenge to conservative attitudes towards sexuality and drug use, particularly those prevailing at the start of the epidemic.

Thus we can understand the production of HIV prevention materials as a part of a dynamic process of social change which includes both tendencies towards the individuation of responsibility and towards the critique of this individuation (Miller et al., 1998). Several of the organizations selected for this study have recognized the potential for their materials to create further stigmatization, and in a spirit of self-reflection have introduced new ways of communicating messages of responsibility. Some have created materials specifically designed to challenge existing approaches to AIDS and sexuality as a means of confronting complacency. At the same time, other materials drawn from the organizations studied continue to demonstrate a reliance on simplistic understandings of individual responsibility for behavioural change.[7]

It is known that AIDS has been able to proliferate globally for a number of reasons, including discriminatory isolation, slow governmental reaction, material deprivation and lack of education. These are not issues for which individuals (or for that matter single AIDS Service Organizations) can be held solely responsible. For example, Jonathan Mann, former director of the WHO Global AIDS programme (now UNAIDS), spent his career promoting the idea that HIV is the infection of the socially excluded. A statement in a UNAIDS paper points to the discrepancy between Mann's view and the implementation of prevention programmes: 'Public health interventions . . . have largely focused on the individual, falling short of addressing societal issues that may be at the root of ill health' (UNAIDS, 1998: 5). It goes on to explain that efforts to reduce individual risk behaviour can only be successful within an environment where the state simultaneously works to reduce the *vulnerability* to HIV experienced by those who are socially excluded. This approach is now internationally recognized, and a United Nations General Assembly Special Session on HIV/AIDS in June 2001 produced a Declaration of Commitment on behalf of member states that, while falling short on some expectations, set direct targets on funding and action to reduce social vulnerability to the disease.

It remains true that many of the materials investigated in this research concentrate on the primacy of personal responsibility at the expense of other issues. This overemphasis on personal responsibility in AIDS prevention materials may serve to deepen social divisions rather than reduce them (Moran, 1997). It is necessary to emphasize, however, that most organizations do not have a singular approach to their presentation of responsibility and may well demonstrate internal contradictions (Field et al., 1997; Miller et al., 1998). Research conducted by the Glasgow Media Group in *The circuit of mass communication* (Miller et al., 1998), exposes complex relationships between personal beliefs, politics and public health that intertwine at each stage of the decision-making process during the design of new HIV/AIDS public health campaigns. Messages of responsibility can change between campaigns and reflect changes in the perception of wider prevention needs of those who design them.

Method

What follows is an analysis of approximately 200 sampled leaflets, brochures, postcards, posters and newspaper advertisements produced up until 1999 reflecting the range of HIV/AIDS prevention publications which people may have encountered in everyday situations in England (particularly in the Greater London area). The organizations selected are listed in Figure 1, including those with national scope and some which target

Gay Men Fighting AIDS (GMFA)	Their publications and condoms for gay men are actively distributed by volunteers in London (particularly popular cruising parks) in order to promote change. The materials are often sexually graphic and always challenge the reader actively to assess his risky behaviour and political complacency.
Health Education Authority (HEA)	This official public health arm of the Department of Health has been campaigning for AIDS prevention since 1986. They produce materials directed at broad audiences as well as specifically targeting men who have sex with men. This organization was reformulated from the dissolved Health Education Council (HEC) in April 1987, and was again reorganized as the Health Development Agency (HAD) in 2000.
NAZ London (NAZ)	NAZ Project London began by producing materials exclusively for Asians, in a wide variety of languages. More recently they have recognized the need to serve Latino and Muslim communities in using religious and culturally sensitive approaches.
Rubberstuffers	Rubberstuffers distributed their print materials and condoms in gay venues, saunas and events around London. As a result of the streamlining of AIDS Service Organizations (ASOs) in England, they closed in March 2000.
Terrence Higgins Trust (THT)	THT began in the early 1980s as an advocacy group for gay men concerned about the emerging epidemic. Since then it has grown into a wide-ranging service provider and policy advocate for all those affected by HIV/AIDS with offices throughout England and is now the largest AIDS Service Organization in Europe.

Figure 1 **List of Organizations.**

more specific communities. The sample was confined to organizations operating within the geographical area of London in an attempt to limit the number of variables. Thus while these materials can be said to be indicative of the English response to AIDS, the sample cannot be said to be exhaustive or evenly representative. It was possible to obtain numerous items produced by the Terrence Higgins Trust and the Health Education Authority in the 1980s and the 1990s so their materials from each decade were analysed separately in order to monitor how messages had changed over time.[8]

Each printed item was recorded and coded, noting both the textual and graphic components of the message.[9] The coding process was designed to assist in the discovery of such concept clusters as those outlined in Figure

individual responsibility for the self – messages or images which directly or implicitly convey a sense that the reader should be willing to change behaviour if it will improve his or her own health

responsibility to others or shared responsibility – images or text which relate the importance of communication with sexual partners; protecting your partner from disease; telling friends about HIV/AIDS; contributing to the decrease in stigma towards those groups most affected by AIDS; or being concerned for the well being of others be they known or unknown

organizational responsibility – images or text referring explicitly to the organization's own commitment to stop HIV/AIDS transmission, or refers to other official organizations that are perceived to have responsibility for the issue

directives or directive language – tells the reader what they must and must not do, often in list form – directive language can be an indicator that the organization giving the orders feels some responsibility for taking charge, but essentially, directives have the effect of being able to blame those who become infected for not doing as they were told

informative language – tells the reader what is known about AIDS, and leaves decisions about behaviour up to the reader – again, this places responsibility for decision making with the individual – the aim here is that individuals will recognize the information as important and applicable to themselves, and will modify behaviour accordingly

street language – uses ‘slang’ rather than biological terms for sexual acts and body parts – this can bring the narrator much closer to the reader and can sound less judgmental – rather than communicating a sense of blame materials using language familiar to the reader can help to affirm the reader’s social context

inclusive language – here the narrator voice is in second person, so that readers are addressed as ‘we’ rather than ‘you’ – this creates a communal tone in which the reader is meant to feel a part of a close-knit social grouping which functions cohesively – rather than isolating responsibility this collectivizes it

Figure 2 **Concept clusters.**

2. The findings were then recorded in a database in order to quantify the number of times in which specific indicators arose for each organization.

We must also take into account that the nature of the materials themselves (printed matter) means that they are directed at individual readers. The sample does not include policy documents or examples of political lobbying which operate at levels beyond the individual. The question here is, in these materials which are all aimed at individuals, are the messages of responsibility contained at only the individual level, or do they extend beyond?

It is clear that public health materials are designed to promote change of one type or another. Leaflets, posters and booklets designed for individual consumption usually promote the type of change that can be implemented at the personal level. What requires some detailed analysis is how these materials go about their task of promoting change, what type of change is advocated and how such messages of change connect to particular representations of responsibility.

Figure 3 displays the percentages of materials demonstrating different types of responsibility. Every print item in the sample was included in at least one of the categories, and in cases where more than one category was applicable to a single item, it was recorded in two or three categories simultaneously. A variety of factors contributed to the determination of an item being categorized, and the results section will look at materials which exemplify how such factors operate together and change over time and across organizations.

Results

This section will summarize the findings obtained through use of the concept clusters (Figure 2), while taking examples from a selection of

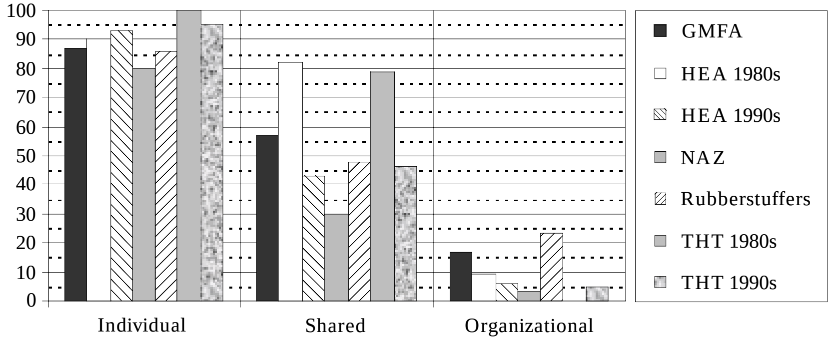


Figure 3 **Percentage of materials representing different types of responsibility.**

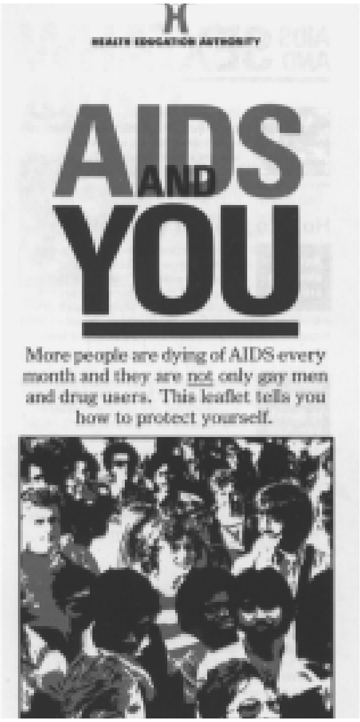
images that are displayed and discussed in turn. In order to guide this analysis most simply, we will use the categories of *individual*, *shared* and *organizational* responsibility. Individual responsibility is that which promotes care of the self as the domain of the individual reader. Given the definition of the term responsibility (see note 5) as an essentially social phenomenon, we may question the value of the concept of a completely individualized responsibility. In common usage of the concept, this dilemma is unresolved and is apparently unproblematic. Some of the materials allude to the notion that 'good citizens' take care of themselves, and in this way give a means of understanding individual responsibility. Somewhat differently, shared responsibility refers to those materials which appeal to the reader's consideration of loved ones, and their duty to hold attitudes and behave in ways which protect others in the community. Organizational responsibility makes reference to the role of organizations, the state and other institutional bodies and their place in HIV prevention.

HEALTH EDUCATION AUTHORITY

AIDS
WHAT EVERYBODY
NEEDS TO KNOW

December
1987

Figure 4 **© HEA 1988.**



HEALTH EDUCATION AUTHORITY

AIDS AND YOU

More people are dying of AIDS every month and they are not only gay men and drug users. This leaflet tells you how to protect yourself.

Figure 5 **© HEA 1986.**

Individual responsibility

We see from Figure 3 that the primary focus of responsibility in the materials rested with the individual. Between 80–100 percent of materials from all organizations conveyed a message of individual responsibility. This provides immediate confirmation that the individualized trend in health promotion discussed in the introduction holds true for this sample of HIV/AIDS prevention materials.

The two organizations with the highest percentages of such materials are the HEA and the THT – both having the widest target populations as well as the longest history of production (i.e. they are the only two organizations in the sample that were publishing HIV/AIDS materials in the early and mid-1980s). We shall see, however, that they each had very different ways of presenting individual responsibility in the earliest days of the epidemic.

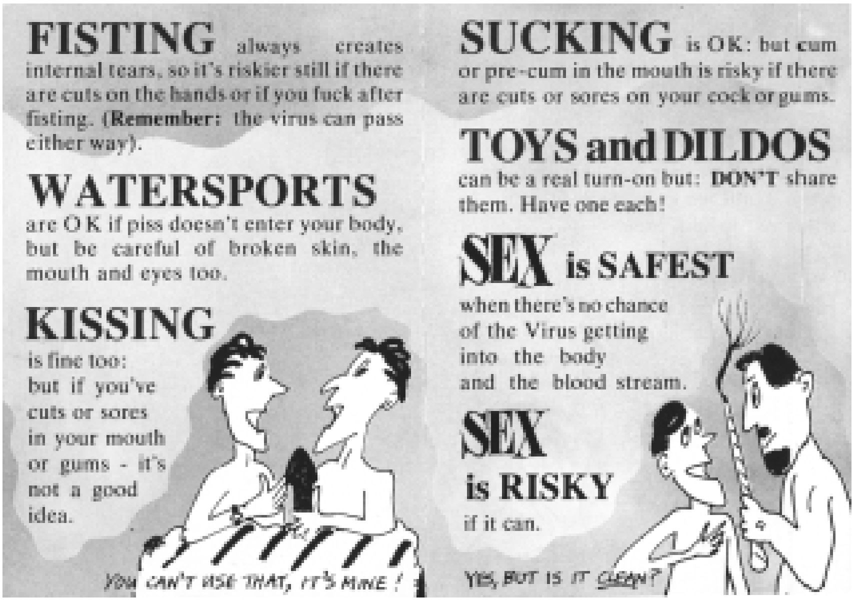
The most characteristic examples of the first HEA materials promoted the national urgency of the problem, and the individual's role in the solution. The title of the first national leaflet shown in Figure 4 conveyed that knowing about AIDS was everyone's concern and was the key to HIV prevention. The introduction said:

> You can find out what is known about AIDS by reading this booklet. The more you know and understand, the more you can do to reduce your risk of ever getting AIDS and help control the spread of AIDS in this country'.[10]

The widespread negative press reaction to this nationalized call-to-arms approach (Berridge, 1996) probably contributed to subsequent campaigns which focused even more on the individual, and less on a nation-wide response.

This shift is evident when we contrast the initial example with the 'AIDS and YOU' pamphlet shown in Figure 5. Just comparing the covers, the focus quite clearly changes from 'everybody' to 'you'. In addition, 'AIDS and YOU' was the first of many HEA materials to have a crowd scene on the cover. Kitzinger (1998) points out that crowd images in AIDS materials signify the 'general population' that is, the 'community of normal individuals' which excludes gay men and IV drug users. This leads to the readers' implicit moral division between 'them' and 'us' as highlighted earlier in Brandt's work. The text inside the pamphlet was still quite similar to the earlier example, with even more stress on the individual's accountability for general social well being.

Such materials provide contrast to early THT publications. In Figure 6 we see an early THT piece directed at gay men which combines factual advice on behaviour change and risk while using cartoons of men with sex



FISTING always creates internal tears, so it's riskier still if there are cuts on the hands or if you fuck after fisting. (**Remember:** the virus can pass either way).

WATERSPORTS are OK if piss doesn't enter your body, but be careful of broken skin, the mouth and eyes too.

KISSING is fine too: but if you've cuts or sores in your mouth or gums - it's not a good idea.

SUCKING is OK: but cum or pre-cum in the mouth is risky if there are cuts or sores on your cock or gums.

TOYS and DILDOS can be a real turn-on but: **DON'T** share them. Have one each!

SEX is SAFEST when there's no chance of the Virus getting into the body and the blood stream.

SEX is RISKY if it can.

Figure 6 **© THT 1985.**

toys alongside familiar language for the readers.[11] Many items created by the Trust in those years were frankly worded. There appears to have been a deliberate emphasis on the use of familiar language so that gay men would easily understand the specific behaviours that required change and those that did not, without feeling alienated by the use of clinical language to describe specific sexual acts.

Accompanying this frankness there was also often a severe tone, matching the perceived urgency of the crisis. The cover of a 1986 THT brochure directed at gay men included stern directives relating to care for the self and for others, such as: 'DO NOT donate blood or semen; DO NOT carry an organ donor card' (these did not appear on the pamphlet for the wider public released simultaneously). Inside the same pamphlet were some strongly worded statements directed at men who had already tested positive: 'You must accept though that you are very likely to be infectious to others if you have "unsafe" sex with them. This means that they could eventually die because of it. Be responsible.' While this type of bold statement can be found throughout THT materials from this era, nothing comparable is found in their sampled materials from the 1990s.[12]

Through various combinations of encouraging behaviour change as well as providing information using explicitly directive language, we see that the early HEA and THT materials were highly focused on individual responsibility. However, the context of such responsibility varied slightly between them. In the nation-wide HEA materials, the individual is constructed as the responsible citizen, taking care of the self in order to protect the country. In the THT materials for gay men, the individual was

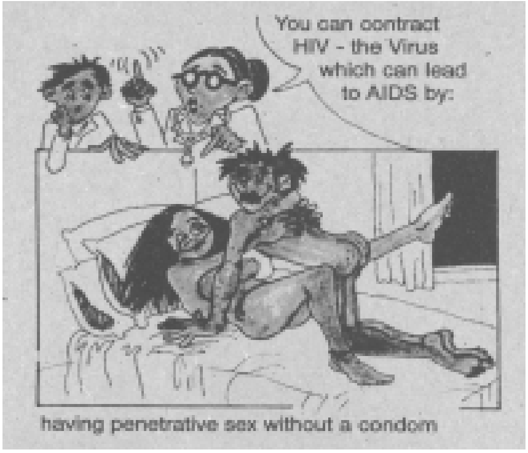


Figure 7 **© NAZ 1996.**

to take responsibility for himself in order to protect his own health; that of the gay community; and also to prevent HIV from spreading to the heterosexual world through blood and tissue donation. Thus we can already see that messages of individual responsibility direct their impact in a range of social contexts – depending on how the organization characterizes their target reader.

This characterization of the reader is also apparent in the excerpt from the NAZ booklet represented in Figure 7. The image of the Asian finger-wagging doctor who appeared on every page would have had a significant impact upon the way in which the 'expert' information about HIV transmission was received. In this example, the reader in the Asian target audience is constructed as someone who would respond best to an authority figure. This focus on the importance of scientific facts was strong among many sampled materials from the 1980s. And still, factual awareness about the virus and its effects as well as routes of transmission continue to make up a large part of prevention materials aimed at those who may be learning about AIDS in detail for the first time.

The 1990's HEA examples collated in Figure 8 were intended for wide 'waiting room' audiences and were typical of the informative style that one would come to expect in a clinical setting. The crowd image was recurrent on many of the covers, again something which could lead to the promotion of a 'them' and 'us' mentality. However, in direct contrast to the communal mentality of the earliest materials, where AIDS was about everyone, here the dominant textual message was about the need for specific individuals to identify their risk behaviours and protect themselves. The information and facts inside the pamphlets were intended to help the reader learn how to

Figure 8 **© HEA 1993, 1992, 1996, 1997.**

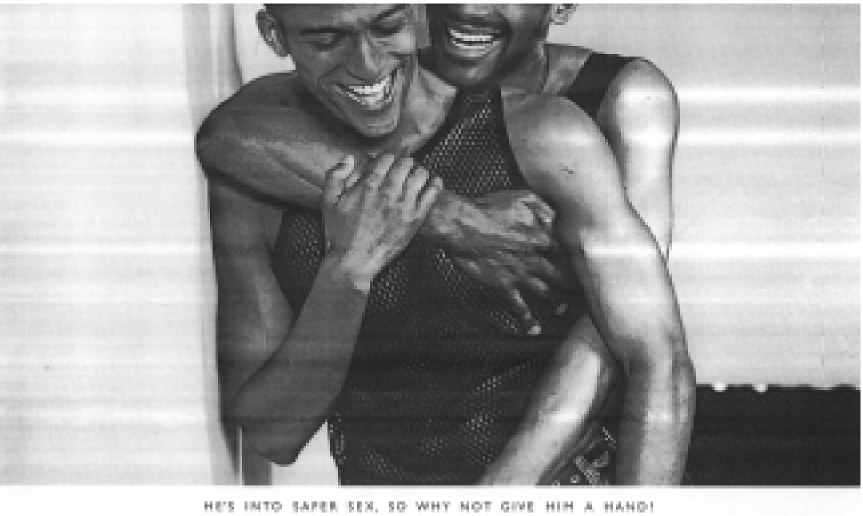


Figure 9 **© HEA 1990.**

protect him or herself. They gave directions on proper condom use, and issued strong directives on needle sharing. In materials from all of the sampled organizations, messages of behaviour change and factual awareness are almost always coupled with a firm focus on individual responsibility.

In contrast to these rather clinical and often directive materials, those campaigns targeting a specifically gay and bisexual male audience began to soften their approach in the 1990s, and encourage individual responsibility through the portrayal of sexual scenarios and through asking the reader to consider his recent sexual experiences. This enabled the materials to remind gay men of the AIDS prevention message while avoiding repetition of extensive facts about HIV transmission. Figure 9 produced by the HEA presents text and imagery conveying an understanding of gay culture in its friendly attempt to encourage non-penetrative gay sex. The caption reads: ‘He’s into safer sex, so why not give him a hand?’.

Thus, by the 1990s, many materials aimed at gay men had adopted a supportive tone, replacing the stern directives from the 1980s. The THT released a series of comic strip style scenarios called ‘Tales of Gay Sex’. They taught gay men about how to negotiate safer sex, offering the skills and phrases they would need. They dealt directly with the problems of assuming your partner’s HIV status and offered safer sex as the alternative. The narration section on the back did not give facts about transmission or list safer sex options. Rather, the purpose of this series was to get beyond ‘arming oneself with knowledge’ as we saw in the 1980s, and move towards the actual negotiation phrases for safer sex as a means of supporting behavioural change.[13]

Figure 10 **© HEA 1996.**

Another important change among some prevention materials of the 1990s was the move towards harm reduction. While still centring on a notion of individual responsibility, this was an approach which encouraged the readers to consider their own position and choices in relation to risk rather than instructing them how to act. Harm reduction approaches laid out the options and possible outcomes for the readers and then left the decision making up to them.

An example of this subtle yet powerful shift is contained in a heterosexually focused booklet produced in the later 1990s by the HEA (Figure 10). The cover images showed a heterosexual couple placed in focus among a blurry crowd. This imagery suggested that they were more than just part of a crowd, requiring individualized attention. Without changing much of the actual content of the text from earlier samples, the booklet was reformatted in a question and answer style. This positioned the reader as questioner rather than simply the passive recipient of facts and lists of risky activities. Additionally, it suggested HIV testing as a harm reduction strategy to protect both self and partner from the possibility of infection.

This provides evidence of a much more evolved and complex message about responsibility than the early days of ‘Always have safer sex’. It recognized that people needed more than one option in their sexual choices, and that condom use was not the only way to demonstrate responsibility for the self or for others. It took the individual into consideration in the context of relationships with others. This same strategy would also become a strong theme in the later work of the Terrence Higgins Trust and many

ok
now
try this

Before you go any further, look back at the page 7.
Be clear to yourself about what is safe enough for you and how you plan to stay safe and keep your partners safe.

Think about the last time you had sex that wasn't as safe as you would want. Write down the real story and list the real reasons as honestly as you can.

DAY AND TIME OF DAY:

WHERE WERE YOU?
DID YOU GO ALONE OR WITH FRIENDS?

Figure 11 **© GMFA 1997.**

other organizations. These types of socially located messages are indicative of an awareness that individually targeted responsibility on its own was not effective. Rather than falling directly under Crawford's strong criticism of victim-blaming health promotion, the newer harm reduction approaches make an effort to steer away from exclusive focus on the vulnerable individual. They aim to help readers situate their decisions in a broader context which takes issues such as power, stigma and desire into account.

The Hard Times workbook (Figure 11) produced by GMFA carries individual harm reduction philosophy to a further level. After starting with a list of minimum standard guidelines for safer sex, the majority of the book is a reflective journal/workbook for men to record their thoughts, feelings and behaviours based on situational and emotional issues (ideally with the assistance of a skilled helper). The reader becomes the author of his own prevention booklet. This approach clearly places responsibility for change with the individual. However, that change is situated in a social context where the individual is asked to reflect on and balance his need for sexual health with his need for sexual and personal fulfilment.

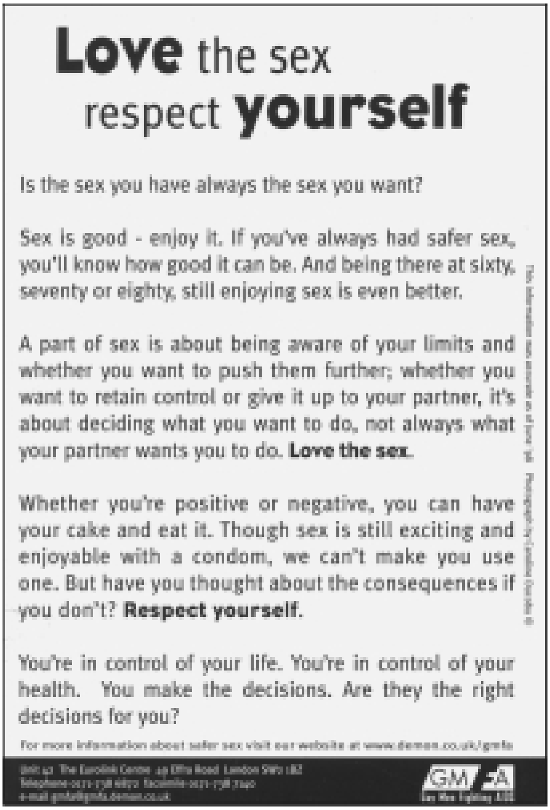
Lastly in this section on individual responsibility, we turn to the materials which focus on attitude, thus encouraging the reader to reconsider stereotypes or traditional ways of thinking that prevent openness and equality. Each of the organizations in the study produced materials challenging readers to question their assumptions about who is affected by

Figure 12 **© Rubberstuffers 1998.**

HIV and AIDS. Somewhat different approaches are found in materials produced by the two gay organizations GMFA and Rubberstuffers. These can employ strong messages about the need for individual gay men to improve their self-perception as a necessary pre-cursor to self-care and individual responsibility.

The Rubberstuffers post card in Figure 12 was designed for those leaving gay saunas. It displayed the vulnerable image on the front while asking the reader some searching questions on the reverse side: 'Did you have the sex you wanted? Did you cheat on your boyfriend? Did you have safer sex or unsafe sex? How are you feeling now?' The language situated the reader in his real context, discussing sex using his own terminology while being supportive of his emotional state. It encouraged him to sort out these issues before entering into potentially unwanted sexual patterns once again. This approach is comparable to the self-affirming text we see in the postcard produced by GMFA in Figure 13.

Like Rubberstuffers, GMFA emphasizes the role of self-esteem and responsibility to the gay community in its HIV prevention materials, yet it is organizationally unique in that some of its messages stand as a challenge to the reader, rather than a support. One card says: 'the next time you're about to put yourself at risk from HIV, remember that you are worth much more than that fuck – however good. Dump the baggage of



Love the sex
respect **yourself**

Is the sex you have always the sex you want?

Sex is good - enjoy it. If you've always had safer sex, you'll know how good it can be. And being there at sixty, seventy or eighty, still enjoying sex is even better.

A part of sex is about being aware of your limits and whether you want to push them further; whether you want to retain control or give it up to your partner, it's about deciding what you want to do, not always what your partner wants you to do. **Love the sex**.

Whether you're positive or negative, you can have your cake and eat it. Though sex is still exciting and enjoyable with a condom, we can't make you use one. But have you thought about the consequences if you don't? **Respect yourself**.

You're in control of your life. You're in control of your health. You make the decisions. Are they the right decisions for you?

For more information about safer sex visit our website at www.demon.co.uk/gmfa

This information was accurate as of June '98

GMFA

Figure 13 **© GMFA 1998.**

homophobia'. The narrative voice of such literature recognizes the struggle which gay men face within the context of daily social rejection. However, the answer to such pressures as recommended by both GMFA and Rubberstuffers (in different ways) is to decide personally how to rise above this, which returns us again to individual responsibility. Such materials also present a challenge to this research in that they place simultaneous emphasis on individual responsibility as well as the social context of their gay male audience.

Respect for self also appears as an approach for female audiences who are perhaps learning how to assert their own needs for the first time. A NAZ booklet entitled 'What every woman should know' stated: 'We believe there is no shame about wanting to preserve and maintain our sexual health. We can only achieve this by being open and taking responsibility for our bodies.' In this case, women are urged to consider themselves first, in an attempt to alter cultural values that emphasize their primary responsibility

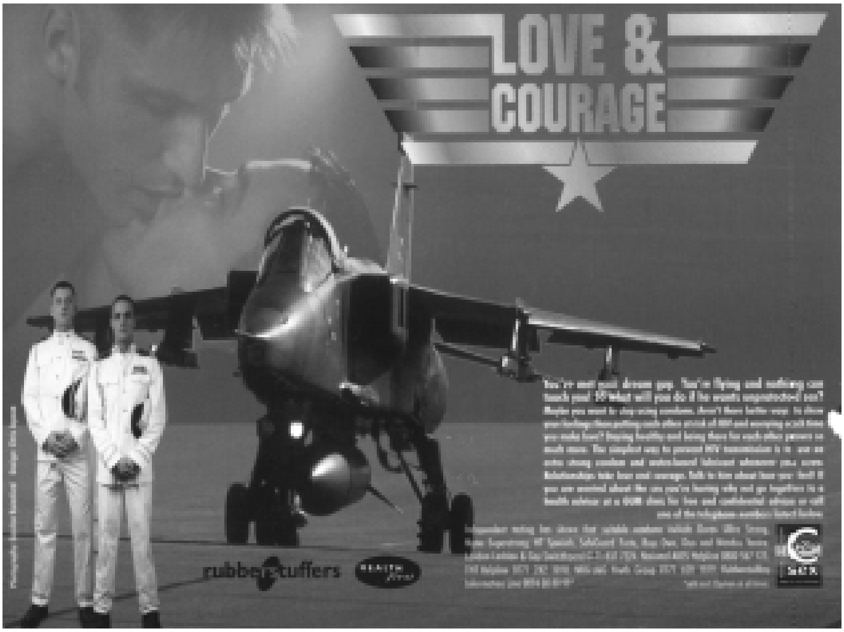


Figure 14 **© Rubberstuffers 1998.**

to other family members through traditional gender roles. While bringing wider social issues into focus, we must also be very aware that this text stresses the role of the individual, without necessarily taking into account the cultural and sometimes material pressures which can make these types of changes very challenging.

Shared responsibility

Figure 3 demonstrates that there is a significantly lower proportion of materials in the sample expressing shared responsibility as compared to individual responsibility. While approximately 80 percent of HEA and THT materials sampled from the 1980s contained messages of shared responsibility, in the 1990s, percentages in this category dropped to less than 50 percent for most organizations. As already noted with individual responsibility, there are also distinct differences in the tenor of messages about shared responsibility depending on whether or not the materials are directed at specifically gay communities. Some of the examples discussed below will highlight this distinction.

The text on the Rubberstuffers postcard shown in Figure 14 stressed the responsibility owed to loved ones while the image was clearly about honour and respectability (as well as incorporating the eroticism of men in uniform). The text says:

PERSONAL CONTACT

Bear hugs may be a threat from grizzlies, but NOT from a friend or co-worker who has AIDS. The AIDS virus is not carried on clothing or in the air, so a pat on the back does not make you an endangered species. You can safely shake hands with someone who has AIDS *without* rubber gloves. People who give an occasional hug or touch (especially family members) are NOT at risk for coming down with AIDS. And in fact, it helps everyone concerned to maintain the same everyday relationships and behaviors they have always had. That way no one will feel badly about ignoring or deserting a friend, and that friend with AIDS won't feel like an outcast.

Figure 15 **© THT 1985.**

> Aren't there better ways to show your feelings than putting each other at risk of HIV and worrying each time you make love? Staying healthy and being there for each other proves so much more. Relationships take love and courage.

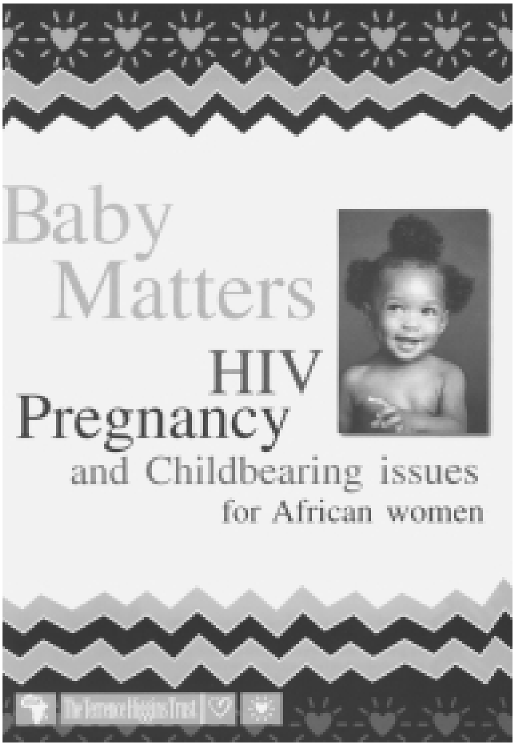
Rather than portraying safer sex as a consideration for one's self, this campaign emphasized the impact of HIV within the context of a loving partnership. As already seen with other materials directed at gay men, the factual details of the safer sex message are often left to one side in order to emphasize issues of shared responsibility and attitude.

Yet in contrast to this approach, a campaign from THT (1999) asks the reader how much they would tell others on a first date. The end-line states: 'Whatever your own views, remember it isn't a duty to tell, it's not a right to be told'.[14] The campaign openly lifts the responsibility for disclosure from

Figure 16 **© NAZ 1999.**

the shoulders of the positive person, acknowledging that privacy is still a right for those living with HIV. Here the implication is that communication and behavioural choices are shared between sexual partners rather than falling solely to the person who is HIV positive. While all of the organizations represented here would also support the right to privacy, this campaign in particular raises many of the questions which lie at the heart of this article, and certainly demonstrates the broad differences between representations of responsibility towards others.

In these examples from Rubberstuffers and THT, there is a sense of background knowledge about HIV that exists among gay men prior to any sexual encounter. The issue at hand is how to deal with the matter of belonging to a community so heavily impacted by the disease, no matter how safely one attempts to make one's own behaviours. In the end, these messages both imply that responsibility is (or should be) shared equally by all members of the gay community, in order for its own continued survival and protection.



Baby Matters
HIV
Pregnancy
and Childbearing issues
for African women

The Terrence Higgins Trust

Figure 17 **© THT 1998.**

While we have examples of shared responsibility messages occurring in materials directed at other audiences, the impact seems to be far less personal. Instead we find more broadly optimistic portrayals of how 'the good society' should react to the epidemic. Returning once again to the early work of the HEA, we find materials that sounded a clarion call for national action against AIDS. The 'AIDS Charter' published by the HEA in national newspapers in 1988 is one such example. 'Unless we act now many thousands more people will become infected, and lives that could have been saved will be lost.' It discussed the need for compassion and inclusion in a society that recognizes 'AIDS as everyone's problem'. This conveys a strong sense of shared response, making the connection between the actions and values of the individual and the safety of the nation. It is a particularly interesting sample of an attitude changing, shared responsibility approach that has been largely abandoned in successive national HEA campaigns after the popular outcry in the press mentioned earlier.

An early mandate for the THT was to destigmatize the image of people living with HIV/AIDS to the 'outside' world. Figure 15 contains a page

Figure 18 **© Rubberstuffers 1998.**

from a 1985 THT booklet designed to educate those concerned about AIDS in the workplace.[15] The text said: 'So now you've learned the less than terrible truth about AIDS. Don't let your fears about AIDS imprison you or cause you to become strangers to your co-workers.' This took account of people's fears about HIV positive co-workers and taught them about the development of a rational and responsible attitude towards others.

More recent examples of the shared responsibility approach include those directed at ethnic and cultural groups. Combined with text about global HIV statistics, or simple directives like 'love safely', the pictures seen in Figure 16 on the front of NAZ's information materials implore the individual to be aware of the impact of AIDS on distinct cultural communities. There is an implied sense in these examples of the need to develop an attitude of shared responsibility for preventing the further spread of HIV within the Asian community.

A THT booklet aimed at African women considering childbearing is shown in Figure 17. The introduction said: if a pregnant woman 'knows she is positive, she can take steps to reduce the risk of passing the virus to another person, including her baby', and later, 'you want to plan for a healthy baby'. The overall tone is one of support and concern, but the primary concern is that the mother does not infect the baby. While other THT brochures for women deal with protecting the self, this booklet shows how the issue of pregnancy can bring responsibility for others to the fore in a very direct manner.

80% of AIDS cases are gay men.

5% of AIDS education funding is aimed at gay men.

This neglect is putting gay lives at risk.

Do you condone it?

Figure 19 **GMFA 1993.**

Organizational responsibility

The final category for consideration represents by far the smallest number of materials in the sample, as presented in Figure 3. Less than 10 percent of all sampled materials for organizations apart from Rubberstuffers and GMFA include representations of organizational responsibility. In this context, it is noticeable that one-quarter of Rubberstuffers' selected materials convey such messages, which is the highest proportion in the overall sample. The sticker shown in Figure 18 was placed inside every locker at sex-on-premises saunas. The simple message: 'We care . . . do you?' referred to individual as well as organizational responsibility. Rubberstuffers presented itself very clearly as an organization that took responsibility for the community it served. Materials from other organizations often describe their activities, but not always in a tone which claims organizational responsibility as directly as in this example.

In Figure 19, the GMFA makes it clear that the state should be taking more responsibility in its approach to AIDS spending and prevention work. In part, this engages with a debate springing from the work of ACT UP founder Larry Kramer who wondered why community groups were taking up the slack in AIDS prevention and care when this should be the responsibility of the state (Kramer, 1990). Once again, this demonstrates that there is not one 'best' way to be responsible. At the organizational level, some would argue that it is more responsible to lobby government to carry out its duty in relation to HIV/AIDS, while others feel that direct support, care and education carried out by the community is the best means of demonstrating responsibility.

Summary

Figure 3 demonstrates marked differences in the overall percentage of materials expressing individual, shared and organizational responsibility. We would expect that the print medium and its modes of distribution are aimed at the readers as individuals, but this does not automatically mandate the use of individual responsibility to the extent that we have seen here. I would argue that the striking use of this approach is a reflection of those trends towards individualism and health discussed near the start of this article. In particular, HIV/AIDS has become a remarkable signifier of this way of thinking in the English context.

The evolution of the harm reduction model of individual responsibility has moved prevention efforts further away from isolation of the individual towards an approach which includes social context in the message. It strikes a chord with the issues raised at the start of the article in relation to stigmatized groups, victim blaming and disease prevention. It resonates with the calls from Jonathan Mann and UNAIDS for equality and positive self-identity in order for HIV prevention efforts to succeed.

We turn with particular interest, then, to the organizations producing high percentages of materials with messages of shared and organizational responsibility. The originally high number of messages of shared responsibility declined after the 1980s within both the HEA and THT as a reaction to changing perceptions of target audiences and national urgency. Yet this still leaves us with questions to ask about the unique approaches to responsibility on all levels expressed by GMFA and Rubberstuffers. Indeed, it would be interesting to see future research that studied the relationship between their somewhat moral messages about responsibility to self, partner and society, and the radical nature of these two groups.

The strong communal bond conveyed by such organizations involves an inherently moral responsibility for others within that community. It has been widely agreed that the reason for the overwhelming behavioural change that took place in gay communities in North America and Europe in the early 1990s is down to this shared sense of ownership of the issue (Denning et al., 2000; Mays et al., 2000; Ortega and Ko Tval, 2000). One wonders if a similar degree of shared responsibility could ever be achieved on a nation-wide scale, simply because of the difficulty of nurturing such attitudes in a large-scale context.

Discussion

The variety of approaches used in HIV/AIDS prevention materials demonstrates the amount of thought and planning that goes into the creation of such campaigns. In organizations such as the Terrence Higgins

Trust and the Health Education Authority for which we have materials that span 15 years or more, it is possible to feel a distinct sense of self-reflection, and adaptation of messages of responsibility that avoid punitive overtones. Many of these organizations campaign in their community to combat social exclusion, to influence governmental policy and to make inroads into the wider social issues which contribute to the existence of AIDS. However, their most public face is their health promotion material, which does not always make reference to the individual's relative position within broad social contexts, or truly acknowledge the difficulty that some types of behaviour or attitudinal change may carry. Some may say that this is too much to expect from simple posters and leaflets. However, we must then ask if individualized approaches create the possibility that some readers will dismiss AIDS, rather than incorporate it into their personal reality. This type of result would be in contradiction to the aims of public health prevention.

None of this discussion should be interpreted as an argument against the necessity of AIDS education. Awareness is an essential feature of prevention. The issue at hand is the social context within which awareness raising is situated, and the extent to which factors other than (and in addition to) individual responsibility are highlighted for the reader. The organizations under consideration demonstrate a strong awareness of the dangerously thin line between personal responsibility and victim blaming, and continue to work on the development of approaches which do not blame the victim. However, many of the samples studied do convey the simple message that the reader has an obligation to follow the advice given; to change sexual behaviour in order to avoid contracting HIV or transmitting it to others. This approach can lead to the isolation of individual readers, who could have a variety of negative reactions depending on their social identities. They may be weary of the continual targeting of their group by prevention campaigns. They may understand the messages only to have import for gay men, with whom they do not identify. Such understandings will then result in the disempowerment of those who identify themselves as 'at risk' and those who are positive; while simultaneously allowing those who do not identify with the message to be dismissive.

At the same time, it is clear that many of the organizations such as the Terrence Higgins Trust and Gay Men Fighting AIDS have crossed over the old boundaries that would have only defined them as producers of HIV prevention information. They are now also part of a political and social lobby force. This force is encouraging England's Labour government to consider the ways in which Section 28 and other forms of social exclusion experienced by those most vulnerable to HIV, prevent the success of awareness and education efforts.[16] It is necessary to emphasize the severe limitations to HIV/AIDS prevention programmes taking place in a wider social milieu that takes little responsibility for the inequalities suffered by the disenfranchised. This argument is often reserved for those in developing areas of the world, but there is no reason why the same issues do not apply in England.

There is still a question, however, about the effectiveness of attitudinal change being targeted at, for instance, individual gay men while little has been concretely done to change dominant homophobic attitudes at the community and state level. NAZ and THT have both launched anti-homophobic campaigns in recent years, but one wonders how much effect these relatively small efforts will have on a whole society. What is required is government-led recognition of the need for broad-based change of attitudes towards sex work, poverty, race, homosexuality and drug use which serve as important barriers to the reduction of HIV transmission.

If we do not provide care and support for those who are infected, and protect the human rights of those groups most affected by AIDS, then not only will HIV continue to spread among those groups but among sexually active members of all communities. Indeed, heterosexual transmission in England has recently eclipsed homosexual transmission (Public Health Laboratory Service, 2000). Successful prevention for the uninfected will depend on the amount to which we attend to the needs of those who are most heavily impacted by the epidemic. UNAIDS continues the struggle to get Dr Mann's posthumous message across to public health providers and governments worldwide: 'To address the vulnerability of such individuals and communities to HIV/AIDS, it is particularly essential that the response be expanded beyond risk-reduction strategies' (UNAIDS, 1998: 6).

Such efforts must be incorporated alongside effective public health strategies. Prevention materials will need to include promotion of the reasons and necessity for such social changes. Readers need to understand the wider relationship between equality and health in addition to understanding their own roles in prevention. Only in this way will the wider public as well as members of the groups most affected by AIDS be able to transform current the misinformed notion that HIV infection is simply the result of individual behaviour choices. Promoting the view that HIV transmission is only the responsibility of the individual leads to the type of stigmatization to which Mann referred. It leads to the commonly held perception that the individual who contracted the disease must have behaved irresponsibly, and allows the uninfected to maintain a false moral high ground. It is precisely this type of divisiveness that continues to work against the important gains made by HIV prevention efforts.

Wider implications

This brings us back to the historical and theoretical issues raised at the beginning of the article in relation to the New Right resurgence which aimed to infuse the rhetoric of individual responsibility into every facet of life. Commentators argue that this approach allowed the moral classification between those who were healthy as responsible, and those who were unhealthy as irresponsible (Crawford, 1994: 1356). The residue of such division lives on today in many areas of the health debate. Explicit efforts by the new public health movement have attempted to change these perspectives. Harm reduction approaches to HIV and other illnesses incorporate the generally increased concern over shared rights and responsibilities in personal and public partnerships – a clear reflection of the Third Way. Yet such partnerships must necessarily rely on trust and good faith, which may not be able to withstand the pressure of conflicting interests. Perhaps these new approaches are simply a means of masking the continuing burden on the individual. Effective public health efforts will need to go beyond risk reduction, and begin to tackle the heart of economic and social inequality.

While the issues regarding responsibility have been raised here in relation to HIV/AIDS prevention materials, there is certainly much broader relevance to the entire field of public health. Indeed, the strong critique of the turn towards individual responsibility began in the 1970s, before AIDS was recognized, or had begun to make its devastating impact known. The issue then, as it is now, is the means through which some expressions of public health can serve further to alienate and stigmatize already disempowered individuals and groups. Readers of well-intentioned public health materials would take away the message that either the warning had nothing to do with them, or be further victimized by materials implying that those who cannot follow the guidelines are guilty of their own destiny.

The key question to be asked at this point is: Is it possible to enhance both social and individual agency over health simultaneously, or is one always necessarily at the expense of the other? It is not only possible but necessary to enhance both simultaneously. I would argue that health promotion efforts that only focus on the individual, or only on the social context will have little effect. In isolation, each of them works against the other, and we have seen examples of this time and time again in the field of HIV/AIDS prevention. Where prevention efforts have had a dramatically positive effect, is where the social milieu and the individual are both mutually supportive agents of change. The XIII International AIDS Conference in Durban resounded with the evidence that nationally based, frank, multi-sectoral (i.e. not just health) policies which target interventions at the most vulnerable, and include the most affected groups in their planning and implementation, are the ones which have proven successful. Those which have continued to carry out their work at the level of individual behaviour change imposed from the top down, have not (UNAIDS, 2000).

We return finally, to a short yet powerful article published by Jonathan Mann in the *British Medical Journal* several years ago. He spoke of the burgeoning awareness among health professionals and international organizations that empowering people through a human rights approach was the way to successful public health strategy. He said this awareness was 'strongly accelerated in work on HIV and AIDS, in which discrimination (and other human rights issues) were found not only to be tragic results of the pandemic but to be root societal causes of vulnerability to HIV' (Mann, 1996: 925). As a result, he noted with some surprise, even institutions such as the World Bank had declared that protecting girls' rights to non-discriminatory education was one of the most powerful means of improving health in the developing world (World Bank, 1993). The experience of HIV/AIDS serves as the starting point for this discussion, but in no way should be considered the end point. We no longer live in an era where the fiction of individual responsibility for health is plausible.

Notes

1. The focus on individual behaviour becomes even more evident in other target areas of the document such as cancer, whereby the two strategies offered are increased uptake of breast screening, and reduction of smoking (Department of Health, 1992: 16–18).
2. Taken from the Foreword of *Our healthier nation* found at: http://www.official-documents.co.uk/document/doh/ohnation/title.htm. This is a direct mirror of one of Mrs Thatcher's rare quotations on AIDS: 'Governments cannot stop people from getting AIDS. They can give the information which enables them to prevent themselves getting it' (McKie, 1986).
3. Not everyone agrees with this reading of the 'New Public Health'. For example, Ashton and Seymour argue that 'it seeks to avoid the trap of blaming the victim. Many contemporary health problems are therefore seen as being social rather than solely individual problems' (1988: 21). While *Our healthier nation* does appear to take social factors for illness into account, it still appears that the individual is given a tremendous burden of responsibility for behaviour change, with minimal outlines as to the public guidance or support which would enable such change.
4. Risky behaviour can be defined as that which leads to the exchange of blood and semen, such as sharing intravenous needles, penetrative sex without using a condom, etc.
5. The word 'responsibility' has its root in the Latin word *respondeo*, meaning 'I answer' (Lucas, 1995: 5). This inevitably involves a prior question, directed at the individual from someone else. We could say that the emergence of responsibility within ourselves is the moment when we fully recognize that we are members of a wider social body (those who question and thus constrain our actions). Levinas (1989) has argued that we only fully become ourselves when we take on this responsibility for the well being for others.
6. Other writers support this view, such as Foucauldian, Denise Gastaldo who argues that health behaviour guidelines can disempower the individual. While knowledge can be the foundation for power, what she calls 'traditional health education' results in self-surveillance for the purposes of the state. 'No educational process can only liberate because at the same time it disciplines bodies' (Gastaldo, 1997: 130).
7. These have particular affinity with the heavily contested Health Belief Model

(see Rosenstock, 1974; Illingworth, 1991; Pollack, 1992; Bloor, 1995; Lollis et al., 1997).

8. The Camden and Islington Health Authority would have been another natural choice, due to their vast HIV prevention efforts, but scope of this research did not allow for such a large sample base. Also, Blackliners and Brook Publications which were originally included in the sample because of their focus on Black and Youth audiences respectively, had to be dropped due to the small number of materials collected from each organization.
9. Those with further interest in this area would be interested in similar research conducted by Jewitt (1997) on images of male sexuality in sexual health print materials. That work refers explicitly to the methods developed by Kress and Leeuwen (1996) for the analysis of visual imagery.
10. The campaign slogan: 'Don't aid AIDS' appears at the bottom of the pamphlet, making the inference that those who do not know about AIDS are assisting its spread – a position that can result in victim blaming.
11. Its language and imagery would have been considered highly immoral by a host of social critics at the time; this points to a significant burden of responsibility taken on by the Trust for printing and distributing such controversial material.
12. Interestingly, we will see that while the Trust moved away from this sort of moral tone, other AIDS organizations targeted at gay men (such as GMFA) took up this approach and maintain it currently.
13. Figure 3 also shows us that all of the sampled (late 1990s) items from Gay Men Fighting AIDS (GMFA) encourage behaviour change, while simultaneously showing the lowest rate of factual awareness change. We can interpret this as confirmation of the current trend towards materials for gay men which reinforce behaviour change rather than repeat the factual components of HIV transmission.
14. In some countries legal prosecution has followed when a person who knows their positive status has not told their sexual partners. The Terrence Higgins Trust has formally challenged the development of such policy in England.
15. Such images contrast greatly with those which the THT was concurrently using in their materials for gay men and this division continues today within most organizations serving a range of audiences (materials for gay men tend to be erotic, while those for heterosexuals are often desexualized).
16. Section 28 of England's Local Government Act disallows the promotion of homosexuality as a 'pretended family relationship'– in turn leading to great fears about addressing the issues of homosexuality in schools at all. While there has been much talk about the need to repeal this amendment by politicians, such change has been repeatedly blocked and delayed.

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