HIV and STD Prevention Needs of Bisexual Women: Results from *Projet Polyvalence*

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Abstract: This article presents the findings from a community-based action research project seeking to contribute to HIV/AIDS and STD prevention by addressing the often marginalized sexual health needs of people with bisexual practices. *Projet Polyvalence* conducted 30 interviews with bisexual women in Montréal, employing participatory-action research methods to gather their perspectives on the gaps in existing prevention information. The action component of the project built on the needs identified in the interviews to develop relevant educational materials that will constitute the first participatory prevention campaign on HIV/STDs for people with bisexual practices in Canada.

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Résumé : Cet article présente les résultats d'un projet de recherche-action communautaire dont l'objectif est d'apporter une nouvelle contribution à la prévention du VIH/SIDA et des MTS en se centrant sur un aspect souvent ignoré, les besoins en matière de santé sexuelle des personnes ayant des pratiques bisexuelles. *Projet Polyvalence* a mené 30 entrevues avec des femmes bisexuelles à Montréal, en employant des méthodes de recherche-action participative pour comprendre quelles lacunes existent, selon ces personnes, dans l'information disponible sur la prévention. En fonction des résultats obtenus lors de ces entrevues, le volet action de ce projet consiste à développer des matériaux d'éducation pertinents qui constitueraient la première campagne de prévention participative sur les VIH/ MTS pour les personnes qui ont des pratiques bisexuelles au Canada.

Mots clés : Santé sexuelle; Recherche-action; VIH-SIDA; MTS; Bisexualité

This article presents some of the results from a community-based action research project seeking to make a new contribution to HIV/AIDS and STD (sexually transmitted disease[1]) prevention in Québec and Canada by addressing the often marginalized sexual health needs of people who have sex with men and women. During the initial three-year phase of the research, *Projet Polyvalence* conducted 87 interviews with three different groups of people who have sex with men and women (bisexual women, swingers, and people with bisexual practices who do not necessarily identify themselves as bisexual). The interviews sought to document and understand their perspectives on the extent to which existing prevention information and resources in Montréal adequately respond to their realities, and how they believe their needs and the lacunae in existing approaches could be better addressed. The action component of the project built on the needs identified by the interview participants to develop relevant educational materials that will constitute the first participatory prevention campaign on HIV/AIDS and STDs for people with bisexual practices in Canada. This research was funded by the Social Sciences and Humanities Research Council of Canada.

We present the findings from the first set of 30 interviews conducted with bisexual women. After considering some of the limitations of existing public health approaches to HIV/STD prevention pertaining to gender and bisexuality, particularly regarding the erasure of women and bisexual practices from epidemiological risk categories, this article outlines the objectives and methodological approaches adopted by *Projet Polyvalence* as an action research project designed to specifically respond to these limitations. We then present the participants' perspectives on the availability and volume of HIV/STD prevention information, existing educational campaigns in Québec, desired content for future campaigns that avoid fear-based approaches, the need to link prevention education to relevant sexual health services responsive to the needs of bisexual women, and the outcome of the educational posters that the project developed.

This article contributes to studies and action in HIV prevention. While bisexuals continue to be blamed for the transmission of HIV and other sexually tranmitted diseases, no major prevention campaigns are directed to this constituency. The research demonstrates the ways in which bisexual women are excluded within public health discourse, research, and education. Moreover, this article challenges conventional understandings of HIV prevention in a number of ways. The women interviewed insist that successful education cannot be based on or motivated by fear, an approach common in recent Québec HIV education. They argue as well that public health education needs to use the language of everyday people, not a specialized vocabulary known only to those working in medicine or public health. Participants further maintain that sexual health education needs to be grounded in people's everyday realities: prevention education needs to begin with the realities of how people have sex and negotiate protection. Finally, the women we interviewed advocate a strong link between HIV/STD *prevention* and sexual health *services* more generally. In all of these ways, then, this research challenges many of the established ways of offering HIV/STD education in Québec. Before presenting the research results in greater depth, however, it is necessary to consider some of the epistemological and methodological reasons why bisexual men and women have received so little attention in public health research and education.

MSMs and bisexual erasure

In recent years, research and education initiatives in public health have paid intermittent attention to the issue of bisexuality. More specifically, the bisexual behaviour of men has been the subject of several research studies within public health and HIV/AIDS (Boykin, 2004; Gooß, 2002; Kennedy & Doll, 2001; Medico, Lévy, Otis, Laroche, & Lavoie, 2002). Indeed, any public health focus on bisexuality and HIV/STDs has become synonymous with (an often pathologizing and selective) attention to the bisexual practices of men, in which their sexual relations with women, as well as women's practices and health concerns in general, are largely erased.[2]

The field of public health has produced a category of "men who have sex with men" as a way to designate males who identify as gay and who have sex with other men, as well as men who do not identify as gay or bisexual, but who nonetheless have sexual relations with other men. This category—Men who have Sex with other Men, or MSM—has been taken up by AIDS policymakers and service providers. Although the effort to include all kinds of men within the prevention efforts of community-based AIDS organizations is commendable, careful consideration of the existing prevention strategies reveals that there is very little consideration of the actual sexual lives of bisexual men (Farajajé-Jones, 1995; Gooß, 2002; Kennedy & Doll, 2001; Namaste, 1998).

Educational materials directed at "men who have sex with men," for instance, speak about the risks involved in having anal or oral sex with a man, but they do not discuss the risks involved in having vaginal, anal, and oral sex with a woman. In an implicit manner, the sexual activities of these men with women are ignored. This creates a situation in which women are made responsible for ensuring safe sexual behaviours with their male partners (Hönnens, 1998). This absence is significant given that existing research demonstrates that bisexual men

engage in high-risk behaviours with their female partners, notably unprotected anal sex (Beeker, 1993; Kalichman, Roffman, Picciano, & Bolan, 1998; Padian, Marquis, Francis, Anderson, Rutherford, O'Malley & Winkelstein, 1987).

In recent years, in English-speaking contexts, the phenomenon labelled "the down low" has drawn attention to bisexuality and HIV/STD transmission. The "down low" refers to heterosexual Black men who are usually married, but who have sexual relations with other men without the knowledge of their spouse. Media portrayals of this issue have concentrated on the danger for heterosexual women—a representation that associates bisexuality with duplicity (Boykin, 2004; King, 2004). In a similar vein, the discourse of "men who have sex with men" implicitly assumes that "bisexual" males are those who live as heterosexuals and who have sexual relations with other men. Men who live as gay but who have sexual relations with women are neglected in this approach. This absence is important when we consider the results of scientific inquiry in this domain. According to one Canadian study, at least 30% of gay men interviewed had had sexual relations with a woman in the past 12 months (Myers, Godin, Calzacara, Lambert, & Locker, 1993). Despite the results of this study, no popular educational campaign addresses this issue within the gay community. Gay men who have sexual relations with women remains a taboo subject (Namaste, 1998).

Bisexual scholars and activists have criticized the limitations of the existing framework—an invocation of an "MSM" discourse gives the impression of addressing a wide variety of sexual practices, while in reality ignoring the involvement of men who have sexual relations with women (Farajajé-Jones, 1995). Methodologically, men with bisexual behaviour are often grouped into a seemingly inclusive category of "gay and bisexual men," with no consideration of the different sampling strategies required to reach men who have bisexual practices but who do not identify as bisexual (Boulton, 1991; Kennedy & Doll, 2001).

If the existing scholarship and community work are limited when it comes to the complex realities of men who have sex with both men and women, there are even fewer resources that address the realities and sexual practices of bisexual women (Feldhorst, 1998; Gooß, 2002; Medico et al., 2002). Community-based AIDS organizations have few if any materials for distribution that address the sexual lives of women who have sex with both men and women (Feldhorst, 1998). Public health research and education only considers bisexual men (if inadequately), leaving the realities and educational needs of bisexual women unaddressed.

Yet the scant public health research that has been undertaken with respect to bisexual women, HIV/AIDS, and STDs shows that the risks are not negligible and that many legitimate public health questions remain unaddressed and unanswered (both with respect to health research and with respect to the health and information needs of bisexual women). Existing research shows that bisexual women are at higher risk for both HIV/AIDS and STDs than either exclusively heterosexual women or lesbians (Bailey, Farquhar, Owen, & Mangtani, 2004; Bauer & Welles, 2001; Bevier, Chiasson, Heffernan, & Castro, 1995; Gonzalez, Washienko, Krone, Chapman, Arredondo, Huckeba-Downer, 1999; Scheer, Peterson, Page-Shafer, Delgado, Gleghorn, Ruiz, Molitor, McFarland, Clausner & The Young Women's Survey Team, 2002).

Regarding woman-to-woman transmission, the sparse research that exists documents reported cases of HIV transmission between women (though actual risk remains debated and unknown) and a non-negligible risk of woman-to-woman transmission of STDs (particularly HPV, herpes, and trichomoniasis) (Bauer & Welles, 2001; Kwakwa & Ghobrial, 2003; Marrazzo, Coffey, & Bingham, 2005; Rich, Back, Tuomala, & Kazanjian, 1993; Troncosa, Romani, Carranza, Macia, & Masini, 1995). Significantly, a recently reported instance of woman-to-woman transmission of HIV in the United States involved a case in which one of the partners was an openly bisexual woman known to be HIV-positive who only used protection with her male partners as advised by her physician (Kwakwa & Ghobrial, 2003).

Importantly, Bauer and Welles (2001) have noted a marked insufficiency of research with respect to non-HIV STDs that may be more readily transmitted between women than HIV/AIDS, something confirmed by the women in our study, who had many questions and noted a serious lack of information and services in this respect. Bauer and Welles' study also found a correspondingly low level of STD/HIV testing among women who have sex with women in proportion to the risk they face, consistent with findings that women who have sex with women are less likely to use health care resources (particularly preventative health care) (Stevens, 1992). Marrazzo, Coffey, and Bingham (2005) found that many of the lesbian and bisexual women in their study had a limited awareness of the potential for STD transmission between women and recommend increased STD-focused prevention education that emphasizes the plausibility of STD transmission among women who have sex with women.

Studies have also documented the institutionalized exclusion of women who have sex with women from "risk group" categories, resulting in the public health and popular perception that sex between women is risk free (Bauer & Welles, 2001; Marrazzo et al., 2005; Richardson, 2000). Furthermore, the scarcity of data with respect to woman-to-woman transmission of HIV/AIDS can in part be attributed to the gendered manner in which a hierarchy of "risk factors" shapes the way in which transmission between women is epidemiologically substantiated. Sex between women is only established as a route for HIV transmission when all other possible risk factors are eliminated (sex with men, tattoos, piercings, injection drug use, transfusions). In other words, as Kwakwa and Ghobrial (2003) note, the epidemiological precedence that other risk factors are given in establishing HIV acquisition among women who have sex with women may mask the actual risk of transmission via sex between women. This data and the results of our study raise important questions about the epidemiological construction of sexual risk in public health, and how the gendered nature of risk categories and risk factors contributes to the erasure of women and bisexuality more generally.[3]

Given that there is no serious consideration of bisexual realities within the current work of community-based AIDS prevention and policy in Canada and elsewhere,[4] HIV education is also completely ignorant of important differences within bisexual communities. There are many different ways people live as bisexual: some men live as married heterosexual men but have secret relations with other men; some individuals are involved with men and women at the same time;

some women have a primary male partner and occasional sexual relations with another woman and their male partner; some women live as lesbians but sleep with men from time to time; some men identify as gay but are sexually involved with women. HIV education materials do not address any of these realities, ignoring the different networks of bisexuals as well as the varied sexual practices and identities of people within them (Kennedy & Doll, 2001; Namaste, 1998).

Given these absences, there is a general lack of visibility of bisexual people, as well as a lack of discussion of bisexual behaviour. These absences reinforce existing prejudices and the marginalization of bisexuals, particularly the criminalization of men who have sexual relations with both men and women. These men are often blamed for transmitting HIV into the "heterosexual" population (Farajajé-Jones, 1995; Miller, 2002). Bisexual women are treated in a similar manner, scapegoated as vectors of disease within a "pure" lesbian community (Weinberg, Williams, & Pryor, 1994). Paradoxically, more than 25 years into the pandemic, bisexuals continue to be blamed for the transmission of HIV, yet no major HIV prevention campaign has ever been directed to them.

Objectives of the action research project

Given the current situation with respect to bisexuality and HIV outlined above, as well as the significant limits of our understandings in this area, our research seeks to make an important contribution to the international scientific literature. Our study has three specific objectives:

- to determine the prevention needs of individuals who have sexual relations with both men and women
- to create and distribute relevant educational materials
- to educate service providers and policymakers about the specific educational needs of people with bisexual behaviour with regards to HIV prevention

Importantly, the project had two stages: 1) identification of needs and gaps in existing prevention; and 2) an action component designed to respond to the limitations of the current situation. Through its design, the research project sought not only to describe the current context for bisexuals and HIV education, but to intervene directly within it (Goyette & Lessard-Hébert, 1987; Lamoureux, Mayer, & Panet-Raymond, 1984; Landry, 1993; Stringer, 1999).

Participatory action research: Recruiting participants

Projet Polyvalence employed methods drawn from participatory action research and grounded theory to undertake a community-based investigation and response to the sexual health needs identified by three different groups of people with bisexual practices. The research was guided by a community-based Advisory Committee whose members were involved in formulating and interpreting the research as well as implementing the action component of the project. Three rounds of interviews were conducted with three different groups of people with bisexual behaviour: bisexual women; swingers; and finally, people who have sexual relations with both men and women but do not necessarily name themselves as bisexual. We interviewed approximately 30 people in each group, and a total of 87 interviews were completed.

Recognizing the diversity among people who have sexual relations with both men and women, the project made a conscious effort to recruit people in different social networks and locations. As such, the recruitment was varied for each specific network: bisexual women were recruited with advertisements that asked them to respond if they identified as bisexual women. Recruitment for swingers, in contrast, was carried out in forums specific to them (such as newspapers and flyers in swinger establishments). Finally, recruitment for the third network of people—those who have sexual relations with both men and women but without identifying themselves as bisexual—was done through advertisements in the mainstream media that did not refer to the term "bisexual," but which referenced sexual relations with both men and women. Of course, the groups identified are not definitive and do not represent the full spectrum or "absolute truth" of bisexual men and women's realities. However, members of the research project felt that by recruiting participants in various milieux, the general findings of the project would be strengthened. It was hoped that such an approach would offer a broad overview of some of the different ways in which people with bisexual behaviour access HIV prevention information. Such an approach would also allow for comparison among the different target groups.

While the overall project seeks to offer a broad overview of the specific HIV prevention needs of individuals who have sexual relations with both men and women, due to space constraints, the research presented here focuses on the results of the first round of interviews, with 30 bisexual women in the Greater Montréal Area. This article, then, offers analysis of one specific network within the study, specifically women who name themselves bisexual.

The women were recruited in the fall of 2004 through a variety of means, notably by publishing advertisements in free weekly newspapers and through the distribution of posters and flyers in community groups and community centres. Importantly, the recruitment did not make use of existing bisexual organizations or networks in the city of Montréal, in an effort to speak with individuals who may not be politicized about, and/or highly invested in, the naming of their sexuality.

The recruitment strategies yielded an overall sample population of bisexual women that was quite heterogeneous. Specific statistics related to the sample population include

- 17% of respondents were from ethnocultural communities; 3% were from Aboriginal communities[5]
- 90% of respondents were Francophone (French as a mother tongue), 10% were allophone (having neither English nor French as a mother tongue), and there were no Anglophone respondents
- the age breakdown of participants was as follows:

10-19:	3%	40-49:	13%
20-29:	50%	50-59:	10%
30-39:	23%		

- the sample had high levels of education: 83% of respondents had some college or university studies
- 67% of respondents had an annual revenue of less than $20,000

The research team (Namaste, Monette, and Vukov) conducted semi-structured, open-ended interviews with research participants, in a location selected by interviewees (e.g., their home, a café, an office located at Concordia University). Interviews lasted about an hour in most cases; some interviews were shorter or longer in duration. All of the interviewers had experience in Montréal's bisexual communities, whether in terms of organizing social events or involvement in local bisexual community organizations.

Importantly, the interviews were primarily concerned with interviewees' access to information and services related to HIV and STDs. Research participants were asked about how they accessed health information and services in general. Interviews also explored what kinds of HIV prevention education the subjects had been exposed to, as well as their overall impressions of such education. Finally, interviewees were asked to comment on the kinds of HIV educational materials that would be relevant to people who have sex with men and women. Participants were also presented with two recent educational campaigns in order to solicit their feedback. The focus in this study on the needs of participants with respect to *information* is a significant departure from many studies on HIV prevention, which typically ask people to discuss their sexual *behaviour*. Such studies thereby tend toward a bias in favour of research subjects who are at ease talking about their sexual behaviours, which does not necessarily offer a representative perspective on the communities in question. This particular research study was interested in learning about the kinds of information people identified as necessary, rather than an inventory of their sexual practices. Several participants expressed their relief at not being solicited to speak about their sexual practices and their appreciation at being asked to formulate their needs and responses to prevention approaches. In this sense, the study was able to elicit and include the perspectives of participants whose contributions would be excluded from studies focused on sexual behaviour.

Data analysis occurred in two primary stages. After the interviews were completed, the research team read through verbatim transcriptions. Drawing on the qualitative research framework known as *grounded theory* (Glaser & Strauss, 1967; Liamputtong-Rice & Ezzy, 1999), the research team then identified specific concepts that emerged from the interviews. Methodologically, the data analysis begins with the concrete pieces of empirical data from the interviews and moves to a much broader, more macrological analysis through a method of constant comparison. The principal concepts and explanatory categories that emerged from the data are presented below. This article focuses on the data explicitly related to what bisexual women participants thought about existing HIV education campaigns.

Seeking advice, consulting the community

From the outset, the research project was overseen by a community-based Advisory Committee, whose members are all listed as authors of this paper. Committee members are individuals with expertise and community experience in public health, bisexuality, swinger culture, and HIV/AIDS prevention. They include active members of local bisexual community groups (Bi Unité Montréal), the swinger scene, and HIV/AIDS organizations oriented toward ethnocultural

communities (GAP-VIES) and women (CRISS).[6] The Advisory Committee was responsible for taking the research results and using them to create relevant educational materials, effectively implementing the action component of this research (Lamoureux et al., 1984; Landry, 1993; Stringer, 1999). The committee produced different posters directed to bisexual women, swingers, and people who have sex with men and women, as a way to respond to the current gaps in HIV prevention. Specific elements of the posters directed to bisexual women are presented and discussed below.

The work of the Advisory Committee was central to the participatory elements of this research. The tradition of participatory action research, as well as that of community-based research, demands that a number of fundamental principles be upheld in the research process. Central among these principles are the notions of initiative, relevance, ownership, and equality (CAAN, 2001; Namaste & Jauffret, 2006).

Initiative refers to research that has emerged within a particular community. The issue to be investigated is one identified by members of a specific population. Research initiated in a particular community often asks different questions than research initiated within the university. Since members of the Advisory Committee have extensive organizing experience in Montréal's bisexual community, this research project was initiated within the target population.

Relevance refers to the idea that the research to be conducted is meaningful to a particular community: the importance of the research has been determined by members of a community. Members of the Advisory Committee, active in bisexual communities, swinger scenes, and public health, all identified the importance of good research and education addressing HIV prevention and bisexual behaviour. In this manner, the project was evaluated to be especially relevant. The action component of the project—the development of educational materials based on the interviews conducted—was deemed to be especially pertinent. This research would not merely describe a problem, it would offer some concrete solutions.

Ownership refers to the idea in community-based research that members of a community have a particular say as to how the resulting data are to be used and distributed. The involvement of Advisory Committee members in the development of educational materials, as well as the formulation of recommendations, are two concrete examples of how ownership of data is located in a community of people as opposed to the domain of one institutional researcher. Finally, the notion of *equality* designates the idea that members of a community and academic researchers are equal partners in the research process. This equality was negotiated at all stages of the research process: the development of interview questions, recruitment strategies, data analysis, formulation of recommendations. Furthermore, the presentation of all results—whether in oral or written form—involves all members of the Advisory Committee. These principles of community-based research reflect a specific feminist commitment to action research, in which the production of knowledge is yoked to political intervention and social transformation (Hesse-Biber & Yaiser, 2004; Morris, 2002; Reinharz, 1992).

The data offer some important results with regards to current HIV/STD education in the Québec context and provide direction for future educational initiatives. The results are presented here in four main areas: information; reflections

on existing educational campaigns; desired content for future HIV/STD prevention education; and linking prevention education to sexual health services.

HIV/STD information: Too much or not enough?

This research asked women how they find and make sense of HIV/STD information relevant to their sexual lives. The responses offered provide a useful overview and strong confirmation that there are significant gaps in our current understanding. Women diverged significantly in their analysis of the current situation: some felt that there was a wealth of HIV/AIDS information available in general, but that it remained difficult to find the precise information sought:

> Ben, ok, je vais t'expliquer de quoi de réel qui est arrivé hier. Je cherchais euh. . . parce qu'il y a quelqu'un que je connais qui a la chlamydia. Fait que elle là, elle a pas Internet. Donc, je suis allée sur le site, j'ai fait Chlamydia. Euh, j'ai trouvé des choses qui m'ont amenée à d'autres choses. En tous cas j'avais comme dix fenêtres ouvertes, pis il y avait rien qui répondait à ma question. . . . Internet, j'ai fait chlamydia, je suis allée sur Toile du Québec, je suis allée sur euh, euh. . . MSN, je suis allée sur Canoë. . . . Tsé, il y avait pas chlamydia: définition, symptômes. . . . Tsé, c'est ça je voulais moi. (A-1-7, p. 8, 329-354)
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> [OK, I'll tell you something that really happened. I was looking, because I knew someone who had chlamydia. And so she, she does not have Internet. So I went on the Web, and I found chlamydia. I found things that led me to other things. So in any case I had like 10 windows open, and nothing answered my question. The Web, I put in chlamydia, I went on the Toile du Québec, I went on MSN, on Canoë. . . . You know, there wasn't chlamydia: definition, symptoms. . . . You know, that was what I wanted.]

Building on this view that there was a wealth of HIV/STD information, some participants noted that the information available was contradictory. The challenge was not in finding information, but in being able to evaluate it properly.

> Parce que je veux dire souvent, le, l'information est contradictoire. . . . Il y a énormément d'informations aujourd'hui. C'est très facile d'en trouver de l'information. Mais laquelle est bonne?. . . C'est ce qui est le plus difficile. Je veux dire, sur Internet, tu tapes n'importe quel mot, ça te sort trois millions cinq cents milles quelque chose fichiers. Il y en a de l'information. Mais souvent il faut lire plusieurs aspects pour se faire une bonne idée c'est quoi du problème. (T-1-2, p. 4, 168-181).
>
> [Because I mean often, the information is contradictory. . . . There is an enormous amount of information today. It's easy to get information. But which one is correct? . . . That's more difficult. I mean, on the Internet, you put in any word, three and a half million dossiers come out. Information is out there. But often you have to read about many different aspects of an issue before you can get a good idea of what the problem is.]

As the quotation makes evident, women had difficulty accessing the specific information they needed with regard to their sexual health.

More specifically, respondents claimed that it was important to obtain reliable information about sexually transmitted diseases, not only about HIV. The most important need identified was for specific, practical information: the symptoms of an STD, its diagnosis, and its treatment, for example.

> Euh, je suis certaine que je vais mettre 5, 6, 8 personnes devant moi puis je vais leur demander de m'expliquer c'est quoi la syphilis. . . la plupart savent pas. Le monde, tout le monde a entendu ce mot-là, tout le monde en a parlé, a entendu parler des morpions, tout le monde a entendu parler de l'herpès. Mais c'est quoi? Ça s'attrape comment? C'est quoi incubation? C'est quoi la. . . Personne sait ça. (T-1-2, p. 8, 346-351).

> [Um, I am certain that if I put 5, 6, 8 people in front of me and I asked them to explain to me what syphilis is. . . most of them do not know. People, people have heard of that word, everyone is talking about it, has heard about crabs, has heard about herpes. But what is it? How is it transmitted? What is its incubation period? Nobody knows that.]

Overall, then, the women who participated in the study expressed a desire to see a more integrated approach to prevention information rather than a segmented focus solely on HIV as divorced from other STDs or matters of sexual health. In other words, they identified the need for a global approach to sexual health that would integrate HIV prevention into larger matters of STD prevention and sexual health in general, taking into account the need to respond in practical ways to the interconnected questions that arise around all of these in everyday life.

If the women named a need for practical information about HIV and STDs in general, this concern was amplified in considering their sexual relations with other women. Indeed, among the most salient findings to emerge in our research is that bisexual women could not find information about the risks related to STDs and HIV when they are having sex with other women. The lack of information on women-to-women transmission was reflected in the knowledge of participants, who offered contradictory responses as to the relative risks associated with sleeping with a woman: some women maintained that there was no risk whatsoever, while others cited personal experiences in which an STD has been transmitted between women.

> Q: Ok. Ok. Bon. Euh, est-ce que t'as des questions spécifiques concernant justement le VIH ou les infections transmises sexuellement?

> R: Euh, j'en ai, j'en. . . euh, comme je, je suis vraiment pu à date là-dedans, pis d'ailleurs je pense que je suis devenue ignorante ou je ne sais quoi. (rires). Euh. . . tout ce qui est euh, quand on fait l'amour oral, je pense et je suis plus sûre, qu'on peut attraper des maladies là aussi. Mais quelles sont ces maladies-là, j'avoue que je suis perdue. (A-1-3, p. 20, 824-831)

> [Q: Okay. Okay. Good.] Do you have any specific questions concerning HIV or sexually transmitted infections?

> R: Well, I, I, like I am not really all that up to date, and I think I've become ignorant or I don't know what (laughs). Everything that is, when

> we have oral sex, I think I am pretty sure that we can get diseases there as well. But what these diseases are, I admit I am lost.]
>
> I think I've got really inconsistent answers on (HIV transmission between) women. . . on lesbians. . . Hum. . . or. . . sexual practices that are or are not risky. . . . My doctor is one of the people that. . . that said something that (was) inconsist(ent). . . . Just really inconsistent. . . things about risk. . . and practices I guess. And you don't, you just don't. . . . I guess. . . safe sex with women was not an issue for me until I almost. . . . I was with a partner who told me after the fact, lied to me that she had herpes. Luckily I was unaffected but hmmmm, that really shocked me and I guess, since then I've taken it a lot more seriously, safe sex with women. . . . But before that, not at all. Not at all. (T-1-13, p. 9, 299-315)
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> Vu que je suis bisexuelle, avec un homme c'est (la prévention) quand même facile. . . . C'est les condoms. Mais pour les femmes, c'est pas évident.
>
> [Since I am a bisexual woman, with a man prevention is quite easy. . . . It's condoms. But for women, it's not obvious.]

These quotations emerge from a general context in which it remains difficult for women to find appropriate sexual health information about having sex with another woman. Two elements of this situation are to be underlined here: 1) it is difficult in general for women to find relevant information about transmission of STDs and/or HIV between women; 2) it is even more difficult for women to be able to evaluate the level of risk associated with different practices (for example, oral sex while one's partner is menstruating). In general, then, bisexual women do not have access to good information about their sexual health. This lack informs us about the implicit gendered bias of public health education, which to date has completely overlooked the education needs of bisexual women.

Existing educational campaigns in Québec as seen by bisexual women

The limitations outlined above can be further elaborated and confirmed by considering the reflections of bisexual women on existing educational campaigns. Participants were shown two advertisements for HIV education and asked to comment. One poster, part of a Québec-wide campaign produced by the provincial network of community AIDS organizations la COCQ-Sida (la Coalition des organismes communautaires québécois de lutte contre le sida), presented a variety of bed headboards arranged as tombstones in a cemetery with the caption "AIDS still kills" (« le sida tue encore »). The second advertisement, known as the "Think Again" or Assumptions campaign and part of a national prevention initiative, had a visual representation of two men in medium close-up placed in a way to suggest they are engaging in anal sex. The caption read, "He would have told me if he was positive. He would have told me if he was negative. How do you know what you know?" The objective of soliciting participants' responses to these advertisements was not to do a full-scale evaluation of these campaigns.[7]

Rather, it was to stimulate discussion and to get participants to talk concretely about what they did or did not appreciate in such education.

Some interviewees appreciated the shock tactics of such advertisements:

> C'était une bonne publicité. Très bonne euh. . . accrocheur comme j'ai dit tantôt, mais euh. . . moi je pense c'est la meilleure publicité qui a été fait à date pour montrer dans un cerceuil, oui ça mène jusque là. (T-1-6, p. 28, 1277-1279.)
>
> [It was a good ad. Really good. . . catchy as I said earlier but. . . I think that the best ad to date has been to show the coffin, that it leads to that.]

If some women felt that education needed to grab people's attention, many were vocal in denouncing an association of HIV with death. For them, educational campaigns that appeal to fear are ineffective.

It should be noted here that recent government and community organizational campaigns in Québec have made a strong return to messages and visual imagery equating HIV and death. For example, the official campaign directed to Québec youth in 2002 represented a variety of different images within a razor blade: a male/female couple, a syringe, and a male/male couple. The campaign slogan read, « Le sida circule toujours » (AIDS is still around). In 2003, the same slogan was found on posters that represented the same three target groups: heterosexual couples, gay male couples, and intravenous drug users. The 2003 campaign represented these people on a tombstone within a cemetery. The slogan « Le sida circule toujours » was inscribed on the tombstone itself, with its origin or "birth" date fixed at 1981. This particular campaign was the object of critical acclaim: the campaign has received no less than 13 different prizes for communication and design, and this internationally (Québec, Canada, the United States, Switzerland, Italy, England, France).[8] La COCQ-Sida's cemetery campaign that we showed to our interviewees is one of the most recent campaigns to adopt this approach. All of these examples, then, provide an overall context in which it is safe to say that HIV education in Québec tends to appeal to a fear of death. This fear-based approach to education is further visible outside the realm of HIV education, for instance in public advertisements related to tobacco consumption, alcohol, and driving.

Many of the bisexual women interviewed in our study were deeply critical of education that relied on fear as a motivating factor in behaviour change.

> Mais pas nécessairement que ce soit euh. . . tsé comme euh. . . percutant mais que ça te donne mal au cœur de regarder l'annonce là. . . . Il faudrait que ce soit plus de la sensibula. . . sensibilisation pis des, des bonnes photos là. Pas d'affaires de. . . . "On veut vous, vous écoeurer pis faites attention, pis on veut vous faire peur parce que attention, il y a la maladie," parce que moi je pense pas que ça marche ça. (T-1-7, pp. 34-35, 1546-1559)
>
> [But not necessarily that it is, you know, like, so catchy that it makes you sick to look at the ad. . . . There has to be more subtlety and good photos. Not things like, "We want to make you sick and so pay attention, we want to make you scared so pay attention, there is illness," because I do not think that this works.]

> Ça fait peur pour la sexualité des gens. Ça leur fait plus peur d'avoir des relations sexuelles que d'avoir. . . des relations protégées puis. . . c'est ça. (T-1-8, p. 12, 503-504)
>
> [It makes people scared with regards to sexuality. It makes them more afraid to have sexual relations than to have protected relations, and that's that.]

This clear rejection of a fear-based approach to HIV education raises serious questions about the limitations of existing prevention work in Québec. This rejection supports findings in the field of health communication that public health education that primarily appeals to fear as a means to alter people's behaviour is not effective (Tripp, 1988).

Building on this insight, the women interviewed stated that educational materials needed to be proactive and specific; they ought to provide people with practical information rather than a general message of protection:

> I think instead of telling you "You can die and you can die and you can die," you could be like. . . "If you die well this is how you stop it.". . . not just criticisms but proactives. . . like constructive criticism. . . . Okay, this is what you shouldn't do. . . but this is what you should do. Not this shouldn't, shouldn't, shouldn't, shouldn't, shouldn't. (T-1-13, p. 11, 375-380)
>
> HIV kills. . . We all know that. . .that we all know, but again there's no prevention, I mean. . . . There's not even a site where we could click on like. . . like no information where to get information for to protect. . . (T-1-14, p. 24, 823-827)
>
> Tsé quand on dit 10% de chance ou 5% de chance avec des relations sexuelles. C'est quoi ça? Pourquoi? À quel moment? Il faut le dire que, tsé tu peux avoir ça pendant tes menstruations. Ça non, je vois pas ça écrit nulle part. (A-1-12, p. 21, 922-925)
>
> [You know when we say 10% chance, or 5% chance with sexual relations. What's that? Why? When? You have to say it, you know, that you could transmit that during your period. That, no, I don't see that written anywhere.]

As the last quotation makes evident, the sort of practical information that participants expressed a need for would help give them the skills to evaluate the risks associated with different sexual practices and behaviours. Much more than a vague appeal to "protection," such an approach encourages people to take an active role in evaluating information about their sexual health and linking such evaluation to their practices.

Aside from a rejection of a fear-based approach to education and a desire for practical information, the bisexual women interviewed cited several limitations of existing prevention work. Referring to one advertisement that read, "Il me l'aurait dit s'il était séropositif" (He would have told me if he was seropositive), interviewees raised the important point that this technical language was unfamiliar to them:

> Parce que peut-être que c'est comme. . . peut-être que c'est un autre vocabulaire qui est comme fréquemment employé là, mais la séronégativité là ou les séronégatifs autour de moi là, c'est peut-être parce qu'il y a juste ça là, mais j'ai jamais employé ça, il y a jamais personne qui m'a dit je suis séropositif, jamais. (A-1-15, p. 38, 33-40)
>
> [Because maybe it's like. . . maybe it's like another vocabulary that is often used, but seronegativity or seronegatives around me, it's maybe just that, well I've never used that, never has someone told me, I am seropositive, never.]

The above comments indicate a general discontent with existing HIV education in Québec among the bisexual women sampled. Importantly, many of the women we spoke to offered sophisticated analysis of the ways in which public health messages are andocentric, reflecting the perspectives, interests, and biases of men.

According to the women interviewed, such a gendered bias occurs in two ways: firstly in representing men and not women:

> L'image aussi, mais c'est juste l'image c'est que. . . je veux dire, là tu vois deux hommes aussi souvent, souvent on voit comme deux hommes quand ils parlent de, d'homosexualité, tu vois jamais, rarement deux femmes là. (A-1-9, p. 52, 2371-2374)
>
> [The image as well, it's just that the image is. . . I mean, you see two men quite regularly, often we see two men when they talk about homosexuality, rarely two women.]

In the second instance, the women interviewed noted that public health information sometimes appeals to bisexuality—male bisexuality in particular—but that the specific information provided actually only deals with sexual relations between men. Thus, although the word "bisexual" may be used, the realities of sexual relations between men and women—including HIV/STD protection—are overlooked. The following quotation illustrates well the ways in which a public health conception of bisexuality is implicitly gendered:

> Ben c'est plus une annonce qui est pour les gais. . . . Tsé, "Il me l'aurait dit s'il était séropositif." C'est pas du tout focussé pour une femme. . . . C'est vraiment focussé pour les hommes. . . . Pour euh l'homosexualité. . . . C'est très bien focussé, c'est très bien ciblé.… Tsé. Mais c'est pas ciblé pour la bisexuelle. . . . Tu vas le focusser pour un homme bisexuel. Mais pas avec son approche avec la femme. Ça l'éduquera pas sur son ap, sur sa, son approche avec la femme. (T-1-2, pp. 42-43, 1906-1937)
>
> [Well, this is more an ad for the gays. . . . You know, "He would have told me if he was positive." It's not at all focused on a woman. It's really focused on men. . . . For homosexuality. It's really well focused, really specific. But it's not focused for the bisexual woman. You want to focus it for a bisexual man. But not with regards to his relations with a woman. It does not educate on his relations with a woman.]

In addition to a gendered bias, participants maintained that the existing education only represents a certain segment of the Québec population with respect to race and ethnicity. The women wanted to see images that were more culturally diverse:[9]

> Il faut que tu prennes des gens noirs, blancs, asiatiques, euh je veux dire, ces campagnes-là tout le monde est blanc tout le temps, tsé. . . . Pourquoi? Les asiatiques ils baisent pas? Les femmes musulmanes, elles baisent elles aussi. Tsé, je veux dire c'est comme on cible tout le temps les mêmes gens pis on dirait qu'on oublie tous les gens différents autour. (A-1-1, p. 20, 876-884)

> [You have to take people who are Black, White, Asian, I mean, those campaigns, everyone is always White, you know. Why? Asians don't have sex? Muslim women, they have sex, too. You know, I mean it's like we always focus on the same people and that we forget all the different people around them.]

These criticisms of current HIV prevention in Québec led the women to identify the specific content they think is necessary in order to educate effectively. The following section addresses these issues.

Desired content in HIV/STD prevention

The main elements identified by bisexual women as desirable for future HIV/STD prevention education are closely linked to the data presented above. Thus, in the first instance women stated that such work needed to begin with the recognition that HIV and STDs can be transmitted among women:

> Ben je pense que les filles euh bisexuelles ont plus tendance à faire attention avec les gars pis beaucoup moins avec les filles. . . . Tsé je pense que souvent les filles partent avec l'idée que. . . tu peux moins attraper des trucs entre filles, tsé. . . . Mais je sais que tu peux très bien attraper des trucs entre filles. . . . Pis on a tendance à plus se faire confiance entre filles, ce qui est un peu niaiseux finalement, tsé. (A-1-1, p. 49, 2223-2235)

> [Well, I think that bisexual women are much more likely to be careful with men and less likely to do so with women. . . . I think that often, women have the idea that it's harder to get something from a woman. . . . But, I know that you can get something from a woman. . . . And we have a tendency to trust more between women, which is in the end quite silly, you know.]

This quotation is quite revelatory. Indeed, while the transmission of HIV and STDs may be lower between women than between men, or between a man and a woman, a risk remains nonetheless. Many of the women participants reported having faced what many described as both implicit and explicit forms of dismissal from medical personnel when attempting to obtain information or services (STD testing, et cetera) that related to same-sex practices among women. Several women interviewed did not believe that any possibility of STD transmission between women existed at all. The women we interviewed stated that in not hav-

ing access to information or services related to these risks, they were unable to take an active role in their sexual health.

Moreover, they raise an important question about the moral and ethical responsibility of public health: the provision of information that is relevant to everyone's sexual lives. Several participants raised further questions and criticisms regarding the extent to which health providers employ the epidemiological framing of women-to-women transmission as low risk to effectively absolve themselves of the public health responsibility to offer effective information and resources to women around these questions when they are sought out. The current context of public health research and education, in which little attention (or even mention) is paid to transmission of infections between women, thus represents an important limitation.

The desire for concrete, practical information outlined above was echoed in the words of the women in terms of what kind of HIV education is needed. Critiquing the male bias of existing prevention, they maintained that women needed information specific to their sexual practices. In very concrete terms, they wanted information that moved beyond the issue of penetrative (penile/vaginal, penile/anal) sex:

> les risques de transmission euh pour euh autres que pénétration là. . . . Je trouve que, ben pour les, les moyens comme autres que pénétration c'est comme si c'est un peu flou là qu'est-ce qui, qu'est-ce qu'il y a à faire en ce cas-là là. (A-1-10, pp. 6-7, 211-276)

> [risks of transmission that are other than penetration. . . . I find that, well, for ways other than penetration, it's like a bit vague what is, what is to be done in such a case.]

> C'est souvent eux-autres qui, ils disent, Oui, on se protège. On se protège, il y a un condom sur le pénis. Mais, il y a plein d'autres choses à risque aussi. (T-1-2, p. 53, 2416-2426)

> [It's often they who say, Yes, we protect ourselves. We protect ourselves, there is a condom on the penis. But lots of other things are risk factors as well. . . .]

Yet the women were equally critical of attempts at HIV/STD prevention education for lesbians and bisexual women that were radically disconnected from women's sexual practices. Several women interviewed spoke of prevention education that encouraged women to use dental dams, pieces of latex rubber to be placed over a woman's genitals before oral sex. Study participants were adamant that women did not use these barriers, nor were they particularly interested in exploring their use for the future.

> Je veux dire, je suis consciente des risques, sauf que ça veut pas toujours dire que j'ai le goût de prendre la protection, tsé, parce que je le sais que ça va impliquer comme moins de plaisir ou. . . . Je te donne un exemple de prendre une digue dentaire avec une femme pour pas avoir d'Hépatite C ou des choses comme ça, ça me tente pas toujours. . . . Je sais qu'il faut le faire. . . . Tsé, je veux dire, j'ai été éduquée comme ça, je le sais qu'il

> faut le faire. Sauf que ça veut pas dire que c'est toujours intéressant à le faire. (T-1-2, pp. 33-34, 1506-1519)
>
> [I mean, I'm aware of the risks, but that doesn't always mean that I want to take the precautions, you know, because I know that will mean less pleasure. . . . For example, to use a dental dam with a woman who has Hepatitis C or something like that, I don't always want to use that. . . . I know one has to use it. . . . You know, I was educated like that, I know that's what one has to do. But that doesn't mean it's always interesting to do.]

The response of this interviewee tells us something important: HIV/STD education for women who have sex with women needs to begin with their current sexual practices. Advocating the use of dental dams establishes a significant barrier between public health education and individual women. Our interpretation of this data is not to say that there is no place for discussion of using dental dams in sex between women. Rather, we favour an approach that is both realistic, grounded in women's current sexual practices, and that provides women with the information and skills to evaluate the level of risk associated with different activities and to assume responsibility for their actions. Thus we feel that HIV/STD prevention for women who have sex with women should not emphasize the use of dental dams. Rather, education could address it as one possible strategy, one especially useful if a woman would like to be assured of *almost no risk* of HIV/STD transmission. Such an orientation is in line with prevention approaches to oral sex between men, which consider the practice of fellatio to be relatively low risk (given a healthy mouth) and which encourage men to make informed choices about the practices with which they are comfortable. Although this concept of risk management is clearly in place for HIV/STD education between men, our data suggest that it has yet to be taken up in education about woman-to-woman transmission.

Linking prevention education to sexual health services

One additionally significant finding from our research relates to the delivery of sexual health services—for example, where to get tested for HIV or what clinics offer treatments for STDs. The women we interviewed said that the challenge was more than a vague appeal to "protection." They said that they needed access to services more generally. Several women also noted that they had previously found themselves in situations where they had to take on the role of educating and challenging health providers in attempting to obtain information and services related to a range of bisexual practices, particularly with respect to woman-to-woman transmission and multiple partners.

However, if they were not already aware of the services that existed in this area, or had had previous negative experiences in accessing services, they were at a significant loss as to how to proceed:

> C'est comme. . . ok, des pamphlets ça peut t'informer mais ça va pas euh. . . régler, si t'as un problème ça va pas te. . . t'aider à trouver comme la solution tsé. Pis j'avais déjà essayé de, d'aller faire un test du sida, mais je le savais pas où. . . . J'ai essayé d'aller au CLSC pis là je. . . ça marchait pas comme, pis il fallait aller voir le médecin avant pis ça me

> tentait pas. Fait que des fois c'est un peu dur d'aller chercher le. . . . Ben en fait d'avoir la solution. Parce que t'as plein d'informations mais quand tu veux avoir la solution ou, tsé. . . vraiment, qu'on puisse t'aider, ben là c'est peut-être un peu plus difficile. (T-1-7, pp. 11-12, 489-504).
>
> [It's like. . . okay, pamphlets they can inform you but that's not going to solve, if you have a problem that's not going to, you're not going to find the solution like that, you know. And I tried, to do an AIDS test, but I did not know where to go. I tried to go to the CLSC and, it just didn't work, you had to see the doctor before and I did not want to. So sometimes it's a little hard to find the, well in fact to find the solution. Because you have lots of information, but when you want to have the solution, you know? Really, that you can get help, well, that's a bit more difficult.]

This respondant echoes the point made in the first section of this article, that there is a wealth of information available concerning HIV prevention. In addition to lacking the skills to evaluate all of this information, the women we interviewed stated that they required knowledge about the different health services that could provide relevant and informed health care. In practical terms, they suggested that a poster have a contact phone number and a website. They also expressed the need for longer-term effort to develop a network of sexual health care providers who are well trained and informed on matters of bisexual health. In this way, the women felt they could access information not only about prevention, but about appropriate services and organizations. Moreover, by facilitating their access to existing services, such a strategy would develop their skills in being able to evaluate available prevention information. In speaking with someone on a telephone line, or in consulting health services directly, women could get concrete answers to the questions they posed about the risks of transmission between women.

Action research: Development of educational posters

Having examined the data gathered through this study, the Advisory Committee of the research project took on the formidable challenge of creating educational materials that could fill in some of the most salient gaps in education. A number of different posters targeted to bisexual women were developed. The posters use two different slogans. The first reads, "I know what safer sex is with him, but with her?" The second slogan reads, "My girlfriend says I can't catch an STD from her. My boyfriend is clueless about these things. What do you think?" All of the posters include a telephone number for a local HIV/STD information line, as well as a website created specifically for *Projet Polyvalence*. The website (www.polyvalence.ca) includes relevant information about HIV and STD transmission, sexual health services, Montréal resources related to bisexuality and swinging, and a summary of the research study. The posters are to be distributed in cafés, bookstores, bars, and community centres of Montréal. Future work in this area (dependent on securing external funding) includes a mass media educational campaign in Montréal using these educational materials. Several of the posters developed for bisexual women are shown here.

Examples of HIV/STD educational materials produced by *Projet Polyvalence*

The posters endeavour to address some of the salient issues identified by our research participants. In the first instance, they recognize that there is a lack of information on HIV/STD transmission between women and encourage people to reflect on their knowledge. Yet they also provide a clear link to a website where they can find additional information, as well as a telephone line where they can ask their questions directly. In this regard, the posters link education to services, as requested by study participants.

On a technical level, the posters use the abbreviation "STD" rather than "STI," since the vast majority of the women we interviewed were unfamiliar with the term "STI" and since they maintained that education needs to speak the language of everyday people. Such an approach goes against the grain of much public health research and education, in that it does not advocate the more technically correct collocation "sexually transmitted infections." This orientation is closely linked to the data, however. The women we interviewed expressed discomfort and confusion about education that was deeply embedded in the language of public health discourse: they did not understand the term "seronegative," for example, and often completely misunderstood the intent of a

campaign because of such technical, specialized language. This is an important lesson for public health: researchers and educators need to be cautious about speaking in terms that are familiar to those working in public health but quite foreign to everyday people (Aguinaldo & Myers, 2006). Our decision to use the abbreviation STD (rather than the more recently adopted technically accurate public health term STI) reflects a commitment to speak the language spoken by the women we interviewed, who represented a diverse range of ages and origins. Public health education can only be strengthened to the extent that its language reflects the values, meanings, and worldview of everyday people (Massé, 1995).

The analysis of HIV prevention education put forward by the bisexual women in this study raises important questions for rethinking prevention education more broadly, including but not limited to the realities of bisexual men and women. Research in the field of HIV frequently asserts that education efforts have been successful in increasing awareness of AIDS (Adam, Sears, & Schellenberg, 2000). At the same time, some critical work also suggests that most studies begin with the unproblematic assumption that there is a rational link between information and behaviour: that the challenge is to provide people with the information necessary to protect themselves against the transmission of HIV, and they will act accordingly (Adam, Sears, & Schellenberg, 2000). This position is contradicted by the most current research in the field, which clearly indicates that merely offering information does not translate into behaviour change (Adam, Sears, & Schellenberg, 2000).

The results of *Projet Polyvalence* are instructive here. In the first instance, our research results underline that for people who have sexual relations with men and women, much work remains to be done to ensure that basic information concerning transmission of HIV and STDs is available. Moreover, participants offer useful suggestions for reorienting prevention education itself. They insist on the need to provide information that is not general or vague ("protect yourself") and that addresses the complex realities of sexual relations with men and women. Such results are consistent with other research in the field of HIV that argues there is a need to offer information specific to different sexual practices (anal sex, oral sex, analingus) (Adam, Sears, & Schellenberg, 2000). The participants of *Projet Polyvalence* go further than much of the crticial literature in HIV prevention, however. They contend that in order to have a real impact on people's everyday lives and behaviours, prevention education needs to be explicitly linked to sexual health services. This insight moves HIV prevention—as well as HIV research—in important new directions.

Conclusion

The bisexual women interviewed in this study maintain that they are not able to access the information they need and understand this lack as stemming from the subtle gender bias of public health that inevitably equates bisexuality with men. Participants offered important feedback on the limits of existing educational campaigns: transmission between women has been completely overlooked; such campaigns are fear based and do not facilitate the practical adoption of safe sexual practices; there is a need to educate about STDs in addition to HIV as part of an integrated approach to sexual health; prevention efforts need to speak the

language of everyday people; and it is important to provide concrete, practical information. Moreover, the participants of our study strongly expressed the need for prevention education to be linked to sexual health services more generally. Based on these results, the research project's Advisory Committee developed a series of educational materials that begin to address some of the major limitations in prevention education. In addition to the prevention materials developed to address some of the needs defined by the bisexual women interviewed by the project, the project is in the process of developing materials targeted to the two other networks of people with bisexual practices interviewed for the project using the same participatory approach: swingers and people who have sex with men and women without necessarily adopting a bisexual identity. In this way, *Projet Polyvalence* has sought not only to document gaps in current HIV/STD education for bisexual women and others with bisexual practices. Grounded in a participatory action research approach, Polyvalence also seeks to intervene in the existing situation.

Notes

1. We use the acronym STD as opposed to the more technically correct term STI as a way to ensure that our findings are grounded in the realities and worldviews of study participants. The women we used did not know what the term STI meant, and expressed a desire for public education to speak the language they know and understand. These issues are discussed in greater depth in the analysis section of this article.

2. The exception to this gendered bias is the popular stereotype and sensational focus on the "innocent" female partners of secretive, lying bisexual men also widely promoted in the media through such phenomena as the "down low," discussed further below (see also Miller, 2002).

3. This epidemiological erasure of bisexuality parallels findings from recent legal and sexuality scholarship that show a corresponding erasure of bisexuality from legal, psychological, and scientific categories (Hutchins, 2005; Rehaag, 2006; Yoshino, 2000).

4. Some of the few publicly available public health campaigns undertaken with respect to bisexuality and HIV/AIDS are documented on *Projet Polyvalence*'s website at http://www.polyvalence.ca/e/outside.html. These include small-scale community prevention campaigns produced by Fenway Community Health Center in Boston, Massachusetts; the community groups Bi'Cause and Couples Contre le Sida in France; and Deutsche AIDS Hilfe in Germany.

5. « Les communautés culturelles » or « ethnoculturelles » is the predominant terminology employed in Québec to designate Québécois communities not of French-Canadian, Anglo-Saxon, or Aboriginal descent.

6. Groupe d'action pour la prévention de la transmission du VIH et l'éradication du SIDA (GAP-VIES) is a service organization largely oriented toward Montréal's Haitian and African communities; Centre de ressources et d'interventions en santé et sexualité (CRISS) is a community organization working with women living with or affected by HIV.

7. For an evaluation of the "Think Again" campaign, see Lombardi and Leger (2006).

8. See the website of the government agency responsible for HIV/STI issues in Québec, le SLITSS, le Service de lutte contre les infections transmissibles sexuellement et par le sang, Ministère de la Santé, Gouvernement du Québec: http://msss.gouv.qc.ca/sujets/prob_sante/itss/index.php?campagnes_information [May 30, 2006].

9. The call for ethnocultural diversity in visual HIV prevention can also have negative consequences, possibly reinforcing associations of non-white bodies with disease and contamination. For an overview of these issues within a context of HIV prevention, see Lawson, Gardezi, Calzavara, Meyers, Husbands, Tharao, Adebajo, Taylor, George, McGee, Remis, Wambayi, & Willms, (2006).

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